

UNIVERSITY OF CAPE COAST

THE LIVED EXPERIENCES OF NURSES IN THE EMERGENCY
DEPARTMENT: A STUDY IN SELECTED HOSPITALS IN THE VOLTA
REGION OF GHANA

BY

CONFIDENCE ALORSE ATAKRO

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Health and Allied Sciences, University of Cape Coast, in partial fulfillment of
the requirement for the award of Master's Degree in Nursing

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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.

Candidates Signature Date

Name: Alorse Confidence Atakro,

Supervisors' Declaration

I hereby declare that the preparation of the thesis was supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature..... Date.....

Name: Professor Janet Gross

Co- supervisor's Signature.....

Date.....

Name: Dr Jerry Paul Ninnoni

ABSTRACT

Emergency care is care that must be rendered without delay. Though today's nurses in emergency departments (ED) are faced with many challenges, little time is spent in teaching or learning the content of emergency nursing care during the basic, master's or doctoral level nursing education program. The purpose of this research was to explore the lived experiences of nurses working in EDs in selected hospitals in the Volta Region of Ghana. The study is a qualitative research in which a phenomenological design was used. Purposive sampling technique was applied in selecting the hospitals and participants for the study. Data were collected through a semi-structured interview of 15 professional nurses who worked in EDs of selected hospitals in the Volta Region. Demographic results revealed 73.3 percent of respondents were between 25 to 29 years. Only 6.7 percent of respondents used knowledge of critical care nursing to practice emergency care in ED. Six thematic categories emerged after content analysis: encountering challenges in ED; ED as a place of learning and increased confidence for nurses; feelings of stress and joy in ED; social and physical consequences of ED on the life of nurses working in ED; nurses taking up jobs in ED that are inconsistent with their job description; clients receiving low quality care in ED. Formal education of nurses in the advance role of emergency care nursing is necessary to improve the practice of emergency care..

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DEDICATION

To nurses working at the Emergency Departments of the Volta Regional
Hospital, Ho Municipal Hospital and the Keta Municipal Hospital

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LIST OF ACRONYMS

ACEP	American College of Emergency Physicians
AED	Automated External Defibrillator
ASW	Acute Surgical Ward
AIDS	Acquired Immunodeficiency Syndrome
CT	Computed Tomography
CTAS	Canadian Triage and Acuity Scale
EC	Emergency Care
ED	Emergency Department
EMHAD	Emergency Mental Health Alcohol and Other Drugs
EMS	Emergency Medical Service
ENA	Emergency Nurses Association
ENP	Emergency Nurse Practitioner
ETZ	The Early Treatment Zone
GAO	Government Accounting Office
GCCED	Guidelines for Care of Children in the Emergency Department
GCS	Glasgow Coma Scale
HMA	Ho Municipal Assembly
HMH	Ho Municipal Hospital
HIV	Human Immunodeficiency Virus
ICN	International Council of Nursing
IOM	Institute of Medicine
KMA	Keta Municipal Assembly
MERP	Medical Emergency-Response Plan
MET	Medical Emergency Team

RGN	Registered General Nursing
RN	Registered Nurse
KMH	Keta Municipal Hospital
NMC	Nursing and Midwifery Council
NTC	Nurses Training College
PIN	Professional Identification Numbers
SA	South Africa
SAS	Senior Assessment and Streaming
SAEM	Society for Academic Emergency Medicine
SRB	Suicide- Related Behavior
TBI	Trauma Brain Injury
UCCIRB	University of Cape Coast Institutional Review Board
UK	United Kingdom
US	United States
USA	United States of America
VRH	Volta Regional Hospital
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

Background to the Study

Emergency care is defined as care that must be rendered without delay (Smelter, Bare, Hinkle & Cheever, 2008). Emergency departments (EDs) are important consideration in today's health policy dialogue (Hines, Frazee & Stocks, 2011). The task of emergency departments (EDs) is to provide safe emergency healthcare while adopting a caring, cost-effective approach (Andersson., Sundström., Nilsson., & Jakobsson, 2014). The goal of an effective emergency medical system should be to provide universal emergency care; that is, emergency care should be available to all who need it (World Health Organisation [WHO], 2005). Nurses are frontline workers during situations of emergencies or crises, working in hospital settings (WHO, 2004). The care provided by nurse practitioners practicing in emergency care requires a body of knowledge relating to acute and chronic illness and injury (Emergency Nurses Association [ENA], 2008). Presently, competency in emergency nursing can be achieved through various pathways including a combination of successful completion of academic courses, and continuing education courses (Emergency Nurses Association [ENA], 2008). Due to rising patient population, emergency department nurses are facing the challenge of serving an ageing population that requires complex and lengthy evaluations (Hwang et al., 2013). Emergency department nurses are challenged to provide safe, quality care to older people; however, nurses' perceptions of their role and experiences are seldom investigated (Gallagher, Fry, & Chenoweth, 2014). While some literature exists, none reported on the

perspective of the nurses' experiences in caring for psychiatric clients in ED (Plant, & White, 2013).

Growing admission volumes, hospital closures, financial pressures, and operational inefficiencies are the principal reasons for ED overcrowding which leads to stress among ED nurses (Institute of Medicine [IOM], (2006). The actual condition in an ED is that when the number of ED patients increases, or patients with severer conditions are admitted to an ED, individual demands for direct nursing care will increase; therefore, patients' needs often cannot be met by the existing nursing staff (Chang, Harnod, & Shih, 2010). Nursing staff may be forced to reduce the nursing care available or contact time with the patient (Chang, Harnod, & Shih, 2010). When the supply of direct nursing care is less than the demand at the time, it may pose a threat to the health of clients (Chang, Harnod, & Shih, 2010). Other challenges faced by the emergency care nurse include inadequate basic preparation for emergency care, leadership challenges and challenges with continuous education in emergency care (Weiner, 2006). Though today's nurses are faced with many challenges, little time is spent in teaching or learning the content of emergency nursing during the basic, master's or doctoral level nursing education program (Weiner, 2006).

Caring for emergency patients in Africa is a challenge because nurses must often treat severely injured patients who have co-existing conditions, such as Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS) or Tuberculosis (TB) (Brysiewicz, 2011). The presence of HIV, AIDS and TB complicates client care and has health implications for staff themselves (Brysiewicz, 2011). Healthcare professionals in Africa work

in difficult circumstances with limited resources (Brysiewicz, 2011). The scope of practice for emergency nurses in Africa is limited and there is no clearly defined advanced nurse practitioner role and there are few institutions that offer emergency nurse training and, therefore, few emergency nurses are available to care in EDs (Brysiewicz, 2011). The formal provision of emergency health care is developing in many Sub-Saharan African countries, including Ghana (Bell et al., 2014). While emergency medicine training programs for physicians are on the rise, there are few established training programs for emergency nurses (Bell et al., 2014).

In Ghana, as in other developing and middle-income countries, little consideration has traditionally been given to optimising the training of nursing staff for the care of acutely ill or injured patients (Osei-Ampofo et al., 2013). Existing emergency care systems in Ghana are rudimentary in comparison to those in developed countries (Osei-Ampofo et al., 2013). Nurses in Ghana are currently an underdeveloped resource for the provision of high quality emergency care (Rominski et al., 2011).

Problem Statement

Historically, emergency care had been under-represented in the advances of global health (Marsh, Rouhani, Pierre, & Farmer, 2015). Growing patient population, hospital closures, financial pressures, and operational inefficiencies are the principal reasons for ED overcrowding which usually lead to stress in ED nurses (Institute of Medicine [IOM], (2006).

The ED is a particularly vulnerable setting for workplace violence, and lack of standardized measurement and reporting mechanisms for violence in healthcare settings (Gacki-Smith et al., 2009). Violence against ED nurses is

highly prevalent (Gacki-Smith et al., 2009). A study conducted in the United States of America to investigate emergency nurses' experiences and perceptions of violence from patients and visitors in emergency departments found that approximately 25 percent of respondents reported experiencing physical violence of at least 20 times in the past 3 years (Gacki-Smith et al., 2009). Similarly almost 20 percent reported experiencing verbal abuse more than 200 times during the same period (Gacki-Smith et al., 2009). Respondents who experienced frequent physical violence and/or frequent verbal abuse indicated fear of retaliation and lack of support from hospital administration and ED management (Gacki-Smith et al., 2009). A similar study conducted in South Africa by Maureen and Hester (2013) concluded that the tolerance of non-physical violence and the absence of policies to deal with the violence, contributed to under-reporting

In an explorative study to explore the everyday work at an emergency department in Sweden, Andersson, Jakobsson, Furåker, Nilsson, (2012) found that everyday work in ED was characterised by a rapid and short encounter with clients in which there was limited scope to provide individualised care, which led to a mechanical approach of care. Practitioners' encounter with patients and relatives was rapid and of limited duration. Anderson et al. (2012) concluded that the care activities that practitioners mainly performed comprised standard medical management and were performed more mechanically than in a caring way.

Current emergency care in Ghana is sub-optimal with significant delays to definitive care with high morbidity and mortality (PEPFAR, 2011). Lack of timely access to health care in Ghana means that many medical needs

present as emergencies (Osei-Ampofo et al., 2013). Patients with infectious and parasitic diseases, such as HIV/AIDS and malaria present late as emergencies, thereby adding to the strain on the already weak emergency system (Osei-Ampofo et al., 2013). In Ghana, as in other developing and middle-income countries, little consideration has traditionally been given to optimising the training of nursing staff for the care of acutely ill or injured patients (Osei-Ampofo et al., 2013). Existing emergency care systems in Ghana are rudimentary in comparison to those in developed countries (Osei-Ampofo et al., 2013). A qualitative and quantitative assessment of the Emergency Centre of the Police Hospital, a second-level hospital in Accra, Ghana revealed marked deficiencies in many essential items and services (Japiong et al., 2015). Nurses in Ghana are currently an underdeveloped resource for the provision of high quality emergency care (Rominski et al., 2011).

Available literature on experiences of nurses in ED was mostly conducted in other countries outside Ghana. Majority of research found in literature were also quantitative. There was no study available on the lived experiences of nurses in ED in Ghana. There was need therefore to explore the lived experiences of emergency care nurses in the Volta Region of Ghana that will form the basis for recommendations to improve the work of ED nurses and ultimately result in quality care to clients.

Main Objectives

The aim of this study was to explore the lived experiences of nurses in emergency department in selected hospitals in the Volta Region of Ghana.

Specific Objectives

The research objectives of this study were to:

1. Explore challenges of nurses in ED.
2. Explore how ED affected nurses learning and confidence in practice.
3. Explore the experience of stress by nurses in ED.
4. Explore how ED affected physical and social lives of ED nurses.
5. Explore performance of ED nurses with regard to their job description.
6. Explore quality of care rendered to clients in ED.

Justification of the Study

Emergency care serves as a key function within health care systems by providing an entry point to health care and by decreasing morbidity and mortality (Hsia, Razzak, Tsai, & Hirshon, 2010). Despite its important and increasing role, emergency care has been frequently overlooked in the discussion of health systems, particularly in developing countries (Hsia et al., 2010). Little research has been done in lower and middle income countries on the burden of diseases reduction attributed to emergency care whether through injury treatment, urgent and emergent treatment of acute conditions or emergency treatment of complications from chronic conditions (Hsia et al., 2010). There is a critical need for research documenting the role of emergency nursing care services in reducing the global burden of disease.

This study was necessary and appropriate because of the implications emergency care has on clinical practice and outcomes for patients, the health institution, policy makers and the body of knowledge of nursing as an evolving profession in Ghana. Findings from this study will help improve the work of ED nurses, patient outcomes and influence quality health care

delivery and quality of life of individuals through utilisation of recommendations of the research. The results of this study will help in the implementation of policies to meet international standards. A framework for the education of nurses in emergency nursing was recommended to Nursing and Midwifery Council (NMC), Ghana College of Nursing, nursing schools and universities that educate nurses.

Limitations of Study

Research was done in only three hospitals in the Volta Region. Therefore research could not be generalised to the general population.

Delimitation of Study

This study was delimited to registered nurses in the emergency units who had professional identification numbers (PINs) and had worked for at least one year in ED.

Operational Definitions

1. Emergency Department (ED) is an emergency department, emergency unit, emergency room or emergency centre within a hospital setting.
2. Continuous education means workshops or conferences that were attended by nurses to improve emergency care knowledge and competence.
3. Urban hospital is hospital located in a regional capital.
4. Rural hospital is hospital located within a district outside the regional capital.

CHAPTER TWO

REVIEW OF LITERATURE

A review of the literature was undertaken through a search of databases that included Google Scholar, Advances in Nursing, Journal of Nursing Education and Practice (JNEP), EBSCOhost, CINAHL, HINARI and Nursing Research and Practice. Key words used in literature search included emergency care nursing, emergency care in Africa, emergency nursing care in Ghana, and experiences of nurses in emergency care. Only literature written in English was considered in this review. Literature review covered the period of 2004 to 2015. 129 articles met inclusion criteria for literature review. Literature review is presented under the following sub-headings: emergency care, preparation of nurses for emergency care, challenges in emergency care, models/guidelines in emergency care and experiences of staff and clients in ED.

Emergency Care

Emergency care systems are uniquely positioned to respond to the array of life threatening emergencies, including acute trauma, surgical disease, acute infectious illnesses, exacerbation of chronic disease and routine medical needs that require emergency care (Marsh, Rouhani, Pierre, & farmer, 2015). Generally emergency care is deemed the component of health care focused on delivery of curative interventions, mainly for critical surgical and medical conditions with threat to life (Marsh et al., 2015). Elements of severity are essentials of an emergency condition (Marsh et al., 2015). The essential components of high-quality emergency services include pre-hospital

(ambulance system) and hospital-based services; trained personnel; supplies such as biomedical equipment, medications and other materials; information systems; and monitoring and assessment (Marsh et al., 2015). Emergency care inherently addresses wide array of illness and injury, including traumatic injuries, surgical disease, acute complication of chronic illness (example strokes, myocardial infarction, diabetic ketoacidosis, complications of HIV, tuberculosis, hepatitis C and other chronic diseases) (Marsh et al., 2015).

Research was conducted by Chu and Nsu (2011) to examine clinical setting learning processes to better understand the practical knowledge content of ED nurses. Study used a phenomenological approach and in-depth interviews of 10 nurses. Chu and Nsu (2011) identified four major practical knowledge themes for ER professionals. These were (a) basic emergency treatment procedure routines and symptom management; (b) disease mechanisms, pharmacodynamics, and treatment responses; (c) newly identified diseases, updated emergency treatments and techniques, and medical treatment discussions; and (d) identifying nursing values including nursing attitudes and continuing patient care. Participants in this study had experience with the first three themes and successfully combined various types of nursing knowledge in their nursing care duties. Only few participants indicated experience with the fourth theme. Chu and Nsu (2011) concluded findings clarify that clinical or practical knowledge in ED nurses evolves first from declarative knowledge (example, basic emergency treatment routines and operating procedures) to procedural knowledge (example, instructions from supervisors, actual practice, and drills) to conditional knowledge (example, observation and treatment involving direct interactions with patients). This

study contributes positively to this study because it is qualitative and also used qualitative phenomenological approach.

Heyns (2008) through an action research in South Africa concluded that rapid changes in the healthcare environment increase the need for nurse practitioners to be motivated, knowledgeable and skilled in order to ensure quality patient care. Accident and emergency units are challenging environments and by ensuring that nurse practitioners work in an enabling environment, they should be motivated, skilled and knowledgeable and be able to think critically to enhance their own professional growth and emancipated practice (Heyns, 2008). A positive environment may increase the nurse practitioners' job satisfaction, which in turn encourage job retention and may influence patient outcomes positively (Heyns, 2008).

Research by Van Der Wath, Van Wyk, and Janse van Rensburg. (2013) guided by the philosophical foundations of phenomenology found that emergency nurses in South Africa are often witnesses of the emotional and physical effects of intimate partner violence. Exposure to the vulnerability and suffering of survivors elicits sympathy and emotional distress (Van Der Wath, Van Wyk, and Janse van Rensburg, 2013). Emergency nurses are left with the emotional impact and disruptive and recurrent memories (Van Der Wath et al., 2013). Van Der Wath et al. (2013) concluded that exploring the tacit internal experiences related to caring for survivors of intimate partner violence revealed emergency nurses' vulnerability to the effects of secondary traumatic stress. The findings generated an opportunity to develop guidelines through which to support and empower emergency nurses (Van Der Wath et al. (2013).

A systematic review of 28 qualitative studies by Shankar, Bhatia and Schuur (2014) identified six broad themes about the elderly's perspective of hospital based emergency care. Themes identified were: the role of care providers; communication and patient education; barriers to communication; wait times; physical needs in the emergency care setting; and general elder care needs. Key findings were that emergency staff should: assume a leadership role with both the medical and social needs; initiate communication frequently; minimize potential barriers in communication; check on patients during prolonged periods of waiting; attend to distress caused by physical discomfort in the emergency care setting; and address general elder care needs, including the care transition and involvement of caregivers when necessary.

A multi-criteria analysis study to evaluate the level of patient satisfaction in a hospital emergency department by the Indian Institute of Health Management Research (2004) revealed that the average levels of complete patient satisfaction was low. Patients attributed great importance to the criteria of processes involved in patient services such as courtesy, friendliness and professional attitude of the nurses in order to feel satisfied. However, the demographic characteristics of India are different from Ghana and therefore a need exists to replicate such a study in Ghana. This research also looked at clients' perception of satisfaction in emergency care. There is also a need to study satisfaction in emergency department (ED) from the health care providers' point of view.

Mutlin, Gunningberg and Carlsson (2006) surveyed patients in ED on patients' perception of quality of care at an emergency department and

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identification of areas for quality improvement at a Swedish University Hospital. Patients estimated quality of care at the Emergency Department as fairly good, but indicated that there were areas in need of improvement. Twenty percent of clients reported that they did not receive effective pain relief. More than 20% estimated that nurses did not show an interest in their life situation nor did they receive useful information on self-care from nurses. The authors recommended that nurses need to be more attentive to the needs of the individual patient. Identifying areas for quality improvement are important to know where to take action. These findings may facilitate the change in attitudes and work routines which are needed to deliver effective care and to improve patients' perception of quality of care at EDs.

Soares, Carmen, Rocha and Graziela (2014) analysed the contributions that research has made to leadership in nursing within the context of emergency care services from 2001 to 2012. The study found that the most commonly used theories among nurses in emergency care were situational and transformational. The study recommended that larger investments are necessary in communication and leadership training for nurses in emergency care. However this study was done in Portugal and there is the need to replicate it in Ghana to know the leadership style used by nurses in emergency care.

Although emergency nurse practitioners routinely impart injury advice, feedback from some patients suggested a need for the provision of more in-depth information regarding their injury (McDevitt & Melby, 2015). This was found in a study by McDevitt and Melby (2015) to evaluate quality of the emergency nurse practitioner service provided to people presenting to a rural

urgent care centre with minor injuries. The study found that despite comparatively low total length-of-stay times, most patients felt they had enough time to discuss things fully with the emergency nurse practitioner (McDevitt & Melby, 2015). The vast majority (97.3%) of patients in the study felt that the quality of the emergency nurse practitioner service was of a high standard. Contrary to some other studies, the findings in this study indicate that patient satisfaction is not influenced by waiting times. The study concluded that emergency nurse practitioners in rural urgent care centres have the potential to deliver a safe and effective quality service that is reflected in high levels of patient satisfaction

Gehlen and Lima (2013) characterised nurses' work process in care practice at Emergency Care Units in a study. The activities the nurses most frequently developed were: a) care, risk assessment, classification and registering of clinical data, b) management: task distribution, shift organisation, data processing and material provision. The work instruments most frequently used were clinical decision - making, listening, monitoring and the risk assessment protocol. Gehlen and Lima (2013) concluded that nurses' work at emergency units was predominantly focused on care, with a great burden of management activities related to resource planning and provision for care practice. The research technique used was mixed- method. Mixed methods research associates the quantitative and qualitative approaches, so that the study's general strength would be greater than that of qualitative or quantitative research in isolation (Gehlen & Lima, 2013).

Rhodes et al. (2012) used a population-based (retrospective) method to determine whether the rates of a first presentation to the emergency

department (ED) for suicide-related behavior (SRB) are higher among children/youth permanently removed from their parental home because of substantiated maltreatment than their peers and to describe the health care settings accessed by these children/youth before a first SRB presentation to help design preventive interventions. Results show that after controlling for demographic characteristics and prior health service use, maltreated children/youth were about five times more likely to have a first ED presentation for SRB compared to their peers. Rhodes et al., 2012 concluded that children/youth permanently removed from their parental home because of substantiated child maltreatment are at an increased risk of a first presentation to the ED for SRB.

Hamilton and Marco (2003) concluded in a study that emergency medicine provides many opportunities to educate health workers at all levels, including faculty, residents, and students. In addition to responsibilities in educating emergency medicine residents, the emergency department also provides an ideal learning environment for medical students and other health care providers (Hamilton & Marco, 2003).

Because children spend a significant proportion of their day in school, pediatric emergencies such as the exacerbation of medical conditions, behavioral crises, and accidental/intentional injuries are likely to occur (Olympia, Wan, & Avner, 2005). Recently, both the American Academy of Pediatrics and the American Heart Association have published guidelines stressing the need for school leaders to establish emergency-response plans to deal with life-threatening medical emergencies in children (Olympia, Wan, and Avner, 2005). The goals of the emergency response plan include

developing an efficient and effective campus-wide communication system for each school with local emergency medical services (EMS); establishing and practicing a medical emergency-response plan (MERP) involving school nurses, physicians, athletic trainers, and the EMS system; identifying students at risk for life-threatening emergencies and ensuring the presence of individual emergency care plans; training staff and students in first aid and cardiopulmonary resuscitation (CPR); equipping the school for potential life-threatening emergencies; and implementing lay rescuer automated external defibrillator (AED) programs (Olympia, Wan, & Avner, 2005). A study by Olympia, Wan, and Avner (2005) to use published guidelines by the American Academy of Pediatrics and the American Heart Association to examine the preparedness of schools to respond to pediatric emergencies, including those involving children with special care needs, and potential mass disasters. Results show that the most common reported school emergencies were extremity sprains and shortness of breath. Sixty-eight percent of school nurses had managed a life-threatening emergency requiring EMS activation during the past school year. Eighty-six percent of schools had a medical emergency-response plan (MERP), although 35% of schools do not practice the plan. Thirteen percent of schools did not identify authorized personnel to make emergency medical decisions. When stratified by mean student attendance, school setting, and funding classification, schools with and without an MERP did not differ significantly. Of the 205 schools that did not have a school nurse present on campus during all school hours, 17% did not have an MERP, 17% did not identify an authorised person to make medical decisions when faced with a life-threatening emergency, and 72% did not have an effective campus-

wide communication system. CPR training was offered to 76% of the teachers, 68% of the administrative staff, and 28% of the students. School nurses reported the availability of a bronchodilator meter-dosed inhaler, and epinephrine auto injector in their school. When stratified by inner-city and rural/suburban school setting, the availability of emergency equipment did not differ significantly except for the availability of an oxygen source, which was higher in rural/suburban schools. School-nurse responders self-reported more confidence in managing respiratory distress, airway obstruction, profuse bleeding/extremity fracture, anaphylaxis, and shock in a diabetic child and comparatively less confidence in managing cardiac arrest, overdose, seizure, heat illness, and head injury. When schools with at least one child with special care needs was analysed, 90 percent had an MERP, 64 percent had a nurse available during all school hours, and 32 percent had an efficient and effective campus-wide communication system linked with EMS. There are no identified authorised personnel to make medical decisions when the school nurse is not present on campus in 12 ~~percent~~ percent of the schools with children with special care needs. When the confidence level of school nurses to respond to common potential life-threatening emergencies in children with special care needs was analysed, 67 ~~percent~~ percent of school nurses felt confident in managing seizures, 88 percent felt confident in managing respiratory distress, and 83 percent felt confident in managing airway obstruction. School nurses reported having the following emergency equipment available in the event of an emergency in a child with special care needs: glucose source, bronchodilator, suction, bag-valve-mask device, and oxygen. An MERP designed specifically for potential mass disasters was present in 74 ~~percent~~

[schoolspercent schools](#). When stratified by mean student attendance, school setting, and funding classification, schools with and without an MERP for mass disasters did not differ significantly. Olympia, Wan, and Avner (2005) concluded that Although schools are in compliance with many of the recommendations for emergency preparedness, specific areas for improvement include practicing the MERP several times per year, linking all areas of the school directly with EMS, identifying authorized personnel to make emergency medical decisions, and increasing the availability of AED in schools. Efforts should be made to increase the education of school nurses in the assessment and management of life-threatening emergencies for which they have less confidence, particularly cardiac arrest, overdose, seizures, heat illness, and head injury (Olympia, Wan, & Avner, 2005).

The nurse practitioner role is developing in many countries around the world (Sheer, & Wong, 2008). In 2008, an international survey by the International Council of Nurses (ICN) identified 22 countries with formal nurse practitioner programmes (Sheer, & Wong, 2008). In some countries, the legislative and policy frameworks had been established before the role was introduced (Fotheringham, Dickie & Cooper, 2011). In others, including the United Kingdom (UK), these frameworks either did not exist or were being retrospectively developed and applied (Fotheringham, Dickie & Cooper, 2011). A longitudinal survey of Scottish ED was done by Fotheringham et al. (2011) to examine how the role of the Emergency Nurse Practitioner has evolved in Scotland. Results show that Emergency Nurse Practitioners are now practicing in the majority (89%) of EDs and Minor Injury Units compared with 47% in 1998. Most departments (78%) use Emergency Nurse

Practitioners in dual roles, and most departments (67%) differentiate their Emergency Nurse Practitioners from other nursing staff by use of a title. Wide variations in pay, role and scope of practice still exist. Fotheringham et al. (2011) concluded that the role of the Emergency Nurse Practitioner has increasingly become part of mainstream health care delivery in Emergency Departments across Scotland and can now be considered to be common place.

Outcomes for patients are often dependent on nurses' ability to identify and respond to signs of increasing illness and initiate medical intervention (Jones, King and Wilson, 2009). In an attempt to improve patient outcomes, many acute hospitals have implemented a rapid response system known as the Medical Emergency Team (MET) which had improved management of critically ill ward patients (Jones, King, & Wilson, 2009). Subsequent research has indicated that the MET system continues to be underused by nurses (Jones, King, & Wilson, 2009). Jones, King and Wilson (2009) conducted a study to identify factors, both positive and negative, that impacted on nurses' effective use of MET in acute care settings. Five major themes emerged from the analysis of the literature as the major factors effecting nurses' use of the MET system. The major themes were: education on the MET, expertise, support by medical and nursing staff, nurses' familiarity with and advocacy for the patient and nurses' workload. Jones, King and Wilson (2009) concluded that ongoing education on all aspects of the MET system is recommended for nursing, medical and MET staff. Bringing MET education into undergraduate programs to prepare new graduates entering the workforce to care for acutely ill patients is also strongly recommended (Jones, King and Wilson, 2009).

McCarthy, Cornally, Mahoney, and White (2013) study showed that activities relating to diagnostic function were conducted most often, followed by activities relating to organisation and work role competencies. Within the helping role, planning patient care was indicated as a key activity. Identifying patient care priorities was conducted most often in the domain of effective management of rapidly changing situations. Activities performed least often were those associated with administering and monitoring therapeutic interventions. Nurses judged themselves to be most competent in diagnostic function. There was a statistically significant positive relationship between nurses' level of perceived competence and frequency of practice. McCarthy et al. (2013) concluded that emergency nurses in Ireland engage in a wide range of activities, many of which are described in other countries as advanced practice. Recognition needs to be given and education prioritised in deficit areas (McCarthy et al., 2013). A similar study needs to be conducted to know procedures that are often practiced by nurses in emergency care in Ghana.

Preparation of Nurses for Emergency Care

Competency in emergency care can be achieved through various pathways including a combination of successful academic course completion, continuing education course completion, and on-the-job instruction (ENA, 2008). According to ENA, competency areas of the emergency nurse includes management of patient health/illness status; performing professional role; airway, breathing, circulation, and disability procedures; performing skin and wound care procedures; performing head, eye, ear, nose, and throat procedures; performing chest and abdomen procedures; performing neck, back, and spine procedures; performing gynaecologic, genitourinary, and

rectal procedures; and performing extremity procedures. Management of patient health/illness status involves triaging patients' needs, responding to the rapidly changing physiological status of emergency care patients, using current evidence-based knowledge and skills in emergency care for the assessment, treatment, and disposition of acute and chronically ill and injured. Management of health/illness also entails recognising, collecting, and preserving evidence, assessing response to therapeutic interventions, and documenting assessment and treatment. Performing professional roles involves directing and clinically supervising the work of other nurses and other health care providers in ED and acting in accordance with legal and ethical professional responsibilities. Airway, breathing, circulation, and disability procedures in involves assessing and managing a patient in cardiopulmonary arrest, assessing and managing airway, assessing and managing patients with disability and assessing and managing procedural sedation patients. Skin and wound care procedures includes injecting local anesthetics, debriding minor burns, incising, draining, irrigating, and packing wounds. Head, eye, ear, nose, and throat procedures involves performing tonometry to assess intraocular pressure, controlling epistaxis and performing cerumen impaction curettage. Chest and abdomen functions of the emergency nurse includes performing a needle thoracostomy for life threatening conditions in emergency situations and replacing a gastrostomy tube. Neck, back, and spine procedures includes clinically assessing and managing cervical spine and performing lumbar puncture. Gynaecologic, genitourinary, and rectal procedures involve removing faecal impactions and performing sexual assault examination. Extremity procedures include reducing fractures

of small bones and reducing dislocations of large and small bones. Other competencies include performing radio communication with prehospital units, interpretation of patient diagnostics (example vital signs, 12-lead electrocardiogram) and removing foreign bodies (example from orifices and soft tissue).

Whitty, and Burnett (2009) examined whether a relationship existed between mass casualty incident knowledge and perceived importance of incorporating competencies regarding mass casualty incidents into baccalaureate nursing programs by faculty in Louisiana. Results indicated that participants had limited training and life experiences regarding mass casualty incidents, as well as limited knowledge of mass casualty incidents. However, participants perceived mass casualty incident instruction as important for inclusion in nursing curricula. There was a positive relationship between self-perceived knowledge of mass casualty incidents and perceived importance of including these competencies into the nursing curriculum. These findings suggested that schools of nursing should take steps to identify or train a pool of educators who can teach mass casualty incident preparation. Nurses who are generalists need to receive training for mass casualty incidents because when disaster strikes, it often occurs in such magnitude that an enormous pool of nurses will be needed (Whitty, & Burnett, 2009). Nurse educators employed full-time in baccalaureate-level programs in Louisiana demonstrated limited knowledge regarding mass casualty incidents (Whitty, & Burnett, 2009). Whitty, and Burnett (2009) concluded that nursing education is being faced with a workforce that did not receive adequate instruction for mass casualty preparation (Whitty, & Burnett).

The International Nursing Coalition for Mass Casualty Education collaborated with the National League for Nursing to survey Deans or Directors of United States (US) nursing schools as to the curriculum for emergency preparedness (Weiner, Irwin, Frankenstein, & Gordon, 2005). Results demonstrated that there was a lack of emergency preparedness content in the curriculum, with only four to five hours of disaster preparedness content taught in each nursing school throughout the US during the academic years of 2000-2003. In the afore-mentioned survey, respondents felt that faculty were not at all prepared or poorly prepared to teach disaster preparedness content (Weiner et al., 2005). Similar findings have been presented by researchers in Japan in relation to faculty and student learning needs (Yamamoto, 2005).

Head nurses in a study indicated that basic nursing education did not provide sufficient emergency nursing competences (Henrik, & Kerstin, 2009). Respondents said there was a need for supplementary formal emergency nursing education (Henrik, & Kerstin, 2009). A minority of the head nurses considered that they had full responsibility for creating the prerequisites of the competence development of nurses (Henrik, & Kerstin, 2009). Henrik and Kerstin (2009) concluded that there was a need to establish competence demands in emergency nursing and evaluate strategies for competence development. Henrik and Kerstin (2009) recommended that the establishment of a Swedish emergency nurses association would be important for the development of national guidelines of emergency nursing. Henrik and Kerstin (2009) also recommended that establishment of competence demands would facilitate the interpretation and concretisation of rules and legislation in emergency care. Competence demands would promote questions related to

research, development, and education in emergency nursing (Henrik and Kerstin). With national guidelines and recommendations, the head nurses' responsibilities for the development of nurses' skills would be clarified (Henrik& Kerstin, 2009).

Caring for the acutely ill or injured patient requires multiple disciplines and specialists working seamlessly together. To address this need for adequate human resources for emergency care, the Ghana Emergency Medicine Collaborative had proposed an innovative training program focused on nurses, medical students and residents with the formation of a new faculty for sustainable training in emergency practice (PEPFAR, 2011). This process had led to the introduction of emergency physician and emergency nursing programmes in Ghana.

Research with the objective to probe into emergency nursing method for patients with acute coronary syndrome, concluded that through training, the emergency nursing ability of nurses could be enhanced. The study also showed that training can enhance the success rate of rescuing patients and can decrease medical disputes and the occurrence of unprofessional activities by nurses (Wang, Dai, & Feng, 2010).

Nurses' self-reported confidence in their professional skills before and after an extensive ED reform was assessed in a study by Rautava et al. (2013). Emergency nurses participated in the transitional training. Training was followed by weekly practical educational sessions. During this process nurses improved their transition skills, defined house rules for the new clinic and improved their knowledge of new technology and instruments. Results showed that nurses' self-reported confidence in their professional skills

improved significantly in 8 classes out of 15. These classes were cannulations, urinary catheterizations, patient monitoring, care of cardiac patients, equipment handling, triaging, care of psychiatric patients as well as infection prevention. The best results were noted in urinary catheterizations, patient monitoring and infection prevention. The study concluded that nurses' education and training program in ED may be successfully put into practice when based on co-operation between nurses and physicians who are dedicated to emergency services. Stuhlmiller, Thomas, de Crespigny, Kalucy and King (2004) in a study found that Self ratings of clinical confidence, including knowledge and skills, showed a significant improvement on all questions following self-ratings of clinical confidence in working with people with mental health issues in ED.

Non-mental health trained nurses are ill-equipped in their psychiatric knowledge, assessment and communication skills to provide best possible care to patients presenting to the ED with a complex mental health issue (Kerrison, 2007). The area of assessment and management of mental health patients in the emergency department is a complex one and staff are required to assess, triage and manage these patients appropriately (Kerrison, 2007). Furthermore, with aggression and violence increasing, emergency department nurses are concerned about their safety in the workplace (Kerrison, 2007). A study was conducted by Kerrison (2007) to investigate the education and training requirements that non-mental health trained emergency nurses need to enable them to effectively care for psychiatric patients presenting to a West Australian ED. Kerrison (2007) found that nurses considered customer focus,

workplace aggression, violence, psychiatric theory, mental health assessment and chemical dependence as key learning areas.

Providing continuing education to support a change in practice for a busy ED poses a challenge. Factors such as shift work, high patient acuity, and unpredictable patient flow create barriers to traditional methods of delivery of a comprehensive educational experience (Curran-Smith, & Best, 2004). A study was conducted by Curran-Smith and Best (2004) to describe an experience with introducing a change in practice using an innovative Web-based delivery plan. Curran-Smith and Best (2004) concluded that the Web-based learning environment proved a successful means of providing nurses in ED with a collaborative learning experience around a new practice issue. This experience highlighted the need for a new skill set for learners and educators using online learning technologies in ED education (Curran-Smith & Best, 2004).

In a mixed method research by McAllister, Moyle, Billett and Zimmer-Gembeck (2009) to evaluate the effectiveness of a solution-focused education intervention in extending and improving emergency nursing responses to patients who present because of self-injury, results showed improvements in knowledge and understanding of self-harm, self-belief in nurses' capacity to positively influence clients and the value of health promotion skills. McAllister et al. (2009) concluded that the solution-focused education intervention appears to show promise as an intervention for enabling nurses to value their unique contribution to providing a health service that is more proactive and health-promoting.

A study was conducted by Attack, and Rankin (2005) to explore the effectiveness of an online course in the 5-level Canadian Triage and Acuity Scale (CTAS) on the clinical practice of the triage nurse. The most consistent finding was that the majority of RN staff enjoyed the online course and believed it had improved their triage practice. Nurses believed that their patient assessments were more thorough, accurate, and consistent throughout the department. Improved communication between staff and with patients and families was identified. Nurses reported using what they learned to improve triage assessment. Triage accuracy was high; the overall agreement between CTAS graduates and the chart auditor/expert within one CTAS level was 99.7%.

A systematic review by Varndell (2007) in Australia to examine the evidence around assessing, monitoring and managing continuous intravenous sedation for critically ill adult patients, and its implications for emergency nursing practice. Analysis of the literature identified several implications for emergency nursing practice and the management of continuous intravenous sedation: workload, education, monitoring and assessing sedation and policy. According to Varndell (2007) limited literature was found that directly addressed emergency nursing practices' in managing on-going intravenous sedation and analgesia for patients. Balancing patient sedation and analgesia requires highly complex knowledge, skills and expertise; the degree of education and training required is above that obtained during pre-registration nurse training (Varndell, 2007). No state or national models of education or training were identified to support ED nurses' practices in managing sedation.

Despite the importance of emergency nurses' oxygen administration decisions, little is known about how these decisions are made (Considine, Botti, & Thomas, 2006). Inconsistent recommendations in the professional literature regarding supplemental oxygen indications, oxygen delivery devices, and oxygen flow rates result in variability in nurses' oxygen administration decisions (Considine, Botti, & Thomas, 2006). A study was conducted by Considine, Botti, and Thomas (2006) to examine the effects of education on emergency nurses' oxygen administration decisions. Results showed that participants' average age was 33.64 years and the average number of years of emergency nursing experience was 5.30 years. Seventy five percent of participants held a Bachelor of Nursing degree and 55% of participants held a postgraduate qualification in emergency nursing. Participants worked an average of 62.65 hour per fortnight. Twenty five percent of participants held higher levels of appointment (Clinical Nurse Specialist or above). Ninety percent of participants reported that they implemented supplemental oxygen daily and 95% reported making this decision independently. Participants' average pre-test score was 62.5% and the mean post-test score was 81.6%. All but two participants had an increase in knowledge following educational preparation. The average difference in test scores following education was an increase of 19.2%.

The overarching theme found in a qualitative ~~study by~~ [study by](#) Weil et al. (2015) was that healthcare professionals held contradictory understandings of palliative care and its application in the ED; subthemes highlighted these inconsistencies when the term "palliative" was used, in understandings of and engagement with palliative care services and in perceptions about the practical

utility of palliative care. Weil et al concluded that there were entrenched contradictions and tensions surrounding the term “palliative care”; confronting these was likely to require more than re-branding, and would promote better care for this vulnerable patient group in the emergency department.

Ross and Bell (2009) in a survey to determine the influence of registered nurses' certifications and years of experience on comfort level of practice in emergencies concluded that number and type(s) of certifications and years of experience as a Registered Nurse (RN) were associated with higher comfort levels of practice. Results showed in a study by Ochejele, ENEGELA and Haywood (2004) that parenteral antibiotics, anticonvulsants, and blood were not immediately available in the maternity unit during the period of care. Results showed that the responsiveness of the staff to obstetric emergencies was low (Ochejele, ENEGELA and Haywood, 2004). The study concluded that quality of emergency obstetric care was poor.

The communities of sub-Saharan Africa face a disproportionate burden of acute injury and illness (Calvillo et al., 2013). While acute care systems can substantially lower the morbidity and mortality associated with these acute illnesses, there are also other social ramifications such as loss of income earner in the family. In Ghana, infectious diseases are among the top 10 causes of morbidity and mortality, with 66% of annual deaths due to infectious and parasitic diseases, HIV/AIDS, and malaria. Most of these patients present with complications as emergencies, thereby adding to the strain on the already weak emergency system (WHO, 2012).

Kwame Nkrumah University of Science and Technology (KNUST) in Ghana has introduced a bachelor of science in emergency nursing program to

prepare nurses to be able to efficiently handle situations of emergencies (KNUST, 2010). This programme is a 2-year programme for professional nurses. Many concepts including paediatric emergencies, medical emergencies, obstetric and gynaecological emergencies, emergency nursing practice, anaesthesia and intensive care are taught during the programme (KNUST).

Challenges in Emergency Care

Globally, injury-related deaths are expected to rise dramatically by 2020 (WHO, 2011). Deaths due to motor vehicle crashes are projected to increase by 80% from the current rates in low and middle-income countries (WHO, 2011). Several patients with diverse health problems may present to the emergency department (ED) simultaneously (Smelter et al., 2008). It is critical to find the right people with the right competencies at the right time and the right place to strengthen preparedness for, response to, and recovery from an emergency (WHO, 2008). Challenges in emergency care include legal issues, occupational health and safety risk for ED staff, and the challenges of providing holistic care in the context of a fast-paced holistic care, technology-driven environment in which serious illness and death are confronted on daily basis (Smelter et al., 2008). In order to contribute to saving lives and promoting health under such difficult conditions, nurses need to have the right competencies (Smelter et al., 2008).

Three main themes were identified in a mixed research by Norris (2006): inter-professional conflict, autonomy, and the need for the Acute Care Nurse Practitioner. Doctors were reluctant to allow nurses to practice certain additional advanced skills. Difficulties appeared to be centered on autonomy

and other associated inter-professional conflicts with the role of the Acute Care Nurse Practitioner (Norris, 2006). Nurses and doctors identified a need for the Acute Care Nurse Practitioner, but indicated that the blurring of boundaries between doctors and nurses can result in inter-professional conflict unless this is addressed prior to the introduction of such advanced practitioners. This research provides a total picture of the challenges of nurses in emergency care. Study was done in the UK and there is a need to use a similar mixed methodology to research into the challenges of professional nurses in middle income and developing country such as Ghana.

Sowney and Barr (2007) undertook a qualitative study to identify challenges of nurses communicating with and gaining valid consent from adults with intellectual disabilities within accident and emergency care service. Effective communication was identified as the most challenging aspect in caring for adults with intellectual disability within ED, having an impact on the assessment of need. Sowney and Barr (2007) concluded that concepts of communication, choice, and control which are fundamental to the provision of quality care in ED are perceived to be challenging in people with intellectual disability. Communication and consent, therefore, require further consideration within the educational and clinical areas to strengthen nurses' competence in caring for people with intellectual disability, with an emphasis and understanding that choice and control are key principles for all people, being central aspects to the provision of an inclusive service for people with intellectual disability (Sowney & Barr, 2007).

A study by Cossette, Frasure-Smith, Vadeboncoeur and Guertin (2015) demonstrated a significant positive effect of nurse interventions on patients'

perceived continuity of care, self-care capacities, anxiety and depressive symptoms and the illness perceptions treatment control subscale. No differences were found for other illness perception subscales or medication adherence. The study concluded that although the intervention did not influence emergency department revisits, it did improve secondary outcomes, suggesting pathways for future research. This study was one of the few randomised control trials found in literature with regards to emergency care and needs to be replicated in Ghana as well.

The role of advanced nurse practitioner in emergency care has emerged in a number of countries, and has brought with it confusion about titles, role boundaries, clinical accountability and educational requirements (Griffin, & Melby, 2006). Initially, the role resulted from a need for healthcare professionals to provide a service to the increased numbers of patients presenting to hospital with less urgent problems (Griffin, & Melby, 2006). The service has evolved to one where nurse practitioners provide high-quality and cost-effective care to persons who seek help for non-urgent, urgent or emergent conditions in a variety of emergency care settings (Griffin, & Melby, 2006). Research by Griffin and Melby (2006) with the aim of determining the attitudes of nurses, doctors and general medical practitioners towards the development of an advanced nurse practitioner service within an emergency department, utilised a 29-item Likert rating scale to measure attitudes, and demographic variables. Two open-ended questions were added to allow respondents to elaborate on what they perceived as benefits and difficulties associated with an advanced nurse practitioner service. All general practitioners, emergency nurses and emergency doctors in one health board in

the Republic of Ireland were targeted, and 25 emergency nurses, 13 emergency doctors and 69 general practitioners were approached to take part. All respondents were positive towards the development of an advanced nurse practitioner service, with general practitioners being less positive. Griffin and Melby (2006) concluded that there was a need for a multidisciplinary approach to the planning of advanced nurse practitioner services. To achieve multi-professional acceptance, an accredited and standardized education programme is required, and this must address existing role boundaries (Griffin, & Melby, 2006). Nurses experienced ethical dilemmas associated with problems of overcrowding in ERs and ICUs, and poor specialized technology and orientation as to the benefits provided by law (Vargas et al., 2013). Vargas et al. (2013) concluded in a qualitative study that it is essential for nurses to participate in discussions that allow the planning of client care (Vargas et al., 2013).

A study was conducted by Martino and Misko (2004) with the aim to analyze the nurses' psychological variables from Engelmann's List of Emotional States. Questionnaires were answered by the subjects at the beginning and end of each shift in different units of hospital on 6-hour and 12-hour schedules in activities developed at the surgical center (SC), Intensive Care Unit (ICU), Coronary Unit (CU) and Emergency Room (ER). The results allowed researchers to certify that nurses' emotional parameters had alterations during the shift, which could be related to the burnout and stress of the care delivery activity. Tiredness was a strong variable at the end of the shifts in all units. The results obtained at the beginning and end of the shifts were statistically compared using the Kruskal-Wallis method and group profiles.

Results demonstrated a variety of feelings and intensities that were statistically significant. This study did not point out the exact situation that caused emotional upsets and burnouts. This gap was addressed in a study by Bezerra, Silva and Ramos (2012) to analyze the scientific literature related to the way in which occupational stress is present in the life of a nurse who works in an emergency care setting. An integrative review of the literature using the Bdenf, Lilacs, Medline, Pubmed, and Scielo repository was done. The results indicated that the occupational stress of nurses in emergency care is related to the scarcity of human resources, number of hours worked, inadequate material resources, night shifts, work-home interface, interpersonal relationships, competitive work climate, and the gap between theory and practice.

A qualitative study with the purpose of identifying challenges of nurses in managing care in emergency units was conducted by Santos, Lima, Pestana, Garlet and Erdmann (2013) through semi-structured interviews with 20 nurses in the emergency department of a university hospital in southern region of Brazil. Results indicated that the main challenges of nurses in managing care in emergency units were: management of overcrowding, maintaining quality of care, and utilisation of leadership as a management tool. The suggestions mentioned to overcome challenges were: reorganization of the health system to focus on emergencies, changes in the flow of patient care, and implementation of training on nursing management. The study concluded that challenges and strategies represented a boost to the development of new practices through collaborative and coordinated work with the emergency care network.

A study by Hunsaker, Chen, Maughan and Heaston (2015) revealed overall low to average levels of compassion fatigue and burnout and generally average to high levels of compassion satisfaction among emergency department nurses. The low level of manager support was a significant predictor of higher levels of burnout and compassion fatigue among emergency department nurses, while a high level of manager support contributed to a higher level of compassion satisfaction. Hunsaker et al. (2015) concluded that improving recognition and awareness of compassion satisfaction, compassion fatigue, and burnout among emergency department nurses may prevent emotional exhaustion and help identify interventions that will help nurses remain empathetic and compassionate professionals. Gert et al. (2011) in a study established a taxonomy of five categories of patient concerns in ED: anxiety, expectations, care provision, endurance and recognition.

In a Swedish study by Andersson, Sundström, Nilsson and Jakobsson (2014) to explore competencies practitioners and managers, results showed that there was polarisation between medical and caring competencies. There was also tension between professional groups in EDs as well as hierarchical boundaries that influenced the ability to develop competencies in everyday work. Medical competencies were valued more and caring competencies were subsequently downgraded.

Hsia, Mbembati, Macfarlane and Kruk (2012) assessed emergency and surgical care in sub-Saharan Africa in a study. The study reviewed key barriers to the provision of emergency and surgical care in sub-Saharan Africa using aggregate data from the Service Provision Assessments and

Demographic and Health Surveys of five countries: Ghana, Kenya, Rwanda, Tanzania and Uganda. Results showed that the percentage of hospitals with dependable running water and electricity ranged from 22% to 46%. In countries analysed, only 19–50% of hospitals had the ability to provide 24-hour emergency care. For storage of medication, only 18% to 41% of facilities had unexpired drugs and current inventories. Availability of supplies to control infection and safely dispose of hazardous waste was generally poor (less than 50%) across all facilities. As few as 14% of hospitals among those surveyed had training and supervision in place. Hsia et al. (2012) concluded that no surveyed hospital had enough infrastructure to follow minimum standards and practices that the World Health Organization had deemed essential for the provision of emergency and surgical care. The countries where these hospitals were located may be representative of other low-income countries in sub-Saharan Africa (Hsia et al.). Thus, the results suggested that increased attention to building up the infrastructure within struggling health systems is necessary for improvements in global access to emergency medical care (Hsia et al., 2012).

June and Cho (2011) to examine the relationship of low back pain prevalence and treatment to personal and work-related characteristics among intensive care unit nurses in a cross-sectional study. Results showed that nurses had back pain at least once a month. Only 18.3% had received medical treatment for their back pain. Compared with neonatal intensive care unit nurses, who had the lowest prevalence, nurses in other specialties, excluding paediatric intensive care units, had a greater likelihood of back pain. Specialty medical (example, cardiology, neurology) intensive care unit nurses had the

greatest probability of back pain and treatment. Perceiving staffing as inadequate and working 6 or more night shifts per month were related to a 64% increase in back pain. Nurses with 2 to 4 years of working experience in intensive care units had the greatest probability of back pain and treatment. June and Cho (2011) concluded that a high prevalence of back pain was found in intensive care unit nurses, even though they comprise a very young workforce. Improving nurse staffing, reducing the frequency of night shifts and assessing risk factors in specific intensive care unit specialties were suggested to decrease back pain prevalence (June and Cho, 2012).

Pines, and Hollander (2007) studied the impact of emergency department (ED) crowding on delays in treatment and non-treatment for patients with severe pain. After controlling for factors associated with the ED treatment of pain (race, sex, severity, and older age), non-treatment was independently associated with waiting room number for each additional waiting patient and occupancy rate. Increasing waiting room number and occupancy rate also independently predicted delays in pain medication from triage. Pines, and Hollander (2007) concluded ED crowding is associated with poor quality of care in patients with severe pain, with respect to total lack of treatment and delay until treatment.

Horwitz et al. (2009) studied vulnerabilities in emergency department (ED) to internal medicine patient transfers. Twenty nine percent of respondents in the reported that a patient of theirs had experienced an adverse event or near miss after ED to inpatient transfer. Analysis of responses identified numerous contributors to error: inaccurate or incomplete information, particularly of vital signs; cultural and professional conflicts;

crowding; high workload; difficulty in accessing key information such as vital signs, pending data, ED notes, ED orders, and identity of responsible physician; nonlinear patient flow; “boarding” in the ED; and ambiguous responsibility for sign-out or follow-up. Horwitz et al. (2009) concluded that the transfer of a patient from the ED to internal medicine could be associated with adverse events. Specific vulnerable areas included communication, environment, workload, information technology, patient flow, and assignment of responsibility. Systems-based interventions could ameliorate many of these and potentially improve patient safety (Horwitz et al., 2009).

A cross-sectional analytical study by Chalfin, Trzeciak, Likourezos, Baumann, and Dellinger (2007) to determine the association between ED “boarding” (holding admitted patients in the emergency department pending intensive care unit transfer) and outcomes for critically ill patients, results showed that during the study period, 50,322 patients were admitted. Both groups, delayed and non-delayed were similar in age, gender, and do-not-resuscitate status, along with Acute Physiology and Chronic Health Evaluation II score in the subgroup for which it was recorded. Among hospital survivors, the median hospital length of stay was 7.0 (delayed) versus 6.0 days (non-delayed). Intensive care unit mortality was 10.7 percent (delayed) versus 8.4 percent (non-delayed). In-hospital mortality was 17.4 percent (delayed) versus 12.9 percent (non-delayed). In the stepwise logistic model, delayed admission, advancing age, higher Acute Physiology and Chronic Health Evaluation II score, male gender, and diagnostic categories of trauma, intracerebral hemorrhage, and neurologic disease were associated with lower hospital survival. Chalfin et al. (2007) concluded that critically ill emergency

department patients with a ≥ 6 -hr delay in intensive care unit transfer had increased hospital length of stay and higher intensive care unit and hospital mortality.

Laxmisana et al. (2007) reported on the nature of multitasking and shift change and its implications for patient safety in an adult ED using the methods of ethnographic observation and interviews. Analysis revealed that interruptions within the ED were prevalent and diverse in nature. On average, there was an interruption every 9 and 14 minutes for the attending physicians and the residents, respectively. In addition, the workflow analysis showed gaps in information flow due to multitasking and shift changes. Transfer of information began at the point of hand-offs/shift changes and continued through various other activities, such as documentation, consultation, teaching activities and utilization of computer resources. The results showed that the nature of the communication process in the ED is complex and cognitively taxing for the clinicians, which can compromise patient safety.

Patel, Gutnik, Karlin and Pusic (2008) investigated the process of triage; the factors that influence triage decision-making, and how the guidelines are used in the process. Results showed that in emergency situations, triage decisions were often non-analytic and based on intuition, particularly with increasing expertise. Guidelines were used differently by nurses during the triage process. These results suggested that explicit guideline information becomes internalized and implicitly used in emergency triage practice as nurses gain experience (Patel et al., 2008). Protocols are interpreted differently by highly experienced (expert) nurses and less experienced (novice) nurses (Patel et al., 2008).

Models and Guidelines of Emergency Care

A number of models of care in ED were identified in the literature. These models of care in ED included triage and registration model, clinical initiatives nurse model, resuscitation model, acute care model, early emergency department senior assessment and streaming model, early treatment zone model, fast tract model, sub-acute model, 2:1:1 model and emergency department short stay units model (New South Wales Ministry of Health, 2012). In the triage and registration model, essential triage functions occurred at the point of triage. The determination of patient acuity and level of urgency, basic first aid if needed, and referral to the most appropriate area for treatment is done at the point of triage. The triage and registration model can be used both within the ED and within the hospital. The Clinical Initiatives Nurse (CIN) model utilises a senior nursing role to manage patients queuing in the ED waiting room. The three priorities of the CIN role in the emergency department waiting rooms are: review patients within their triage benchmark time to ensure they remain clinically safe, provide ongoing communication with the patient and initiate diagnostics or treatment with a particular emphasis on managing the patient's pain. The Resuscitation Model of Care is a set of guidelines that outline the most appropriate clinical and preparatory processes and team model that should be used in the resuscitation of patients in the ED. The key reason for implementing the Resuscitation Model of Care is to provide a coordinated team approach to better manage patients requiring resuscitation, provide a structured process for resuscitating patients and provide standardised communication between pre-hospital personnel and ED staff who will assume care for the inbound patient(s). The Acute Care Model

of Care is a set of principles and processes that aim to promote efficiency in initiating, assessing, performing and transferring the care of patients who are acute, potentially unstable and complex. These are patients that require: Cardiac monitoring, frequent observation, specialised interventions, a higher level of care, and more comprehensive management plan. Early ED Senior Assessment and Streaming (EDSAS) is a flexible Model of Care that can operate during peak periods of demand. The EDSAS is an assessment and treatment process that focuses on determining an early diagnosis, clinical management plan and disposition decision for patients. An important component of EDSAS is the streaming zone with physical space and appropriate staff. The Early Treatment Zone (ETZ) is a multi-functional and flexible clinical area that may be utilised as: A clinical area where the patient management plan from the streaming zone can be implemented and completed with the patient discharged within 2 hours, a clinical area where the patient management plan can be commenced prior to the patient moving to another area in ED, and an internal waiting area for patients still requiring observation prior to discharge or who are waiting for results of tests such as pathology. Fast Track model provide an alternative option to treat non-complex patients in a timely manner, reducing long waiting times for minor problems. Fast track is a dedicated area in the ED to treat ambulant, non-complex patients who can be discharged within two hours. Sub-acute Model of Care is a designated area in the ED for patients: Who are low acuity and do not require an acute bed or cardiac monitoring, who can be high-complexity (with multiple co-morbidities), resource-intensive and require multiple investigations, consults and/or procedures, and are therefore not eligible for

Fast Track or an Urgent Care Centre, and/or who are non-ambulant and need to be cared for on a bed for treatment. 2 : 1 : 1 model of care is a process that divides the 4-hour emergency access target for admitted patients into 3 manageable timeframes: Up to 2 hours to complete an ED assessment and commence the clinical management plan, up to 1 hour to obtain specialty team consult and/or request allocation of an inpatient bed, up to 1 hour to transfer the patient to an inpatient bed or another hospital or community service or discharged home. Emergency Department Short Stay Units (EDSSU) refer to designated units, co-located within the ED, which have been developed for the short-term care of ED patients who require observation, specialist assessment and diagnostics and whose length of hospital stay is deemed to be limited (for example less than 24 hours).

A number of guidelines of emergency care can be found in literature. One of such guidelines is the Remote Area Emergency Guidelines (RAEG) (Department of Health Western Australia, 2005). RAEG consist of rapid assessment, initial assessment and focused assessment. Rapid assessment deals with airway, breathing and circulation (ABC) in emergency care. Rapid assessment is followed by initial assessment which is the physical assessment of the client. Initial assessment is followed by focused assessment which concentrates on the main problems of the client.

Guidelines for Care of Children in the Emergency Department (GCCED) by the American College of Emergency Physicians [ACEP], 2009) was another set of emergency guideline found in literature. GCCED spells out persons who should be coordinators of the paediatric emergencies. These coordinators are physician coordinator for pediatric emergency medicine

appointed by the ED medical director and nursing coordinator for pediatric emergency appointed by the ED nursing director. Other health care ~~providers~~ also providers also staff the ED. The nursing coordinator should possess special interest, knowledge, and skill in the emergency medical care of children as demonstrated by training, clinical experience, or focused continuing nursing education and should also maintain competency in pediatric emergency care. The nursing coordinator may be a staff nurse who is assigned other roles in the ED, such as Clinical Nurse Specialist. The nursing coordinator is responsible for facilitating ED pediatric quality improvement (QI) or performance improvement (PI) activities, serving as liaison to appropriate in-hospital and out-of-hospital pediatric care committees, serving as liaison to inpatient nursing as well as to a definitive care hospital, a regional pediatric referral hospital and trauma center, Emergency Medical Service (EMS) agencies, primary care providers, health insurers, and any other medical resources needed to integrate services for the continuum of care of the pediatric patient. The nursing coordinator should facilitate, along with hospital-based educational activities, ED nursing continuing education in pediatrics and ensure that pediatric-specific elements are included in orientation for new staff members. The nursing coordinator also has the responsibility of promoting pediatric disaster preparedness for the ED and participating in hospital disaster preparedness activities, promoting patient and family education in illness and injury prevention. Additional responsibilities of the nursing coordinator in paediatric emergency nursing include providing assistance and support for pediatric education of out-of-hospital providers affiliated with the ED, working with clinical leadership to ensure the

availability of pediatric equipment, medications, staffing, and other resources through the development and periodic review of ED standards, policies, procedures and collaborating with the physician coordinator to ensure that the ED is prepared to care for children of all ages, including children with special health care needs. The Guidelines for Care of Children in the Emergency Department specifies rules of quality improvement in the ED; rules to improve pediatric patient safety in the ED; and policies, procedures, and protocols for the ED.

Dinh, Walker, Parameswaran, and Enright (2012) investigated the quality of care delivered by an emergency department fast track unit where both doctors and an emergency nurse practitioner (ENP) treated patients. Of the 236 patients who submitted completed survey forms, median satisfaction scores were 22 out of 25 with 84% of patients rating care as “excellent” or “very good”. At two week follow up, health status score was comparable to normal healthy populations. When comparing study groups, patient satisfaction scores were significantly higher in the ENP group compared to DR group. Dinh et al. (2012) concluded that patients received high quality care fast track unit where both nurse practitioner and doctors treated patients. Emergency nurse practitioners were associated with higher patient satisfaction (Dinh et al., 2012).

Damkliang, Considine, Kent, and Street (2014) described the development of an evidence-based care bundle for initial emergency nursing management of patients with severe trauma brain injury (TBI) for use in a Thai emergency department context in a study. The evidence-based care bundle focused on seven major elements which were: establishment of a

secure airway along with c-spine protection; maintaining adequacy of oxygenation and ventilation; maintaining circulation and fluid balance; assessment of Glasgow Coma Scale (GCS) and pupil size and reactivity; maintaining cerebral venous outflow; management of pain, agitation, and irritability; and administration for urgent Computed Tomography (CT) scan. The study concluded that a care bundle is one method of promoting consistent, evidence-based emergency nursing care of patients with severe TBI, decreasing unnecessary variations in nursing care and reducing the risk of secondary brain injury from suboptimal care. Implementation of this evidence-based care bundle developed specifically for the Thai emergency nursing context has the potential to improve the care of the patients with severe TBI across the world (Damkliang et al.).

Terrell et al. (2009) in collaboration with The Society for Academic Emergency Medicine (SAEM) Geriatric Task Force, including members representing the American College of Emergency Physicians (ACEP), selected three conditions where there were quality gaps in the care of older patients: cognitive assessment, pain management, and transitional care in both directions between nursing homes and EDs. For each condition, a content expert created potential quality indicators based on a systematic review of the literature, supplemented with expert opinion when necessary. The quality indicators were cognitive assessment, pain management, and transitional care. The quality indicator for cognitive assessment on older clients states that if an older adult presents to an ED and is found to have cognitive impairment, then an ED care provider should document whether there has been an acute change in mental status from baseline. Secondly if an older adult presenting to an ED

is found to have cognitive impairment that is a change from baseline and is discharged home, then the ED provider should document support in the home environment to manage the patient's care and a plan for medical follow-up. The quality indicator for pain management states that if an older adult presents to the ED, then a formal assessment for the presence of acute pain should be documented within one hour of arrival to the ED and if an older adult remains in the ED for more than 6 hours, then a second pain assessment should be documented within six hours of arrival in the ED. If an older adult receives pain treatment while in the ED, then a pain reassessment should be documented prior to discharge home from the ED. The pain management indicator also states that if an older adult receives analgesic medication while in the ED, then meperidine should be avoided because meperidine is associated with increased risk of delirium, fractures, and even death in older adults. The quality indicator for transition care states that if a nursing home resident is transferred to an ED, then the nursing home should provide a medication list in the transfer paperwork because absence of a medication list places the patient at risk for drug interactions and other medication errors. Quality indicator for transition care also states that if a nursing home resident will be released from an ED back to the nursing home, then the emergency practitioner should document communication with a nursing home provider or the primary care or on-call physician prior to discharge from the ED in order to develop a shared care plan and to initiate planning for the next setting before the transfer occurs.

Considine et al (2010) explored older peoples' experience of accessing emergency care in Australia in which a descriptive approach was used.

Participants were ED patients aged 65 years or over and able to give informed consent. Observation of participants and care-givers and follow-up interviews were conducted from September to November 2008. Participant demographics were summarised using descriptive statistics and thematic analysis was used to analyse observation and interview data. Results are based on data from 27 participant interviews and 12 care-giver interviews. Four major themes related to access to emergency care: (i) variation in ED use by older people, (ii) reluctance to access ED care, (iii) mixed experiences of waiting, and (iv) perceived factors influencing access to emergency care. Results of this study highlight important issues regarding access and triage elements of the ED experience for older people and their care-givers and should inform age appropriate triage and waiting processes to improve outcomes for older ED users (Considine et al., 2010). Though the researchers stated that they used a descriptive approach in conducting the study, a careful scrutiny of methodology showed that a descriptive explorative design would have been more appropriate.

The delivery of quality care in the emergency department is emerging as one of the most important service indicators in health delivery (Jennings, Clifford, Fox, O'Connell, & Gardner, 2015). Increasing service pressures in the emergency department have resulted in the adoption of service innovation models: the most common and rapidly expanding of these is emergency nurse practitioner services. A comprehensive search of four electronic databases from 2006 to 2013 was conducted by Jennings, Clifford, Fox, O'Connell, and Gardner (2015) to identify research evaluating nurse practitioner service impact in the emergency department. This systematic review showed that

emergency nurse practitioner service had a positive impact on quality of care, patient satisfaction and waiting times. There was insufficient evidence to draw conclusions regarding outcomes of a cost benefit analysis. Synthesis of the available research attempts to provide an evidence base for emergency nurse practitioner service to guide healthcare leaders, policy makers and clinicians in reform of emergency service provision. The findings suggest that further high quality research is required for comparative measures of clinical and service effectiveness of emergency nurse practitioner service.

Currie, Edwards, Colligan, and Crouch (2007) compared the Emergency Nurse Practitioner (ENP) role in the UK, Australia and New Zealand. Whilst geographically distant, Currie et al. (2007) found that the role of the ENP within these three countries shared fundamental similarities, leading to the question, is this a time to implement international standards for the ENP role? The ENP role in all three countries is gradually establishing itself, yet there are shared concerns over how the role is regulated and deficits in standardisation of scope of practice and educational level. Together these issues of deficits in standardisation of scope of practice and educational level generate confusion over what the ENP role embodies (Currie et al., 2007). One method of demystifying the ENP role would be to progress towards international standards for regulation, education and core components of practice (Currie et al.).

Experiences of Nurses and Clients in Emergency Care

Frank, and Asp (2009) conducted a study to describe patients' qualitatively different conceptions of patient participation in their care in an emergency department. Based on a life world perspective, nine interviews

were performed with patients in an emergency department. The phenomenographic analysis showed that participation by patients means contact with the emergency department staff in three categories of conceptions: being acknowledged; struggling to become involved; and having a clear space. The different conceptions of patient participation give us a deeper understanding of how patients may experience their care. This result may provide a foundation for developing nursing practice and the quality of health care in line with international guidelines (Frank, & Asp, 2009).

Andersson, Jakobsson, Furåker, and Nilsson (2012) explored everyday work at a Swedish ED from a practitioner's perspective. Results showed that the everyday work is characterised by a rapid, short and standardised encounter with limited scope to provide individualised care, which leads to a mechanical approach. ED was characterised by an adaptive approach in which practitioners strive to be adaptable by structuring everyday work and cooperation to achieve a good workflow. The study showed that the practitioners' encounter with patients and relatives was rapid and of limited duration. Anderson et al. (2012) concluded that the care activities that practitioners mainly performed comprised standard medical management and were performed more mechanically than in a caring way. The practitioners strived to balance the requirements and the realisation of the everyday work through structures and in cooperation with other practitioners, although they worked more in parallel than in integrated teams (Andersson et al., 2012).

Mogensen and Pedersen (2013) investigated patients with acute abdominal pain and their experiences upon arrival and stay in an acute surgical ward versus an ED with an observation unit. A phenomenological-

hermeneutic comparative field study with participant observation and interviews was performed. The analysis showed five themes: waiting, being placed on the edge, taking or not taking initiative, being the object of attention and being taken seriously. The conclusion was that the ED included a multidisciplinary team with nurses, who mainly had interactions with the patients before surgical assessment. In acute surgical ward, focus was on assessment by a senior physician only, and the nurses' interaction with the patients took place after surgical assessment. In all, patients experienced long waiting times. The study shows a need to define the roles of the professionals in units receiving patients with acute abdominal pain in order to fulfill the medical as well as the experienced needs of the acute patient.

Richardson, Casey and Hider (2007) examined the experience of the older patient (aged 80 years or over) admitted to an in-patient bed via the ED of a major tertiary level teaching hospital. Patients who were admitted to a medical ward over a four month period were followed by means of an internal audit process, and a sample of patients were asked to consent to an in-hospital face to face interview and a telephone interview following discharge. Findings suggest that patients in this age group were reluctant to criticise any of the hospital processes and in generally expressed satisfaction with their time spent in- hospital.

For the last 25 years, there has been mounting concerns that ED's fast-paced environment is not suitable to meet the care needs of the ever-increasing older population (Schnitker et al., 2011). Schnitker et al. (2011) reviewed research-based literature regarding negative health outcomes and adverse events experienced by older patients in the emergency department (ED).

Electronic databases were searched for relevant English references. The literature outlined a number of negative health outcomes and adverse events in older ED patients, including outcomes related to changes in health status, administrative outcomes suggesting negative health outcomes, and adverse events potentially associated with suboptimal ED practice. Further research is needed on the extent to which these apparent outcomes and events are avoidable (Schnitker et al., 2011). There are potential gains to be made in quality of geriatric emergency care by establishing evidence-based care that attended to the identified adverse events to achieve desirable health outcomes in this vulnerable ED population (Schnitker et al., 2011).

Coughlan, and Corry (2007) described the experiences of patients and/or their relatives/significant others who had spent 12 hours or more in Accident and Emergency (A&E) awaiting admission to hospital. Participants in the study described the A&E departments as resembling a disaster zone or a hospital scene from a third world country. Descriptions portrayed an environment that was overcrowded, dirty and lacking in resources. Participants were generally positive in their attitudes towards the care they received, but some descriptions appeared to suggest that the quality of care was not always ideal. Recommendations from participants included reduced waiting times with a maximum of six hours from admission to transfer or discharge; better communications systems with perhaps a liaison person who could advise them about the expected duration of stay in A&E and what was happening regarding their care; and better privacy and security within the departments.

Oliveira, Junior, Miranda, Cavalcante, and Almeida, (2014) studied social representations of Portuguese nurses regarding the stress that they experience in emergency care. Nurses regarded stress in emergency care as harmful to their health, indicated by such words as ~~“overload“~~ “overload”, and ~~“work—work—being”~~ being mentioned more frequently and considered more important by the respondents. Oliveira et al. (2014) concluded that the study of the elements of social representation of these workers needs to be taken to a greater depth. This complementation is very important in order to better understand and describe the social representations from the stress experienced by nurses in emergency care (Oliveira et al., 2014).

A study was conducted by Adriaenssens, De Gucht, and Maes (2015) to (1) explore the prevalence of burnout in emergency nurses and (2) identify specific (individual and work related) determinants of burnout in ED nurses. A systematic review of empirical quantitative studies on burnout in emergency nurses, published in English between 1989 and 2014 was done. Adriaenssens et al. (2015) found that on average 26 percent of the emergency nurses suffered from burnout. Individual factors such as demographic variables, personality characteristics and coping strategies were predictive of burnout. Work related factors such as exposure to traumatic events, job characteristics and organizational variables were also found to be determinants of burnout in ED nurses. Adriaenssens et al. (2015) concluded that Burnout rates in emergency nurses are high. Job demands, job control, social support and exposure to traumatic events are determinants of burnout, as well as several organizational variables (Adriaenssens et al., 2015)

Twibell et al. (2008) tested two instruments used to measure nurses' perceptions of family presence during resuscitation, to explore demographic variables and perceptions of nurses' self-confidence and the risks and benefits related to such family presence in a broad sample of nurses from multiple hospital units, and to examine differences in perceptions of nurses who had and who had not invited family presence. Results showed nurses' perceptions of benefits, risks, and self-confidence were significantly and strongly interrelated. Nurses who invited family presence during resuscitation were significantly more self-confident in managing it and perceived more benefits and fewer risks. Perceptions of more benefits and fewer risks were related to membership in professional organizations, professional certification, and working in an emergency department. Twibell et al. (2008) concluded that Nurses' perceptions of the risks and benefits of family presence during resuscitation vary widely and are associated with how often the nurses invite family presence.

Tudor, Berger, Polivka, Chlebowy, and Thomas (2014) explored nurses' experience with resuscitation, perceptions of the benefits and risks of having a patient's family members present, and self-confidence in having family presence at their workplace. Results showed nurses' self-confidence and perceived benefit of family presence were significantly related. Self-confidence was significantly greater in nurses who had completed training in Advanced Cardiac Life Support, had experienced ten or more resuscitation events, were specialty certified, or were members of nurses' professional organizations. Barriers to family presence included fear of interference by the patient's family, lack of space, lack of support for the family members, fear of

trauma to family members, and performance anxiety. Tudor et al. (2014) concluded that changing the practice of family presence will require strengthening current policy, identifying a team member to attend to the patient's family during resuscitation, and requiring nurses to complete education on evidence that supports family presence and changes in clinical practice.

New nurses typically begin their practice in acute care settings in hospitals, where their work is characterized by time constraints, high safety risks for patients, and layers of complexity and difficult problems (Hodges, Keeley, & Troyan, 2008). Retention of experienced nurses in acute care settings is an issue central to patient safety. A study was conducted by Hodges et al. (2008) to explore the nature of professional resilience in new baccalaureate-prepared nurses in acute care settings and to extrapolate pedagogical strategies that can be developed to support resilience and career longevity. Findings revealed the following: common process of evolving resilience among participants; new nurses spend a significant amount of time learning their place in the social structure; with positive experiences, new nurses begin to feel more competent with skills and relationships and become increasingly aware of discrepancies between their ideas of professional nursing and their actual experiences in the work setting; the risk of new nurses leaving their practice is constantly present during these struggles; acceptable compromises yield a reconciliation of the current crisis, typically occurring long after formal precepting has ended; personal growth is evident by the evolving clarity of professional identity, an edifying sense of purpose, and energy resources to move forward; For new nurses, professional resilience

yields the capacity for self-protection, risk taking, and moving forward with reflective knowledge of self (Hodges et al., 2008).

Saadati (2006) determine nurses' job satisfaction at ED in Shaheed Beheshti Hospital in Yasooj. Findings showed that 80 % of the subjects did not have job satisfaction and 62 % did not have job security in the ED. Saadati (2006) concluded that most nurses were dissatisfied, which could be related to job insecurity, low job improvements and general vision of society about nursing particularly at small towns.

Romanzini, and Bock (2010) identified the feelings that result from the practice and training of nurses working in mobile Emergency Medical Services (EMS). Bardin's content analysis was used and six categories emerged: "Feelings aroused in the EMS", "Experiences in the daily routine", "nurses' activities in EMS", "Personal and professional preparedness", "Reflecting on the professional training" and "Nurses' perceptions of the EMS" (Romanzini, & Bock, 2010, p. 240). The results revealed that nurses working in EMS feel secure, prepared and motivated to work and they also experience diverse feelings such as compassion, gratitude, anger, pity, sadness and anxiety. Acknowledgment and the possibility of restoring lives motivated EMS nurses.

Won and Byoungsook (2013) identified relationships among post-traumatic stress (PTS), job stress and turnover intention in emergency department (ED) nurses. Results showed there were significant relationships between PTS, job stress and turnover intention. PTS influenced turnover intention directly and was indirectly mediated by job stress. The experience of traumatic events influenced PTS, job stress, and turnover intention. Indirect

experience of traumatic events in the ED was an important predictor, explaining 20.1% of PTS in high-risk post-traumatic participants. Won and Byoungsook concluded that PTS can be an important factor for job stress and turnover intention. The direct and indirect experience of traumatic events can influence PTS, job stress, and turnover intention in ED nurses (Won, & Byoungsook, 2013).

Today the proportion of acute patients entering the health care system through emergency departments continues to grow, the number of uninsured patients relying primarily on treatment in the emergency department is increasing, and patients' average acuties are rising (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010). At the same time, support resources are constrained, while reimbursement and reputation depends increasingly on publicly available measures of patient satisfaction (Hooper et al., 2010). A study was conducted by Hooper et al. (2010) to explore the prevalence of compassion satisfaction, burnout, and compassion fatigue among emergency nurses and nurses in other selected inpatient specialties. Approximately 82% of emergency nurses had moderate to high levels of burnout, and nearly 86% had moderate to high levels of compassion fatigue. Differences between emergency nurses and those working in three other specialty areas, that is, oncology, nephrology, and intensive care, on the subscales for compassion satisfaction, burnout, or compassion fatigue did not reach the level of statistical significance. However, the scores of emergency nurses evidenced a risk for less compassion satisfaction, while intensive care nurses demonstrated a higher risk for burnout and oncology nurses reflected a risk for higher compassion fatigue. ED nurse managers, along with other nurse leaders, are

faced with the competing demands of managing the satisfaction of patients, recruitment and retention of experienced nurses, and provision of quality and safe care customized to patients' needs and preferences (Hooper et al., 2010).

Ogundipe et al. (2013) surveyed nurses perception of violence in ED. Results showed that 88.6 percent of respondents had witnessed ED violence while 65 percent had been direct victims before. Nurses followed by doctors were the usual victims. The acts were carried out mostly by visitors to the ED. Men were usually responsible for the violence, which usually occurred in the evenings. Weapons were not commonly utilised. Only 15.8 percent of the nurses had been threatened with a weapon over a one year period. The main perceived reasons for violence were overcrowded emergency rooms, long waiting time and inadequate system of security. All the institutions were lacking in basic strategies for prevention. While most of the nurses were not satisfied with the EDs that were considered not safe, few would wish for redeployment to other departments / units. Ogundipe et al. (2013) concluded that there is a need to make the EDs safer for all users. This can be achieved by a deliberate management policy of zero tolerance to workplace violence, effective reporting ~~systems~~, systems, adequate security and staff training on prevention of violence (Ogundipe et al., 2013).

Key Findings from Literature Review

Emergency care meant a number of things to clients and nurses. These meanings include good communication with clients; reduction in wait times; meeting physical needs; nurses attending to distress by physical discomfort in emergency setting; friendliness; courtesy; professional attitude in ED; effective pain relief and attention to individual patients; overcrowding;

burnout, and compassion fatigue among emergency nurses; anger, pity, sadness and anxiety (Shankar et al, 2014; Ogundipe et al, 2013; Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010; Romanzini, & Bock, 2010)

Literature revealed that there was lack of emergency preparation in nursing schools. Some practicing nurses thought that faculty were not well prepared to teach emergency care nursing. Nurse managers in ED felt basic nursing education did not provide sufficient emergency nursing competency and that there was a need for supplementary formal emergency nursing education. Head nurses of EDs wished that there was national guidelines and recommendations for emergency care. Head nurses of EDs recommended formation of emergency nursing associations to help address challenges related to emergency care (EC) education. Literature reviewed also showed that there was a need for specialists nurses in ED to work together with other team members in the hospital to improve EC (Henrik& Kerstin, 2009; Weiner et al. 2005).

Literature reviewed demonstrated that there were legal, occupational, and safety risks in ED. There was a need for the right competencies in the face of numerous challenges in ED. There were issues of inter-professional conflict in emergency care where recognition of autonomy of the acute care nurse was a challenge. Sub-sahara Africa faces a disproportionate burden of acute injury and illness. However, low responsiveness to clients by ED staff in ED is a challenge that needs to be addressed in ED in order to provide quality care to clients. Nurses also need to improve on communicating with adults with intellectual disability in order to provide care that is in line with ethical

principles of health care (Smelter et al., 2008; Calvello et al., 2013; Sowney, & Bar, 2007).

A number of guidelines and models of emergency care for adults and children were identified in literature which can be adopted in giving care in the ED. These guidelines include triage and registration model, clinical initiatives nurse model, resuscitation model, acute care model, early emergency department senior assessment and streaming model, early treatment zone model, fast track model, sub-acute model, 2:1:1 model and emergency department short stay units model and Remote Area Emergency Guidelines (New South Wales Ministry of Health, 2012; Department of Health Western Australia, 2005). Literature revealed that one method of demystifying the ENP role would be to progress towards international standards for regulation, education and core components of practice. A research conducted in which quality of care by nurses and doctors were investigated revealed that patients received high quality care in fast track unit where both nurse practitioner and doctors treated patients. However emergency nurse practitioners were associated with higher patient satisfaction in a fast unit (Currie et al., 2007; Dinh et al., 2012).

There were various experiences in ED by clients and nurses. Some clients described the A&E departments as resembling a disaster zone or a hospital scene from a third world country. Descriptions portrayed an environment that was overcrowded, dirty and lacking in resources. Some client participants in a research were generally positive in their attitudes towards the care they received, but some descriptions appeared to suggest that the quality of care was not always ideal. Literature outlined a number of

negative health outcomes and adverse events in older ED patients, including outcomes related to changes in health status, administrative, and adverse events potentially associated with suboptimal ED practice. On the contrary, Findings from another studies suggest that older patients were reluctant to criticise any of the hospital processes and generally expressed satisfaction with their time spent in- hospital (Coughlan, & Corry, 2007; Schnitker et al., 2011; Hider, 2007).

A qualitative study aimed at exploring the everyday work at ED from a practitioner's perspective, showed that everyday work in ED is characterised by a rapid, short and standardised encounter with limited scope to provide individualised care, which led to a mechanical approach. Practitioners' encounter with patients and relatives was rapid and of limited duration. ED practitioners strive to balance the requirements and the realisation of the everyday work through structures and in cooperation with other practitioners, although they work more in parallel than in integrated teams. Literature review revealed more experiences of clients in ED than experiences of nurses and other health care professionals in ED (Andersson, Jakobsson, Furåker, & Nilsson, 2012).

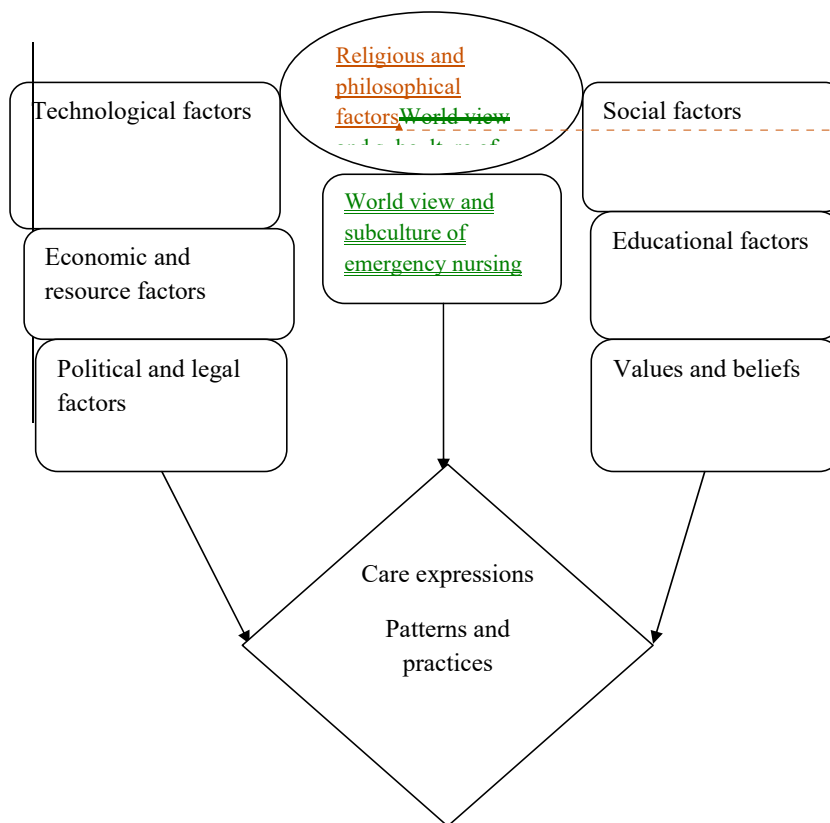


Figure 1. Modified Leininger's Sunrise Enabler to Discover Culture

A modified version of Leininger's Sunrise Enabler to discover culture (Leininger, & Mcfarland, 2004) was used as a guide for this study. Leininger (2004) defined nursing as a learned scientific and humanistic profession and discipline focused on human care phenomena and caring activities in order to assist, support, facilitate or enable individuals or groups to maintain or regain their health or well-being in culturally meaningful and beneficial ways or to help individuals face handicap or death (Leininger, & Mcfarland, 2004). When

looking at the lived experiences of emergency room nurses, it is appropriate to apply the dimensions as seen in the model to help understand their responses and the phenomenon of emergency nursing care. There are a number of factors that can influence the world view of the emergency care nurse and emergency care delivery. With reference to the sunrise model of Leininger, technological, religious, philosophical, social, cultural values, beliefs, political, legal, economic and educational factors could influence ED nursing and care expression patterns and practices. Technology such as cardiac monitors, defibrillators, pulse oximeters and suction machines are needed to be able to effectively practice emergency care. Therefore availability of technological devices may influence the way emergency nursing care is provided. Nurses religion may influence nurses beliefs and his or her practice in the emergency room. Nurses' philosophies and beliefs about human life, choices, and emergency care among other things may influence emergency practices in the ED. The nurse's social relationships with people may influence his or her practice. A nurse who is socially interactive and lively may communicate more with clients than a nurse who is not. Political and legal structure of the immediate health care organisation and Ghana as a whole may have influences on how emergency care is provided in Ghana. Economic, financial and resource implications exist for emergency nursing care. Availability of funds to provide resources will affect the phenomenon of emergency nursing care. Education is critical in the acquisition of necessary competencies in order to provide emergency nursing care. Inadequate competencies in emergency care are likely to negatively affect the practice of emergency care.

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter presents research design, study setting, population, sampling technique, instruments, and procedures that were used to address the research objectives for this study. The purpose of this chapter is to provide methodological processes that were employed in conducting the study.

Research Design

A qualitative phenomenology study design was used in carrying out this study. Phenomenology, rooted in a philosophical tradition is an approach to exploring and understanding people's everyday life experiences (Polit, & Beck, 2010). The qualitative study design was chosen because the researcher wanted to explore the lived experiences of nurses in emergency nursing care in selected hospitals of the Volta Region of Ghana.

Ethical Considerations

The research proposal was submitted to and approved by the University of Cape Coast Institutional Review Board (UCCIRB). Additionally, study received approval from each hospital where research was conducted. All principles of research ethics were adhered to. Participants were briefed about the study aim and procedures before obtaining their written informed consents. Participants were informed about their rights to refuse to participate in the study or to leave at any time without giving any reason. Also, participants were informed that their refusal to participate in the study would

not be used against them in any form. The confidentiality of participants was enforced, and they were assured that the data would be used only for research purposes. The study process did not entail any harmful effects on participants.

Study Setting

The Volta Region was selected for this research because there was no study found in literature about lived experiences of ED nurses in the Volta Region. The study was done in three hospitals located in the Volta Region: Volta Regional Hospital (VRH), Ho Municipal Hospital (HMH) and Keta Municipal Hospital (KMH). These hospitals had established emergency care units and serve as referral facilities in their catchment areas. VRH and HMH were selected to explore nurses' experiences in emergency care from an urban hospital's perspective. KMH was selected to explore nurses' experiences in emergency care from a rural hospital's perspective. Two of the hospitals (VRH and HMH) were located in Ho whilst one (KMH) was located in Keta. Ho Municipal is one of the twenty five municipalities and districts in the Volta Region of Ghana (Ho Municipal Assembly [HMA], 2015). The municipality is also the administrative capital of the people of the Volta Region (HMA, 2015). According to the 2010 Population and Housing Census, the Volta Region has a population of 2,118,252 while Ho has a population of 96,213 (HMA, 2015).

The Volta Regional Hospital is located in Ho. The Volta Regional Hospital is a 240 bed hospital and it is the main referral point for all other health facilities in the region and sometimes beyond (HMA, 2015). The hospital is still yet to be fully operational due to human resource constraints (VRH, 2015). Out of the available 14 wards with 240 beds, only 9 wards are currently in use with 160 beds (VRH, 2015). VRH has bed turnover rate of

29.3% and bed occupancy rate of 72.9 (Volta Regional Hospital, 2015). The hospital was originally built to provide tertiary care for referred patients but currently provides primary health care service for the people of the region and beyond.

According to the Ho Municipal Hospital (2015) the Ho Municipal Hospital (HMH) was commissioned in 1927 as a small health post and has grown to a one hundred and fifty bed capacity hospital which includes an accident and emergency unit with 3 beds located near the out-patient department. Until the commissioning of a new ultra-modern hospital designed as a regional hospital in 1999, the current municipal hospital played the role of a regional hospital. Even though the hospital continues to render valuable services to many people within the catchment area, it suffers from lack of proper physical planning, bureaucracy, inadequate critical staff, lack of residential accommodation for staff, neglect and lack of maintenance as well as poor attitude to work by some staff impacting negatively on service delivery of the hospital. The objective of the hospital is to cater for the health needs of the people of the Ho municipality and its environs including Agortime-Ziope, Adaklu-Waya and Ho West District. HMH serves as referral centre for numerous clinics and health centres within the municipality. It also serves as a diabetic centre for the Volta Region.

Keta Municipal, with Keta as the administrative capital is one of twenty five municipalities in the Volta Region of Ghana (Keta Municipal Assembly [KMA], 2015). It is located east of the Volta estuary, about 160km to the east of Accra, off the Accra-Aflao main road (KMA, 2015). Keta was

selected for the rural perspective of nurses' experience in emergency care (KMA, 2015).

According to the Keta Municipal Hospital (2015) the Keta Municipal Hospital is the maiden government hospital to be built in the Southern Volta and serves as the main referral facility in the Keta municipality. Services provided include general medical and surgical cases for out-patient department and in-patients. Obstetric and Gynecological and eye care services are provided as specialised services. The hospital operates with hundred and fifteen beds distributed as follows: male ward-28 beds, female ward-22 beds, children's ward- 24 beds, maternity ward-20 beds, fevers unit-16 beds, emergency unit-5 beds (Keta Municipal Hospital, 2015)

Study Population

The target population for this study was nurses working at the ED in the Volta Regional Hospital (VRH), Keta Municipal Hospital (KMH) and Ho Municipal Hospital (HMH).

Sample and Sampling Technique

Two urban hospitals (VRH and HMH) and one rural hospital (KMH) were purposively selected. Originally only one urban (VRH) and only one rural (KMH) and ten participants were sampled for data collection. However after content analysis, it was realised that there was a need to interview more participant in the urban area to achieve saturation. Therefore three more participants in the HMH were sampled. KMH was sampled to explore the rural experiences of emergency nurses in ED. VRH and HMH were selected to explore the urban experiences of nurses working in ED. Participants were purposively selected for semi-structured interviews. Only nurses who had

professional identification numbers (PIN) and had worked in the ED for at least one year were selected for the study. Professional nurses who had worked for a year or more had more experiences to share, thus their inclusion in the study. The researcher went to the EDs and requested the list of professional nurses from the ward managers out of which nurses who met the inclusion criteria were selected. The purpose of the research was explained to selected ED nurses. Nurses who were willing to participate in the study were required to sign a written consent form. The mobile phone numbers of participants were collected and a convenient time and place to meet was arranged between researcher and participants. Participants were selected for interview until saturation was reached in each hospital. The minimum number that researcher wanted to interview was five participants in each hospital. However, saturation was reached after 5 participants were interviewed in Keta Municipal Hospital, seven participants were interviewed in Volta Regional Hospital and three participants were interviewed in Ho Municipal Hospital.

Instrumentation

Semi-structured interviews were used to collect data. A semi-structured interview is a verbal interchange where one person, the interviewer elicits information from another person by asking questions (Clifford, French, & Valentine, 2010). Although the interviewer prepares a list of predetermined questions, semi-structured interviews unfold in a conversational manner offering participants the chance to explore issues they feel are important (Clifford et al., 2010). Interviews were guided by interview schedule which was formulated to address research objectives. Follow up questions were asked when clarification was needed. A pre-test of interview schedule was

done in the Hohoe Municipal Hospital where 3 ED nurses were interviewed and recorded in order to address any problems in the interview schedule and also verify the workability of the recorder. Results of pretest were shown to supervisor who advised modification of interview questions to arrive at qualitative responses. To ensure face and content validity, interview questions were modified and pretested on three respondents in Hohoe Municipal Hospital. Results of second pretest was reviewed with the supervisor. Data collection started after supervisor and researcher were satisfied that the new interview guide explored the experiences of nurses in ED.

Data Collection

Participants for data collection were selected through purposive sampling technique. A list of all professional nurses in EDs was requested from Nurses Managers of EDs and professional nurses with PINs who had worked for one year or more were selected for interview. The mobile phone numbers of selected participants were requested. Participants were called on phone to arrange a convenient time and place for interviews. Seven participants in VRH, five in KMH and three in HMH were interviewed. One semi-structured –interview was conducted with each participant. Interviews took place at places convenient for participants. Most interviews were done in the homes of participants and others were done at hospitals after nurses had closed from their shift duties. Interviews were audio recorded and recordings were transcribed verbatim by researcher. In this study, the researcher ensured that participants told their stories with minimal interruption. The interviews ranged from 30 minutes to 60 minutes. Transcribed interviews were stored in electronic folders that were created and labeled appropriately for easy

identification. These folders were kept on a pen drive solely meant for the purpose of this study and kept under lock and key. Data were collected from May to June 2015. Initially data was collected from five participants each in VRH and KMH. However saturation was not determined in the urban area. Two additional participants were interviewed in VRH and three participants in HMH to determine saturation for urban hospitals. Saturation was determined for the rural hospital after five participants were interviewed in Keta Municipal Hospital. Saturation occurs when the researcher finds that no new descriptive codes, categories or themes are emerging from the analysis of data (Rebar et al., 2011). Participants were debriefed to ensure reliability of data collected.

Data Analysis

Interviews were analysed through content analysis. The content of interview notes was transcribed verbatim from audio recordings and was read several times to identify key concepts and codes. Codes were developed to describe identified key concepts. Codes with similar meanings were collated as themes. Similar themes were grouped together to form categories. Data from KMH, VRH and HMH were analysed according to themes developed and reviewed by supervisor to facilitate face and content validity. Participants were also debriefed about themes to make sure it represented their lived experiences in ED. Themes developed were: a) encountering challenges in ED; b) ED as a place of learning and increased confidence for nurses; c) feelings of stress and joy in ED; d) social and physical consequences of ED; e) nurses taking up jobs in ED that are inconsistent with their job description; f) clients receiving low quality Care in ED.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

The first part of this chapter presents demographic results and the second part presents thematic categories that were arrived at after content analysis of data. The summary of the demographic data for professional nurses is found in Tables 1.

Results of Demographic Data

According to data in Table 1, 73.3 percent of respondents were between 25 to 29 years. Twenty percent of respondents were between 30 to 34 years. Only 6.7% of respondents were between 35 to 39 years.

Almost 48 percent of respondents obtained knowledge from the Nurses Training College (NTC) to practice emergency care. Only 6.7 percent of respondents used knowledge of critical care nursing to practice emergency care in ED.

Of the 15 nurses interviewed, 46.7 percent of them worked in VRH. 33.3 percent worked in the KMH. Twenty percent worked in HMH. Results showed that 66.7 percent worked in the urban hospitals, that is, VRH and HMH. Only 33.3 percent worked in the rural hospital.

Nurses interviewed had worked for an average duration of 2.53 years. Sixty percent of participants had worked for two year or less in ED and only 13.3 percent had worked for five years. No participant had worked beyond five years.

Almost 67 percent of participants indicated that there was only one professional nurse on a shift in ED. Only 13.3 percent of participants indicated that they had 3 professional nurses on a shift.

Results on bed capacity of ward showed that 20 percent of wards had less than 4 beds. About one-third (33.3 percent) had bed capacity of 5-9 beds. Almost 47 percent had bed capacity of 20-24 beds. The majority of respondents were single (80 percent) and had no children (86.7 percent).

Almost 87 percent of participants completed NTC. Only 6.7 percent completed critical care nursing. Sixty-six percent of respondents were men whilst 33.3 percent were women. All respondents (100 percent) were Christians.

Table 1: Results of Demographic Data

Demographic Information	Frequency	Percentage
Age (in years)		
25-29	11	73.3%
30-34	3	20.0%
35-39	1	6.7%
Source of Knowledge to Practice Emergency Care		
NTC	7	46.7%
Critical care	1	6.7%
NTC and continuous education	7	46.7%
Area of Work		
Urban (Volta Regional Hospital)	7	46.7%
Rural (Keta Municipal Hospital)	5	33.3%
Urban (Ho Municipal Hospital)	3	20.0%
Length of Time Worked in ED		
1 year	4	26.7%
2 years	5	33.3%
3 years	2	13.3%
4 years	2	13.3%
5 years	2	13.3%
Profession Nurses Staff Strength of a Shift		
1	10	66.7%
2	3	20.0%
3	2	13.3%

Bed Capacity of Ward		
0-4	3	20.0%
5-9	5	33.3%
20-24	7	46.7%

Table 1: Cont'd

Religion		
Christian	15	100.0%
Number of Children		
None	13	86.7%
1	1	6.7%
2	1	6.7%
Marital Status		
Single	12	80.0%
Married	3	20%
Education of Respondents		
NTC	13	86.7%
post basic (critical care)	1	6.7%
university first degree	1	6.7%
Gender of Respondent		
Male	10	66.7%
Female	5	33.3%

Results of Thematic Categories

Fifteen professional nurses with valid PINs participated in the research. Participants were ten males and five females aged 25 to 39 years. Six categories emerged from data analysis which were: encountering challenges in ED; ED as a place of learning and increased confidence for nurses; feelings of stress and joy in ED; social and physical life of nurses affected by ED work; nurses taking up jobs in ED that are inconsistent with their job description; clients receiving low quality care in ED.

Theme one: Encountering Challenges in ED.

The first category of ED care was encountering challenges in ED. The challenges that were encountered in ED by nurses were: lack of preparation for ED role, negative attitude from patient relatives, lack of resources in ED,

stressful and time consumption nature of ED, overcrowding in ED, and lack of administrative support from hospital management.

The first challenge encountered in ED was lack of preparation for ED role. Almost sixty seven percent of respondents said they had no formal education to practice in ED. Only 6.7 percent of participants said they had advanced knowledge in critical care. Thirty-three percent of nurses in ED said they had emergency nursing education through workshops on treatment of some emergencies before their placement in ED. One participant in VRH likened ED to a battle ground:

“Nurses are just brought into the unit like soldiers to battle but the soldiers don’t know how to even shoot a gun. You have to push yourself to learn. It is like lotto and it is not good [participant 7].” The rest of the nurses either had diploma from NTC or had their first degrees in nursing from a university in Ghana.

The second challenge encountered was negative attitude of relatives toward ED nurses. Respondents stated that they usually encountered negative attitudes from client relatives. A participant said *“Relatives here sometimes are ungrateful. Some relatives talk to you very rudely [participant 10].”*

Another participant stated: *“I feel so good in ED but there is stress and patients and relatives don’t appreciate. Sometimes you have worked for long and tired and the patient and relative coming don’t know and always want immediate attention [participant 4].”*

The third challenge encountered was lack of resources in ED. Respondents mentioned that they did not have enough resources to perform their duties in ED. A participant stated:

“The supply of essential materials is not the best. Sometimes supply of materials delay and sometimes you are embarrassed when clients come and you cannot care for them as a result of lack of materials. We also need more doctors and nurses in ED [participant 6]”.

Another participant stated:

“The problem is about staffing. At least staff strength should be increased. Nurses are really sacrificing in ED. We do not have items too and patients come and it looks like we are not prepared for them [participant 7]”.

Stress and time consumption nature of ED was the fourth challenge in ED that participants described. Majority of respondents indicated that ED was stressful and time consuming. A participant described this in the following statements: *“I do extra hours on duty. I do not partake in church activities as I used to do. Sometimes friends call me but I am not able to call back because of tiredness [participant 7].”* Another participant said *“Sometimes you don’t have time for yourself ... or even your family, because of the staff situation. Social life is affected. You can’t go for occasions [participant 1]”.* A participant also said: *“It’s like going to work and you never sit your ass down, working, going up and down. Sometimes you leave work late because you have to assist colleagues who have come to work [participant 2].”*

Overcrowding in ED was the fifth challenge participants expressed. Participants said lack of space and overcrowding was a major challenge in ED. A participant stated that: *“Accident and Emergency unit is always hectic. The bed capacity is affecting us. We always have to add extra stretchers. The place is always messy [participant 1].”* Another participant said: *“There is so much pressure over here and we are not organised. And if you are not careful, you*

may give the wrong medication to a client. Sometimes we misplace clients medications as well” [participant 12].

Lack of administrative support for ED nurses from hospital management was the sixth challenge emergency care nurses faced. Nurses interviewed said that ED nurses did not enjoy administrative support. A participant from the VRH said: *“Management does not support us ..., they are fault finders. Management does not take our suggestions [participant 8].”* Another participant said: *“In terms of motivation, nurses are discriminated against. Doctors are given lunch but nurses are given nothing [participant 15].”* A participant said: *“You can work the whole day but you will not be given any food or lunch. The doctors receive lunch but nurses are ignored [participant 6].”*

Theme two: ED as a Place of Learning and Increased Confidence for Nurses.

All professional nurses indicated that ED was a learning environment and that working in ED increased their confidence level for practice. A participant said: *“Working in ED is interesting; it exposes you to many challenges and broadens your mind. Everybody must experience ED [participant 1].”* Another participant said:

Working in ED has brought a lot out of me. It has broadened my mind because it comes with many challenges. ED has really affected my attitude towards work. When I was a student I never thought I could work at ED. But now I come to work early, respect client and treat them with respect. I now have an attitude of urgency [Participant 2]

Another participant stated: *“I feel bold and great anywhere I go*

...

even other wards. I feel I can take charge of everything, even in other hospitals, I feel I can handle everything. Emergency unit has broadened my knowledge and skill [participant 12].” Participant 8 stated:

Working in ED has opened my eyes to know how to work in and out of the hospital. It makes me feel sufficient as a nurse. I have met a lot of different cases. It has prepared me to work in diverse situations.

Theme three: Feelings of Stress and Joy in ED.

All participants indicated that though ED was stressful, it was an interesting environment and was also a learning environment. A participant stated: *“Aside the stress, anything else is pleasure. When I see someone healed and coming back for review, I feel so good [participant 5].”* Another participant stated:

Even though the place is stressful, it is an interesting place. You meet a lot of people. It’s interesting so I will always prefer emergency. I think I enjoy working with the people I work with now. It’s not only about colleagues but working to satisfy relatives and patients. At ED we are guys so we are easy to deal with [participant 6].

Many of the nurses interviewed said they would not want to be reshuffled to another department because of the interesting nature of ED. They also stated that they wished some of them could be sent to do emergency nursing in Kumasi and come back as specialist emergency nurses. A participant stated: *“I would have loved to do critical care nursing but it is not*

degree. I will like to do the emergency nursing in Kumasi but I hear it is not licensed by NMC [participant 2].” Another participant said:

Our bosses here are friendly. There is no senior and there is no junior. Sometimes you are home and you are called that there is an accident and you are able to come with happiness. If our bosses in management will behave the same way, it will be very nice.

Some nurses also stated that working in emergency is more enjoyable when working with fellow professional nurses. A participant stated: “*Emergency care is more interesting when working with colleague professional nurses (participant 8)*”

Theme four: Social and Physical Consequences of ED on lives of ED Nurses in Practice.

Many nurses interviewed indicated that emergency care affected aspects of their physical and social lives negatively. A participant indicated that: “*I had peptic ulcer when I started working here. I don’t put on weight. I don’t even have time to eat and rest. When I have off, I have a whole lot of things to do. Socially, I am deprived. Like funerals, wedding, parties, I can’t attend’.*

Theme five: Nurses taking up Jobs in ED that are Inconsistent with their Job Description.

Nurses interviewed in KMH stated that they performed functions which did not fall under their job description as a result of lack of medical officers in ED especially at night. A participant said:

Due to the staffing situation, we are now prescribers especially at night shift. In ED we don’t have prescribers so sometimes nurses at

emergency department are forced to prescribe though it is not our job. Because of legal issues I wish we have a standing prescriber [participant 3].

Another participant said: *“We sometimes actually request investigations which should have been done by medical officers. These things make me feel uncomfortable because it does not fall within my job description [participant 5].”*

Theme six: Clients receiving Low Quality Care in ED.

Participants said they could not give quality care to clients because of the overwhelming nature of ED. A participant stated: *“The patients at the ED do not get quality care because of the mess sometimes [participant 6].”* Another participant said: *“sometimes I feel we are not giving the best of care to our patients because of the minimal contacts we have with them” [participant 8]*

Discussion of Demographic [ResultsData](#)

ED nurses were generally younger nurses. Seventy three percent of nurses in ED were between ages 25 to 29. Sixty percent of nurses in ED had worked for two years or less. ED needs to have older, experienced nurses. ED should not be a place of learning for the majority of nurses that work there. Younger nurses may not have the necessary competence to provide emergency care without guidance from more experienced nurses. June and Cho (2011) concluded in their study that intensive care unit comprised a very young nursing workforce. A study was done by Patel, Gutnik, Karlin, and Pusic (2008) in which they found that triage decision processes in ED are interpreted differently by highly experienced (expert) nurses and less experienced

(novice) nurses. A study was conducted by Considine, Botti, and Thomas (2006) to examine the effects of education on emergency nurses' oxygen administration decisions in ED. Results showed that participants' average age was 33.64. A descriptive research was conducted by Henrik and Kerstin (2009) in emergency departments in Sweden with the aim of describing head nurses' conceptions of emergency nursing competence needs and their responsibility for creating prerequisites of competence development in emergency nursing. Head nurses considered that they had full responsibility for creating the prerequisites of the competence development of nurses since they had the requisite experience. Young nurses have to be preceptored by these experienced nurse managers if emergency nursing is to achieve its maximum benefit.

Participants indicated that they were not educated formerly for the role of emergency nursing care, though some said they had some workshops on treatment of some emergency conditions. Only 6.7% of respondents had advanced education to provide emergency care. This agrees with Bell et al. (2014) who indicated that the formal provision of emergency health care is a developing specialty in many sub-Saharan African countries, including Ghana. While emergency medicine training programs for physicians are on the rise, there are few established training programs for emergency nurses (Bell et al., 2014). Ross, Erin, Bell, and Sue (2009) also conducted a study to determine the influence of registered nurses' certifications and years of experience on comfort level of nurses in emergency care. Ross et al. (2014) concluded that number and type(s) of certifications and years of experience as an RN were associated with higher comfort levels of practice in nurses.

Of the 15 nurses interviewed, 66.7% worked in the urban hospital, that is, VRH and HMH while 33.3% worked in a rural hospital (KMH). The result of more human resources being available in urban areas and less resources in the rural area of this study agrees with Hines, Frazee and Stocks (2011) that challenges in the health sector are magnified in rural areas which typically have fewer health care resources including medical staff, facilities, adequate financing, and modern technologies.

According to demographic data, 66.7% of participants indicated that there was only one professional nurse on a shift in ED. Forty-six point seven percent had bed capacity of 20-24 beds. Though there was no literature found on staff strengths and ward capacities of EDs, results of this study show the staff strength of emergency wards were inadequate for the ward capacities and this may be a contributing factor to the stress nurses in ED encountered.

All respondents were Christians. Though no research was found on the religion of emergency care nurses, the value of Christianity which centers on doing good to all and loving neighbor as self may have been one of the coping mechanisms for nurses in ED. Respondents indicated that they felt happy when they see that their actions have led to the recovery of clients in ED.

Eighty percent of respondents were single and 86.7 % of respondents had no children. Though there was no research found on marital status and number of children of ED nurses, this study show that majority of ED were single and therefore did not have children. Since 90% of respondents indicated during interview that ED affected their social lives, it is possible that many ED nurses do not have enough time to have good relationships that will lead to marriage.

Almost 87% of participants completed NTC. Only 6.7% completed critical care nursing. This agrees with Bell et al. (2014) who indicated that the formal provision of emergency health care is a developing specialty in many sub-Saharan African countries, including Ghana.

Sixty-six percent of respondents were men whilst 33.3% were women. Though there was no literature found on the gender of nurses working in ED, it looks like managers of the hospital placed male nurses in ED because of the hectic nature of ED.

Discussion of Themes.

Based on the theoretical foundation and data obtained, interpretation and the study's proposed objectives were carried out of which six themes related to emergency care emerged. Themes that emerged were: encountering challenges in ED; ED as a place of learning and increased confidence for nurses; feelings of stress and joy in ED; ED affected social and physical lives of ED nurses in practice; nurses taking up jobs in ED that are inconsistent with their job description; clients receiving low quality care in ED.

Theme one: encountering challenges in ED.

The first category in ED care was encountering challenges in ED. The challenges that were encountered in ED by nurses were: lack of preparation for ED role, negative attitudes from patient relatives, lack of resources in ED, stressful and time consuming nature of ED, overcrowding in ED and lack of administrative support for ED nurses.

Lack of preparation for ED role is the first challenge in ED that participants described. Majority of respondents said they had no formal education to practice in ED. Only 6.7% of participants said they had advanced

knowledge in critical care nursing. A participant stated: *“nurses are just brought into the unit like soldiers to battle but the soldiers don’t know how to even shoot a gun [participant 7]”*. This consistent with Bell et al. (2014) that the formal provision of emergency health care is a developing specialty in many sub-Saharan African countries, including Ghana (Bell et al., 2014). While emergency medicine training programs for physicians are on the rise, there are few established training programs for emergency nurses (Bell et al., 2014).

The second challenge was negative attitude from patient relatives. Respondents stated that they usually encountered negative attitudes from client relatives. A participant stated that: *‘Relatives here sometimes are ungrateful. Some relatives talk to you very rudely ... [participant 10]*. A participant said: *“I feel so good here but there is stress and patients and relatives don’t appreciate. Sometimes you have worked for long and tired and the patient and relative coming don’t know and always want immediate attention [participant 4]”*. This is consistent with Ogungipe et al (2013) that ED violence is common and widespread and that ED staff receives both verbal and physical abuse, with ED nurses bearing the brunt of this violence. According to Ogungipe et al. (2013) the main perceived reason for violence were overcrowded emergency rooms, long waiting times and inadequate systems of security.

Lack of resources in ED was the third challenge expressed in ED. Respondents mentioned that they did not have enough resources to perform their duties in ED. A participant indicated: *“The negative aspects of emergency care is that sometimes you are embarrassed because there are no*

resources and when patients come, it looks like you are not ready for them [participant 9].” This is in agreement with Hines, Frazee, and Stocks (2011) who indicated that emergency care nurse faces a number of challenges which include increased over time, decreased reimbursement by insurers and fewer health care resources including medical staff, facilities, adequate financing, and modern technologies. In most emergency units in Ghana, patients presenting are not triaged and most emergency centres are poorly equipped and overcrowded (Osei-Ampofo et al., 2013).

Stress and time consumption nature of ED was the fourth challenge in ED that participants described. Majority of respondents indicated that ED was stressful and time consuming. A participant described this in the following statements: *“I do extra hours on duty. I do not partake in church activities as I used to do. Sometimes friends call me but I am not able to call back because of tiredness [participant 7].*” A participant also said: *“It’s like going to work and you never sit your ass down, working, going up and down. In other wards they closed on time but here we don’t [participant 2].*” Participants indicated that the staff strength of their unit was one professional nurse on a shift and this may be a contributing factor to the stress that ED nurses face. This is consistent with Sevban, Karaman, Nadiye, and Evşen (2015) that work load and time limitation create more stress for emergency care nurses. This is consistent with Won, and Byoungsook (2013) who indicated that there were significant relationships between Post Traumatic Stress (PTS), and job stress. The experience of traumatic events influenced PTS and job stress (Won and Byoungsook).

Overcrowding in ED was the fifth challenge participants expressed. Participants said lack of space and overcrowding was a major challenge in ED. A participant stated that: *“Accident and emergency unit is always hectic. We always have to add extra stretchers. The place is always messy [participant 1].”* Another participant said: *“There is so much pressure over here and we are not organised. And if you are not careful, you may give the wrong medication to a client. Sometimes we misplace client medication as well” [participant 12].* A participant stated: *“Here we do triaging, but we do mental triaging because there is no space [participant 14]”* This agrees with Coughlan, and Corry (2007) who conducted a study in which participants described the A&E departments as resembling a disaster zone or a hospital scene from a third world country.

Lack of administrative support for ED nurses from hospital management was the sixth challenge in ED. Many of the nurses interviewed said that ED nurses did not enjoy management support. A Participant from the VRH said: *“Management does not support us always, they are fault finders. Management does not take our suggestions [participant 8].”* Another participant interviewed said: *“In terms of motivation, nurses are discriminated against. Doctors are given lunch but nurses are given nothing [participant 15].* These statements agree with Weiner (2006) who indicated that challenges faced by the emergency care nurse includes leadership challenges.

Theme two: ED as a Place of Learning and Increased Confidence for Nurses.

All professional nurses indicated that ED was a learning environment and that working in ED increased their confidence level of practice. A

participant said: *“Working in ED is interesting. ED exposes you to many ... challenges and broadens your mind. Everybody must experience ED [participant 1].”* Another participant stated: *“I feel bold and great anywhere I go to even other wards. I feel I can take charge of everything, even in other hospitals. I feel I can handle everything [participant 12].”* Sixty percent of nurses in ED had two years or less experience and seventy three percent of them were within the age ranges of 25 to 29 years. Therefore nurses found ED to be a learning ground for them. This agrees with Hodges, Keeley, and Troyan (2008) that nurses spend a significant amount of time learning their place in the social structure of emergency nursing and begin to feel more competent with skills.

Theme ~~T~~hree: Feelings of Stress and Joy in ED.

Nurses who participated in study indicated that though ED was stressful, it was an interesting environment and was also a learning environment. A participant stated: *“Aside the stress, anything else is pleasure [participant 5].”* Another participant stated:

Even though the place is stressful, it is an interesting place. You meet a lot of people. It’s interesting so I will always prefer emergency. I think I enjoy working with the people I work with now. At ED we are guys so we are easy to deal with [participant 6].

Many of the nurses interviewed said they would not want to be reshuffled to another ward because ED is interesting. They also stated that they wished some of them could be sent to do emergency nursing in Kumasi and come back as specialist emergency nurses but were concerned about the certification of the course. A participant stated: *“I would have loved to do*

critical care nursing but it is not degree. I will like to do the emergency nursing in Kumasi but I hear it is not licensed by NMC [participant 2].”

Another participant said:

We easily learn because our bosses here are friendly. There is no senior and there is no junior. Sometimes you are home and you are called that there is an accident and you are able to come with happiness. If our bosses in management will behave the same way, it will be very nice [participant 10].

Some nurses also stated that working in emergency is more enjoyable when working with fellow professional nurses. A participant stated: *“Emergency care is more interesting when working with colleague professional nurses (participant 8)”*. Another participant stated: *“Sometimes you come to work alone at day and there is no assistant but for night you may be two, but you may go with an enrolled nurse, so you can’t rest and leave that person [participant 2].”* A participant stated: *“In the first year, I use to regret and wanted to be changed when there was a reshuffle but now in my second year, and I am enjoying it [participant 10].”* This agrees with Ogundipe et al (2013) that while most of the nurses in ED were not satisfied with the EDs that were considered not safe, few would wish for redeployment to other departments / units. These also agrees with Hamilton and Marco (2003) that the emergency department provides an ideal learning environment for health care providers.

Theme Four: Social and Physical Consequences of ED on lives of ED

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Nurses in Practice:

Many nurses interviewed indicated that emergency care affected aspects of their physical and social lives negatively. A participant indicated that: *“I had peptic ulcer when I started working here. I don’t put on weight. I don’t even have time to eat and rest. In other wards they close on time but here we don’t. When I have off, I have a whole lot of things to do. Socially, I am deprived. Like funerals, wedding, parties, I can’t attend”*. This agrees with Smeltzer et al. (2008) that challenges in emergency care include occupational health and safety risk for ED staff, and the challenges of providing holistic care in the context of a fast-paced holistic care (Smelter et al., 2008). Martino and Misko (2004) found nurses' emotional parameters in ED have alterations during the shift, which can be related to the burnout and stress of the care delivery.

Theme Five: Nurses Taking up Jobs in ED that are Inconsistent with their

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Job Description:

Participants in the KMH indicated they usually performed functions that were inconsistent with their job descriptions. A participant said: *“We sometimes actually request investigations which should have been done by medical officers. These things make me feel uncomfortable because it does not fall within my job description [participant 5].”* These situations came about as a result of inadequate numbers of medical officers to perform functions such as prescription of medication and request of diagnostic investigations. Nurses in ED did not feel comfortable performing functions outside their job description because of the legal implication that may arise. Participants

wanted legal backing for jobs they had to do as a result of resource constraints that faced KMH. This is consistent with Norris (2006) that difficulties appeared to be centered on the autonomy with the role of the Acute Care Nurse Practitioner. Nurses and doctors identified a need for the Acute Care Nurse Practitioner, but indicated that the blurring of boundaries between doctors and nurses can result in inter-professional conflict unless this is addressed prior to the introduction of such advanced practitioners (Norris, 2006).

Theme Six: Clients Receiving Low Quality Care in ED

Participants said they could not give quality care to clients because of the overwhelming nature of ED. A participant stated: *“The patients at the emergency department do not get quality care because of the mess sometimes [participant 6].”* This agrees with Andersson, Jakobsson, Furåker, and Nilsson (2012) that everyday emergency work is characterised by a rapid, short encounter with limited scope to provide individualised care, which leads to a mechanical approach. ED practitioners’ encounter with patients and relatives is rapid and of limited duration (Andersson et al., 2012). The actual condition in an ED is that when the number of ED patients increases, or patients with severer conditions are admitted to an ED, their individual demands for direct nursing care will increase; thus, their needs often cannot be met by the standard direct nursing services provided by fixed nursing staffing (Chang, Harnod, & Shih, 2010). Therefore, nursing staff may be forced to reduce the nursing care available or the time provided for each patient (Chang, Harnod, & Shih, 2010). Nurses in ED were young and inexperienced. Nurses in ED (93.3%) indicated they had no formal education to practice ED nursing

and this could be a contributing factor to the low quality care provided in ED. Sixty percent of nurses had two years or less experience in ED. Seventy-three percent of nurses were within the age ranges of 25 to 29. These factors may also be reasons for the low quality care clients in ED received.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This chapter consists of summary, conclusion and recommendation of the study. The purpose of the summary section is to briefly describe the processes used in conducting this research. Based on study results and discussion conclusions are drawn. Recommendations will briefly discuss suggestions by the researcher on improvements needed in emergency care.

Summary

This research sought to explore the lived experiences of nurses in the ED. The specific objectives were to explore 1) challenges of nurses in ED; 2) how ED affected nurses learning and confidence in practice; 3) experiences of stress by ED nurses; 4) physical and social consequences of ED on lives of ED nurses; 5) performance of ED nurses with regard to their job description; 6) explore quality of care rendered to clients in ED. The study was a qualitative study which used phenomenological design. The Keta Municipal Hospital, Volta Regional Hospital and Ho Municipal Hospitals were selected through purposive sampling. Approval for the research was received from the Institutional Review Board of the University of Cape Coast. Pre-test was done at the Hohoe Municipal Hospital. Participants were purposively selected. Written informed consent was obtained from participants. Data were obtained through a semi-structured interview until saturation was achieved at rural and urban hospitals. Analysis was done through content analysis. Result of demographic data was analysed using descriptive statistics and displayed with tables. Six thematic categories were also identified and discussed. Key findings of the study were:

- Majority of the nurses (73.3 percent) working in ED were within the age range of 25-29 years.
- A large number of participants (46.7 percent) used knowledge from NTC to practice emergency care. Another 46.7 percent used knowledge from NTC and continuous education in the practice of emergency nursing. Only 6.7 percent used an advanced knowledge in critical care to practice emergency nursing.
- Majority of nurses who participated in this research worked in the urban area.
- A majority (60 percent) had worked two years or less in the ED. The average length of time nurses worked in ED was 2.53 years. This meant that nurses who were working in ED were not experienced enough to practice emergency nursing on their own.
- Six themes were derived from interview: encountering challenges in ED; -ED as a place of learning and increased confidence for nurses; feelings of stress and joy in ED; social and physical effects of ED on the life of nurses working in ED; nurses taking up jobs in ED that are out of their job description; clients receiving low quality care in ED.

Conclusions

Based on the analysis of findings and the discussions, the following conclusion have been drawn:

Emergency care nurses experiences in ED included joy in ED, experience of learning and increased confidence in ED, experiences of challenges such as inadequate preparation for ED role, experience of stress and overcrowding in ED, lack of appreciation from patient relatives, lack of resources in ED, and lack of administrative support for ED nurses from hospital management. Nurses in ED also provided care that was not consistent with their job description. Nurses in ED also experienced negative social and physical consequences in ED. Nurses felt they provided low quality care to their clients in ED.

It is imperative to take steps to mitigate negative experiences in order to improve emergency care in the Volta Region of Ghana. It is also necessary to use positive experiences to the advantage of health facilities to improve on care at the ED. Nurses who are willing to pursue emergency nursing care as a specialty should be given the necessary support by management to do so. There is need to educate professional nurses in the Volta Region as specialists emergency nurses.

Recommendations

Recommendations are discussed under the following sub-headings: nursing practice, nursing education, nursing administration and nursing research.

Nursing practice

Management of health facilities should have plans of sponsoring nurses to do emergency nursing so that these emergency nursing specialists can return to provide leadership in the emergency department. Unit heads of ED should organise frequent internal workshops on emergency nursing for ED

nurses to upgrade their knowledge in emergency care. Resource person such as emergency physicians, critical care nurses, nurse anesthetists and emergency care nurses should be invited to educate nurses at the ED. Health facilities should adopt a model of emergency care in order to have a more effective and organised emergency care practice. Emergency Nursing Association could be formed by the few emergency and critical care nurses in Ghana to push the agenda of the education of more emergency care nurses.

Nurses must have appropriate education to practice emergency nursing care. In hospitals where nurses are prescribing medications and requesting investigation, management of those facilities need to make sure ED nurses receive the appropriate education for ED practice. Management should also make policies that will give legal backing to the work of nurses in EDs and protect nurses from possible legal actions. Out-patient departments should be run twenty four hourly to reduce pressure on the emergency department.

Nurses who find ED too challenging within few months of being placed in ED should only be changed after a year. Most of the nurses who wished to be reshuffled will most likely prefer to stay in ED after the first year.

Nursing education

Formal education in emergency nursing is necessary in the practice of emergency nursing. Other universities in addition to KNUST should introduce emergency nursing as a specialist course for nurses so that the numbers of emergency nurses can increase in Ghana. Nurses who are placed at the emergency unit should go through some orientation in emergency care before

placement so they can be ready for the challenges in emergency practice. Orientation could take a form of workshops or conferences in emergency care.

Efforts should be made by the Nursing and Midwifery Council (NMC) of Ghana and the Ghana College of Nursing and Midwifery to certify the emergency nursing being organised by KNUST. Though many nurses are interested in undertaking the emergency nursing course, their worry is that NMC does not give a licensing certificate to nurses who graduate from the programme.

Nursing administration

Hospital administration should improve its relationship with nurses working in emergency care. They should work in ED occasionally to know some of the challenges confronting emergency care nurses. Nurses working in ED and other units should be accorded privileges that medical officers enjoy. Lunch should not be provided for only doctors. Nurses in emergency care also deserve some motivation to make up for the challenges they go through in emergency care. Management could organise educative programmes on local radio stations and in churches or mosques in order to make the public know challenges in emergency care. This will reduce the verbal attacks on nurses from patient relatives.

Nursing research

A similar study should be extended to the various regions of Ghana to know if it will produce the same result. There is the need to conduct a quantitative research into the lived experiences in ED. Further research needs to be conducted to understand in details the good interpersonal relations in ED. Research also needs to be conducted to understand why nurses in ED

think that the interpersonal relationship in ED is good because there are more males in ED.

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APPENDICES

APPENDIX A

DATA COLLECTION INSTRUMENT

As one of nurses working in Emergency Department (ED), you are invited to participate in a research to study about the lived experiences of the emergency care nurse in selected hospitals in the Volta Region. This study will help us better understand the experiences of ED nurses, feeling of practicing nurses in ED, challenges for nurses in emergency care and effect of emergency care nursing on the life of ED nurses. By agreeing to participate in this study, you are agreeing to be interviewed. You will be interviewed after you fill your biographical information on the sheet that will be provided. An initial interview will be done and follow up interviews may be necessary to fully understand the lived experiences of nurses working in ED. Each interview will take about thirty minutes to an hour to complete and will be video recorded. The recording will only be used for academic purposes only. This study does not involve any type of physical risk. The information you provide will be kept strictly confidential and anonymous. To protect your privacy, your responses to the interview questions will only be identified with a code number. Your name will not be associated with your study materials or with the research findings. The decision to participate in this research project is entirely up to you. You may refuse to take part in the study without affecting your relationship with anyone or any office. You have the right to

ask questions about this study and to have those questions answered by any of the study investigators before, during or after the research.

Participant signature.....

SECTION A. BIOGRAPHICAL INFORMATION

The purpose of this study is to explore the lived experiences of nurses working in emergency department: a study in selected hospitals in the Volta Region of Ghana. Information collected for this research will be treated with utmost confidentiality. You are humbly requested to circle where appropriate and fill- in spaces provided for responses.

1. What is your age category?

- [a] 15-19 []
- [b] 20- 24 []
- [c] 25-29 []
- [d] 30-34 []
- [e] 35-39 []
- [f] Above 40 []

2. What is your gender

- [a] Male []
- [b] Female []

3. What is your level of education?

- [a] Nurses Training College (diploma). []
- [b] Post basic (advance diploma) []
- [c] University first degree, []
- [d] University second degree. []

[e] Others state.....

4. Where do you work?

[a] Urban hospital (Volta Regional Hospital) []

[b] Rural hospital (Keta Municipal Hospital) []

5. Marital status:

[a] Married []

[b] Single []

[c] Widowed []

[e] Divorced []

[f] Co-habitation []

6. Number of children

[a] 1 []

[b] 2 []

[c] 3 []

[d] 4 []

[e] Above 4 []

7. Which is your religion?

[a] Christian []

[b] Islam []

[c] Traditionalist []

[d] Others (specify).....

8. What is the bed capacity of your ward?

a. 5-9. []

b. 10-14. []

c. 15-19 []

d. 20-24 []

e. 25-29. []

f. Other, state _____

9. How many professional nurses are assigned to a shift in your department?

[a] 1 []

[b] 2 []

[c] 3 []

[d] 4 []

[e] other, Indicate number _____

10. How long have you worked in the ED?

a. 1 years

b. 2 years

c. 3 years

d. 4 years

e. other, state number _____

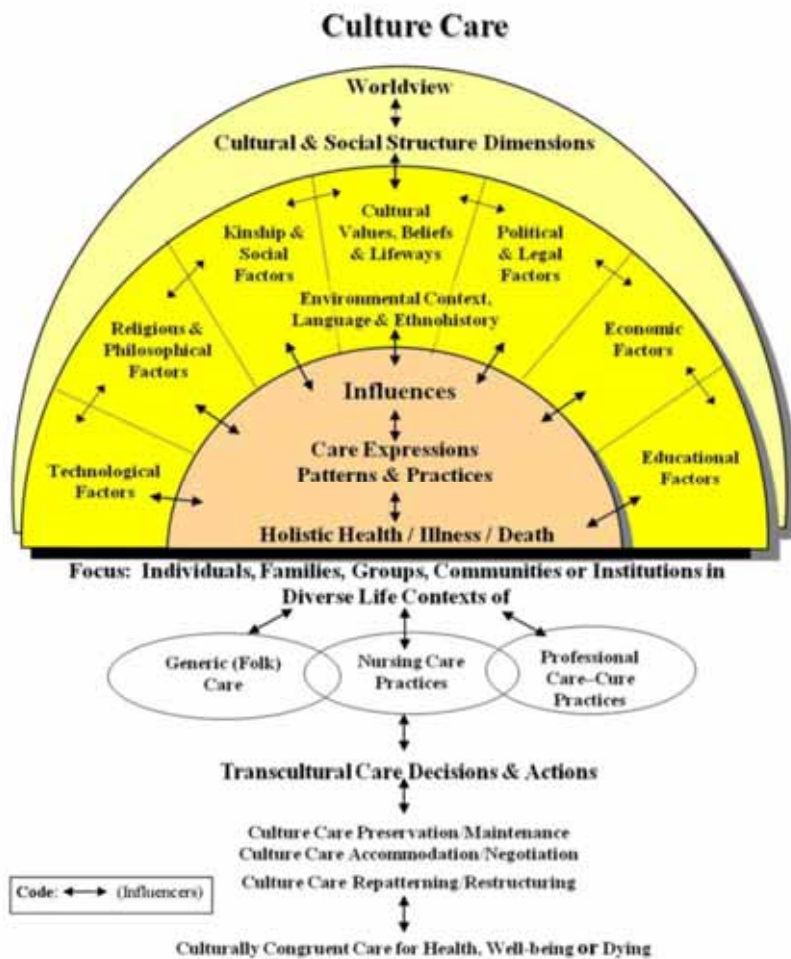
SECTION B. INTERVIEW GUIDE

1. Can you describe your experiences of working in emergency care?
2. How does the experiences of working in emergency department (ED) make you feel?
3. Has working in emergency affected any aspect of your life? Describe please if it has
4. What are your feelings when you come to work at ED each day?
5. Can you describe your typical day in ED?

6. Do you feel you would you have been happier working in another ward?
Why
7. Is there anything you would like to add that has not been asked?

APPENDIX B

Figure 1.0 Leininger's Sunrise Enabler to Discover Culture



APPENDIX C

UNIVERSITY OF CAPE COAST
INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 03321 331725 / 0207355653 / 0244207814

CEO Directorate of Research, Innovation and Consultancy

E-MAIL: irb@ucc.edu.gh

OUR REF: UCC/IRB/318

YOUR REF:



9TH JUNE, 2015

Mr. Confidence Aforse Atakro
School of Nursing and Midwifery
University of Cape Coast

Dear Mr. Atakro,

ETHICAL CLEARANCE –ID NO: (UCCIRB/CIAS/2015/26)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for implementation of your research protocol titled **"the lived experiences of Nurses in the emergency room: A study in selected hospitals in the Volta Region of Ghana."**

This approval requires that you submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

Please note that any modification of the project must be submitted to the UCCIRB for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol

Yours faithfully,

(Faustina Quainoo (Mrs)
Administrative Secretary

cc: The Chairman, UCCIRB

