UNIVERSITY OF CAPE COAST

FACTORS INFLUENCING NURSES' ATTITUDE TOWARD PATIENTS REQUIRING EMERGENCY CARE IN THE CAPE COAST METROPOLITAN HEALTH FACILITIES

ANASTASIA EPHRAIM

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BY

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DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this University or elsewhere.

Candidate's Signature…….. Date…….

Name: Anastasia Ephraim

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature…… Date……

Name: Mr. Frank Bediako

Co-Supervisor's Signature……. Date……

Name: Dr. Joseph Kwesi Ogah

ABSTRACT

The aim of this study was to assess the factors influencing nurses' attitude toward patients requiring emergency care in Cape Coast metropolitan health facilities. The objectives of the study were to determine nurses' attitude towards caring for patients requiring emergency care, to determine the degree of work satisfaction experienced by these nurses and how such attitude differs by patient characteristics, nurse characteristics, job satisfaction and institutional factors.

One hundred and fifty nurses working in the emergency units of hospitals in the Cape Coast Metropolis participated. With the help of four student nurses the questionnaire was administered to all the nurses stationed at the emergency departments of hospitals in the Cape Coast Metropolis.

Attitude to care was significantly influenced by age (0.41), sex (0.031) rank (0.01) and working experience (0.39). Nurses felt more comfortable dealing with victims of abuse and more objective in their interventions for those families. Results from the study was contrary to previous researchers, in-service education have no influence on attitude. This is because the f-statistic (F [2, 147] = 3.10) with a highly significant value of 0.048 is less than 0.05 level of significant in the analysis of correspondent's take on the influence of in-service education on nursing care. The deduction is that general life satisfaction greatly influences the attitude of nurses towards patients with emergency needs. Negative attitudes towards patient care persist and are influenced by personal characteristics of nurses and institutional factors.

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DEDICATION

To my son, Samuel Nii Ayitey Quaye, and my dear mum, Mrs. Anna Ephraim. Their inspiration and support have seen me through.

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CHAPTER ONE

INTRODUCTION

Background to the Study

The goal of emergency care is to save lives of patients with life threatening but reversible medical and surgical conditions and offer the dying a peaceful death. Open discussion between nurse and patients, the nurse and patient relatives will ensure that appropriate care is provided in a manner most consistent with the patient's wishes and that which will have positive impacts on patient's health status.

In the 1970s and early '80s, there was an emergence of a number of specialties in Nursing Practitioner (NP) practices. While these specialties focused mainly on primary care,there was no specialty focused mainly on the acutely ill population. This population was ultimately cared for by one of the primary care NPs working in a specialty sector but not one that specifically focused on acute and/or critical care. The American Nurses Association and the American Association of Critical Care Nurses recognized a developing NP role and created a task force to define the scope of practice and standards for the ACNP (NONPF, 2004). This would identify the practice capacity of the ACNP in the critical care setting. ACNPs now have become employed in all types of intensive care units (ICU): cardiothoracic, coronary, medical, neurological, surgical, and transplant. Working in the ICU setting was the original idea for the ACNP (Kleinpell, 2005). However, the ACNP has recognized the need for expanding their role in the ICU and other practice settings. Howie-Esquivel & Fontaine (2006) describe the evolving role of the Acute and Critical Nurse

Practitioner (ACNP) in critical care, as the nurse who desire to gain greater knowledge about the patients they routinely carefor. In the early 1990's, nursing schools began to offer NP programs that specifically focused on acute and/or critical care.

This expansion includes administrative responsibilities, teaching, research, program development, quality assurance, and department projects (Kleinpell, 2005). Family and Adult NPs in Emergency Care NPs began practicing in the Emergency Department (ED) in the 1970s (McGee & Kaplan, 2007). The initiation of nursing practice in the ED stemmed mainly from the problem of overcrowding. Nurses were introduced to streamline care for those who presented to the ED for non-emergent situations, thus to improve the efficiency and care of the physician in the ED (McGee & Kaplan, 2007).

The health sector has had concerns with poor quality of service and the nurse seems to be the most accused. Most authors on health care quality assurance recognize that health care is only in part a technical process and that however complex the medical technology, it is delivered by a person to a person. No patient's treatment is devoid of face-to-face contact with the practitioner. In line with this, various workshops on implementation of quality assurance have been held at all regional levels and most districts (GHS, 2005).

There has been a wide public expectation on the Ghana health sector on various aspects such as the provision of prompt, humane, non-discriminatory and effective services that would promote adequate patient recovery from health problems (Akosah, 2001). Contrary to these expectations, it is a common phenomenon to find patients and their relatives as well as some media personnel expressing displeasure regarding the unfavourable attitude of nurses,

most especially in the Ankaful Psychiatric Hospital (DHMT, 2009). Whilst some patients report that nurses often neglect them in the hospitals, others are of the view that nurses speak rudely to them, do not regard them as human beings, deliberately delay in attending to their needs, sell drugs which ought to have been served free, render preferential services especially to the richer patients and occasionally threaten to physically assault patients.The key challenges to improved quality of care in health delivery facilities are inadequate standards, non-adherence to existing standards, and inadequate skilled personnel (Adams, 2002).

Emergency departments nationwide are seeing acutely ill patients enter their doors frequently. The level of patient acuities is climbing, resources are decreasing, and insurance reimbursement is being linked to patient satisfaction (Medicare, 2013). It is more important now, perhaps more than any other time in healthcare, to appreciate the factors that influence nurses at the emergency departments. By understanding factors that influence overall job satisfaction a nurse experiences at work, perhaps this research may raise awareness of qualities which may help nurses maintain caring relationships and positive attitudes.

Statement of the Problem

In today's ever-changing health care environment, health care providers must work together to increase the ability to deliver safe and effective care that is accessible and cost-effective. Collaboration is needed between the public, clients, nursing regulatory bodies, employers and government in order to ensure the public's need for safe, accessible, affordable health care and to maximize utilization of nurses (WHO, 2005).

Major emergencies, disasters and other crises are no respecter of national borders and never occur at convenient times. The magnitude of human suffering caused by these events is huge, and many aspects of people's lives are affected – health, security, housing, access to food, water and other life commodities, to name just a few. Although many emergencies are often unpredictable, much can be done to prevent and mitigate their effects as well as to strengthen the response capacity of communities at risk.

The reviewing and evaluation of current trends about rights in health care system have revealed that as the public becomes more informed about issues in health care, there is a corresponding increase in public complaints regarding the practice of nursing. Often, these complaints seem to stem from a "systems" problem or issue that is specific to a health care facility or organization rather than practice issues that may be against the Nurse Practice Act. While the nursing board has no authority over individual health care facilities or organizations it does have the right, per rule, to issue a comment to its members that appear not to be practicing for the ultimate safety of their patients (WHO, 2005).

It is vital to have emergency plans in place, so that the effects of disasters on people and their assets can be mitigated, and a coordinated response may be launched as effectively and efficiently as possible when disasters or other crises strike. The aim is to save lives and reduce suffering. The government has become increasingly aware of the need to prepare the population to respond to emergencies, including those involving hazardous chemicals, to help protect and preserve human resource. There is the need to form local emergency responders who need to be educated on the types of

accidents and their management, possible chemicals involved and how they should be stored at in the homes (GHS, 2005).

Purpose of the Study

The study aims to exploring the psychosocial attitude of nurses to clients requiring emergency care. I aim to understand their attitude towards patients who present in the emergency department with their emergency needs and to know the factors that influence care and care outcomes. I hope to find out reasons for the negative or positive attitude nurses. My interest also was to find out how their working environment, workload, training and working experience contributed to their attitude.

Research Questions

1. What is emergency nurses' attitude towards emergency patients?
2. What patient characteristics determine nurses' attitude towards emergency patients?
3. What personal characteristics influence nurses' attitude towards patients with emergency needs?
4. How does level of job satisfaction influence nurses' attitude towards patients with emergency needs?
5. How do institutional factors influence nurses' attitude towards emergency patients?

Significance of the Study

Cultural barriers including allegiance to traditional models of ward care and fear of criticism may restrict use of a medical emergency team service, particularly by nursing staff. Nurses in the accident and emergency units care for patients from different races, cultures, and ethnic backgrounds. Because of

this, it is imperative that nurses appreciate and respect ethnic views of health and illness as they care for culturally diverse individuals.

It is not understood that for a lot of people, healthcare is more than just a question of physical illness. It could have a whole mental, psychosocial component to it; there is just too much fragmentation to try to treat these folks for their physical problems while ignoring the psychosocial stresses. If someone has high blood pressure and they have a very stressful life, all the medication in the world is not going to help. The physician sees the patient in the clinic, but nobody knows what the patient's home situation is like. So, social service and outreach programs which bring those services to the healthcare team are important in terms of treating the patient on a holistic basis.

To address current issues, focus is on nursing practice and education while keeping an eye on the future. In order to plan and predict the possibility of new, improved or revised programs and regulations that will positively impact the citizens of our state there must be an evaluation of current activities. To this end the Nurses and Midwives Council has been meeting over the last year to come up with a three-year plan that will address issues of advancing nursing systems, maximizing effectiveness for public protection and maximizing service to our public. Other issues that we see from the public appear to stem from a "customer service" viewpoint.

Patients' characteristics, nurses' characteristics, institutional factors and overall job satisfaction may have severe professional consequences in addition to affecting a nurse's personal well-being. These factors can affect nurses' the ability to care for others, affect nurse retention, patient safety, and patient satisfaction (Burtson & Stichler, 2010; Hooper et al., 2010; Potter et al., 2010;

Vahey et. al, 2004). Understanding the factors that contribute to nurses attitude to patients requiring emergency care and improving early recognition of precipitating factors may help ED nurses maintain their ability to experience work fulfillment and contribute to patient satisfaction. Identifying trends and contributors to work life satisfaction is also an important element which may be used to educate nursing management in best ways to support and uplift nursing standards.

Delimitation of the Study

The study focuses on the attitude of nurses in the Central Regional Hospital to patients with emergency needs. Though there are a lot of issues in the nursing profession, among them are inadequate staffing when considering patient to nurse ratios, poor working conditions with regard to the unavailability of equipment and other resources, accommodation for staff, and motivation. Despite all these problems in nursing, research into the attitude of the practitioner to patients with emergency needs is being addressed owing to the fact that the profession evolved from an empathetic view that seeks to meet the needs of the client regardless of the cost to the provider.

Limitations of the Study

The study is primarily on the nurse's psychosocial attitude to patients with emergency needs in the Cape Coast metropolis in the Central Region. Due to the sensitive nature of the matter, and the ethical implications on their professions, the items of the questionnaire might not receive the most accurate of answers thus the objectivity of the study might be compromised.

Definition of Terms

Care: Relieving the suffering of individuals, families, communities, and populations by providing, protecting, promoting, and advocating the optimization of health and abilities.

Emergency Care: Emergency care is provided by clinical care personnel operating in a medical treatment facility. They usually work in an ED or equivalent military facility, evaluating and or treating patients before they are discharged, admitted to an inpatient facility, or deceased. They may include physicians, advanced practice nurses (e.g. nurse practitioners, nurse anesthetists), emergency nurses, physician's assistants, and military corpsmen.

Triage: The sorting of and allocation of treatment to disaster victims according to a system of priorities designed to maximize the number of survivors.

Burnout:psychologicalterm for the experience of long-term exhaustion and diminished interest.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

This chapter is dedicated to the review of related literature on the topic. The works of earlier researchers have also been reviewed to show differences and similarities in findings, purposefully to compare and validate findings of earlier researchers with the current study. It examines the concepts under the topic such as:

1. Emergency Nursing and Attitude of emergency nurses
2. Characteristics that determine nurses attitude
3. Attitude of emergency care nurses
4. Level of job satisfaction influences nurses' attitude
5. Institutional factors that influence nurses 'attitude

Emergency Nursing

Emergency Nursing is a nursing specialty in which nurses' care for patients in the emergency or critical phase of their illness or injury.In contrast to practically every other specialty of nursing, in which a patient arrives with a diagnosis applied by a physician and the nurse must manage the patient's care according to that diagnosis, emergency nurses work with patients in whom a diagnosis has not yet been made and the cause of the problem is not known. Emergency nurses frequently contact patients in the emergency department before the patient sees a physician. In this situation, the nurse must be skilled at rapid, accurate physical examination, early recognition of life-threatening illness or injury, the use of advanced monitoring and treatment equipment, and in some cases, the ordering of testing and medication according to "advance

treatment guidelines" or "standing orders" set out by the hospital's emergency physician staff. Emergency nurses most frequently are employed in hospital emergency departments, though they may also work in free-standing urgent care clinics(Wikipedia, 2011).

The term Emergency Medical Service evolved to reflect a change from a simple transportation system (ambulance service) to a system in which actual medical care occurred in addition to transportation. In some developing regions, the term is not used, or may be used inaccurately, since the service in question does not provide treatment to the patients, but only the provision of transport to the point of care. The Emergency Department (ED) provides guaranteed 24/7 care for patients with illness and injury of all severities and in all age groups. The workforce providing such care includes Emergency Medicine Consultants, middle grades (trainees and staff grades/associate specialist) and junior doctors together with Emergency Nurse Practitioners. Increasingly, such care is led and directed by Emergency Medicine Consultants into the evenings and weekends when the Emergency Departments are often at their busiest.

The accident and emergency department has been described as the shop window of the hospital. For some patients it will be the only time they have been to the hospital and for others first impressions of the hospital are gained in the department. This means that the maintenance of high standards of care is particularly important since the rest of the hospital's nursing staff may be judged by the standards of those in this small area. Various researches have been carried out to confirm nurses' attitude to patients. This chapter reviews studies that are relevant to the study into the reasons behind the attitude of the

nurses to patients' emergency needs(Hospice Nurses Association Standards and Accreditation Committee, 1995).

Emergency Medical Service is provided by a variety of individuals, using a variety of methods. To some extent, these will be determined by country and region, with each individual country having its own 'approach' to how Emergency Medical Service should be provided, and by whom. In some parts of Europe, for example, legislation insists that efforts at providing advanced life support (ALS) services must be physician-led, while other permits some elements of that skill set to specially trained nurses, but have no paramedics. Most clients have sustained minor injuries such as sprains, small burns or lacerations which will not necessitate their admission to hospital. Some may require treatment under local anaesthetic, for example to suture a wound or drain an abscess; others will be x-rayed or have their wounds cleaned and dressed or given an anti-tetanus injection before being allowed to leave (Nandi, 1973).

Hospitals in the inner cities tend to receive fewer patients with minor traumatic injury because of the relatively slow traffic speeds in such locations but any department situated near a major road will frequently be dealing with the victims of road traffic accidents. Such patients may sustain severe and multiple injuries which sicken even the most experienced members of staff. Also, burned patients can be upsetting to deal with, particularly if the burns are painful, as many are, or if the patient is a child (Hospice Nurses Association Standards and Accreditation Committee, 1995).

Studies have identified negative attitudes of registered nurses and nursing students toward geriatric nursing and general care of older patients.

These attitudes have prevailed into the 1990s and highlight the low status associated with working with older patients. Gerontological nursing is still an unpopular specialty and nursing students' interest in pursuing it as a career decreases during their education. Social developments and ageist stereotypes combined with increases in the aged population have significantly influenced the health care system (Courtney, 2010).

Emergency patients include huge numbers presenting with potentially significant symptoms, for example: headache, chest pain, abdominal pain, collapse of unknown cause. It is the role of the Emergency Department to establish the underlying diagnosis and arrange victims correct subsequent disposition. The Emergency Department also lead in time, in the management of critical interventions for example: Leading trauma teams for the severely injured patient. Another pivotal new development in modern Emergency Medicine practice is the role of the Clinical Decision Unit (CDU), providing focused protocol-driven care for a range of patients who would otherwise be admitted into a scarce and expensive hospital bed or discharged home precipitately and possibly unsafely. The benefits of this type of "observation medicine" provide care for patients presenting with conditions such as minor head injury, head injury plus alcohol intoxication, low risk chest pain patients, asthma, collapse of unknown cause in the frail camp; elderly, self-harm etc. The maximum length of stay for patients on the CDU is 24 hours with many patients staying for less than 12 hours (Hospice Nurses Association Standards and Accreditation Committee, 1995).

The role of the Emergency Department is therefore increasingly important and each local health economy should ensure staffing and skill

mixed and tailored to meet local demands. Most Emergency Departments remain significantly understaffed at senior level and there is an urgent need for expansion, supported by a robust body of evidence confirming the clinical and cost benefits resulting from such modest investment. It is no longer a surgical or orthopaedic based specialty. Our patients include the critically ill and injured, less serious illness and injury, children which comprise of approximately 25% of most Emergency Department attendances, mental health problems etc. In particular, Emergency Medicine provides care for the undifferentiated patient presenting with symptoms which may be significant for underlying serious pathology for example headache, chest pain, abdominal pain and the febrile child. It is now understood that such patients presenting to the ED are far more likely to have significant underlying disease than those who attend general practice (Hospice Nurses Association Standards and Accreditation Committee, 1995).

Skilled services are provided by or under the supervision of registered nurses following a medically approved plan of care developed by the Emergency Unit. Nurses are adept in the art and science of pain and symptom management and have well-developed physical assessment and evaluation skills. Other services include administration of medication and treatments, emotional support, and patient and family education and instruction. Each Nurse Care Manager maintains contact with the patient and family and other healthcare providers across the continuum of care should the patient require services outside the home setting (Hospice Nurses Association Standards and Accreditation Committee, 1995).

The nurse collects patient and family data through the assessment of the patient's physical, emotional, spiritual, social, psychological, and cultural status. The nurse assesses the patient's and family's coping strategies, support system, and learning needs in collaboration with other members of the team. The scope and intensity of reassessment is determined by on-going and systematic evaluation of the patient's needs and family condition. Real or potential problems to be addressed are derived from analysis of the multidimensional assessment data collected by the team and validated by the patient and family (Hospice Nurses Association Standards and Accreditation Committee, 1995).

Nurses frequently give education, treatment, instructions or screen patients before they are seen by a physician. As a consequence, they interact with patients just as a physician do and in the course of their practice, must explain disorders as well as their diagnosis, prognosis and treatment. Other advanced practice of nursing with emergency care include certified nurse midwives, who are responsible for some obstetrical care and births; clinical specialized area, such as cardiac or cancer care, mental health, or neonatal health; and certified registered nurse anaesthetists, who administer anaesthesia (Hospice Nurses Association Standards and Accreditation Committee, 1995).

Nandi, (1973) studied the development of an in-service education program for the preparation of nurses expected to work in the burns unit of the hospital. The objectives of the study were to find out the expected knowledge and the skills for the nurses to work effectively in the unit, and find out the nurses' knowledge and skills which they are already possessing. The method of an opinionnaire and the questionnaire checklist and the investigator arrived at

the conclusion that nurses' pre-service preparation is not adequate to function effectively in the burns unit and may need in-service training (Nandi, 1973).

Ben-Sira (1980), and Ware and Daves-Avery (1978) have observed that more often people judge the adequacy of their care by the criteria that are irrelevant to the technical quality of the care. Although we might discern a case of blatant incompetence, most of us are insufficiently knowledgeable about medicine and standards of practice to know if we have been treated well or not. Most of the time, success is judged by whether the symptoms of the disease have improved – a criterion that may be only somewhat related to good treatment. What people do know is whether he or she was warm and friendly or cool and non-communicative. When people are asked what is important to them in their medical care, they rate the manner in which their care is delivered at least as high as or higher than technical quality in care (Hall & Dornan, 1998).

Webster-Stratton, Glascock and McCarthy (1986) also studied nurses' styles in interactions between 35 paediatric nurse practitioners from 13 states and the mothers of the children. These investigators did a detailed content analysis of audiotapes of the pediatric practitioners. In analyzing the tapes they found that the interaction between the paediatric nurses and the mothers were dominated by the nurses' questions, commands and opinions. Rarely were the mothers encouraged to ask questions, solve problems and disclose their knowledge. The nurses rarely touched on the emotional aspects of the child's health. The investigation acknowledged that the nurses demonstrated social distance and authoritativeness on their part to the client.

In Australia a recent study shows that many health practitioners have a very bad attitude towards substance abusers (Grace, 2009). They stereotype them in ways that preclude the possibility of interventions directed at helping the problem of substance misuse. Levitt, Baganz, and Plachy (1963) revealed that health professionals attitudes are clouded by the attitudes that emanate from society, these beliefs are internalized and it becomes part of their belief system. Society in general views substance abusers as deviant and beyond help.

Moodley-Kunnie (1988) stated that the attitudes and beliefs that health professionals have are mostly from the beliefs that society perceives of certain substance abusers that they may know. There is a generalization of the substance abuse community that is being carried forth into the perceptions of health professionals. It is due to these attitudes that society collectively has about substance abusers which ultimately hinders the progress of intervention. As a result nurses and practitioners feel that interventions are not part of clinical practice.

A survey including a 21-item AIDS Attitude Scale measuring the constructs of avoidance and empathy to describe the nurse attitudes and care practices related to such patients has shown that nurses have relatively low avoidance and high empathy and hence, are comfortable treating such patients (Baylor & McDaniel, 1996). But, nurse's awareness, fear and emotions do play a role in determining the comfort level. A study to determine nurses' knowledge, attitudes and overall level of comfort in giving nursing care to acquired immune deficiency syndrome patients and identify the socio-demographic variables that influence nurses' attitudes has shown that nurses with low levels of knowledge show negative attitudes towards people with

acquired immune deficiency syndrome and other STDs. Nurse's specialty, rank, prior education and experience with patients have been shown to influence their attitudes (Oyeyemi, 2006).The positive beliefs and values about sexuality of nurses do play a role in shaping nurse attitudes in STD care.

The existing literature supports a link between nurse attitudes and the care they provide their patients (Sullivan, 1995). Plumlee an author in the field of nursing education, states (in Sullivan 1995) that an accepting, non-judgemental, caring attitude is essential when treating patients with alcohol problems, yet, moralistic, stereotypic, pessimistic, and ultimately counterproductive attitudes still endure.Even more significant, since people are poor judges of technical quality in care, is to judge technical quality on the basis of the manner in which care is delivered (Abdella&Levene, 1965). A warm, confident, friendly practitioner is often judged to be both nice and competent where a cool, aloof practitioner may be judged less favourable, as both unfriendly and incompetent.

Patients Characteristics that Determine Nurses Attitude

On the surface, the hospital environment, specifically the emergency unit is an unlikely setting for effective communication. A person who regards himself as ill must communicate that fact to another person who is often a stranger (the nurse); he or she must respond to specific and difficult question and then be content to be poked and prodded while the diagnostic process goes on. At the very least it is difficult to present one's complaint effectively when one is in pain or has a fever, and the patient's ability to be articulate may be reduced further by any anxiety or embarrassment he or she feels about the symptoms or the examination (Oyeyemi, 2008).

Surprisingly, there have been few published research studies on abortion attitudes among nursing students and professional nurses. This might be because of the divisiveness that this issue can generate among health professionals (Timpson, 1996). A study among Korean nursing students on attitudes towards ethical issues revealed three ethical stances with regard to the life of the unborn, i.e., sacred, scientific, and humane (Yeun, Kwon, & Kim, 2004).

Patients' own attitudes also influenced their evaluation of nurses' politeness. Some patients expect to be handled rudely even before they enter the health facility. For instance, a labour ward patient expected to be insulted because of what she had been told before she went to the facility. Such presumptions could influence the patients' linguistic behaviour leading to choice of strategies aimed at countering the preconceived notion that the nurses were bound to be impolite. In such instances, the patient would be the aggressor by initiating the dignity-violating acts and failing to engage in what Eelen (2001) has called strategic conflict avoidance. Moreover, Arnold and Boggs (1989) argue that such stereotyping by patients would be a barrier to smooth interaction.

A study designed to determine if demographic characteristics of patients such as age, gender and cultural background influence perceptions has shown that patients who were older, female and from aged care wards perceived that physical aspects of nursing care were more important than did patients who were younger, male and from medical wards (Chang, Chan, Yeung, Wan &Ho, 2003). A qualitative descriptive study aimed to evaluate surgical patient satisfaction with nursing care with a sample of six general

surgical patients revealed patients' satisfaction with the personal and professional nature of nurses. Participants have been shown to understand information from nurses. Minimal nurse contact, lack of personalized care and lack of information about the operation, recuperation and minor treatment options have been identified as factors that cause dissatisfaction (Hogan, 2000).

Characteristics of different types of abuse and professionals' beliefs and attitudes about children at different ages may contribute to their relative degree of comfort in dealing with child victims. For example, infants are generally perceived to be relatively helpless and vulnerable, needing adults' protection, whereas toddlers are often perceived as needing discipline(Stanton, 1990). In a similar vein, expectations about the roles of mothers and fathers as protectors of children, as compared with other adults, may affect the professional nurse's dealings with perpetrators of abuse. Results of the study concluded that, overall, more than half of the nurses surveyed felt comfortable dealing with all three types of abuse and victims of all age groups, but were undecided or unable to deal with the perpetrators of child abuse. However, nurses were most comfortable dealing with emotional and physical abuse and least comfortable with sexual abuse. Significantly, nurses are uncomfortable with the emotional abuse of infants under one year and teenagers. Nurses are also uncomfortable dealing with children under a year and who have been physically or sexually abused. Nurses were more comfortable dealing with abusive mothers as opposed to fathers. They were least able to deal with fathers as perpetrators of sexual abuse (Stanton, 1990).

In Australia, an estimated 81000 people are hospitalised due to excessive alcohol consumption. The result of this is that an increasing number

of nurses are having contact with patients suffering from conditions caused by, related to, or comorbid with alcohol problems. These problems consist not just of issues related to alcohol abuse and dependence (DSM-IV, 1994, American Psychiatric Association cited in Roche and Pidd (2010) but also of more generalised issues of misuse, such as binge drinking. Caring for these patients are progressively becoming part of the job, not only of nurses in emergency and specialist drug and alcohol departments, but also of those working on more generalised inpatient wards. Around 41% of nurses spend 80–100% of their time responding to alcohol and other drug issues, and the provision of care to these patients can often be a difficult task (Roche &Pidd, 2010).

Patients with alcohol problems often provoke a complex array of negative attitudes toward and erroneous stereotypes of "the alcoholic." These attitudes and stereotypes are present in many societies, including Ghana, and nurses, given they arguably spend the most time with patients, must deal with these when treating patients with alcohol problems. In addition, they must also contend with attitudes and stigmas considered unique to the hospital environment, including those depicting patients with alcohol problems as unpleasant, difficult, and unworthy of care (Allen, 1993).

These attitudes, beliefs, and opinions, present in the hospital environment, are complex. They include not only the attitudes of society, which depict people with alcohol problems as a dangerous, weak-willed, immoral "drunk", but also stereotypes of these patients as difficult and unrewarding, as well as nurses' own personal or professional experience and their judgments of how deserving these patients are of their care. These beliefs

can all shape and influence the relationship that forms between a nurse and his or her patient (Sullivan, 1995).

Drug use has become more prevalent among the general population (UK Anti-Drugs Coordination Unit, 2000), so the likelihood of nurses coming into contact with drug users has increased. This contact should be viewed by nurses as an opportunity to improve the health status of each individual, as an overarching theme within the 10-year drug strategy to encourage drug users into treatment. While admission for treatment in a general medical or surgical setting may not be primarily related to drug use, there is hope during this interaction for the nurse to make an impact, however subtle. Nurses often lack confidence in their ability to look after problem drug users and this can potentially undermine care. Additionally, drug use may influence the nurse's attitude towards a patient.

Safety is the overriding principle that should govern a nurse's involvement with a drug user. Safety should be considered in the context of the patient, their family, other patients, staff and the public. Nurses need to be familiar with local policies and protocols that relate to illicit drug use in their working environment, in both a hospital and a community setting. Professional and legal responsibilities are not overridden by moral or ethical duties (GHS, 2002). Society has the tendency to label and stereotype people who are abusing drugs. The stigma and behaviour of the society towards drug abusers and the innocent lives that they harm as a result of their addictions have found its way into the minds of the people on the ground that are expected to help alleviate the problem (GHS,2005).

Alcohol and other mind-altering drugs are frequently the reason for agitation and violence in the emergency department. Withdrawal from alcohol and or benzodiazepines can also be a cause of agitation and are of medical concern as well (Nordstrom, 2012). According to the Emergency Nurses Association (2011) Violence Survey, the most frequent source of violence against emergency nurses is patients (97.1%) with alcohol intoxication as a factor in more than half (55%), other drugs also contribute to violent behavior (46%) and psychiatric diagnoses are an issue in 43%. It is important for all emergency department staff to have training in verbal de-escalation techniques in keeping with Center for Medicare and Medicaid Services (CMS) guidelines. In the situation of an agitated patient, verbal de-escalation should be tried before any type of restraint or seclusion is instituted (Knox & Holloman, 2011). De-escalation is a critical strategy in preventing the agitated patient from becoming violent (Strout, 2010).

A strong fear of acquiring HIV infection at work substantiated by the fact that needle stick and sharps injuries are the most common method of transmitting blood-borne pathogens between patients and nurses has been shown in a sample of 601 surgical and emergency nurses and this fear factor has been shown to instigate inappropriate HIV testing of all surgical patients and inpatients (Gańczak&Barss, 2007). A cross-sectional survey from seven health settings undertaken with a self-administered written questionnaire to study HIV-related knowledge, attitudes and risk perception and to identify predictors of willingness to provide care for such patients has shown that perceived risk of fatal occupational infection and previous experience in STD care greatly influence the attitudes of nurses although these nurses have a

positive attitude towards caring for people with HIV and STDs (Kermode, Holmes, Langkham, Thomas & Gifford, 2005).

A recent study to assess nurses' level of comfort in providing care to patients living with AIDS and to determine the socio-demographic variables that influence nurses' comfort using a questionnaire to elicit information on their comfort taking vital signs, handling, administering enema and mouth-to-mouth resuscitation and in recommending exercise or physical therapy to patients living with AIDS has shown that nurses are uncomfortable with resuscitation and prefer wearing gloves while handling these patients (Oyeyemi, 2008).

From Fehring (2005), the availability of pre-implantation abortion pills has increased the probability that advanced practice nurses (i.e., nurse practitioners and certified nurse midwives) will be instrumental in providing abortion services in the United States. The study indicated that most Marquette nursing students did not intend to provide abortion services, but many feel that abortion should be available for certain circumstances (e.g., anomaly of the child). Most further indicated that the decision to have or not have an abortion should be a personal right for the woman and use this approach as their ethical stance. Many see abortion services especially medical abortion services as part of the scope of advanced practice nursing. Broad ethical stances of the students were split between Sacred-Life and Humane Life Utilitarian. The Sacred-Life students tended to apply ethical principles to both the mother and foetus, as compared to a tendency to apply ethical principles only to the mother with the students who took the Humane Life Utilitarian ethical stance. Although the majority of advanced practice nursing students did not intend to provide

abortion services, most were open to referring for abortion services and saw abortion as a personal right (Fehring, 2005).

Marshal, Gould and Roberts (1994) examined nurses' attitudes towards induced abortion and the effect these attitudes have on subsequent standards of care they provide and their own psychological well-being. More nurses had a strongly positive attitude score than a strongly negative. Nurses in the gynaecology wards had much lower attitude than those in the medical and surgical wards. The longer the nurses worked in the gynaecology ward, the lower their attitude suggesting that their direct involvement in abortion puts them under constant stress. Nurses who had some religious affiliation especially Roman Catholic nurses had a much lower Caucasian nurses had higher attitude scores than did Afro-Caribbean nurses because attitudes towards abortion changed with increasing gestational age (i.e., 12 weeks). Generally in a negative direction, nurses considered abortion to be permissible under all circumstances (risk to woman's physical/mental health/foetal disorder/rape). The most important implication of these findings is the possible effect of the negative attitudes among gynaecology nurses on their well-being and on the women for whom they provide care. Gynaecology nurses likely need more support to help them develop insights into their own beliefs and separate their attitudes from the needs of their patients (Marshal, Gould & Roberts, 1994).

A recurrent theme in current nursing literature is that caring is a moral ideal, not a moral imperative. Nursing prisoners in a general hospital environment extremely challenging and this unique patient group requires specific nursing interventions that are caring but that also maintain the nurses'

integrity and ability to do their job. As American prison nurse Steve Dighton says every practising nurse has had the experience of meeting that person who qualifies unequivocally as the difficult patient, but in jail, we have the equivalent of an entire hospital of them (Crampton, 2007).

Social prejudice, negative attitudes and stereotyped perceptions of substance misusers and dual diagnosis patients are held widely among healthcare professionals and this may lead to minimal care being given to this population (Rassool, 2006). There is some evidence that health professionals' attitudes towards substance misusers exert a significant influence on their willingness to intervene and the quality of such interventions (Karam-Hage& Brower, 2000). Therefore, negative attitudes towards substance misusers are likely to make nurses reluctant to work with alcohol and drug misusers or provide minimal care to this group of patients. Negative attitudes have been associated with substance misusers' reluctance to use health services for drug-related or other health problems, reduced likelihood of pursuing referrals and reluctance to engage in management and treatment of substance. Much professional education and training reinforces the view that dealing with substance misuse is the job of a specialist and there is a real need for educational programmes for nurses on alcohol and drug education (Rassool, 2006).

A 2007 qualitative study done with 18 district nurses in England, using semi-structured interviews to gain insight on their attitudes towards substance abusers had revealed the following: district nurses were not well prepared to work with substance abusers as their roles were influenced by prejudice and stereotypical views regarding substance abusers. As a result of the stereotypical

views they treated clients in a dehumanizing manner. The nurses had felt threatened by substance abusers because of the aggressive behaviour substance abusers presented at the clinic. Research had shown nurses had resorted to this view to protect their own emotional wellbeing (Peckover, &Childlaw, 2007).Therefore their attitude was merely a defence mechanism against drug abusers.

A significant difference was found for caring attitude, responsiveness and ward organization. A recent study in the America examined attitudes of professional nurses in the labour and delivery setting and found that although 95% would agree to care for patients terminating a pregnancy, few nurses would care for patients terminating a pregnancy due to sex selection, selective reduction, or for personal reasons (Marek, 2004).

In a study of nurses' perspectives on patients' rights vis-à-vis patients' behaviour, nurses' behaviour, and other variables in Kenya (Mbindyo, Gilson, Blaaw, & English, 2006), nurses were able to specify the positive behaviours that they expected from patients in order for the latter to be accorded their rights. One nurse expected the patient to observe the norms of territoriality by keeping a distance from bystanders when presenting a problem. Although this approach might look conspiratorial in a context where other patients also wait for service, it would guarantee the right to confidentiality and personalized attention in case of embarrassing or taboo topics. Despite the overriding formality nurses expected, a degree of liberalism was seen in the response of two nurses who stated that the patient was free to approach them in any way as long as the point was made.

Mallory (2003) found that previous death education didnot have an effect on attitudes toward care of the dying in spite of very high score on the Attitudestoward Care of the Dying (FATCOD). But this result may be due to the small number of participants who hadprevious death education. Similarly, Barrere et al. (2008)studied 73 student nurses and found no significanceeffect of previous death education on dying attitudes.

When asked, most nurses would respond that they would treat a prisoner patient the same as any other, which in reality is often not possible, for a number of reasons. The major health issues facing this population group have been identified as infectious disease, substance abuse and mental illness. Substance abuse among prisoners' affects not only their general health but can also determine behaviour, influence prison culture and contribute to negative staff attitudes. In addition, patients with substance abuse issues will have a high tolerance to drugs and may genuinely require much higher analgesia doses than we would normally expect. Not understanding this reality might lead nurses to doubt their pain score and restrict, however inadvertently, the delivery of analgesia. Such extreme caution with analgesia by both medical and nursing staff is a factor in patient care. Fear of the patient becoming violent is a very real concern for some nurses. Reports of patients hiding a knife under their hospital mattress or sharps being grabbed by a prisoner patient and used to threaten staff, show how verbal abuse and aggression from prisoners are not uncommon in the hospital setting. The fear of violence also taints all nurse, prisoner, patient interactions, as we tend to err on the side of caution, perhaps wisely (Crampton, 2007).

Personal Characteristics of Emergency Care Nurses

Crothers and Dorrian (2011) identified an association between nurses' personal characteristics and attitudes toward alcohol problems. The study revealed thatolder nurses believed more strongly that alcoholism is an illness and that pessimism is not the most realistic attitude to take toward drinkers. An association between the average number of times per week a nurse drinks and their personal and professional satisfaction in working with patients with alcohol problems was evident, as well as an association between the number of standard drinks they usually consume and nurses personal attitudes toward drinking (Crothers &Dorrian, 2011).

Experience has a significant influence on attitude change (Barrere, Durkin & Lacooureier, 2008). Research has revealed that years working as registered nurse (RN) and years employed at a cancer centre emerged as the strongest indicators of exhibiting a positive attitude toward caring for dying patients (Lange, Thom & Kline, 2008). DunnOtten and Stephens (2005) found out that nurses with 17-21 years of experience have more favourable attitudes toward caring for dying patients than nurses with less experience. Also, nurses who cared for a greater percentage of terminally ill patients had more positive attitudes toward caring for dying patients than other nurses and feel more comfortable talking about EOL (Kurz& Hayes, 2006). This is because nurses expose briefly to dying patients during their study, but as they care for dying patients, their coping develop and their skills improve (Weigel, Parker, Fanning, Reyna, &Gasbarra, 2007).

Attitudes can be changed through education andexperiences and exploration of feelings, attitudes, andbeliefs of self and others (Wessel

&Rutledge, 2005).Care for the most seriously ill patients requires specialknowledge and training for all health care professionals(Hegedus et al., 2008). Many research findings supportthe importance of education in changing attitude towardcaring for death and dying patients. This was clearlyevident in a research study with a larger sample size(Iranmanesh et al., 2009).

Although, nurses play a pivotal role in palliative andend of life care, nurses either don't received end of lifecare topics in their nursing school curricula (Dickinson et al., 2008) , or the curricula don't contain enough topics related to care for the dying(Mallory, 2003). It seemstherefore logical that nursing school curricula shouldinclude these topics in their course provisions (Dickinsonet al., 2008).

Age has a significant influence on nurses' attitude toward dying (LangeThom& Kline, 2008; Barrere, Durkin &Lacooureier, 2008). It was found that younger adults tend to report higher levels of death anxiety than do middle-aged adults (Abdel-Khalek& Al-Kandari, 2007), and older nurses feel more comfortable talking about EOL issues than younger nurses (Deffner& Bell, 2005; Kurz& Hayes, 2006). This becomes clear if young healthcare providers do not care dying patients before they became qualified nurses. It then reflects on their attitudes toward caring for dying patients; as revealed by the previous studies findings (DunnOtten& Stephens, 2005). Also it is found that younger nurses were more adaptive to attitude change after an educational intervention (Barrere, Durkin & Lacooureier, 2008).

McCann, Clark, McConnachie and Harvey (2006) studied and assessed if accident and emergency (A & E) nurses have positive or negative attitudes towards patients with deliberate self-harm, and to assess if nurses' age, length

of accident and emergency experience, or in-service education influence their attitudes towards these patients. Their results were that most nurses had received no educational preparation to care for patients with self-harm. Over 20% claimed the department either had no practice guidelines for DSH or they did not know of their existence; one-third who knew about them had not read them. There were significant differences between respondents on several variables. Older and more experienced nurses had more supportive attitudes than younger and less experienced nurses. Nurses who had attended in-service education on DSH had more positive attitudes than non-attendees. Overall, the findings have implications for improving the educational preparation of accident and emergency nurses, improving awareness and adoption of practice guidelines, mentoring nurses, and improving attitudes towards patients who self-harm (McCann, Clark, McConnachie & Harvey, 2006).

Herdman (2002) found that older nurses expressed negative attitudes toward older people, whereas Murphy (2007) found that older nurses experienced positive attitudes. Other researchers have reported no significant correlation between nurses' age and attitudes toward older people (Chasteen, Schwarz, & Park, 2002; Hweidi& Al-Hassan, 2005). Previous work experience is another factor found to affect nurses' attitudes toward older people. Teeri et al. (2006) and Williams, Zimmerman, Sloane, and Reed (2005) reported that nurses working in long-term care institutions acquired paternalistic views. Other reports, however, have noted that clinical experience in chronic care institutions had a positive effect on positions regarding older people (Hartley et al., 1995; McKinlay& Cowan, 2003). Soderhamn et al. (2001) have stated that

there is no clear correlation between the type of care facility and views of the elderly.

Experience is a necessary but not sufficient condition for expertise and not all experienced nurses are experts (Christensen & Hewitt-Taylor, 2006; Ericsson, Whyte, & Ward, 2007). For example, Benner (1984) noted that a number of years on the job in the same or similar situations may create competence; however, the passage of time and occurrence of events and interactions does not automatically confer expert status. As Benner stated, there is a discontinuity or leap between expertise at the competent level and expertise at the proficient and expert levels. One potential explanation for this discontinuity is that years of experience may provide fluidity and flexibility but not the complex reflexive thinking that has been hypothesized to be an important component of clinical nursing expertise (Bobay, 2004).

Few quantitative studies have been able to capture both the temporal and transactional nature of experience, and these studies have been limited to measuring experience in terms of years in practice. Young, Lehrer, and White (1991) found that nurses with more experience reported performing more complex functions than those with less experience. In a recent study of five hospitals, Bobay, Gentile, and Hagle (2009) found that years of experience were associated with expertise.

The majority of the research on how experience contributes to expertise is at the individual nurse level; however, experience has also been assessed as a contextual variable. This latter work has primarily focused on the influence of aggregate experience on patient and nurse outcomes. For example, Aiken, Clarke, Cheung, Sloane, and Silber (2003) assessed the influence of the mean

years of experience among nurses on surgical patient mortality in 168 hospitals. They found that the mean experience level was not a significant predictor of mortality. In a study that used the patient care unit as the level of analysis, researchers found that a higher proportion of nurses with ≥ 5 years of experience was associated with fewer medication errors and lower patient fall rates (Blegen, Vaughn, & Goode, 2001). Similarly, Clarke, Rockett, Sloane, and Aiken (2002) examined the effect of the mean nurse experience level at the hospital level on nurse needlestick injuries; they concluded that a low mean experience level was associated with more near-miss needlestick incidents. In another study of nursing outcomes, Kanai-Pak, Aiken, Sloane, and Poghosyan (2008) found that the odds of high burnout, job dissatisfaction and poor-to-fair quality of care were twice as high in hospitals with 50% inexperienced nurses (i.e., nurses with less than 4 years' experience) versus those with 20% inexperienced nurses.

The nurse working in the accident and emergency department must learn to hide her feelings of fear, horror or uncertainty from her patients. If these are allowed to surface she may fail to win her patient's confidence and trust. It behoves her to remember always that the patient's feelings are feelings that are usually far stronger than her own. The reception of patients must be carefully managed. An impression of quiet, friendly efficiency must be conveyed in the first few seconds of the encounter with each new, strange patient. The client who feels at once that he is in safe, caring hands is far more likely to co-operate with and respond to any treatment (Hospice Nurses Association Standards and Accreditation Committee, 1995).

Agyemang (2001) maintains that every MOH staff must benefit with a minimum participation of between 3 to 5 times a year from educational programmes, especially in- service training, conferences, workshops or seminars among others. In achieving this, health sector workers according to Agyemang, (2001) have been given individual log books which are expected to be used in checking on staff participation in such programmes.

As a reinforcing measure, a couple of disciplinary related submissions have also been released by the Nurses' and Midwifery Council to public and private hospitals including corporate organizations that are in need of nursing services to desist from engaging nurses who fail to renew their Professional Identification Numbers (PINs). Employment of nurses with expired PINs is illegal and unacceptable since they lack the request knowledge and skills in service delivery.

Education influences expertise by providing a theoretical and practical knowledge base that can be tested and refined in actual situations (Dreyfus & Dreyfus, 1996). Didactic learning alone cannot generate clinical expertise, and one distinguishing aspect of nursing education is a focus on clinical learning. Benner (2004) suggested that hands-on learning is at the heart of good clinical judgment. Mentored clinical learning situations in both classrooms and practice sites offer critical opportunities for nurses to apply and integrate theoretical knowledge with actual events (Field, 2004). A sound educational foundation expedites the acquisition of skills through experience (Benner, 1984). Without background knowledge, nurses risk using poor judgment and lack the tools necessary to learn from experience.

The collective education level of staff may impart a unique contribution to the development of expertise in the clinical setting. Few researchers have focused directly on the aggregate educational composition of the staff with whom a nurse practices as a factor affecting individual clinical nursing expertise. There are, however, examples where researchers have examined the relationship of contextual variables including education at the hospital level, to outcomes. For example, Aiken et al. (2003) found that the proportion of BSN-prepared nurses in a hospital was associated with lower surgical patient mortality and failure to rescue. In the same study, mean years of experience in a hospital was not associated with outcomes and did not alter the relationship between education and outcomes. Aiken et al. (2003) hypothesized that the effect of education was due, in part, to better critical thinking and clinical judgment skills associated with BSN preparation. Estabrooks, Midodzi, Cummings, Ricker, and Giovannetti (2005) also found that the proportion of BSN-prepared nurses in a hospital was associated with lower patient mortality.

Aside the use of in- service training programmes, workshops, conferences and seminars, other significant strives by MOH in aid of skill and knowledge acquisition by staff is the establishment of internet/literary facilities. This has been carried out in hospitals, health centres and clinics and is expected to among other benefits, enable easy access of staff to current information on health issues (MOH, 2005).

On the part of the Ghana Registered Nurses Association (GRNA), efforts have equally not been spared to empower the nurses through participation in research, writing skills, and the need to read broadly. This has been made possible through the monthly publication of the magazine entitled

"the Ghanaian nurse." In line with this initiative, nurses from all corners of Ghana are encouraged and expected to obtain copies, read and also submit their opinions, experiences and research findings for publication. Nurses with a higher level of professional education had more positive attitudes toward older people (GHS, 2005).

Similar results were obtained from studies in long term care settings. Carter and MccIeannes (1996) found educational interventions altered nurses' decision making practices with older patients from a 'medically orientated, professional' approach to a 'patient choice' approach allowing patients more control over decisions relating to their care and place of residence following discharge. Similarly, Hubber, Renox and McKenney (1996) found significant increases in knowledge and a significant reduction in negative attitudes following a continuing education program for all employees in a long term care facility, but, this program did not strengthen positive attitudes.

Sex-related differences in death anxiety are real rather than artificial, and it is most probable that these differences are the product of differential socialization of men and women as supported by studies conducted on Arab samples (Abdel-Khalek& Al-Kandari, 2007).Women are more open to death-related thoughts and feelings, and men are somewhat more concerned about keeping these thoughts and feelings in check. The relatively higher level of reported death anxiety among women perhaps contributes to empathy with dying and grieving people and the desire to help them cope with their ordeals. This is explained by the close relationship of personality characteristics of femininity with anxiety, and thus fears of death. It is argued that the higher levels of empathy were associated with higher levels of death anxiety (Abdel-

Khalek& Al-Kandari, 2007). In contrast, according to (Barrere, Durkin &Lacooureier,2008), gender is not a significant factor.

Helmuth (1995) also established that those who reported holding negative attitudes toward older patients held positive attitudes toward restraint use and stereotyped older patients rather than regarding them as individuals. Nurses who placed a high degree of importance on talking to patients held more positive attitudes than those who placed a high degree of importance on general nursing care (e.g., bathing, toileting). Although older patients were perceived as pleasant to interact with, they were not perceived as being capable of making their own decisions or carrying out important functions.

Tabak and Ozon (2004) also echoed this fact in their work on the influence of nurses' attitudes, subjective norms and perceived behavioural control on maintaining patients' privacy during hospitalization based on the theories of reasoned action and planned behaviour. In the research, a positive and significant correlation was shown between nurses' attitude to promoting and maintaining patient privacy and their planned behaviour, while perceived behavioural control was the best variable for predicting the nurses' behaviour. Better educated nurses believed that they had fewer resources and anticipated more obstacles in acting to promote and maintain patient privacy. This research further adds a new dimension to the phenomena about nurses' attitudes to maintaining patients' privacy, nurses' planned behaviour and their actual behaviour (Tabak&Ozon, 2004).

A survey by the American Society of Registered Nurses included a 21-item AIDS Attitude Scale measuring the constructs of avoidance and empathy to describe the nurse attitudes and care practices related to such patients has

shown that nurses have relatively low avoidance and high empathy and hence, are comfortable treating such patients (Martin &Bedimo, 2000). But, nurse's awareness, fear and emotions do play a role in determining the comfort level. A study to determine nurses' knowledge, attitudes and overall level of comfort in giving nursing care to acquired immune deficiency syndrome patients and identify the socio-demographic variables that influence nurses' attitudes has also shown that, nurses with low levels of knowledge show negative attitudes towards people with acquired immune deficiency syndrome and other STDs.

Nurse's specialty, rank, prior education and experience with patients have been shown to influence their attitudes (Oyeyemi, 2006). A strong fear of acquiring HIV infection at work substantiated by the fact that needle-stick and sharps injuries are the most common method of transmitting blood-borne pathogens between patients and the nurses has been shown in a sample of 601 surgical and emergency nurses and this fear factor has been shown to instigate inappropriate HIV testing of all surgical patients and inpatients (Gańczak&Barss, 2007).

A cross-sectional survey from seven health settings undertaken with a self-administered written questionnaire to study HIV-related knowledge, attitudes and risk perception and to identify predictors of willingness to provide care for such patients has shown that perceived risk of fatal occupational infection and previous experience in STD care greatly influence the attitudes of nurses although these nurses have a positive attitude towards caring for people with HIV and STDs (Kermode et al., 2005). A recent study to assess nurses' level of comfort in providing care to patients living with AIDS and to determine the socio-demographic variables that influence nurses' comfort using

a questionnaire to elicit information on their comfort taking vital signs, handling, administering enema and mouth-to-mouth resuscitation and in recommending exercise or physical therapy to patients living with AIDS has shown that nurses are uncomfortable with resuscitation and prefer wearing gloves while handling these patients (Oyeyemi, 2008).

Chan,Chan, Yeung, Wan&Ho, (2003) in a study of the attitude of nurses toward alcoholic patients in Hong Kong aimed to understand the attitude of nurses toward alcoholic patients in local AEDs. Alcoholism is a stigmatized 'disease' and some studies have revealed that nurses tended to have negative attitudes toward people with alcoholic problems which then influences the quality of healthcare provided to this group of patients. As a result, alcoholic patients may not be properly treated. The researchers of this study employed a cross-sectional survey to gather data from the targeted sample. The Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ) was used to evaluate the attitudes of nurses toward alcoholic patients. In addition, relationships between therapeutic attitude toward alcoholic patients and various independent variables including experience in specialty, education related to alcohol and alcoholic problems, the degree of support received from co-workers and self-esteem of individuals were analyzed. Six hundred nursing staff, including registered nurses, enrolled nurses and nursing officers working in AED, was invited to participate in the study. Of the one hundred and ninety (31.6%) who responded, findings showed that nurses working in AEDs tended to have negative attitudes toward alcoholic patients. Most of those surveyed got low scores in role security, which indicated they perceived themselves inadequate in both skills and

knowledge relating to problem drinkers. The findings also reflected that the degree of support received and self-esteem correlated with the overall attitude toward alcoholic patients. Chan then concluded that providing more support and training opportunities to nursing staff will culminate in they putting up more positive attitudes.

The nurse patient relationship, according to research by Press Ganey Associates Inc. (2010) sets the tone of the care experience and has a powerful impact on patient satisfaction. Nurses spend the most time with patients. Patients see nurses' interactions with others on the care team and draw conclusions about the hospital based on their observations. Also, nurses' attitudes toward their work, their co-workers and the organization, affect patient and family judgments of their quality of care. Without a positive nurse patient relationship, there cannot be patient and family satisfaction.

A report from a quality assurance assessment from the University of Cape Coast (Abnorey, 2007) revealed complaints from clients concerning the nurses at the emergency unit such as that the nurses were not polite, and were too harsh on the patient. Some of the clients also complained that the nurses did not show any caring attitude when they visited the unit with their injured relative. Others complaints were that, the nurses made them wait for long hours without telling them anything. There was also reports of nurses refusing to answer enquires from clients.

Bosu (1991) surveyed user's perception on quality of care services at the Cape Coast Regional Hospital. Three hundred and twelve users from 24 communities were interviewed using a structured questionnaire. Of this number, 23% described the behaviour and attitude of the staff of the hospital as

not good. They generally described the medical staff as rude, insulting, unfriendly, impatient or harsh and castigating that they also collect illegal fees. The majority of the users however, described the staff as polite, friendly patient, lively, respectful, understanding and ready to help. The staff received them nicely and had time for them. Forty –one percent of the out-patient department users observed others had jumped queues; most disapproved of their observations. The quality of nurse –patient relationship influences treatment, understanding of information, ability to cope with disease condition and quality of life. The patients wanted nurses to be patient with them and avoid discrimination. Communication attitudinal problems as suggested could be improved through in-service training, increase of staff numbers at units, reporting of staff to work on time, work faster, reduction of staff personal conversation during working time, availability of equipment and staff meetings convened after working hours.

Kernberg, (1998)suggests that staff may deny differences among patients,believing that they all have the same needs and responses, and that this maycontribute to the regressive group tendencies mentioned above. Campling (1996)discusses the problems of maintaining a therapeutic alliance using examples from herexperience in a therapeutic community for young adults diagnosed as having SeverePersonality Disorder. She suggests that characteristically these patients find it difficultto ask for help, so use maladaptive behaviours to draw attention to their needs;however she emphasizes that the response to the crisis may overlook the cause, anddifficulties with the therapeutic alliance escalate. She suggests that the establishmentof trust is crucial. Patients should be encouraged to both take

responsibility andunderstand what staff see as their responsibility; further, they should try and talkabout feeling self-destructive, rather than being self-destructive. Nevertheless, actingout can be dealt with by the community, both by role modelling, focusing on roles andboundaries, and understanding what lies beneath the behaviour. Otherwise“Pandemonium, muddle and rocketing anxiety levels [of the staff] will cause patientsto feel dangerously omnipotent.”

Domestic violence is of special concern to nurses, as they are often the first health care professionals to interact with battered women. The purpose of this study was to explore and describe nurses’ attitudes toward the survivors and perpetrators of domestic violence. A holistic ecological health promotion framework guided this qualitative investigation. Thirteen participant experts in the care of abused women were interviewed using semi structured questions to describe nurses’ attitudes toward survivors and perpetrators. Significant statements were identified, clustered, and placed into categories of response. Findings included identification of general themes and specific categories related to attitudes nurses have about battered women and those who abuse and injure them. The significance of this research underscores the importance of nurses’ attitudes as influencing factors in their interactions with women and families involved in domestic violence. Application of a health promotion framework encourages a holistic perspective of care for this vulnerable population (Medland,Howard-Ruben, & Whitaker, 2004).

Interpersonal violence can be defined as a consciousphysical attack, with the intention to cause physical andpsychological harm. Although in Switzerlandreports on interpersonal violence appear every day in thetabloid and hospitals treat victims of violence on a regularbasis, socio-medical studies

on the causes are very rare inour country. The majority of studies concentrates onsocial factors when discussing the causes and explaininterpersonal violence by referring to the "wrong timewrong place" line of argumentation.

Rafii, Oskouie and Nikravesh (2004) also partook in a more extensive research to identify the most important factors that intervened in the nurses' responses to burnout in burn centres of Tehran. Results are that nurses had responded to burnout. These responses included emotional, attitudinal, psychosomatic, behavioural and organizational. Indications are that the nurses and patients characteristics and interaction between these two factors had a very powerful effect on the responses and determined the kind of caring behaviour. Moreover social support from managers (e.g. head nurses and nursing administrators) and peers modified some of the nurses' responses to burnout.

The influence of positive personal characteristics, especially conscience, religious beliefs, philosophy, commitment, a sense of responsibility and altruism on the nurses' responses to burnout, the finding that, long lasting and persistent problems in the work setting can deteriorate even the personal characteristics, and regarding the numerous problems in burn centres of Tehran, there is an urgent need for helping the nurses. We suggest that due to the intense staff shortage in these centres, the managers try to keep these nurses. The only way they can do this is by using stress reduction programs. Data strongly indicated that these nurses need to rest periodically to preserve energy and to refresh their morale. Moreover, giving importance to moral and ethical aspects of care by managers could be helpful and motivating. Changing burn patients' inherent characteristics and their other characteristics

such as poverty and socio- cultural level is not a possible alternative. Promoting nurses' morale is possible and must be done promptly if we want our burn survivors receive at least an ethical effective care (Rafii, Oskouie&Nikravesh, 2004).

Patients and families count on nurses to keep them informed, to connect them to their physicians and other caregivers, to listen to them, to ease their anxiety, and to protect and watch over them during their healthcare experience. Because of these high expectations of nurses, it's no wonder that nursing performance, and more specifically, the nurse patient relationship, is so central to patient satisfaction and a quality patient experience (Rafii, Oskouie&Nikravesh, 2004).The practitioner, on the other hand has the task of extracting information as quickly as possible from the unhappy body that is before him or her. The practitioner is often on a tight schedule, with other patients backing up in the waiting room. The difficulties presented by the patient may have been made more complex by the use of various home remedies, so that symptoms may now be masked and distorted. The patient's idea of which symptoms are important may not correspond to that of the practitioner's knowledge, so important signs may be overlooked. With the patient seeking solace and the practitioner trying to maximize the effective use of time, it is imperative that there are many potential sources of strain and miscommunication(Rafii, Oskouie&Nikravesh, 2004).

Attitudes are significantly influenced by both nurses' current and preferred area of practice. Armstrong-Esther, Sandilands & Miller, (1989) found those preferring to work in geriatrics and rehabilitation had more positive attitudes than those preferring to care for surgical patients and patients

less than 65 years of age. Interestingly, intensive care nurses were found to be both more knowledgeable about ageing and have more positive attitudes toward older people than medical-surgical nurses. The nature of intensive care patients may explain these nurses' greater knowledge of ageing. Intensive care patients are dependent, therefore, older intensive care patients' nursing needs may not be perceived as burdensome or different from the needs of other intensive care patients.

Hope (2005) noted that nurses working in an acute elderly patient care setting reported more positive attitudes than nurses in a medical setting. Those in the elderly care setting may have a preference for working with older patients explaining their more positive attitudes. Interestingly, in one study the volunteers had more positive attitudes than nurses, licensed practitioner nurses or nursing aides, possibly indicating their reason for their work in this area. Other studies have identified the influence area of practice has on nurses' perception of, and attitudes toward older patients.

Astudy of patient's perception of nursing care conducted in a large teaching hospital revealed almost 1/3rd of patients (31.6%) perceived that the nurse did not offer adequate 'explanation and information' about their treatment in the hospital and home care and follow up advice. Regarding 'caring attitude' around 1/10th (11.5%) had a poor perception. A very good percentage of respondents had a good perception regarding 'responsiveness' (95.9%) of the nurse, her 'ward organization' capabilities (95.7%) and her 'availability' (96.5%) respectively.Perceptions regarding all the five aspects were better among those aged beyond thirty years. Significant differences were found regarding responsiveness and ward organization only. it was observed

that for 'caring attitude' 89.9% males had good perception vs 86.1% females. However females had a better perception regarding 'explanation', 'responsiveness', 'ward organizational capabilities' and 'availability' of the nurse than males (Mufti,Qadri,Tabish, Mufti,&Riyaz, 2008).

Instances of patients and relatives attacking nurses verbally and assaulting them have occurred in many hospitals such as Korle-Bu Teaching Hospital, because patients complained of lack and inadequate attention given to them. Many have also complained of rude behaviour towards patients and their relatives. Many nurses fail to provide a conducive and therapeutic environment for the patients which tends to be source of worry and anxiety to the patient who see the hospital environment as unfamiliar and unfriendly (Yeboah, 2005).

Level of Job Satisfaction and Nurses' Attitude

Job satisfaction is defined as quantity of work accomplished was a key factor in having felt productive in their days work. Common themes of respondents were "finishing all tasks", "being efficient", "staying late", and "doing extra around the unit"(McNeese-Smith, 2001), done without monetary compensation. The quality of work was found to be based on several aspects of nursing care. Respondents felt that outcomes of teaching and caring for individuals proved to be rewarding and contributed to productivity of work. Many felt that an offering of suggestions to improve the nursing unit contributed to work quality, as well as the day-to-day process of nursing care (McNeese, 2001).

Working in a health-care environment can be as difficult and stressful asit can be rewarding and challenging depending on individual perception and cognition (Lazarus &Folkman, 1984; Payne, 1999). TheEmergency

Department is an area of complex and challenging workwhere different health-care professionals are required to work together toachieve effective patient outcomes. There is good evidence that workinginteams enables people to more effectively meet the challenges of this type of work (Carter & West, 1999). A large-scale survey of stress inhealth-care organisations in England (Wall et al., 1997; Borrill et al.,1998a) identified that individuals who work together in well-definedteams have clear, shared objectives, need to work with each other toachieve those objectives, have different roles for team members andrecognise a team as performing a specific function. These individuals are more likely to report lower levels of psychological stress and better jobsatisfaction than those who work in less clearly defined teams (teams thatdo not share the above criteria; Carter and West, 1999).

According to Bitton and Tabak (2002), the degree of job satisfaction that individuals experience has an influence on their level of functioning, devotion at work and long-term continuance in the specific field of work. Job satisfaction is also related to one's emotional interpretation of work experiences. This in turn affects the attitude and quality of care delivered by the individual. According to Lu, While and Barriball (2005), job satisfaction depends on the nature of the job, as well as on the expectations that individuals have of what their job should offer.

Lu, While and Barribal (2005) argue that the most important contributor to job satisfaction in the nursing environment is the degree of cohesion that exists among nurses. The ability to deliver good patient care, effective communication, teamwork and good collegiate relationships also play an important role in job satisfaction.

Two reviews of the nursing literature (May and Kelly1982, Ganong et al1987) on "good" and "bad" patients show that nurses tend to express negativejudgements about patients who are (a) perceived as hostile, uncooperative,complaining and manipulative; (b) suffering from chronic or stigmatised illnesses; making staff feel ineffective. Personality disordered patients fit several of thesecharacteristics, and studies of nurses show that they also have negative responses topatients who self-harm (e.g. Sidley and Renton 1996, Suokas and Lonnqvist 1989).

In a rare controlled study, Miller and Davenport (1996) demonstrated that aneducational programme may help to change negative staff attitudes to such patients. Although the sample for this study was small, and was based upon a selfadministered learning package, improvements in both knowledge and attitude weredemonstrated. This holds out the hope that similar interventions may work withnurses negative attitudes towards personality disorder in general.

Lewis & Appleby(1988) also developed their own 22 item semantic differential scale to be used inconjunction with a variety of forms of the same case history. The only other researchscale that has endeavoured to assess staff's emotional response to difficult patients isthe Hospital Treatment Rating Scale (HTRS, Colson et al 1986). Publishedpsychometric data on this scale is incomplete, and it consists of several subsectionswith different properties. However its use in long term psychiatric care settings hasrevealed that staff considers patients with "character pathology" to be particularlydifficult. In short there is no adequately tested scale to assess nursing attitudes topersonality disordered patients.

Hospitals are facing serious challenges to provide high quality care with current nursing shortages (Khowaja, Merchant&Hirani, 2005). Nurse shortages are of major concern for nursing management, clinicians and administrators as they lead to impact on quality of care. Over-stressed, frustrated and demoralized nurses give rise to concern for hospital nursing management in providing quality care according to set standards. A descriptive qualitative research design was used to explore the registered nurses' perceptions regarding the high turnover rates among nurses at a Tertiary Care University Hospital. The data analysis showed that the most dissatisfying factors at work and within the work setting were identified as: high workload, stress associated with high workload, biased Nursing Management, lack of appreciation and monitory incentives, finally a rigid attitude of Nursing Management. However, the most satisfying factors were: working with an internationally reputable organization, patients' positive feedback and availability of required material or equipment. The study participants recommended that nursing retention could be improved at the facilities by reducing workload by adequate nurse-patient ratios according to international standards, promoting respect of nurses in front of patients and other staff, rewards and recognition of nurses, simplifying nursing documentation, increasing recreational activities for nurses and empowering nurses and Nursing Management group(Khowaja, Merchant&Hirani, 2005).

According to the Kenya Nursing Workforce and Training Analysis Project, the flight of nurses contributes to a severe shortage of health workers, thereby crippling health care. Due to this attrition, nursing officials say Kenya is facing a nursing shortage of up to 50%. The Nurses and Midwives division

of the MOH estimates that Kenya has 17,000 public sector nurses but requires 35,000. There are 49 nurses to 100,000 citizens compared to the WHO recommended ratio of 143 to 100,000. This imbalanced ratio renders nurses overworked and has been cited as one cause of nurses' dissatisfaction and may be a result of nurses displacing their anger and frustrations on helpless patients (Mbindyo, 2006).

The current ratio of nurses to patient 1:1 for (ICU) and 1:6 for the general wards is seen in most hospitals in Africa. In West African Hospitals, the ratio of nurses to patient is 1:30, 1:32 and 1:20. The quality of care cannot be guaranteed; imagine a ward of 30 patients with only two nurses in attendance. The workload will be too much, creating stress that makes the nurse harshly to the patients or being forgetful (WHO 2005).

Mbindyo,Gilson, Blaaw and English, (2006) states that the large-scale emigration of nurses is attributed to various factors such as the working conditions of nurses being quite deplorable in a number of government institutions. While a basic certified nurse is supposed to be assigned to no more than six patients at a time in a hospital setting, nurses can be responsible for up to eight times that number, and sometimes must treat three patients who are sharing a single bed. The secretary general says that a nurse may have the knowledge, skills, and drive, but not the necessary tools and a supportive environment. This causes a feeling of frustration and lowers performance. Nurses' strikes are therefore rampant in Kenya. The nurses' grievances often include complaints about long working hours, overload, unpaid risk allowances, uniform allowances, and delayed promotion.

Mbindyo, Gilson, Blaaw& English, (2006) further adds that long-serving nurses in Kenya professed to have been attracted to work within the health care sector by the altruistic nature of the service (that is, rewards associated with caring for others), while other nurses joined due to the prestige associated with medical work. According to one nurse, doctors are not at all supportive of nurses. She complained that a doctor would come, perform the reviews, and leave. The nurse is then left with the patient. During night duty, a single nurse attends to almost 60 patients. This leads to burnout among staff, which results in poor attitudes towards patients and work. This has been compounded by the negative attitude of the community towards nurses.

Promotion in organization serves as a way of encouragement, since it can boost the morale of staff, thereby increasing their interest at work. In Ghana and more especially with MOH, staff promotion has also been recognized as a key factor in achieving productivity. All MOH staff including doctors, nurses, laboratory technicians/technologist etc. are being promoted on a four yearly basis. Aside the use of promotion, other incentives in the form of annual / study leaves are also beneficial. In the case of annual and study leaves, workers are able to stay away from work for a while. This helps them to shed-off exhaustion and burn – out that can be associated with everyday work (MOH, 2005).

The attitudes of the nurse to patient's emergency needs are critical if patient are to be satisfied with the care given. Studies have shown that the patient's report of satisfaction with care is different from what the nurse perceives as patient's satisfaction. Some factors that contribute to this dilemma include aspects of the hospital setting, the changing nature of health care

delivery, practitioner's behaviour, patient's behaviour and quality of interaction (Bosu, 1991).

There are various ways in which workers in organizations can improve upon their knowledge and skills in order to provide better services. A significant aspect of this is the individual worker's interest; desire to cultivate continuous reading habit especially in line with his or her job description. Versatile reading exposes an individual to innovative methods of carrying out procedures and in the case of health workers – nurses, doctors and other paramedics – can benefit from new and improved medical discoveries(Khardi, 2001).

Interestingly, Floyd (1985)was the only identified study examining job satisfaction in 213 psychiatric aids in Texas and found that 80% of the respondents surveyed reported that good relationship with doctors was a major source of satisfaction for them. In addition, 97% of the respondents reported that their relations with co-workers, especially peers, influenced their job satisfaction. Moreover, half of the respondents rated professional relationships with members of different professions as very important to their satisfaction. Nursing aids in particular valued "communication of ideas" and teaching among medical and nursing staff (67%) because they were dissatisfied with other academic opportunities which were -for them- limited. The quality of professional relationships between nurses and doctors as an important contributory factor of nurses' job satisfaction was supported by Stamps et al.[46] who examined job satisfaction in health professionals.

In recognition of this fact, the Ministry of Health (MOH) in collaboration with the Nurses and Midwives Council (NMC) has formulated

basic policies that are expected to help uphold and sustain the knowledge and skills of staff for quality service delivery in the hospitals. The most notable of these initiatives is the introduction of in – service training programmes on nosocomial infection, regenerative health, patient's charter and infection prevention and control among others. The significance of in- service training, conferences, workshops and seminars cannot be over emphasized. Apart from exposing staff to new ideas and methods of carrying out medical and nursing procedures, it also provides more favourable platforms for staff interaction and release of work – tension, thereby refreshing their minds and giving them renewed strength each time they get back to work (Khardi, 2001).

Studies comparing mental health nurses with other group of nurses have found that mental health nurses are less stressed than other specialities. However, most stressors identified are common to both mental health and general nurses, and stress seems to arise from the overall complexity of nurses' work, rather than specific tasks required within hospital settings. Dolanidentified significantly lower levels of burnout in psychiatric nurses compared with general nurses. She suggests that this is so because psychiatric nurses have the opportunity to express their opinion in a multidisciplinary team whereas general nurses have fewer opportunities to do this. Thus, this aspect of their work appears to protect mental health nurses from the levels of stress and burnout experienced by their general nursing counterparts and that burnout was negatively correlated with job satisfaction (Dolan, 1994).

Cronin-Stubbs and Brophy (1998)comparative study of psychiatric nurses and nurses working in theatres, intensive care and general medicine, using a random sample of 269 female nurses found that psychiatric nurses

experienced intense interpersonal involvement and stated that frequent conflicts with patients, families, physicians and colleagues took place in their working environment. This study demonstrated that interpersonal relationships were the most frequent sources of undesirable personal stress for psychiatric nurses and that it had a greater impact on them than on nurses of other specialities. Working in a burn unit has been described as a stressful occupation. Every nurse who cares for a burn victim knows that stress is a part of working in this field. Some authors have emphasized that these nurses experience dealing with self-inflicted burns, uncooperative patients, inter-staff conflicts and dying patients on a daily basis. Unresolved job stress may results in emotional withdrawal and burnout. Professional burnout has been defined as a syndrome manifested by emotional exhaustion, depersonalization, and reduced personal accomplishment (Steenkamp&Merwe, 1998).

Nurses who have worked in burn centres of Tehran have experienced burnout in comparison to nurses working in other areas. The main researcher's previous study of burnout and coping in burn centres of Tehran indicated that the majority of nurses had been experienced high levels of burnout [unpublished thesis]. The consequences of professional burnout for nurses are serious. It results in emotional withdrawal or indifference; reduces the limits of nurses' activity and their contact with patients. Burnout results in a poor quality and quantity of nursing care and has negative effects on the most areas of personal, interpersonal and organizational performance(Steenkamp&Merwe, 1998).

Institutional Factors and Nurses Attitude

In Ghana, like most other countries, all schools and colleges that offer nursing programmes are under the supervision of the Ministry of Health (MOH) and the Nurses and Midwives Council of Ghana (NMC). MOH and NMC are both regulatory bodies that collaborate in accrediting Nurses' Training Colleges (NTCs) in Ghana in partnership with the national accreditation board. In the case of the public NTCs, the MOH is predominantly responsible for the infrustructural and human resource allocation and development whereas the NMC caters for the curriculum development, indexing of newly admitted students, conducting licensing examination for candidates, award of certificates and budges, renewal of Professional Identification Numbers (PIN) of staff, collaborating with international nursing organizations as well as the withdrawal of certificate and budges in the event of misconduct on the part of some staff. The MOH, Nurses' and Midwives Council and the International Council of Nurses (ICN) have collectively collaborated at various levels in the formation of acceptable standards for nursing training college and schools and these standards are binding irrespective of whether the schools and colleges are public or privately owned (GHS, 2005).

Nursing training colleges are unique tertiary institutions that are accredited to admit and train interested persons to acquire knowledge and skills that are necessary for the care of sick people. There are a large number of Nurses Training College (NTCs) but they are classified based on the type or calibre of nurses that they train. The most common of these colleges include the Psychiatric NTCs, General NTCs, Community health NTCs, Ophthalmic

NTCs, Public health nursing schools, Peri-operative schools, Intensive or Critical Care schools and the Midwifery training schools among others (GHS, 2005).

According to Carr (2009), surgical or medical intensive care units, “shock-trauma” and “step-down” units, burn unit, neurosurgicalICUs, and emergency room (ER) setting are considered critical-care units. For the current study, cardiac care unit,surgical ICU, medical ICU, cardiothoracic ICU, the neuro-ICU, and the burn-ICU, are the critical-care units selected forthe current study. American Association of Critical-Care Nurses (AACN) stated that critically ill patients as thosepatients who are at high risk for actual or potential life-threatening health problems. A critically ill patient is highlyvulnerable, unstable and complex, requiring intense and vigilant nursing care. Hain(2007) explained that the presence of thenurse at the bedside is valuable for the care of the critically ill. He also postulates that the population of critical care patients will increase due to higher life expectancy. He reports that,annually, more than five million patients are currently admitted to critical care settings. This increase in the number ofpatients will further result to increase shortage and the demand for critical care nurses.

Organizational commitment is the ability of an employee to act in such a way that meets the organization's goals andinterests. Employing committed employees is essential to organizations. It was noted that the importanceof commitment in understanding the work behavior of employees in organizations. In the nursing profession, commitment is critical. Empirical evidence indicates that there is a direct correlation between staff satisfaction andpatient satisfaction in healthcare organizations. Organizational culture of

trust and justice can be measured by the levelof nurses' satisfaction, commitment, and the quality of care that are rendered to the customers. Studies about organizationalcommitment are prevalent as the pursuit to improve organizational effectiveness and commitment, especially innursing profession. Previous studies indicated that unsatisfied health care employees negatively affect the quality of carewith adverse effects on patient satisfaction and loyalty to the organization. Research showed that organizations thatpromote job satisfaction and career satisfaction reap the benefits of increased retention and reduced attrition (Williams, 2006).

Nogueras (2006) examined how intent to leave nursing predicted job commitment, education, and experience. A sample of908 nurses participated in the study. Correlation between Registered nurse continuance commitment and intent to leavenursing revealed a relationship that was significant (r = -.14, p = .00). The results implied the more continuancecommitment Registered Nurses experienced, the less likely they were to leave nursing. Krichbaum*et al.* (2007) blamed jobdissatisfaction and lack of organizational commitment on the part of nurses on something they call "Complexity Compression" (CC). Using focus groups and open discussions concluded that increasingly stressful and complex demands on nurses have created a new phenomenon (i.e., ComplexityCompression) that is causing widespread job dissatisfaction among modern day nurses.

Commitment to an organization occurs to the extent that employees perceive some beneficial or equitable exchange relationship. Employees who feel that they are cared for by their organization and managers also have not only higherlevels of commitment, but they are also more conscious about their

responsibilities, have greater involvement in theorganization, and are more innovative. Research indicated that employee commitment is antecedent to and inverselycorrelated with turnover intentions and turnover. Wu and Norman studied a sample of full-time final-year degreelevelChinese nursing students. Wu and Norman found a positive correlation between job satisfaction and organizationalcommitment (r = .464, p < .01), indicating that student nurses who were more satisfied with nursing as a job were alsomore likely to be committed to the nursing profession. Job satisfaction is vital to nurses' lives that can affect patient safety,Clinical practice is another significant component or training requirement of student nurses. It is compulsory for all student nurses and must be supervised by both nursing tutors and ward in-charges in the hospitals. Clinical practice exist in two forms and include demonstration room activities in the college which is supervised by tutors and the ward clinical sessions which is supervised by both tutors and the ward in – charges as well as other qualified staff nurses. Under normal circumstances according to Standards of Hospice Nursing Practice and Performance (1995), a clinical demonstration room in a college must be well equipped with all items that nurses work with in the ward. Students must be scheduled for clinical experience in the demonstration room, with an average attendance of between 3 to 5 times in a week. This is expected to enhance their understanding on the various nursing procedures taught in the lecture halls.

Weak governance in setting the agenda and providing direction by senior managers to lead, mentor and guide staff persists. This is mainly attributed to ineffective communication with poor feedback, poor interpersonal relationships leading to poor information flow on policy and strategic issues to

lower levels. In addition, inadequate delegation of responsibilities with micromanagement leads to poor team spirit, morale and low performance. Problems of weak planning processes leading to non-realization of goals and objectives continue within the Ghana Health Service (GHS, 2005).

There is insufficient monitoring and supervision across all levels of the GHS, contributing to a general lack of commitment and little accountability for performance. Inadequate support and oversight from the national level to the regional and district levels through supervisory visits and performance appraisal also leads to reduced morale and sometimes indiscipline of lower-level managers. Self-assessment or routine assessment of individual performance within GHS is lacking probably due to non-functional appraisal system with no uniform tools for assessment and if available not well disseminated and shared with all managers. There is also a huge challenge with reporting systems within the service. Hence data is often not used in defining district priorities, planning and resource allocation. This creates a gap between data collection and the decision-making process. Inadequate information also hinders effective planning, monitoring and evaluation of health services, and poor data quality leads to inadequate utilization of information for policy decision-making GHS (2003).

Accountability of staff to patients and clients and the inability to deliver the very best of ourselves is a major weakness. Facilities are the face by which the GHS is judged, yet staff attitude towards clients and work leaves a lot to be desired, resulting in low productivity. Low quality of clinical services below the approved standards persists in most facilities and there is inadequate number of accidents and emergency units in health facilities. Production of the

human resource has not been matched with need. The human resource planning process does not take into account the standard institutional requirements. This is compounded by GHS inability to define and attract resources to meet the standards and norms for each level of care/operation (GHS, 2003).

Chronic staffing imbalance due to attrition and inequitable distribution continue to plague the GHS despite various efforts and initiatives to retain and deploy staff to the rural areas. The situation is further compounded by an ageing workforce negatively affecting the uptake of services. The introduction of National Health Insurance Scheme (NHIS) has brought with it challenges leading to increased workload and overreliance on casual staff. There also appears to be lack of coordination between population needs and the management of the human resources available. Despite increasing human resource investment, poor staff attitude and low productivity continue to persist with intermittent strike action resulting in decline in utilisation of services in health facilities (GHS, 2005).

The Ghana Health Service has no direct stake in the enrolment into and curriculum of Health Training Institutions. The numbers recruited in these institutions are not matched with the Service requirements based on projections. This fundamentally underpins most of the critical human resource shortages, particularly, nurses, midwives, laboratory assistants and Medical assistants (GHS, 2003).Workers also suffer a couple of problems, some of which are job related and it beholds on management of organizations to identify and support victims of such problems. Occupational hazards can take several forms. In hospitals, especially the psychiatric hospitals, the most

common of these problems include occasional attacks on nurses, doctors and ward assistants by aggressive patients.

A study by Gandiri (1992) at Nigeria revealed a case in which a psychiatric patient severed the ear of a psychiatric nurse in the ward. In line with the International Labour Organization (ILO) policy on occupational hazards, every victim of occupational injury must be appropriately compensated by way of free medical treatment, procurement of medical aids including prosthesis and depending on the degree of disability, a percentage entitlement of salary among others.

Adams and Stephany (2001) also noted institutional support systems and policies as major factors that influence job performance on the part of workers. The most notable of these systems include motivation in terms of staff promotion, granting of annual/study leaves, promotion of effective/healthy communication, provision of accommodation for staff, organization of annual get together with awards, recruitment of adequate number of staff and the adoption of appropriate compensation for victims of occupational injuries or hazards among others.

In the MOH and Ghana health service, annual leave of one month duration is compulsory for every staff. The role of effective channels of communication cannot be over- emphasized in relation to productivity. People get de-motivated and frustrated if they do not know the patterns of communication in their organization, who to confront with their needs/problems, or what they should expect at any given point in time

The medical stories one hears at parties rarely praise practitioners for their ability to communicate effectively. Rather, people usually tell about

volumes of jargon, little feedback, and depersonalized care. Clearly, the quality of communication with the practitioner is important to the patient, but the question is whether it does more than produce a vague sense of satisfaction or dissatisfaction in the patient's mind. The answer is "yes". Poor patient-practitioner communication has been tied to outcomes as problematic as patient noncompliance with treatment recommendations and the initiation of malpractice litigation (Abnorey, 2007).

Makabila (2006) reported that there was public concern in Kenya that medical practice had become more hazardous because caretakers perform most of the patient care duties due to nursing shortages. Medical practice is also increasingly becoming impersonal and dehumanized. The Kenya Institute of Public Policy Research and Analysis report of 1994 indicated that facets of patient satisfaction range from politeness of providers to the time spent waiting for service. The report also recorded complaints that nurses in Kenya's public hospitals were rude, impolite, and offered cold reception. Promotion of the patient's dignity through respect, empathy, courtesy, advocacy, and a short turn-around (response) time form the core commitments in the Kenyan charter of patients' rights. Similarly, the nurses' training curriculum emphasizes humaneness. This is implied by the objective that nurses should support their patients at all times, and that their care should enable those who are dying to do so with dignity.

Despite these clear policy statements, public perception in Kenya still points to blatant violation of patients' rights through verbal abuse. There is a demonstration of the interdependence of dignity, patients' rights, and broader human rights. This relationship forms a basis upon which to ascertain the

validity of the perceptions of Kenyan patients and nurses on the impact of acts that violate dignity on the chances of the realization of rights. Nurses are the gatekeepers of doctors' operations, and also serve as patients' advocates. Their actions and utterances can therefore determine the extent of patients' access to health. The nurses' critical role of control can frustrate or facilitate the patients' access to health, which is a basic human right (Mbinyo et al., 2006).

Quality services can also be guaranteed when organizations have the right number of workers. Gandiri (1992) estimate the required nurse- patient ratio of 1:4 per every unit. Work overload can result from cases of fewer nurses attending to large number of patients. The skeletal staff could get exhausted as they may occasionally have to stay and work beyond eight hours a day which is unacceptable by ILO standards. Work overload on health workers invariably can lead to burn-out and some may manifest this by projection of anger on patients as well as work absenteeism in extreme cases.

Another significant factor in relation to productivity in organizations is the development of code of conduct. Codes of conduct define acceptable standards of behaviour in organization and therefore serve as basis of disciplinary action against misconduct. Workers in most cases may report late to work, engage in other private activities during official working hours, appearing insensitive to the needs of their clients/customers and in advance cases may not even tend up for duties at all.The Ministry of Health, in an award-giving ceremony, highlighted the professional staff situation of the health sector. There has been mass exodus of nurses all over the country particularly in the regional capitals. This brain drain in the sector has affected the quality of nursing care.

A study using a five-point Likert type scale ranging from 'strongly agree' to 'strongly disagree' with seven statements regarding the nurse attitudes towards caring for patients with HIV and two statements regarding perceived risk of occupational HIV infection has shown that nurse's unwillingness to care for such patients was associated with a lack of prior experience in STD patient care and the majority perceive their risk of occupational infection with HIV as 'high' especially following a needlestick injury with a needle contaminated with HIV-positive blood (Kermode et al.,2005). Studies have also shown that nurses want to prevent themselves or colleagues from becoming infected after experiencing a needle stick accident (Tsai &Hsiung, 2003). Studies have also shown that nurses who have training in communication aspects of STD care are better equipped to care STD patients.

There are various ways in which workers in organizations can improve upon their knowledge and skills in order to provide better services. A significant aspect of this is the individual worker's interest; desire to cultivate continuous reading habit especially in line with his or her job description. Versatile reading exposes an individual to innovative methods of carrying out procedures and in the case of health workers – nurses, doctors and other paramedics – can benefit from new and improved medical discoveries.

Al-Hussani(2008) revealed a strong association r (55) = .90, p < .05 between job satisfaction an organizational commitment.Supporting these findings is a descriptive and explorative study done by Altuntas and Baykal (2010), to investigate both thelevels of nurses' organizational trust and citizenship, and also the relationship between the two factors and found that the nurses' level of organizational trust was directly associated with positive

citizenship organizationalbehaviours, such as conscientiousness, courtesy, altruism and civic virtue. Spector (1997) stated that job satisfaction is howpeople feel about their jobs and different aspects of their jobs and suggested that job satisfaction is important for three reasons: The humanitarian perspective which required that people respected and treated fairly which is areflection of good treatment to the employees, The utilitarian perspective is that job satisfaction can lead to behavior byemployees that affect organizational functioning, and Job satisfaction can be a reflection of organizational effectiveness.

In today's competitive health care environment, recruiting and retaining top talent is very essential in meeting the demandfor quality patient care and management. Study showed that healthcare organizations that implement strategic initiativesthat enhance staff satisfaction have higher Healthcare Consumers Assessment of Hospital Performance (HCAHP) scores,higher reimbursement, and revenue. Organizational performance such as productivity, retention, customer service andloyalty, employee retention, and turnover correlate to employee engagement to the organization. Nurses with higherjob satisfaction care about the quality of their work, are more motivated and committed to the organization, are moreproductive, and have higher retention rates. Nurses who feel that their contributions are noticed experiencesatisfaction, and nurses who experience satisfaction stay where they are, contributing to organization retention (Upeniek,Akhavan,&Kotlerman,2008).

Employees who are satisfied with their work are more engaged more productive, creative, and commitment to their organization. The demand for

critical care nurses is high. The unique work settings in critical care nursing, impactsjob satisfaction among nurses and patient care outcomes. The work environments in critical care nursing andburnout and stress have a relationship to job satisfaction of nurses. Job dissatisfaction of nurses affects commitment to the organization. It has been noted that critical-care setting is a stressful environment and the existence of nurseshortage further increases stress among critical-care nurses.

In recognition of this fact, the Ministry of Health (MOH) in collaboration with the Nurses and Midwives Council (NMC) has formulated basic policies that are expected to help uphold and sustain the knowledge and skills of staff for quality service delivery in the hospitals. The most notable of these initiatives is the introduction of in – service training programmes on nosocomial infection, regenerative health, patient's charter and infection prevention and control among others. The significance of in- service training, conferences, workshops and seminars cannot be over emphasized. Apart from exposing staff to new ideas and methods of carrying out medical and nursing procedures, it also provides more favourable platforms for staff interaction and release of work – tension, thereby refreshing their minds and giving them renewed strength each time they get back to work (Khardi, 2001).

Handy(1990) in an in-depth case study examined stress in psychiatric nursing in England from a different perspective. She used qualitative techniques to collect data of nurses working in two wards within a large psychiatric hospital and a community psychiatric nursing unit attached to the same hospital. She found that stress in psychiatric nurses occurs due to the contradictory therapeutic role which is attributed to the concept psychiatric

care and the control-oriented practice which is used to organise daily activities. However, nurses failed to understand that in order to increase their understanding - particularly on occupational stress- they need to consider the factors affecting the organisation as well as the social context of psychiatric wards. Thus, nurses -especially the young ones- who haven't developed defensive mechanisms feel frustrated when their attempt to improve patients' quality of life is unsuccessful. Hence, Handy[30] concluded that nurses through that process are dissatisfied and the effort to recreate the formed system in the ward causes stress and dissatisfaction to psychiatric nurses.

Health Care Quality Assurance Manual (2000) indicates that good interpersonal relations make the care delivery environment friendly both for the health care provider, and the user of the service. Health professionals must make conscious effort to improve their inter-personal relationship. Aspects of the interpersonal relationship that need particular attention are the attitude of staff to patients, patient's relatives, availing relevant information to clients and allowing them to make good informed decisions.

Changes underlying the philosophy of health care delivery are affecting how patients and practitioner relate to each other. Among such is the philosophy of holistic health, which has led to a very different type of patient orientation among practitioners who subscribe to this orientation. Increasingly, health care is characterized by a belief that health is a positive state to be actively achieved, not merely the absence of disease. Often service improvement strategies in health care have emphasized cosmetic aspects of the service relationships. Nurses are keenly aware of working with people who are emotionally drained and emotionally charged, and facing traumatic life

circumstances. Making them happy hardly seems like a relevant goal, and nurses perceive it as superficial and discounting of the important work they do (Friedman &Dimatteo, 1979).

Resistance to raised service standards is also understandable when nurses perceive leaders as doing too little to remove obstacles to provide excellent care and service. Broken equipment, linen shortages, short staffing, inadequate support in the face of disrespectful doctors – all of these and more obstacles contribute to poor care quality. Cynical nurses who are very dedicated to patients and families sound their frustration over past initiatives that raised their hopes but then fizzled due to lack of follow-through by the organization's leaders (Health Care Quality Assurance Manual, 2002)

Patient and relatives are not merely saying that the nurse should smile, as did the old family nurse, while giving care. Nor are they saying that the nurse should remember that the patient is a person with feelings, and should be treated as such as a matter of civility. Rather they are proposing that interpersonal relations are a part of the basic process of healing. Ignoring these factors is not an error of ethics or courtesy; it is a scientific error (Friedman &Dimatteo, 1979).

Summary

The nurse patient-relationshipsets the tone of the care experience and has a powerful impact on patient satisfaction.The nurse working in the accident and emergency department must learn to hide her feelings of fear, horror or uncertainty from her patients. If these are allowed to surface she may fail to win her patient's confidence and trust.

The attitudes, beliefs, and opinions, present in the hospital environment, are complex. These attitudes and stereotypes are present in many societies, including Ghana. Nurses, given they arguably spend the most time with patients, must deal with these when treating patients with varied problems.

The attitudes of society, which depict people with alcohol problems as a dangerous, weak-willed, immoral "drunk", but also stereotypes of these patients as difficult and unrewarding, as well as nurses' own personal or professional experience and their judgments of how deserving these patients are of their care. These beliefs can all shape and influence the relationship that forms between a nurse and his or her patient.

CHAPTER THREE

METHODOLOGY

This chapter describes the type of study, the target population, research setting, the sample and sampling technique used in the research. Attention is also focused on the pre-testing, instruments used for data collection, the validity and reliability of the instruments and the method or procedure for data collection as well as data analysis.

Research Design

The research design used for this study is descriptive, non-experimental survey that assesses the factors influencing nurses' attitude towards patients with emergency needs in the Cape Coast Metropolis. This method of investigation attempts to describe, analyze, interpret and report what exists at present in the form of attitudes. The word survey indicates the gathering of data regarding current conditions. Normative is used because surveys are frequently made for the purpose of ascertaining the typical or normal conditions or practice (Sidhu, 2003, Ary, Jacobs &Razavieh, 1990). According to Ary, Jacobs &Razavieh, (1990) descriptive research studies are designed to obtain information which concerns the current status of phenomena. Descriptive research studies aims at determining the nature of a group or a situation in existence at the time of the study. Best and Kahn (1993) indicates that any similarities in individuals outside the group to be studied cannot be assumed. Thus descriptive surveys are meant to describe one group and one group alone.

From Descombe (2003) view, a survey suggests that the research has involved an active attempt by the researcher to step out, observe and search for information. He maintains that surveys are associated with deriving information 'straight from the horse's own mouth' and that the information is solely purposeful and structured. Descombe further states that surveys are easily associated with large scale research, covering many people and events. This enables the researcher collect enough data, that would best give an appropriate description of the nature of the group to be studied at the time of the study. The breath of coverage validates the scores of a research when it is to be generalised. If the coverage is suitably wide and exclusive, it gives credence to credibility to generalised statements on the basis of the research. This strategy supports the use of methods such as the use of questionnaires, which can help generate large volumes of quantitative data for statistical analysis. Surveys are known to save cost and time. Descombe (2003), however states that data produced from surveys are likely to lack detail or depth in relation to the topic under investigation, despite their ability to cover a wide population. Emphasis placed on wide and exclusive coverage, limits the degree to which the research can check accuracy and honesty of respondents.

Frankel and Wallen (2000), views the set of carefully designed and administered questions the bedrock to obtaining answers from a large groups of people. They outlined three key advantages associated with descriptive surveys:

1. It provides a meaningful picture of events and seeks to explain people's perceptions and behaviour on the basis of information obtained at a point in time.

2. It can be used with greater confidence with regard to particular questions which are of special interest and value to the researcher.
3. Follow-up questions can be asked and items that are not clear can be explained further.

Frankel and Wallen (2000) also outlined a number of disadvantages including the difficulty of ensuring that questions to be reacted to, have exact wording. Data is able to produce untrustworthy results due to its tendency to delve into private and emotional matters which respondents might not be completely truthful.

Population

Population is described as a group of elements or cases, whether individuals, objects, or events that conform to specific criteria and to which we intend to generalize the results of the research. This group is also referred to as the target population. Creswell (2002) further describes population as a complete set of individuals (subjects or events) having common observable characteristics in which the researcher is interested. That population can be of any size and can have at least one or more identifiable traits that are set in any other population.

Although the study aimed at all health facilities in the Cape Coast Municipality, most health facilities in the municipality do not have emergency units and thus do not provide emergency care services. The study was carried out inthe three main hospitals in the Cape Coast metropolis of the Central Region providing emergency care services. They are the Cape Coast Regional Hospital, Cape Coast Metropolitan Hospital, and Cape Coast University

hospitals which are the hospitals in the Cape Coast Municipality. With the exception of the Cape Coast University Hospital which is under the management of the Cape Coast University authority, the Regional and Metropolitan hospitals are Government hospitals. These health facilities are near the Takoradi-Accra highway and get its fair share of accident and emergency cases. They are also in the regional capital and thus attend to about seventy percent of the population in the metropolis. The accident and emergency centres of the hospitals are adequately equipped with the needed facilities for an effective and efficient working environment. They have a bed capacity of thirty averagely.

The Accidents and Emergency Unit centres in the hospitals in the Central Region care for a variety of patients' complaints such as minor illnesses, critical medical conditionsofneonates and the elderly to injuries or trauma patients. The staff includes doctors, registered nurses, critical care nurses and nursing assistants. The unit provides patient-focused care while maintaining a team attitude and approach. All attending physicians are board certified in Emergency Medicine. Residents, interns, medical and nursing students from other services also rotate through the accident and emergency for training, providing all members of the health care team opportunities for clinical education and teaching (Bosu, 1991).

The population and the sample was the same since the whole population of nurses at the emergency units of the selected hospital was captured. The target population for the survey consists of ward nurses employed during the period of administration of the survey. The estimated number of emergency care nurses was 210. From this, the wards were visited

and all nurses working on the morning, afternoon and night shifts were approached. The nurse manager's on each ward were notified of the planned times for survey administration and collection. The administration of the instrument was done two hours after the nurses had resumed duty and settled-in. The total number of instrument administered was two hundred, however, only one hundred and fifty was retrieved. The total population was used on the premise that the accuracy of data is determined by absolute sample size and also because the population was small and the time needed in administering the instrument was adequate (Sidhu, 2003).

Sample and Sampling Technique

Sampling refers to the process of selecting a portion of the population to represent the entire population. In this study, Census sampling technique was applied since the three hospitals in the municipality happen to be the only ones proving emergency care services. Then again due to the limited number of nurses in the emergency care units in the hospitals, the whole population of nurses at the emergency units of the hospitals were used.

The mean age of the participants was 30.5 with a standard deviation ±8 years. The youngest respondent was 20 years old and the oldest was 53 years of age. The sample was 63% (n= 94) female and 37% (n = 56) male. Approximately 49% of the sample were junior registered nurses and 51% were senior registered nurses and allied health disciplines. Of the nurses, approximately 49% were diploma graduates; 35% had post diploma certificate in nursing; 12% had a degree in nursing; 2% had master's preparation in nursing; and 2% had received a degree outside of nursing. The mean number of

years as a nurse was 17 years with a standard deviation of ±10 years. Of the nurses who participated, 39% listed their current or most recent primary work area as medical-surgical; 27% as paediatrics; 15% as geriatrics; and 15% as psychiatry. With regard to marital status, the majority of respondents (49%) (n = 74) were married; 47% (n = 71) were single; and the remainder of the sample was widowed, separated, or divorced. Among the respondents, 61% (n = 91) had no children while 39% (n = 59) had a child at the least.

Research Instrument

In educational research there is the use of varied data gathering methods, with special areas of study having to use specified methods in gathering data. Some methods are also selected based on their appropriateness. Nwana (1981) points out that, data on educational research may be gathered through a variety of ways namely: study of documents, filling out of questionnaire by persons, observation of people and objects and interviews of persons.

A questionnaire is a set of questions prepared and distributed to secure responses on an issue personally from respondents. It collects both quantitative and qualitative information and is for indirect data collection. A questionnaire can be standardized or self-developed. A structured questionnaire was self-designed to obtain data for the study. This is also in line with suggested guidelines from Nwana (1981) and Sudman and Bradhurn (as cited in Cohen &Resse, 1994). The guidelines helps check for length, wrong wording and poor organization.

The questionnaire contains forty seven questions; personal information, knowledge and skills on medical emergency, behaviour of patients, nurses'

attitude and its influence on care outcomes. This questionnaire format was in two parts. The first part applied a bi-polar Likertuni-dimensional Scale with five possible answers for both sites. The answers ranged from 'definitely more', 'somewhat more', 'equal', 'somewhat more', to 'definitely more'. These five positions were assigned scores from 5 to 1 or sometimes 4-0. That is if agreement to the question indicates a positive attitude. If the question is written in such a way as to require disagreement with it to indicate a positive attitude reverse scoring is used. In this study, four positions were used.

The number of positive and negative questions was roughly the same to ensure a balanced result. The questions should also be scrambled by putting then in more or less random order in the questionnaire (Oppenheim 1992). The individual question choices should also be balanced with regard to alternatives, equal number in both the positive and negative direction.

Validity and Reliability of Instrument

The validity of the instrument is its ability to measure what it is supposed to measure (Ary et al., 1990). This was possible because ambiguous and irrelevant questions were eliminated during the pre-testing. Face and content validity was also affirmed by the research supervisor.

Reliability is the degree of consistency of the result derived after administering the instrument (Sidhu, 2003). To ensure reliability of the instrument, when conducted on two groups of people with similar characteristics, it indicates same trends in the responses and proofs the consistency of the results and its ability to be generalized. To establish the content validity and reliability of the instrument, data was collected using a bi-polar the Likertuni-dimentional scale appropriate for measuring attitude

(Beaumont, 2009). The instrument embodies both knowledge and attitude items, as such the internal consistency, reliability coefficients which was analysed separately.

The validity of the questionnaire is endorsed by the fact that differences were foundbetween nurse attitude to care of patients requiring emergency care andfactors such as patient characteristic, job satisfaction, institutional factors and the nurses' personal characteristic. The reliability and validity of the research instrument was computed and the Cronbach's alpha Coefficient was 0.68 or 0.7.

Pre-testing

Prior to the actual administration of the instrument, a pre-test was conducted to predict the attitude of the target population. This group included nurses with different levels of working experience on target wards for the purpose of analysis. A pre-test is conducted on a limited number of participants,prior to the main study to pre-test the questionnaire for any ambiguitiesand inaccuracies (Burns & Grove, 2007) and also the validity and reliability of the questionnaire. The initial questionnaire was administered on a small group of 40 respondents at the emergency unit of theEfiaNkwanta Regional hospital. A quota sampling technique was used to select theparticipants for the pre-test and these participants were excluded from the main study. After pretesting, poorly worded items were modified and new items added.

According to Burns and Grove (2009) purposive sampling, a non-randomconvenience sampling technique, is used to ensure that the knowncharacteristics of the target population are represented in the sample.

Thetarget population was known to include nurses working in the emergency unit of the hospital.

Data Collection Procedure

Prior to the collection of data from respondents, approval from my supervisors and preliminary contact with the nurse managers and medical directors concerned was sought; through an introductory letter collected from the Department of Health, Physical Education and Recreation. An oral explanation on the requirement of the instrument was given to the nurses prior to its submission. With the help of four students nurses the questionnaires were administered to all the nurses stationed at the emergency departments of hospitals in the Cape Coast metropolis to answer appropriately and collected immediately after filling. This was done to facilitate immediate collection of data, recovery of most of the instrument and also avoid biases due to consultations among the respondents.

Data Analysis

Data analysis is the ordering and breaking down of data into constituent parts and the performing of statistically calculations with the raw data to provide answers to the research questions which initiates the research. In the analysis, the responses to the questionnaire were categorised and edited to determine their uniformity, accuracy, consistency and appropriateness. The data was coded for easy tabulation on the computer and also to confirm the actual number of respondents scoring in each category of a variable.

Descriptive statistics were used to describe and summarise the data (Brink, 2006). Frequency distributions were compiled and measures of central tendency were determined. Descriptive inferential statistics also provides some

information concerning the distribution of scores on continuous variables (skewness). This information may be needed if these variables are to be used in parametric statistically techniques (e.g. t-tests, one-way ANOVA). Skewness was used in analyzing variables in research question one and two, (nurses' attitude and patients' characteristics that influence nurses attitude). The skewness value provides an indication of the symmetry of the distribution. If the distribution is perfectly normal you would obtain a skewness value of 0.

If Skewness is positive, the data are skewed to the right, meaning that the right tail of the distribution is longer than the left.Data that are skewed to the right have a long tail that extends to the right. An alternate way of talking about a data set skewed to the right is to say that it is positively skewed. In this situation the mean and the median are both greater than the mode. As a general rule, most of the time for data skewed to the right, the mean will be greater than the median.A positively skewed distribution also indicates respondents operating within the approved ethical standards prescribed by the profession.

The situation reverses itself when we deal with data skewed to the left. Data that are skewed to the left have a long tail that extends to the left. An alternate way of talking about a data set skewed to the left is to say that it is negatively skewed. In this situation the mean and the median are both less than the mode. As a general rule, most of the time for data skewed to the left, the mean will be less than the median. If Skewness is negative, the data are negatively skewed or left, meaning that the left tail is longer, hence respondents' characteristics influence nursing care which is contrary to ethical standards. If skewness = 0, the data are symmetrical. Bulmer as cited by Brink (2006) suggested this rule of thumb:

1. If skewness is less than -1 or greater than +1, the distribution is highly skewed.
2. If skewness is between -1 and -1/2 or between +1/2 and +1, the distribution is moderately skewed.
3. If skewness is between -1/2 and +1/2, the distribution is approximately symmetric.

An analysis was carried out to find differences of group means of therapeutic attitude under each demographic attribute. Analysis of variance was used to examine differences between variables, for example if the differences in age, religious beliefs, marital status and ranks of nursesinfluencetheirattitude to the careof patients requiring emergency services. Furthermore, inferential statistics was used to make inferences about the population and significance of the study (Brink, 2006).

Analysis of data collected for research question two, three and four was through t-tests and One-way Analysis of Variance (ANOVA). The t-test is used for numerical data to determine whether an observed difference between the means of two groups can be considered statistically significant. ANOVA however takes into account more than one independent variable. In analyzing research question two, the personal characteristics of the nurses such as their age, rank and professional experience would be considered to estimate the difference (if any) is between the nurses' characteristics such as rank to working experience.

In research questions three and four, a test of the nurses' work experience against factors such as clients' appreciation of emergency services,

training of staff and working environment at the emergency unit was analysed. The t-test was used to estimate the significance of the analysis.

CHAPTER FOUR

RESULTS AND DISCUSSION

This chapter is a presentation of the results of the analysed data collected and their discussion.This study sought to explore personal characteristics ofnurses, patients'characteristicsand to assess their influenceonnurses' attitudes toward the care of patients requiring emergency care. Findings indicate that, contrary to expectations, on average nurses have rather positive, or at least quite neutral, attitudes towards patients requiring emergency care.

Research Question 1: What is the Emergency Nurses' Attitude to Emergency Patients?

Figure 1 shows the main variables used in the analysis. There is a normal curve with a near perfect skewness (0.014), a low value indicating values from both sides are clustered around zero (0). It can thus be deduced from the graph that the attitude of nurses to patients requiring emergency care is neutral and influenced by patients' characteristics.

Although the results of this study indicate that generally nurses' attitude towards patients requiring emergency care is neutral. Reviewed literature indicates contrary, that nurses are inclined to attend to victims based on their personal beliefs, religion and societies perception of the victims' situation. Levitt, (1963) reiterated that health professionals attitudes are clouded by the attitudes that emanate from society and these beliefs are internalized and become part of their belief system.

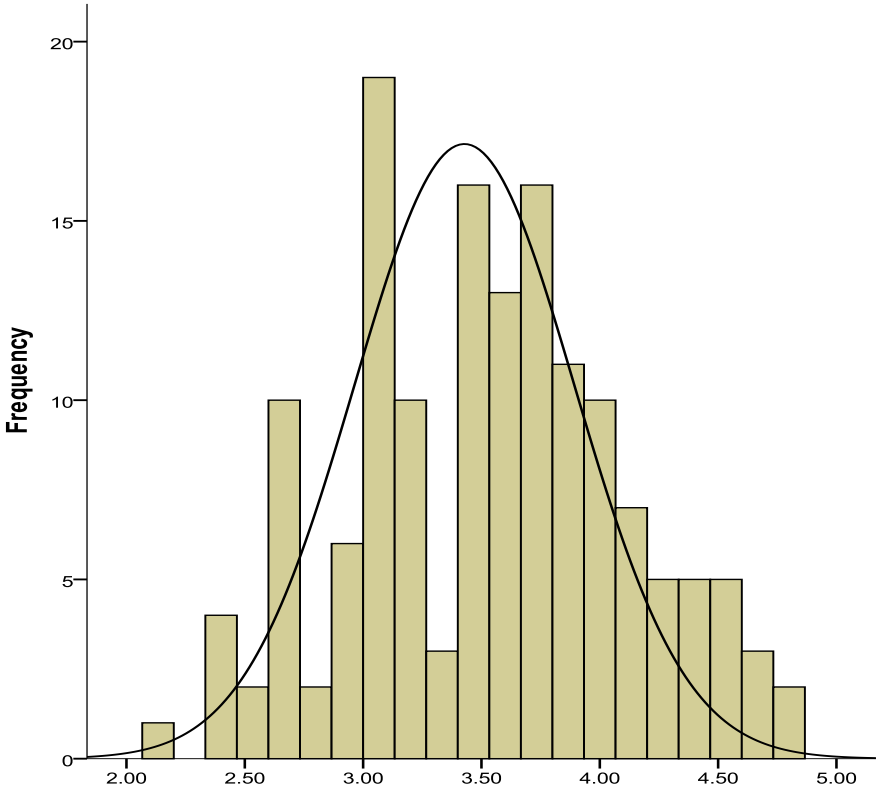


Figure 1: Nurses Attitude to Emergency Care

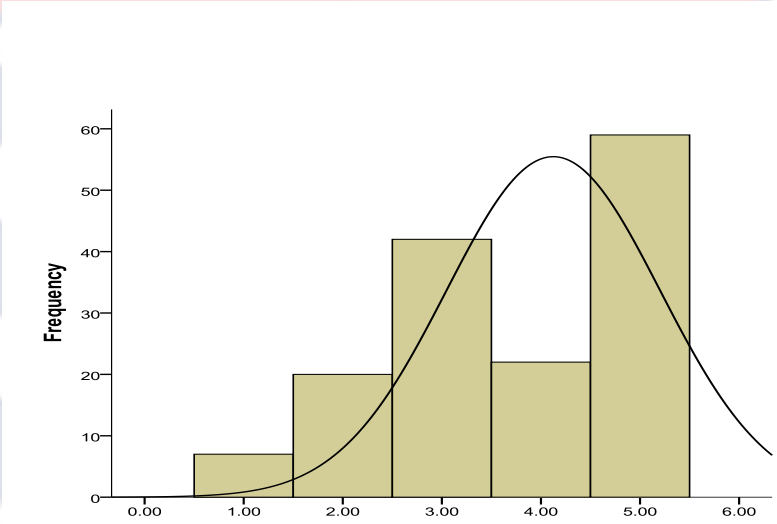
Kermode (2005) and GańczakandBarss (2007) in their study recapped perceived risk of fatal occupational infection and previous experience in STD care having an influence on attitudes of nurses to such patients. Additionally, in contrast to results of this study a survey measuring the constructs of avoidance and empathy to describe nurses' attitudes and care practices related to patients has shown that nurses have relatively low avoidance and high empathy and hence, are comfortable treating such patients (Martin &Bedimo, 2000).

Researchers, Webster-Stratton, Glascock and McCarthy (1986), Crampton (2007) adds that nurses have negative attitudes towards patients and argues that, a good nurse needs both technical skills and the ability to care on an emotional level for the well-being of patients. This means that the maintenance of high standards of care is particularly important since the rest of

the hospital's nursing staff may be judged by the standards of those in this small area (Hospice Nurses Association Standards and Accreditation Committee 1995).

Research Question 2: What Patient Characteristics Influence the Emergency Nurses' Attitude to Emergency Patients?

Figure 2 indicates a skew to the left.Negatively skewed or left tailed skeweddatameans that the left tail is longer, hence respondents' will more likely care for victims of domestic violence than the perpetrator regardless of ethical standards.

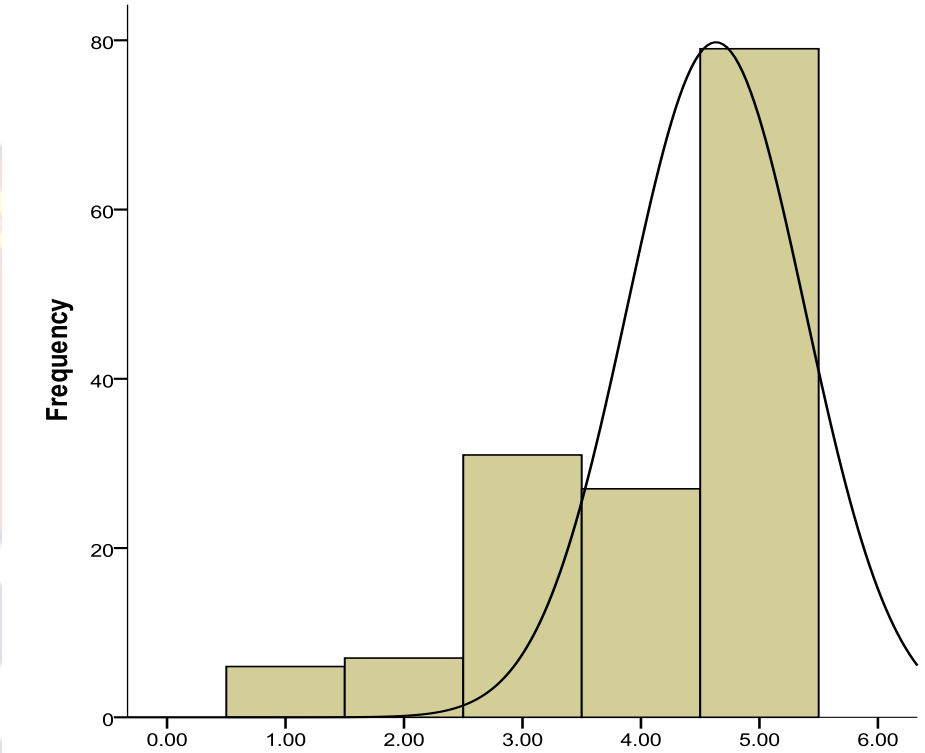


Perpetrator < ---------->Victim of Domestic Violence

Figure 2: Nurses Attitude towards Perpetrator versus Victim Domestic Violence

With reference to figure 3, there is a negative skewness of (-1) from the analysis of victims of domestic violence and their perpetrators. The tail of the graph is to the left, a high negative skewed distribution giving an indication that nurses at the emergency unit are inclined to care for victims of rape than the perpetrator of rape or that nurses appear to feel least comfortable dealing

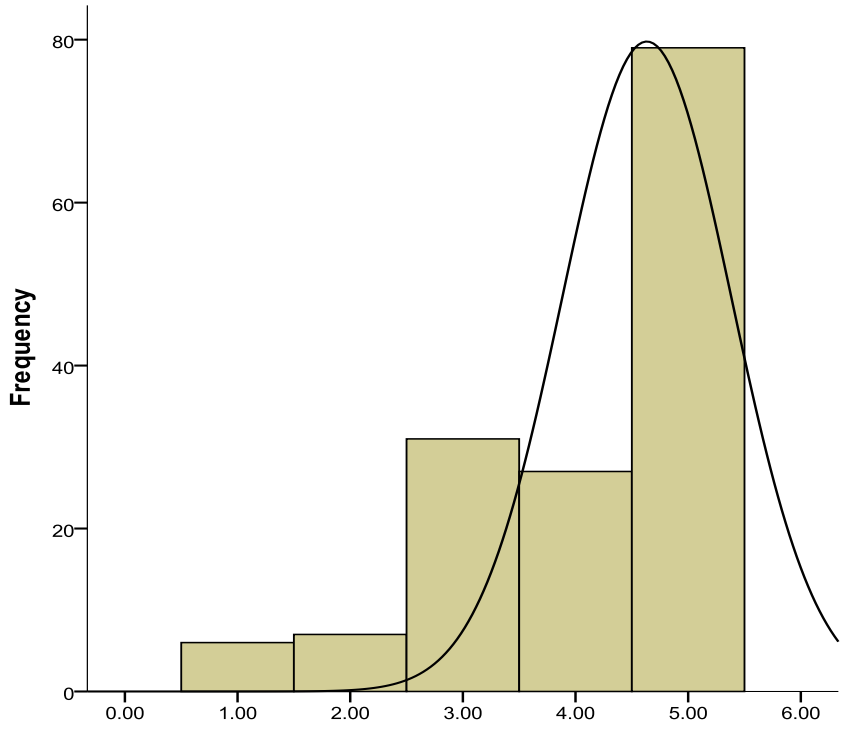
with situations involving sexually abused victims than the perpetrators' of sexual abuse.



Rapist <----------> Victim of Rape

Figure 3: Nurses Attitude towards Rapist versus Victim of Rape

Figure 4 shows a negative skewness since the tail to the left is longer than that to the right, with a skewed value -1.3. A highly skewed distribution noting nurses' comfort levels in dealing with sexual molestation. Nurses from this result feel more comfortable dealing with victims of molestation than sexual molester as in Figure 4.

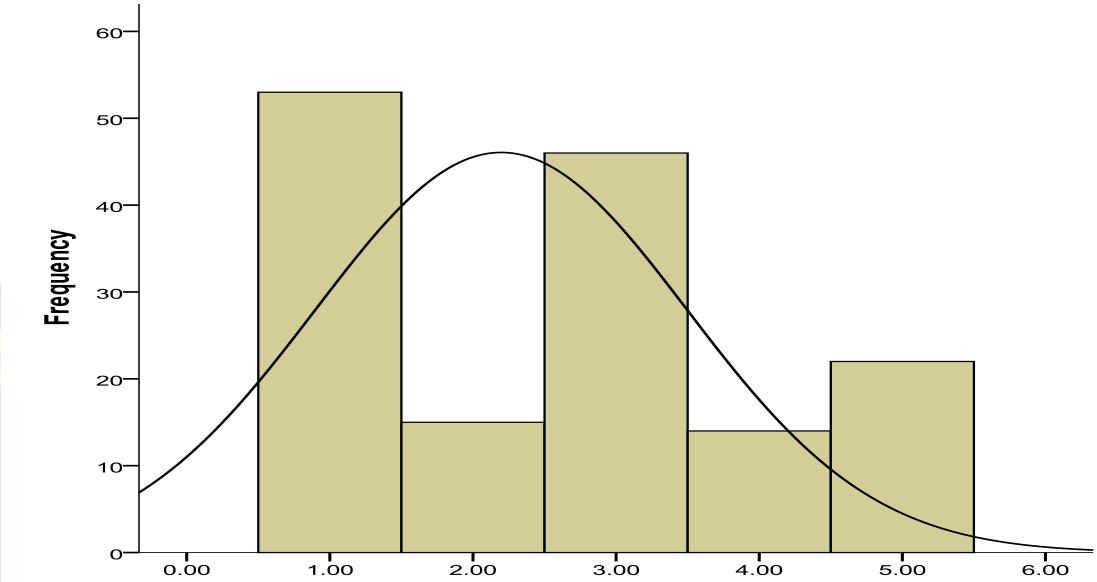


Child Molester < ----------> Molested Child

Figure 4: Nurses Attitude towards Molester versus Molested Child

Figure 5 shows there is a normal curve with a near perfect skewness (0.014), a low value indicating values from both sides are clustered around zero (0). It can thus be deduced from the graph that the attitude of nurses to patients requiring emergency care is neutral and not influenced by patients' characteristics.

Although there appears a normal curve in figure 6, the statistical results is a skewnessof -0.1, an approximately skewed distribution, suggesting that emergency nurses' care for a client who self –induceabortiondoes not differfrom care given to a patient who report with spontaneous abortion.



Suicidal < ---------->Victim of Attempted Murder

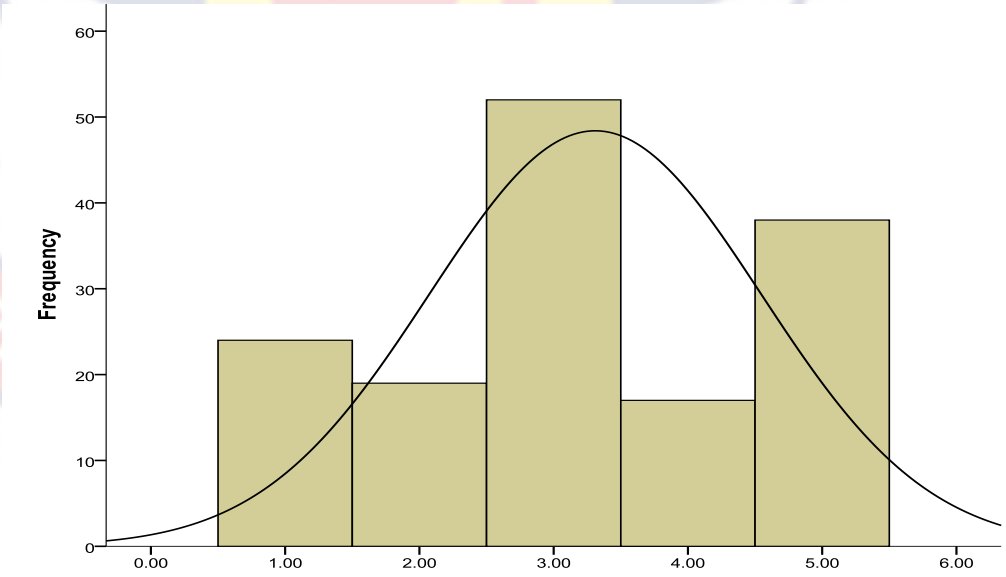
Figure 5: Nurses Attitude towards Clients who Attempt Suicide versus Victim of Attempted Murder

Stanton (1990), Finkelhor and Baron (1985), Seidl et al. (1993) and McCann et al (1985) documented that different characteristics (types) of abuse and professionals' beliefs and attitudes about children at different ages may contribute to their relative degree of comfort in dealing with child victims which is in agreement with results of this study. In agreement with the findings of this study Marshal (1994), McCann et al (1985),Yeun, (2004) and Marek, (2004) also submits that nurses who felt more comfortable dealing with victims of self- harm and had more objective interventions for those families than do nurses who feel uncomfortable dealing with abusive persons and contrary to findings from this study nurses who had in-service education have more positive attitudes than non-attendees. Significant differences were noted between nurses' comfort with sexual abuse and either physical or emotional abuse. Similarly, the nurses' reports on dealing with the various types of

abusers revealed that nurses seem least comfortable with an abusive client than the victim of abuse.

A possible reason for some of the respondents having reported negative attitudes towards the care of patients that have emergency needs, may well have been due to them not being able separate their personal bias and reactions to certain patients characteristics (Roche and Pidd, 2010) or due to them being uncomfortable with interacting, touching, or communicating with patients that have grave conditions.

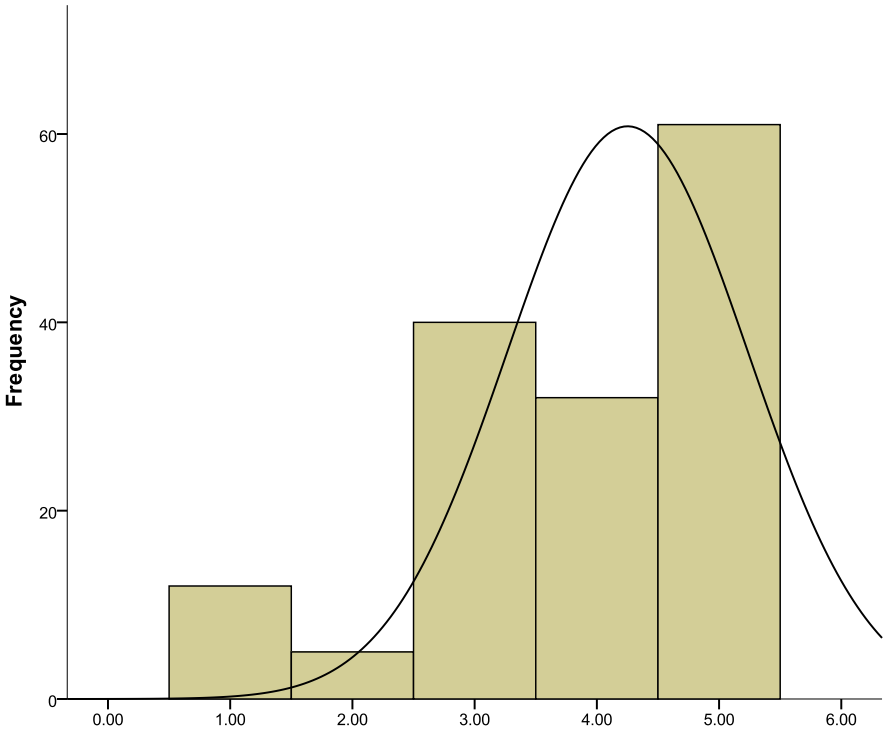
Levitt, (1963),Ducci and Goldman (2008), Allen (1993), Sullivan (1995), and Moodley-Kunnie (1988) further stated that the attitudes that health professionals have towards substance abusers definitely emanate from society. The negative transference of particular instances then causes a generalization about people with substance abuse problems.



Self-Induced Abortion < ---------->Spontaneous Abortion

Figure 6: Nurses Attitude towards Self-Induced Abortion versus Spontaneous Abortion

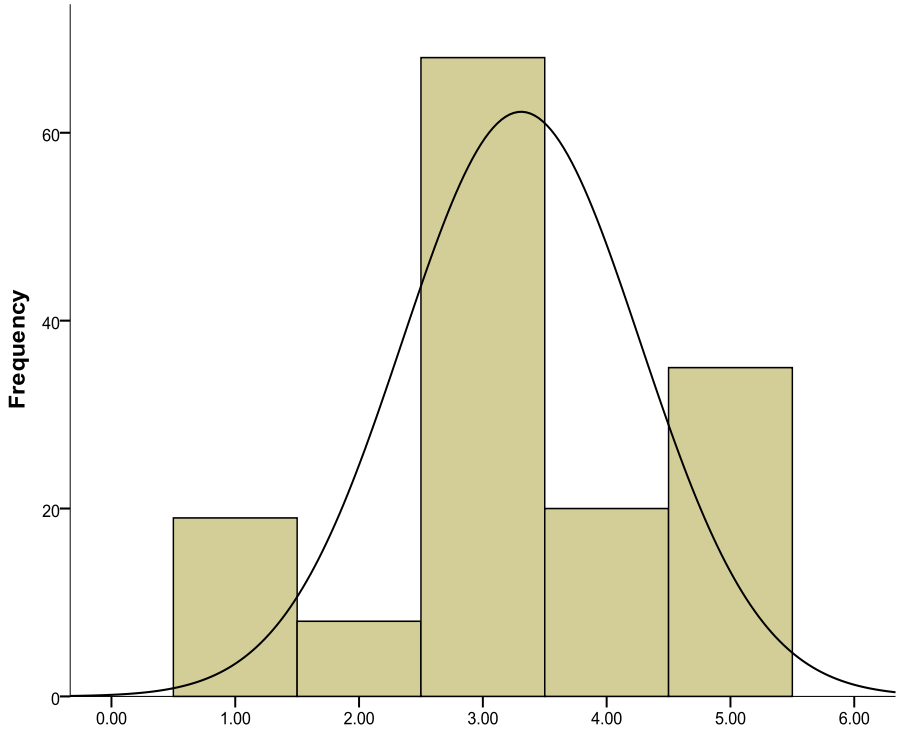
The results of skewness for figure 7 is -1, a highly skewed distribution to the left that pre- proposes that emergency nurses are likely to provide prompt care for clients with food poison than those who report with illegal drug use. Negative attitudes towards substance misusers are likely to make nurses reluctant to work with alcohol and drug misusers or provide minimal care to this group of patients.



Drug User< ---------->Victim of Drug Use

Figure 7: Nurses Attitude towards Drug Use versus a Victim of Food Poisoning

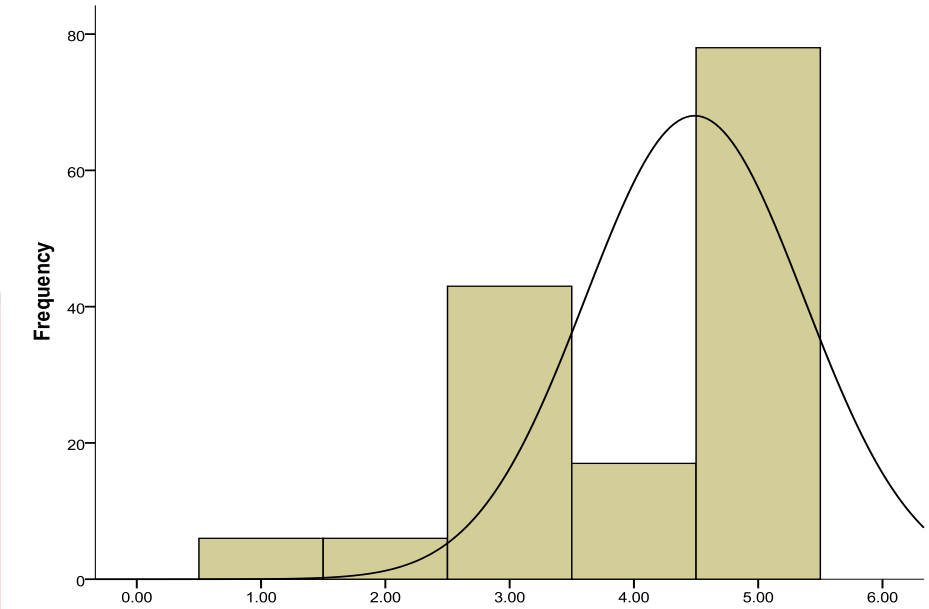
Figure 8 indicates the distribution is highly skewed with a skewness of -0.2, despite the normal curve. The general negative attitudes towards patients with alcohol problems observed in previous research are also repeated in this study meaning nurses at the emergency unit are more prone to providing prompt medical care for victims injured by a drunken than the drunk.



Drunk<----------> Victim Injured by a Drunk

Figure 8: Nurses Attitude towards a Drunken versus a Victim Injured by a Drunk

Figure 9 has a skewness of -1. Highly skewed distributions to the left, meaning nurses' are more inclined to attend to a victim of armed robbery than the armed robber (patient) in need of emergency care. Crampton (2007), Ellis (1999), Eelen (2001), Arnold and Boggs (1989) adds that the fear of violence also taints all nurse- patient (prisoner) interactions and that the reception of patients must be carefully managed. An impression of quiet, friendly efficiency must be conveyed in the first few seconds of the encounter with each new, strange patient. The client who feels at once that he is in safe, caring hands is far more likely to co-operate with and respond to any treatment (Hospice Nurses Association Standards and Accreditation Committee, 1995).



Armed Robber <------->Victim Injured by Armed Robbers

Figure 9: Nurses Attitude towards Armed Robbers versus Victims Injured by Armed Robbers

Research Question 3: What Personal Characteristics Influence Nurses' Attitude to Patients with Emergency Needs?

From Table 1, the males had a mean attitude of 3.63, while the females had a mean attitude of 3.42. This shows that the attitude of male nurses toward emergency service is higher than that of their female counterpart. In relation to the t-test performed, it can be observed that t statistics is 2.23 with a degree of freedom of 148 and a significant value of 0.03 smaller than 0.05 indicating a difference in attitude between the male and female nurses and that the difference is significant. The implication is that male nurses are more inclined to care for patients with 'correct' characteristics than female nurses.

Table 1: Gender Differences in Attitude of Nurses' towards Patients with Emergency Needs.

SEX	N	Mean	SD	df	T	Sig.
Male	56	3.63	0.54	148	2.23	.031
Female	94	3.42	0.57			

Results from Table 2 show an Independent sample t-test was conducted to find the influence marriage have on attitudes of nurses towards patients with emergency needs. Married nurses (n = 71, mean 3.50, SD = 0.62) and those not married (n =74, mean = 3.5, SD = 0.54) were compared. The results showed that there was no significant difference in the attitude between these two groups of nurses (t= -0.03, df =143, p > 0.88) and that the marital status of nurses does not influence their attitude to patients requiring emergency care.

Table 2: Influence of Marital Status on Nurses'Attitude towards Patients with Emergency Needs.

Marriage	N	Mean	SD	df	t	Sig.
Married	71	3.50	0.62	143	-0.03	0.88
Not Married	74	3.50	0.54			

In Table 3 an ANOVA test was used to examine the influence of age on nurses' attitude to patients with emergency needs. The results showed no statistical difference in the age and nurses' attitudes towards caring for patients with emergency needs ($F(2,147) = 0.90$, $p = 0.41$). Nurses with ages 25 - 34years (mean = 3.55; SD = 0.57), 35 - 44years (mean = 3.40; SD = 0.67), and more than 45years (mean = 3.44; SD = 0.44) had not much difference in their

attitudes towards caring for patients with emergency needs. However, there was no statistically significant difference (p = 0.41) between the ages of the nurses at the emergency departments in hospitals in the Cape Coast Municipality.

Table 3: Influence of Age on Nurses'Attitude towards Patients with Emergency Needs.

Age	N	Mean	SD	df	f	Sig.
25-34years	92	3.55	0.57			
35-44years	32	3.40	0.67	2, 147	0.90	0.41
45years or more	26	3.44	0.44			

Table 4 shows results from an independent sample t-test was conducted to look into the influence of parenthood on therapeutic attitude. Nurses with at least a child (n = 59, SD = 0.56) and those with no children (n = 91, SD = 0.60) were compared. The results showed that there was no significant difference in therapeutic attitude between these two groups of nurses (t= 0.57, df 148, p > 0.88); meaning the number of children a nurse has does not influence their attitude towards patients requiring emergency care.

Table 4: Influence of Number of children on Nurses'Attitude towards Patients with Emergency Needs.

No of Children	N	Mean	SD	df	t	Sig.
No Child	91	3.52	0.56			
				148	0.57	0.881
At Least One Child	59	3.47	0.60			

Results from Table 5 shows, Staff Nurses (n= 74, mean=3.62, SD=0.54) and nurses senior to Staff Nurses (n=76, mean=3.38, SD=0.57). At significance of 0.05 Level, it can be concluded that there is a difference between rank of respondents and respondents care for patients with emergency needs. This is because the t-statistic of 2.61 has a highly significant value of 0.01 which is less than 0.05 level of significant, after analysis of variance was conducted.

Table 5: Influence of Rank on Nurses' Attitude towards Patients with Emergency Needs.

Rank	N	Mean	SD	df	t	Sig.
Staff Nurse	74	3.62	0.54			
				3;146	3.50	.01
Senior to Staff Nurse	76	3.38	0.57			

Nurses with over four years of specialty experience and those with less than or equal to four years of specialty experience werecompared.In Table 6 an ANOVA test was used to examine the differences between working experience and nurses' attitude to patients with emergency needs. The results showed no statistical difference between working experience and nurses' attitudes towards caring for patients with emergency needs (F (3,146) = 1.00, p = 0.39). Nurses with less than 4years working experience (mean = 3.57; SD = 0.58), 5 -9years (mean = 3.40; SD0.67), 10 – 14 years (mean = 3.50; SD = 0.50) and more than 15 years (mean = 3.42; SD = 0.55) had similar attitudes towards caring for patients with emergency needs. However, there was no statistically significant

difference (p = 0.39) between the working experiences of the nurses at the emergency departments in hospitals in the Cape Coast Municipality.

Table 6: Influence of Working Experience on Nurses' Attitude towards Patients with Emergency Needs.

Rate	N	Mean	SD	df	F	Sig.
Less than 4years	83	3.57	0.58			
5 – 9 years	53	3.40	0.67	3, 146	1.00	0.39
10–14years	11	3.50	0.50			
15years or more	3	3.42	0.55			

Although age was discarded as a variable because of the results of the analysis, it has also been noted to significantly influence nurses' attitude toward patients (Lange, 2008; Barrere, 2008; Abdel-Khalek& Al-Kandari, 2007; Dunn, 2005; Helmuth, Lookinland, Anson, & McCabe1995).

The directions of the correlations have been inconsistent. For example, Herdman (2002) found that older nurses expressed negative attitudes toward older people, whereas Murphy (2007) found that older nurses experienced positive attitudes. Other researchers have reported no significant correlation between nurses' age and attitudes toward older people (Chasteen, 2002; Hweidi& Al-Hassan, 2005). Previous work experience is another factor found to affect nurses' attitudes toward older people. Teeri et al. (2006) and Williams et al (2005) reported that nurses working in long-term care institutions acquired paternalistic views. Other reports, however, have noted that clinical experience

in chronic care institutions had a positive effect on positions regarding older people (Hartley et al., 1995; McKinlay& Cowan, 2003). Soderhamn et al. (2001) have stated that there is no clear correlation between the type of care facility and views of the elderly.

According to the results of this study, it is significant that nurses at the emergency departments in the Cape Coast Metropolitan hospitals value work satisfaction, the physical work environment to positively influence nursing care and work satisfaction. Furthermore, the appreciation of emergency services rendered positively influences nurses' attitudes.

Nurse's specialty, rank, prior education and experience with patients have been shown to influence their attitudes. Although the results on education and experience were not statistically significant in this study, results from rank however support findings of earlier studies. Other studies further add that the longer the years of experience the more favourable the attitudes toward caring patients than nurses with less experience (Oyeyemi, 2006; Lange et al., 2008; Dunn, 2005).

In this study, there was no significant difference in the attitude measurements between respondents who had been educated to handle emergency patients and those who had not. The result contradicted the findings of previous studies (Barrere, 2008), Carter and MacInnes (1996), Huber, (1996) that nurses with a higher level of professional education and those who had taken education programs had more positive attitudes and did show significant improvement in their attitudes. Also, younger nurses are more adaptive to attitude change after an educational intervention.This may have

explained the attitudes being demonstrated by the majority of the respondents in this study.

Research Question 4: How Does Level of Job Satisfaction Influence Nurses' Attitude towards Patients with Emergency Needs?

With reference to Table 7, respondents whose rated workload as 'too high' had (mean=3.67: SD = 0.55), 'too low' (mean = 3.05; SD =0.49) and 'average' (mean = 3.47; SD = 0.56). With a significant level of 0.00, it can be concluded that there is a huge difference in the rate of work load at emergency units and nurses' attitude in caring for patients with emergency needs is greatly influence by workload. This is because the f-statistic (F (2,147) = 8.93) a highly significant value of 0.00 which is less than 0.05 level of significant. A Post Hoc, multiple comparisons analysis also showed that the significant variables were between 'too high and too low' at (0.001), and 'too low and ok' at (0.01).

Table 7: Influence of Workload at the Emergency Unit on Nurses Attitude towards Patients with Emergency Needs.

Rate	N	Mean	SD	df	F	Sig.
Too High	61	3.67#	0.55			
Too Low	18	3.05*#	0.49	2, 147	8.93	.000
OK	71	3.47*	0.56			

In Table 8, respondents who do have "adequate" emergency care training had (mean=3.50; SD= 0.57), "somewhat adequate" training (mean = 3.47; SD = 0.68) and "not adequate" training (mean = 3.71; SD = 0.58). At significant at the 0.05 Level, there is no difference in a nurses' level of training

in emergency care and their attitude in the care for patients with emergency needs. This is also evidenced by the f-statistic (F (2,147) = 1.11) a highly insignificant value of 0.33 which is greater than 0.05 level of significant, after analysis of variance was conducted. There were significant differences in the adequacy of emergency training and its influence on nurses' attitude. Bonferroni Post Hoc revealed the differences in the adequacy of training existing between 'somewhat good' and 'not adequate'.Changes underlying the philosophy of health care delivery are affecting how patients and practitioner relate to each other. Among such is the philosophy of holistic health, which has led to a very different type of patient orientation among practitioners who subscribe to this orientation. Increasingly, health care is characterized by a belief that health is a positive state to be actively achieved, not merely the absence of disease. Often service improvement strategies in health care have emphasized cosmetic aspects of the service relationships. Nurses are keenly aware of working with people who are emotionally drained and emotionally charged, and facing traumatic life circumstances. Making them happy hardly seems like a relevant goal, and nurses perceive it as superficial and discounting of the important work they do (Friedman & Dimatteo, 1979).

Table 8: Influence of Emergency Care Training on Nurses Attitude towards Patients with Emergency Needs.

	N	Mean	SD	df	F	Sig
Adequate	46	3.50	0.57			
Somehow Adequate	90	3.47*	0.68	2, 147	1.11	0.33
Not Adequate	14	3.71*	0.58			

With reference to Table 9, respondents who are very appreciative of emergency service had (mean = 3.57; SD = 0.50), those who somewhat appreciate emergency service (mean = 3.40; SD = 0.57) and those who do not appreciate emergency service (mean = 3.81; SD = 0.67). Thus at significant level 0.05, it can be concluded that people's level of appreciation for emergency service greatly influences nurse' care for patients with emergency needs. This is because the f-statistic (F [2,147] = 4.50) with a significant value of 0.01 which is less than 0.05 level of significant after analysis of variance was conducted. There were significant differences in clients' appreciation of care rendered at the emergency unit thus influencing their attitude. Bonferroni Post Hoc revealed the differences in the adequacy of training existing between 'somewhat appreciative' and 'not appreciative'.Chronic staffing imbalance due to attrition and inequitable distribution continue to plague the GHS despite various efforts and initiatives to retain and deploy staff to the rural areas. The situation is further compounded by an ageing workforce negatively affecting the uptake of services. The introduction of NHI has brought with it challenges leading to increased workload and overreliance on casual staff. There also appears to be lack of coordination between population needs and the management of the human resources available. Despite increasing HR investment, poor staff attitude and low productivity continue to persist with intermittent strike action resulting in decline in utilisation of services in health facilities (GHS, 2010).

Table 9: Influence of Client's Appreciation of Emergency Service on Nurses' Attitude towards Patients with Emergency Needs.

	N	Mean	SD	Df	F	Sig.
Very Appreciative	47	3.57*#	0.50			
Somewhat Appreciative	86	3.40*	0.57	2, 147	4.50	.01
Not Appreciative	17	3.81#	0.67			

In Table 10, respondents generally satisfied about life had (mean = 3.63; SD = 0.58), those somewhat satisfied (mean = 3.40; SD = 0.52) and not satisfied (mean = 3.73; SD = 0.73). At significant at the 0.05 Level, it can be concluded that there is no difference in general life satisfaction and respondents care for patients with emergency needs. This is because the f-statistic F = (2, 147) = 3.10 with a significant value of 0.048.

Table 10: Influence of General life Satisfaction on Nurses' Attitude towards Patients with Emergency Needs.

	N	Mean	SD	df	F	Sig.
Very Satisfied	58	3.63	0.58			
Somewhat Satisfied	87	3.40	0.52	2, 147	3.10	.048
Not Satisfied	5	3.73	0.73			

Mbindyoet al. (2006), Bitton and Tabak (2002), Lu, While and Barriball (2005) reiterates the degree of job satisfaction that individuals experience has an influence on their level of functioning, devotion at work and long-term continuance in the specific field of work.

Steenkamp and Merwe (1998), Khowaja, Merchant and Hirani (2005) further argues that dissatisfying factors at work and within the work setting such as high workload, stress associated with high workload, biased Nursing Management, lack of appreciation, monitory incentives and finally a rigid attitude of Nursing Management also influences attitude of nurses in providing care to patients with emergency needs.

Research Question 5: How Do Institutional Factors Influence Nurses' Attitude Towards Emergency Patients?

With reference to Table 11, respondents who suggested the physical condition of emergency care unit to be bad (mean = 3.75; SD = 0.58) those who think it somewhat good (mean = 3.38; SD = 0.52) and very good (mean = 3.48; SD= 0.73). At significant of 0.05 Level, it can be concluded that there is a difference in physical condition of emergency care unit and respondents care for patients with emergency needs. This is because the f-statistic (F(2,147) = 6.826) had a highly significant value of 0.001 which is less than 0.05 level of significant, after analysis of variance was conducted. The mean difference at a significance of 0.05 is between 'Bad' and 'Somewhat Good' (0.36995). There were significant differences in their attitude as a result of their physical conditions. Bonferroni Post Hoc revealed the differences exist between 'somewhat good' and 'bad'.Contrary to these expectations, it is a common phenomenon to find patients and their relatives as well as some media personnel expressing

displeasure regarding the unfavourable attitude of nurses, most especially in the Ankaful Psychiatric Hospital (DHMT, 2009). Whilst some patients report that nurses often neglect them in the hospitals, others are of the view that nurses speak rudely to them, do not regard them as human beings, deliberately delay in attending to their needs, sell drugs which ought to have been served free, render preferential services especially to the richer patients and occasionally threaten to physically assault patients.The key challenges to improved quality of care in health delivery facilities are inadequate standards, non-adherence to existing standards, and inadequate skilled personnel (Adams, 2002).

Table 11: Influence of Physical Conditions of Emergency Care Unit on Nurses' Attitude towards Patients with Emergency Needs.

	N	Mean	SD	df	F	Sig.
Bad	45	3.75*	0.58			
Somewhat Good	96	3.38*	0.52	2, 147	6.83	.001
Very Good	9	3.49	0.73			

In Table 12, respondents who suggested the social environment of emergency care unit to be bad had (mean = 3.78; SD = 0.50), those who think it's somewhat good (mean = 3.45; SD= 0.57) and very good (mean = 3.48; SD = 0.67. At significant at the 0.05 Level, it can be concluded that there is no difference in social environment of emergency care unit and respondents care for patients with emergency needs. This is because the f-statistic (F (2, 147) = 2.89; p = 0.06) which is greater than 0.05 level of significant. Aside the use of

promotion, other incentives in the form of annul / study leaves are also beneficial. In the case of annual and study leaves, workers are able to stay away from work for a while. This helps them to shed-off exhaustion and burn – out that can be associated with everyday work.

This fundamentally underpins most of the critical human resource shortages, particularly, nurses, midwives, laboratory assistants and Medical assistants (GHS, 2003).Workers also suffer a couple of problems, some of which are job related and it beholds on management of organizations to identify and support victims of such problems. Occupational hazards can take several forms. In hospitals, especially the psychiatric hospitals, the most common of these problems include occasional attacks on nurses, doctors and ward assistants by aggressive patients.

Table 12: Influence of Social Environment of Emergency Care Unit on Nurses' Attitude towards Patients with Emergency Needs.

	N	Mean	SD	df	F	Sig.
Bad	20	3.78	0.50			
Somewhat Good	116	3.45	0.57	2, 147	2.89	0.05
Very Good	14	3.48	0.68			

With reference to Table 13, respondents who suggested the leadership at emergency care unit to be bad had (mean = 3.62; SD = 0.58), those who think it somewhat good (mean = 3.47) and very good (mean = 3.56; SD = 0.73). At significant level 0.05, it can be concluded that there is no positive difference in the level of leadership at emergency care units and respondents care for patients with emergency needs. This is because the f-statistic (F

(2,147) = 0.68) is a highly insignificant value of 0.50 which is greater than 0.05 level of significant.

Table 13: Influence of Leadership at Emergency Care Unit on Nurses' Attitude towards Patients with Emergency Needs.

	N	Mean	SD	df	F	Sig.
Bad	18	3.62	0.58			
Somewhat Good	109	3.47	0.52	2, 147	0.68	.50
Very Good	23	3.56	0.73			

Gandiri (1992), Yeboah (2005), Abdella and Levene, (1965) from their findings cement results of this study that physical conditions of the work environment influences attitude of nurses and quality of services. Work overload however, can result from cases of fewer nurses attending to large number of patients which will invariably lead to burn – out and some may manifest this by projection of anger on patients as well as work absenteeism in extreme cases.

Adams and Stephany (2001) also recapped institutional support systems and policies as major factors that influence job performance on the part of workers and the possibility that the reason for nurses attitude is duetoinadequate delegation of responsibilities with micromanagement which leads to poor team spirit, morale and low performance(GHS, 2010).

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to assess the factors influencing nurses' attitude towards patients with emergency needs in the Cape Coast Metropolitan Health facilities. This chapter is devoted to the summary, conclusions and recommendations derived from the study.

Summary

This is a quantitative, descriptive study, exploring nurses' attitudes towards patients requiring emergency care in the Cape Coast Metropolitan Health Facilities. Nurses, working in the emergency units of these health facilities are on the frontline of healthcare workers who frequently contact patients in the emergency department before the patient sees a physician, rapidly perform accurate physical examination, quickly diagnose life-threatening illness or injury and use advanced monitoring and treatment equipment to save lives. Such demanding work may influence their attitudes towards caring for patients that require emergency care. Several research studies have shown that the attitudes toward scaring for patients at the emergency units affect the quality of care patients receives.

The health sector has had concerns with poor quality of service and the nurse seems to be the most accused. Most authors on health care quality

assurance recognize that health care is only in part a technical process and that however complex the medical technology, it is delivered by a person to a person. No patient's treatment is devoid of face-to-face contact with the practitioner. In line with this, various workshops on implementation of quality assurance have been held at all regional levels and most districts. There has been a wide public expectation on the Ghana health sector on various aspects such as the provision of prompt, humane, non-discriminatory and effective services that would promote adequate patient recovery from health problems (Akosah, 2001).

This study sort to assess the factors that influence nurses' attitude towards patients requiring emergency care. The influence of the nature of emergency being sort for and the client needing the care was studied. It further sort to find out if any personal characteristics of the emergency nurse influences their attitude towards patients. Impact of job satisfaction and institutional factors on the nurses' work output at the emergency unit was also assessed.

The analyzed data show that emergency nurses have a greater propensity to care more for the victim than the victimizer. This was shown in the skewed graphs in favour of victims of Domestic violence, Rape, Molestation, Drug user's actions, Drunken persons or Armed robbers. However, the attitude towards victims of attempted murder versus persons committing suicide and persons with self-induced abortion versus spontaneous abortion was more neutral.

Younger nurses would more likely attend to victims without considering their characteristics. In addition, both positive and negative relationships were

found between various aspects of nurses' attitudes toward the care of patients with emergency needs and nurses' age and working experience. These results indicate that at least some of the attitudinal aspects measured are important predictors of their attitude toward working with patients requiring emergency care.

Findings

Younger nurses would more likely attend to victims without considering their characteristics. This is a typical attitude of a person working under instruction or supervision. It is also an expected trend which might change with time when the nurse becomes familiar with the profession, falling prey to the adage 'familiarity breeds contempt'. Patient characteristics influence nurses' attitude to emergency care

On the issue of rank, respondents with less working experience were found to favour the 'clean' patients or patients with societies accepted characteristics than those with more working experience. Nurse's specialty, rank, prior education and experience with patients have been shown to influence their attitudes.

Nurses have also been noted to have expectations about their role and job description and that their knowledge and skills should be devoted to treating patients with very severe illnesses. The suggestion is that training sessions should be implemented to facilitate modification of employees' behaviours through experience sharing. Appropriate training can be a powerful stimulant for change. Inadequate logistics and infrastructure significantly influence nurses attitude to patient care at the emergency units in the Cape Coast Municipality.

Conclusions

From the findings of the study a policy on compulsory emergency care education for nurses working in emergency care settings is urgent. Furthermore, possible managerial changes based on the outcomes of the study, could have a positive influence on the quality of care delivered to patients' with critical conditions and are near death.

Nearly all nurses surveyed had practical experience involving patients with emergency problems, with no reports of professional training in this area, this may be an important addition to educational programs. On average, the nurses had neutral to positive attitudes regarding patients' requiring emergency care, which is encouraging compared to the predominantly negative views uncovered from earlier researcher. The higher the rank of the nurse the poorer the attitude towards patients requiring emergency care.

In conclusion, support from departmental and conjunctive services would strengthen and boost the professional standards of the nurses and equip them to promote timely assistance to patients requiring emergency care. It is also hoped that additional training and refresher courses when provided could enhance clinical skills and knowledge and also arouse their moral consciousness.

Recommendations

1. The Ministry of health, the municipal health directorate and other stakeholders need to organize emergency training to prepare nurses for the job at the emergency units.
2. The Ministry of health and the Nurses and Midwives Council need to enforce professional Codes of conduct that will define acceptable standards of behaviour in health institutions and therefore serve as basis of disciplinary action against misconduct.
3. Further research on need assessment is required to assess the exact needs that would impact greatly on emergency care nursing in Ghana. There is also the need to include both academic and practical training modules in the nursing training institutions to improve on the overall output of emergency nursing.

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APPENDICES

APPENDIX A

UNIVERSITY OF CAPE COAST

DEPARTMENT OF HEALTH, PHYSICAL EDUCATION AND RECREATION

QUESTIONNAIRE FOR NURSES

INTRODUCTION

I am an MPhil student conducting a survey as part of my thesis on the topic: Attitude of nurses to patient with emergency needs in the Cape Coast Metropolis of the central region. You are kindly requested to read through the items and respond to them as frankly and objectively as possible. Your responses will be treated confidentially will be used solely for academic purpose. Do not write your name on the questionnaire since this not a test and you will not be identify with the results this not a test and you will not be identify with the results

Thank you for taking time to help with this research. You may contact my supervisor Dr.Ogah for any clarification. Supervisor's Contact: 024-3102322

Name: Anastasia Ephraim Contact: 024-4614016

How much effort, resource and attention of the emergency unit should be given to each of the following patients with emergency conditions indicated in the chart? Tick where appropriate (√) the box corresponding to your choice concerning each statement below.

A				B		
	Definitely more	Somewhat more	Equal	Somewhat more	Definitely more	
Anal fistula due to homosexual activity						Injured while rescuing others
STD due to prostitution						STD due to health work
Victim of lightning						Self induced injury
Attempted suicide						Victim of attempted murder
Injured by armed robbers						Injured armed robbers
Drug overdose due to self-medication						Given wrong drugat hospital
Illegal drug use						Food poisoning
Child sexual molester						Sexually molested child
Spontaneous abortion						Self-induced abortion
Labour problem with 8thchild						Labour problem with first child
Did not you delay in seeking care						Did you delay in seeking care
Rapist						Victim rape
Baby in crisis						Mother in crisis
Young person in crisis						Very old person in crisis
Injured by a drunkard						Injured while drunk
Bleeding pregnant 26-yr old						Bleeding pregnant teenager
Patient with						Patient the

depression						aggression and violent behaviour
Unconscious patient						Patient with violent seizure
Patient with caretakers with bad attitude						Patient with nice, respected caretakers
Patient with severe but hopeful condition						Patient with near hopeless condition
Perpetrator of domestic violence						Victim of domestic violence
Extremely talkative patient						Quiet patient with lethargy
Person without health insurance						Person health insurance
Married person						Unmarried person
Married with children						Married without children
Married						Divorced
Trusting of health workers						Suspicious ofhealth workers
Crisis due to blood transfusion						Crisis due to refusal of blood transfusion
Reporting deep in the night						Reporting during the day
Patient with caretakers						Patient with no caretakers
Patient with less of control over defecation						Patient able to visit toilet

32. How will you describe your workload at the emergency unit?

- Too high
- Too low
- Ok

33. How adequate is your institutional emergency unit?

- Adequate
- Somewhat adequate
- Not adequate

34. How adequately are you trained to work at an emergency unit?

- Adequate
- Somewhat adequate
- Not adequate

35. How will you rate the physical conditions under which you work at the emergency unit?

- Bad
- Somewhat good
- Very good

36. How will you rate the social environment in which you work at the emergency unit?

- Bad
- Somewhat good
- Very good

37. How will you describe leadership at the emergency unit?

- Bad
- Somewhat good
- Very good

38. How do you think nurses at the emergency unit should be paid compared to other nurses?

- Equal salary as other nurses
- More than other nurses
- Equal salary as other nurses but receive more allowances

39. How appreciative do you think people are of work at the emergency unit?

- Very appreciative
- Somewhat appreciative
- Not appreciative

40. Your age……

41. How long have you worked as a nurse?

- Less than 4 years
- 5-9years
- 10-14years
- 15 years or more

42. How long have you worked at the emergency unit?

- Less than 4 years
- 5-9years
- 10-14years
- 15 years or more

43. Your sex

- Male

- Female

44. Your rank

- Staff nurse
- Senior staff nurse
- Nursing officer
- Senior nursing officer
- Principal nursing officer

45. Marital status

- Never married
- Married
- Married before but currently not married

46. Number of children……..

47. How satisfied are you about your life in general?

- Very satisfied
- Somewhat satisfied
- Not satisfied