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PERSPECTIVES OF NURSES ON CONTINUITY OF PATIENT CARE: A STUDY AT THE TRAUMA AND SPECIALIST HOSPITAL, WINNEBA

BY

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DECLARATION

I (Josephine Okine) declare that this dissertation is my work produced from research under the supervision of Dr. Lydia Aziato, Head of Adult Health Department of School of Nursing and Ms. Linda Norman all of University of Ghana, Legon. This dissertation has not been submitted in any form for a degree or diploma at any University or any tertiary institution. Authors and publishers whose works were used in the study have been acknowledged in the text and listed in the references.

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ABSTRACT

The purpose of the study was to explore how nurses perceive continuity of patient care at the Trauma and Specialist Hospital, Winneba. The study looked at nursing documentation, communication and teamwork and was approved by the Institutional Review Board of the Noguchi Memorial Institute for Medical Research at the University of Ghana. The study adopted a qualitative exploratory descriptive design and purposive sampling method was used to recruit participants. Data were collected by using a semi-structured interview guide. Data collected reached saturation with the 15th participant. All interviews were recorded, transcribed verbatim and analysed using content analysis techniques. Data was coded, and themes and sub-themes generated. Confidentiality and privacy of the participants were ensured using pseudonyms.

Four themes emerged, these were; techniques of ensuring continuity of patient care by nurses, nursing documentation of patient care, the use of oral communication in the continuity of patient care, and teamwork during a shift. The study found that nurses continue care by running shifts for the 24 hours. This entails reading folders, nurses' notes and report book before continuing care. Nurses also document in appropriate books and charts such as fluid chart, temperature, pulse and respiration charts. Other findings were that most nurses did not sign or write their initials after documenting care; nurses always discuss detailed information at the nurses' station before moving to the patient bedside. Behaviours of nurses such as lateness to work, rudeness and laziness were noted to affect the continuity of patient care. It was recommended that nurses be trained through workshops and in-service training on the need for nursing documentation, communication and teamwork.

DEDICATION

This work is dedicated to God Almighty whose faithfulness has brought me this far. I also dedicate it to my parents, spouse and family.

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TABLE OF CONTENTS

Content **Page**

LIST OF TABLES

LIST OF ABBREVIATIONS

A&E	Accident and Emergency
CHPS	Community Based Health Planning Services
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CSSD	Central Sterilization Services Department
EBSCO	Elton B. Stephens Company
ENT	Ear Nose and Throat
HAMS	Hospital Administration Management System
HINARI	Health-Internetwork-Access-to-Research-Initiative
OPD	Out-Patient Department
TPR CHART	Temperature Pulse and Respiration chart
WHO	World Health Organization

CHAPTER ONE

1.0 Introduction

This chapter provides the background of the study, problem statement, purpose and objectives of the study. Other sub-sections include the research questions, the significance of the study and operational definition of terms.

1.1 Background of the Study

Nursing care is the means by which independent and trained persons give continuous care to people of all ages and groups sick or well in all settings (Gill, Kendrick, Davies, & Greenwood, 2016). This care must be given by well-motivated, knowledgeable nurses with a well-supported environment that will reflect in the way they make decisions (Downing & Hastings-Tolsma, 2016). Nursing care of patients involves the physical, psychological, emotional and social aspect of the person and aims at ensuring that, patients come to the hospital and leave as a whole (Enns, Sawatzky & Manitoba, 2016). Nurses use the nursing process as a guide to make clinical reasoning and decisions to care for patients. This is done by assessing the needs of the patient, planning for the care to be given, giving interventions and evaluating the care given (Lee, Lee , Bae, Alfaro- LeFevre,Wilkinsin, 2016). The nursing care given to patients can be standard when nurses use the extended range of technologies to care for their patients (Gill, Kendrick, Davies & Greenwood, 2016).

To give maximum care to the patients, nurses run “a 24-hour shift”. Some run it 12 “hourly” in two shifts whilst others run 8 “hourly” in three shifts. Each shift’s aim is to give the optimum care so as to ensure healing (Kenner & Boykova, 2016). During each shift work, nurses engage in group discussion, team teaching and then handing over of all that went on during the shift to be able to care for the patient well (Randell, Wilson, &

Woodward, 2011). The nurses always have a sense of responsibility to be able to give better care to the patients (de Almeida Vicente, Shadvar, Lepage, & Rennick, 2016). Therefore the nurses must try and finish their work to be able to continue care in the next shift such as nurses rounds and development of competency of staff (Palese et al., 2017).

Continuity of care of a patient is the process by which patients experience care from a health care provider over a period of time, either by an individual caregiver or a group of caregivers (Khalafi, Elahi, & Ahmadi, 2016). During the care, nurses establish relationship with patients and interact with them at a level that patients can comprehend. This agrees with Poremski et al. (2016) that, greater continuity occurs when there is a form of relationship between the staff and the client which creates support for the patient. The nurses become the counsellors, advocates and friends to the patient whereby the patient builds trust in them and is sure that whatever is said to the nurse is confidential (Ryan, 2017). There is an understanding between them and the nurse documents everything done for the patient. If the care by the next provider will be effective and efficient, then what the previous nurse did must be continued and this can only be done when there is evidence that care has been rendered (Rinner et al., 2016).

However, discontinuity of patient care occurs when patients are denied access to equitable and quality health care. This normally comes about if clients are not involved in their care and denied access to information about the disease (Haggerty, Roberge, Freeman, & Beaulieu, 2012). Moreover, many patients cannot be cared for by the primary caregiver and there is, therefore, the need to refer them to another facility (Uijen, Schers, & Weel, 2010). The new facility will have to start afresh with everything about the patient and try to build a good relationship with the client. Also, even from one department to another, information about patients may be lost as a result of lack of documentation, misfiling or

creation of multiple folders for a patient in the same facility (Ogoe, Agyapong, & Lutterodt, 2014).

Globally, it is accepted that patients are cared for as long as their illnesses exist because patients are the centre for health care and there must be an improvement in the quality of care given (Jayadevappa & Chhatre, 2011). In World Health Organization's (WHO) 2015 report on quality of care for pregnant women and newborns, "Experience of care includes firstly effective communication, a woman (or her family if required) should feel that she understands what is happening, what to expect and knows her rights. Secondly, she should receive care with respect and dignity. Thirdly, she should have access to the social and emotional support of her choice''(Tunçalp et al., 2015 pg 1046). This shows that continuity of care at the primary level is necessary and all must avoid interruption of care.

In Africa, continuity of patient care has become an issue due to poverty, lack of infrastructure and improper documentation of patient care (Nakate, Dahl, Petrucka, Drake, & Dunlap, 2015). These situations prevent patients from even visiting the facility when sick as many facilities allow clients to pay for services. This makes it difficult for many clients to assess healthcare but rather will stay away and die (Aveling, Kayonga, Nega, & Dixon-Woods, 2015). Also, information about patients is not adequately transferred from one caregiver to another denying patients of their continuous care when referred from one facility to the other in search of expert care (Park et al., 2016) .

The issue of continuity of patient care in Ghana is not different from other Africa countries where there is lack of infrastructure and poverty. Ghana is a middle-income country yet there are many nurses trained without jobs. There is this other issue of rude behaviour of nurses and this is making patients with chronic diseases prefer the church houses for divine healing or deny themselves access to health care (Rominski, Lori,

Nakua, Dzomeku, & Moyer, 2016). Patients are not involved in their care during hospitalisation and so are distant from the care he or she is receiving. To bridge the gap in the behaviour of staff, the Ghana Health Service introduced the patient charter spelling out the rights and responsibilities of both the patients and the staff (Yarney, Buabeng, Baidoo, & Bawole, 2016). The government also established the National Health Insurance Scheme (Alhassan et al., 2015). This is to help pay for drugs and services rendered to clients and make health care accessible. Most health care facilities are not well equipped with logistics resulting in patients referral from their primary health facility to a secondary facility away from the community where relatives cannot visit (Alhassan et al., 2015).

Keeping over aged patients' folders is becoming a burden for health care institutions in Ghana as there is lack of space for storing them. However, this create misfiling and difficult identification of patients' folders. (Teviu et al ., 2012). This makes keeping paper records for continuity of patient care difficult (Ogoe, Agyapong & Lutterodt, 2014). Information gathered cannot be transferred easily and so a software which will help update patient health records should be developed (Ogoe, Agyapong & Lutterodt, 2014). Since 1996 the Ghana Health Service has been committed to client care by looking at its strategic policies every 5 years. According to the Quality Assurance Policy of 2006-2011, the objectives are patient-centred care and re-enforcing continuum of care; the policy is focused on improving information, communication, and technology within the Ghana Health Service. (Ghana Health Service, 2007).

Anecdotal evidence at the Trauma and Specialist Hospital showed that the patients complain of staff being rude and delayed services at the OPD (Out-Patient Department). Nurses' documentation is lacking as they are unable to write all the things that are important. Patients are often referred to other facilities for care. Patients also complain of

seeing different providers when they visit the hospital and this is because of the shift work. To improve the way nurses care for the patient, they must document information obtained, communicate among themselves and work together.

Nursing documentation is how nurses write everything done for the patient. This involves checking for vital signs, assessment of the patient, history taking, nursing intervention done for the patient and the outcome of care for the patient (Dehghan et al., 2013). When documentation is done properly, it serves as a form of information to the rest of the team and gives knowledge to the patient and family, as well as the next facility (Park et al., 2016). Nursing documentation is very important because it helps the nurse to track patient's history. It also continues care, gives follow-up care when the patient is referred to the next level, help nurses to communicate among themselves as well as serves as evidence to prevent a lawsuit (Teviu et al., 2012). Nursing documentation occurs in all the shift work of nurses. It must be done by all in the appropriate record book with time and signature (Asamani, Amenorpe, Babanawo, & Ofei, 2014).

Communication on the other hand, is the exchange of information by an informant to a receiver through an appropriate channel. For example by a face to face interaction between the nurses and the patients (Serksnys, Nanchal, & Fletcher, 2016). Communication can be formal, informal, interpersonal, organisational, oral or verbal and nonverbal (Chung, Lee, & Han, 2015). During the care of the patient, there is an exchange of information between the nurse and the patient; the nurse and the family; the nurse and other healthcare workers and the nurse and other nurses in order to give a better care to the patient (Clayton, Isaacs, & Ellender, 2016). With the familiarity among staff and the use of common language, most staff exchange patient information orally without officially writing down what has been discussed. The use of oral communication is dangerous since memory loss can affect

it and soon there is a loss of vital information (Randmaa, Mårtensson, Swenne, & Engström, 2015).

Furthermore, a team is a group of people coming together to achieve a common goal and has a leader (Deneckere et al., 2012). All members of the team are assigned roles and there are laid down rules and regulations. The team succeeds with the good relationship among team members (Sandstrom, Nilsson, Juuso, & Engstrom, 2016). The nursing profession also works in teams for each shift and is led by the charge nurse of that team and handover to the next team for continuity of care (Manser & Foster, 2011). The team is made up of different expertise coming together to ensure good quality patient care within a given period. For example, the operating room team are made up of the surgeons, the perioperative nurses, the critical care nurses, the nurse anaesthetists, staff nurses and orderlies who form the surgical team (Kalisch & Lee, 2013). Every team's aim is to ensure that work assigned to it is accomplished and this when done well brings about client and job satisfaction. There is built up of expertise that brings out various nursing skills (Polis, Higgs, Manning, Netto, & Fernandez, 2015). When teamwork is satisfactory, it brings about an environment loved by all and it becomes difficult to leave the team (Lambrou & Merkouris, 2014).

1.2 Problem Statement

Globally, continuity of care has improved the outcome of patient care. Regardless of the above, there are challenges such as specialisation in nursing and changing professional work pattern which results in fragmentation of care (Freeman & Hughes, 2010). A study in America showed that patients' information keeps changing as patients visit different hospitals to receive care. This fragmentation of information makes it difficult for patients to receive continuous care (Rinner et al., 2016). In Africa, there is increase in non-

communicable disease which needs better continuity of patient care, yet it cannot see much improvement (Siddharthan et al., 2015). This is because of poor infrastructure, low staffing levels and reduced coordination among staff (Aveling, Kayonga, Nega, & Dixon-Woods, 2015).

In Ghana continuity of patient care is about information sharing. There is no standard way of recording information about patient care (Asamani, Amenope, Babanawo & Ofei, 2014). Most facilities use paper folders to record care (Ogoe et al., 2014) and refer patient to the next level of care without giving intense information about the patient (Machudo & Mohidin 2015). Anecdotal evidence at the Trauma and Specialist Hospital showed that nurses work a lot but fail to document all, especially exact time, signature and date. Information about the patient is not shared with other facilities or the patients and relatives. Despite all these, patients still visit the hospital in their numbers.

Most studies done on continuity of care are quantitative and looked at the perspective of patients and physicians. Many of the studies were not done in Ghana. Qualitative studies to look at the perspective of nurses on continuity of patient care are not largely documented. Considering the difference in culture, infrastructure and income level, it is important to explore the perspectives of nurses on continuity of patient care at the Trauma and Specialist Hospital in Ghana.

1.3 Purpose of the Study

The main purpose of the study is to explore the perspectives of nurses on continuity of patient care by nurses.

1.4 Objectives

1. To explore the means used for continuity of patient care by nurses
2. To describe how nurses document care during the continuity of patient care.

3. To explore ways in which nurses use oral communication in continuity of patient care
4. To describe how nurses exhibit teamwork during shift work

1.5 Research Questions

The research is intended to answer the following questions:

1. In what ways do nurses provide continuity of patient care.
2. How is nursing documentation done during continuity of patient care
3. In what ways do nurses use oral communication in continuity of patient care
4. How do nurses exhibit teamwork during shift work?

1.6 Significance of the Study

Exploring continuity of patient care from the perspectives of nurses is expected to bring on broad gaps in terms of nursing documentation, communication and teamwork. It is therefore anticipated that management of the Trauma and Specialist Hospital will find the results and recommendations useful in training nurses and midwives on the importance of continuity of patient care. Furthermore, it is expected that the hospital will establish protocols with respect to sharing of patient information, keeping of accurate and adequate records and working collaboratively. There is going to be contributions to the field of nursing in terms of practice, policies, education, and research. Knowledge gained from the research will be of benefit to both nurses and patients.

In practice, there would be increased knowledge on continuity of care, helping practising nurses to improve the relationship with their clients as well as with colleagues. Nurses will understand the importance of documentation of patient information and how it will improve quality care given, augment teamwork and sustain continuity of care even if the patient is referred from one facility to another.

The research will help people who develop curricula for health education to include checklists on how nurses should document and transfer patient care information and also teach communication in nursing care. This will also add to the existing knowledge of students on how to communicate with nurses and patients. The research will also be an asset to policy makers as they will formulate policy guidelines that will address standardisation of nursing documentation, protocols on patient information transfer and referral systems in Ghana.

In administration, the research will enhance nursing leadership and the way teamwork is handled in nursing. The administration will have knowledge about how to empower nurse leaders to be proactive in leading teams and making an impact by monitoring and supervising nursing work. Finally, the research will add to the existing knowledge to help in further research on continuity of nursing care in Ghana.

1.7 Operational Definitions

Communication The process by which people exchange information to express what they feel and think, and this could be expressed in formal and informal way, verbal or non-verbal way (Clayton et al., 2016).

Nurses are people educated and trained and have successfully completed and passed a four-year degree or a three-year diploma in nursing or midwifery in an accredited nursing school. He/ She must be registered and certified as a professional nurse with the Nursing and Midwifery Council of Ghana (NMC) to operate in the country.

A patient is any person who receives continuous care from a healthcare provider (Gill, Kendrick, Davies & Greenwood, 2016).

Nursing documentation is the means by which nurses write everything done for the patient (Dehghan & Dehghan, 2013).

Continuity of care the process by which patients experience care from a health care provider over a period of time (Khalafi et al., 2016).

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter will review literature related to the objective of the study and its relevance. A wide range of journals, papers, reports, and the internet were searched for appropriate information. For this review, the following databases were searched through for information and these were Google Scholar, EBSCO (Elton B. Stephens Company) host, Science direct, CINAHL (Cumulative Index to Nursing and Allied Health Literature) and HINARI (Health-Internetwork-Access-to-Research-Initiative) among others. Terms such as Continuity of Care, Teamwork, Nursing Documentation and Communication among nurses were used as keywords.

The literature was reviewed under the following headings:

- Means of ensuring continuity of patient care
- Communication as part of continuity of care
- Nursing documentation in continuity of care
- Teamwork to enhance continuity of care

2.2 Means of ensuring continuity of patient care

Continuity of patient care is the care patients receive from an individual nurse or a group of nurses over a period of time (Freeman & Hughes, 2010). Continuity of care must be constant, vibrant and be watched out for, as a good response through the body of the individual (Khalafi, Elahi,Ahmadi, 2016). Continuity of patient care must be good, affordable, standard and equitable. Continuity of care can be with the primary health care

provider and when not interrupted can be continued by the secondary care provider (Pu & Chou, 2016). Care is interrupted if there is a referral or discharge home but with good communication, care would be continued. Continuity of care is important in the health care setting to reduce the rate of visitation to the hospital by patients with diseases such as Diabetes Mellitus and Hypertension (Nam, Cho, Kang, Lee, & Park, 2016).

Continuity of care is in three forms and these are informational, relational and management continuity (Haggerty, Roberge, Freeman, & Beaulieu, 2012). The three forms of continuity always relate with each other. Trust and the interpersonal relationship is the toughest form of continuity of care (Hill, Twiddy, Hewison, & House, 2014). The most used forms of continuity of patient care are the management and relational continuity of care (Naert, Roose, Rapp, & Vanderplasschen, 2017). Continuity of care is therefore a very important component of patient care and the proper use of management and information continuity will help ensure that, a very good relationship is built between the provider and the client (Naert et al., 2017).

Relational continuity is the situation by which the health care provider has a continuous association with the client as care progresses (Cornwell, Levenson, Sonola, & Poteliakhof, 2012). Relational continuity creates the environment necessary for the patient to participate in the care. The client becomes the focus of the care whiles the caregiver puts all the attention on the patient's well-being (Starfield & Care, 2011). Being with the client so many times helps the client to have a healing relationship, have belief and assurance in the nurse. Depending on the age, mental status and level of education, patients experience continuity of care (Kristjansson et al., 2013)**.** Improved continuity of patients' care ensures that, patients receive support from a healthcare provider and experience great improvement in their outcome to treatment. It also reduce re-admission and mortality of the patients (Lustman, Comaneshter, & Vinker, 2016)**.** Though care is not perfect,

effective relationships among nurses and the patients with needed support from nursing staff increases the continuity of patient care (Poremski et al., 2016).

Moreover, informational continuity brings about the exchange of information between the patient, the healthcare providers and the healthcare facility (Freeman & Hughes, 2010). This movement of information is done by nurses in a shift work or when patients are referred from a facility to another. Frequent flow of information to the patients and nurses ensures better continuity (Renholm, Suominen, Puukka, & Leino-Kilpi, 2016). Giving information to the patient gives security and helps the patient to do self-assessment, monitoring and management of his own care (Haggerty, Freeman, & Beaulieu, 2013). This involves health information system being shared with other facilities (Rinner et al., 2016).

To continue care from where others left off, nurses must be able to communicate among themselves and with the patient. According to Park et al. (2016), access to current information about patients' care boosts the confidence of the care providers. The providers are able to give optimal care and avoid a lawsuit (Rathor, Rani, Shah, & Akter, 2011). Information given to a patient authorises the patient on his care and help to cope in times of sickness. The patient is not confused about the care because he or she knows what is next on the plan of care and is able to tell what must be done. Patients gain trust in the providers and the facility (Haggerty et al., 2012). The care givers must focus on previous care so as to be able to continue with the current care (Uijen et al., 2010) .

Furthermore, management continuity deals with similar care by providers at different facilities with the use of protocols, processes and policies displayed for use (Cornwell et al., 2012). Nurses are well trained to give care using coordination of other care providers as well as the transfer of information to plan care for patients. Patients feel confident and

secured about the care received (Haggerty et al., 2012). When quality care is given, patients' re-visit to the hospital after discharge is reduced and patients are able to cope with their care (Donisi, Tedeschi, Salazzari, & Amaddeo, 2015). For a patient to enjoy good and quality management continuity, he or she should be able to access the facility. Providers must be able to share information about the care of the patient so that the patient can contribute to the care he or she receives (Haggerty et al., 2012). To continue care properly, patients who need secondary care must be referred to the next facility (Pu & Chou, 2016). Care is appreciated by patients if the nurses are friendly, good communicators, show positive attitudes and help them navigate health services (Gillespie, Kelly, Duggan, & Dornan, 2016).

In a research conducted by Aller et al.(2013), with the aim of analysing patients reported elements of continuity of care, they used cross- sectional survey with sample size of 400 participants. Three forms of continuity of patients' care were identified and these were relational, management and informational. They found out that most patients experienced one of these elements of continuity of care. In their findings, 20% of patients were seen by more than one primary care provider and 15% were seen by more than one secondary provider.

However, they also identified that, some elements of discontinuity also existed. the elements of discontinuity are from both the provider and the patient. The factors that influences discontinuity were age, sex, uncoordinated care, education level, a patient with multiple health conditions (Aller et al., 2013). Furthermore, discontinuity of patients' care can be because of low relationship among caregivers and patient, lack of access to information and refusing to care for the patient (Haggerty, Roberge, Freeman & Beaulieu, 2012). Discontinuity may again occur when there is a change in teams creating interruption as well as abrupt break in the relationship between the providers and the

patients (Jones et al., 2009). In their conclusion, they noted that patients cared for by their primary caregiver experienced more continuity than when cared by the secondary caregiver. They further recommend that, future research should look at understanding the reasons underlying why patients experience the differences in the continuity of care. The research was limited in the choice of the setting; the primary setting does not say anything about the referral (Aller et al. 2013).

The core business of the nurse is to care for the patient to be well or to die. Therefore nursing care is all about caring for the patients "as a whole" and advocating for him or her (Enns, Sawatzky, & Manitoba, 2016). Nurses give better care to their patients when they are competent in their field of work. This, the nurses must do by communicating effectively, showing encouraging attitude and having good rapport among themselves (Gillespie, Kelly, Duggan & Dornan, 2016). Building a good relationship between the provider and the client is to ensure that the provider knows the patient, the history and what is being planned for him or her (Lafferty et al., 2011). Information flow from the nurses encourages the patient to experience continuity through care (Renholm, Suominen, Puukka & Leino-Kilpi, 2016). To continue care effectively, both the nurse and the patient must be in touch and this can be done using a mobile or the social media. In caring for the patient over a period of time, there is the need to get both material and human resource in the health facility (Chaves & Santos, 2016).

This agrees with findings from a study conducted by Enns et al (2016), in Canada, the aim of the study was to "Explore nurses' perspectives of caring". They used qualitative descriptive design with a sample size of 17. They found out that, factors that influences care were workload, lack of time, staffing issues, shift work, and lack of self-care. Also, the worse of them all were the lack of management support. They concluded that caring is a vital part of nursing that helps in improving retention of staff. In a study conducted by

Woodward, Abelson, Tedford, & Hutchison (2004), they grouped continuity of care enabling factors into two. These were managing care and providing the service. To them, managing the care is when one plans, monitors, review and coordinates others. To provide the service is to provide care with competent, skilled staff who are consistent with the care and have a very good relationship with them. The relationship between the caregivers and the patients must be a trusting one. Sometimes care is missed and this may be because there were unexpected patient admissions with serious illness, inadequate assistants, increased admissions and non-availability of medications (Winsett, Rottet, Schmitt, Wathen, & Wilson, 2016).

Furthermore, nurses run shifts to cover the hours in which patient is in their care. Nurses who work more than 12 hours are often stressed out than nurses who work less than 8 hours (Dall'Ora , Griffiths ,& Ball , 2015). Nursing shift work is different among countries and even among facilities (Griffiths, Ora, Simon, & Ball, 2014). Nurses who work more than 12 hours may not give quality care due to burnout (Griffiths et al., 2014).

2.3 Communication as part of continuity of care

Communication is the face to face exchange of information between a sender and a receiver through a medium (Serksnys, Nanchal & Fletcher, 2016). During continuity of patient care, nurses communicate with other professionals, patients and their families. They search for information and use the information to calm, reassure and give opinions during care and also join in team discussions (Sedgwick & Garner, 2017). Nurses who care for patients in the healthcare facility run shift to be with the patient 24 hours. Information flow from one shift to the other depends on the delivery process of the information (Abraham, Kannampallil, & Patel, 2012). Patient information must reach the next caregiver or the facility by way of communication in which the nurse will receive feedback (Thraen, Bair, Mullin, & Weir, 2012). Communication among nurses is seen

most when nurses share patient information, document care of patient properly and transfer patients information appropriately (Fathi et al., 2016). Nurses exercise restrain when handing over nursing care at the patient bedside by discussing sensitive information away from the bedside. When patients are transferred to other units or hospital care is interrupted because information flow is interrupted from one unit to another (Liu, Manias, & Gerdtz, 2012).

Lack of communication occurs when the clinician refuses to relay information about the disease condition of the patient (Berglund, Gustafsson, Johansson, and Bergenmar, 2015), when the patient receives confusing messages from different providers and when clinicians are not aware of the treatment given by the others. (Haggerty, Roberge, Freeman, & Beaulieu, 2013). According to Griffiths, Morphet, Innes, Crawford, and Williams (2014), there is a recurrent shortage in the way nurses communicate among themselves which brings about errors in caring for the patient. This shortage is as a result of nurses refusing to nurture unity among themselves and the patients (Clayton et al., 2016). Furthermore, communication gaps occur when nurses fail to document what has been done for the patient (Thraen et al., 2012). This can lead to error in patient care and these inadequacies are as a result of the culture of the organisation, the settings, the educational level of the patient and the knowledge base of the staff (Griffiths et al., 2014).

On the other hand, handover is a means of passing on an information about a patient to another nurse or to another facility (Manser & Foster, 2011). Handover involves all staff who share ideas about previous care and discuss current care about the patient (Abraham, Kannampallil & Patel, 2012). The way nurses handover differs in many facilities and does not have a particular pattern that is followed (Lockwood, 2016). This can be by verbal means or by a safety checklist (Smeulers et al., 2016). Verbal handover occurs when the information to be given is not written down but is shared from the minds of the

nurses sometimes through discussions (Liu, Manias & Gerdtz, 2012). Verbal reports can create misunderstanding among staff during patient care rounds by the care teams (Walden, Elliott, & Gregurich, 2009). It becomes difficult for staff to remember the same information being passed on and others also forget things easily so will lose more information than will remember (Randmaa et al., 2015).

A report from an observational research conducted by Randmaa et al. (2015), showed that, 47% of the verbal information given during handover was remembered by staff. Items likely to be forgotten were the anaesthesia drugs. They concluded that lack of structure and long duration of hand-over affect the information given and how much is retained. This results in the loss of vital information when the staff has short memory span. (Deneckere et al., 2012). On the other hand, verbal handover which is mostly face to face can be flexible allowing the nurse to gather more information for use (Randell, Wilson & Woodward, 2011).

Sharpe and Hemsley, (2016) found out in their studies that the use of mobile technology can enhance communication among staff. This agrees with the assertion that some physicians give treatment on phone; however, this needs to be documented to avoid problems later. Some facilities have forms that are filled with a telephone conversation and later is signed by the physician who does the prescription (Reyniers, Houttekier, Cohen, Pasman, & Deliens, 2014). There are times information about the patient given verbally to staff does not augur well for the management of the patient. This is because there will be no feedback from monitoring and supervision of the patient care (Manser & Foster, 2011). This shows lack of effective communication among staff as a result of non-availability of logistics and equipment such as patient folders for recording patient information and telephone for transfer of information from one ward to the other (Randmaa et al., 2015).

2.4 Nursing documentation in continuity of care

Nursing documentation is a way of getting all the nursing care given to a patient in one record (Heikkilä, Peltonen, & Salanterä, 2016). According to Nakate, Dahl, Petrucka, Drake and Dunlap, (2015), nurses spend about 15 to 25% of their time in documenting patient care. Proper documentation serves as a means of communication among nurses (Flatley Brennan et al., 2014); it brings about teamwork (Fathi et al., 2016); it serves as protection from law suits (Rathor, Rani, Shah & Akter, 2011); it helps the nurses to finish the care to be given to the patient and then confer what is done. It promotes patient safety and helps give individualized care (Ogoe et al., 2014). The nursing record should be precise, full of information deemed to be important, it should be written on time and be very accurate and clear to all to avoid doubt (Machudo & Mohidin 2015). Nursing records are either done on a paper or electronically on a computer. Any nurse who works on any patient is to report on the patient as this helps to give clear meaning to what is on the paper. Most nurses do not record care (46%) others do not write in the nurses notes whiles others do not sign after documentation (57%) (Asamani et al., 2014). For nurses' record on paper to be accepted there should be a date, time and signature, and what was done for the patients. The use of the paper folders has become a problem to the nurses because of the lack of space, the items to use in recording, untrained staff and the type of systems used in filing (Teviu et al., 2012).

According to Wang, Yu, and Hailey (2013), using the computer to keep records of patients is the best as it ensures quality care in the area of keeping correct and up to date data. Patient information is easy to retrieve which makes the patients build confidence in the health care personnel. However, the use of the computer is not without a challenge to nursing documentation. Some of the challenges to computer documentation are frequent power cuts which can create data loss, lack of sufficient resources such as computers and

funds to maintain them as well as inadequate staff knowledge on the use of the computer (Lin, Chiou, Chen, & Yang, 2016). Also , time, workload, support from nurse leaders, knowledge about documentation, time factor about the electronic documentation and lack of policy guidelines on how to document with the computer are some of challenges that come with the use of computers for nursing documentations (Heikkila, Peltonen & Salantera, 2016).

A lot of efforts must be put in place to address the issue of non-documentation in the nursing field as this is a threat to the continuity of patient care. In their studies, Nakate et al. (2015), suggest that there should be constant supervision and monitoring and support by the leadership of nursing. Nurses should be trained both in school and when working on the importance of nursing documentation and how it must be done (Lindo et al., 2016). Finally, there should be the development of a software for the nursing process so that correct records would be gathered on the patient. Policies and guidelines must be formulated for its usage and nurses must be trained both as students and providers on the policy on documentation. However, nursing documentation has become a great task in the nursing profession. There is improper documentation as nurses do not have what it takes to document care such as patient folders, or these cannot be found; no internet connection and no computer for a few who would want to record through electronics (Asamani et al., 2014). Staff who fail to record would always blame it on factors such as the shortage of staff, workload, and oversight while to others it is a lack of experience and little knowledge about what to document, how to document and where to document (Nakate et al., 2015).

2.5 Teamwork to enhance continuity of care

When members feel connected to each other there is success in their practice of teamwork (Grover, Porter, & Morphet, 2017). Continuity of patient care can be effective if all

members caring for the patient are committed to the care and practice independently to enhance patient outcome (Poghosyan, Boyd, & Knutson, 2014). When this is done there is patient safety, good care and omission of mistakes. Every team is influenced by the leader and the number of staff involved in the team (Nelsey & Brownie, 2012). The leader must exhibit a sense of leadership, be a mentor and be able to manage conflict and create an enabling environment for staff (Nelsey & Brownie, 2012). The smaller the team, the greater the level of teamwork but when large, the team becomes ineffective (Kalisch & Lee, 2010). When teamwork is enhancing in a facility, nurses are retained and there is a reduction in the rate at which nurses absent themselves from work (Nelsey & Brownie, 2012). High levels of teamwork help the nurses to report an error and create a safe environment for patient care.

Health care teams use available information to make knowledgeable decisions for patient care. They identify specicific patient problems and find ways to solve them. Support for nurses, leadership style and creating good environment enhances nurse work (Cummings et al., 2010)

However, teams can experience burnout and stress even though work is shared in a manner to get all hands working. A team must be engaged to boost their activeness (Montgomery, Spânu, Adriana, & Panagopoulou, 2015). Subsequently, the team coordination and cohesion help them to produce results in an efficient and an effective manner. Teams can work efficiently and effectively if trained on team formation and dynamics and when management of the facility are much involved in their care (Wrammert, Sapkota, Baral, Malqvist & Larsson, 2017). Training can also focus on communication among the team, mutual performance and leadership (Andersen, Jensen, Lippert, & Østergaard, 2010). When teams are trained, it brings out the roles of individual team members which will improve performance through feedback (Deneckere et al.,

2012). Teamwork may fail to work in nursing if there are inadequate skill mix and resources to work with resulting in the creation of errors (Grover, Porter & Morphet, 2017).

Team members feel alienated when the aim of the team is not told all. Factors that influence teamwork are numerous and include the level of education, expertise, planning, the role of members, effective communication and organisational norms (Manser & Foster, 2011). In a study conducted by (Polis, Higgs, Manning, Netto & Fernandez, (2015), on factors contributing to teamwork, it was found that communication plays a very important role in teamwork in nursing. Information must flow in all direction which allows all to feel belonging to avoid challenges associated with caring for the patient (Clark, 2015).

2.6 Summary

It is realised from the literature that most of the studies were done quantitatively. Most of the study participants were patients or patients records that were reviewed. This did not allow them to explore the attitudes, beliefs and perception of the nurses on continuity of patients' care. Also, studies conducted in Ghana were mostly on nursing documentation during patient care. Using a qualitative inquiry, the researcher intends to explore more from the perspectives of nurses on what contributes to the continuity of patient care. This, the researcher thinks will fill the gaps identified.

CHAPTER THREE

RESEARCH METHODS

3.1 Introduction

This chapter is about how the study would be conducted. The aim of this chapter is to explain the research design and methods that would be used to conduct the study. Since the guiding question for the study is toward understanding nurses' perspectives on continuity of their patient care, the chapter begins with the study design which is qualitative, the setting and why the setting would be chosen. This is followed by the population and inclusion and exclusion criteria. Also, the sampling techniques that would be used to select the sample, the sample size and the methods of data collection are discussed. The chapter also covers rigour, ethical considerations, and limitation of the study.

3.2 Study Design

A study design is the approach that is selected to combine different research in a logical sequential manner to address a "research problem" that is, the direction to follow to collect and analyze data (Labaree, 2014 p.1). A qualitative study is defined as the means of collecting words as data and analyzing them in a wider context. The qualitative research is about the beliefs and values and practices of the study (Braun, & Braun, 2013). The qualitative descriptive design is appropriate because the researcher want to gather data to describe an event or process (Abdul-Mumin, 2016). An exploratory descriptive design was used. According to Moen and Middelthon (2015), using exploratory descriptive design will be flexible enough to help discover the perspectives of participants. This design is chosen with the aim that an in-depth understanding of the problem under study would be

gained by investigating the various forms and perspective of nurses on continuity of patients care. The design is used when an in-depth analysis is done to describe dimensions, variations, importance, and when a new area or topic is being investigated to understand the phenomenon (Moen & Middelthon, 2015). The researcher used the design in exploring and describing the phenomenon under study. The design helped the researcher to get an in-depth knowledge on how nurses perceive continuity of their care to the patient. The design helped gather enough data which was useful to the study (Leppink, 2017). The researcher also used the design to gain understanding into the reason why people behaved the way that they did (Rosenthal, 2016).

3.3 Research Setting

The study was done at the Trauma and Specialist Hospital -Winneba in the Effutu Municipality within the Central Region of Ghana. The Effutu Municipality has a target Population of 68,597 of which Winneba has 40,017. Winneba is the administrative head of the municipality. Many of the people are fishermen and fishmongers. The Municipality has many students as part of their population due to the establishment of the University of Education, Winneba and the Perez University College. The Effutu Municipality shares boundaries with districts including Gomoa East and West and Awutu-Senya Districts. The municipality has one Trauma and Specialist Hospital, one Municipal Hospital, a University Clinic, three private hospitals a health centre and three Community Based Health Planning Services (CHPS) compounds.

The Trauma and Specialist Hospital located in Winneba was commissioned on 27th February, 2012. The hospital is designated for trauma and emergency care which forms the core of the facility. The hospital serves as a secondary referral or specialist hospital to cater for the emergency health needs of the people of Winneba and its catchment area. The new magnificent hospital is located at the Low-cost community, in the northern part of the

Winneba Township. It is located between the main Winneba roundabout (junction) and the University of Education, Winneba, North Campus along the Winneba junction to the Winneba township road and lies adjacent to the Community Health Nursing Training School.

The setting was chosen because the facility serves as both primary and referral hospital. The hospital has a bed capacity of 127 with almost all the departments within the healthcare facility working vigorously within 24 hours to ensure their patients are cared for. The staff capacity of the hospital is 317 including nurses, doctors and other supporting staff. The hospital has clinical and non-clinical units. The clinical units are Surgery, Internal Medicine, Paediatrics, Obstetrics and Gynaecology, Anaesthesia, Physiotherapy, Ophthalmology, Dental, Oral & Maxillofacial Surgery, Ear Nose and Throat (ENT) services, Antenatal services, Diagnostic services (Laboratory, X-ray, ultrasound), Pharmaceutical services, Blood transfusion services and Biostatistics (Patient information). Other services are the Administration and Support services (Administration, Supply chain, Laundry, Catering, Central Sterilization Services Department (CSSD), Estate, Security, Transport, Social welfare. The hospital also caters for the numerous accident victims on Accra-Cape Coast Corridor. The hospital staff are well trained to offer quality care to its clients.

3.4 Population

The target population refers to a group of people the researcher wishes to draw a conclusion from after completing the study (Moen & Middelthon, 2015). These were the people that had the experience to give meaningful information towards the study. Therefore, the population studied were all registered nurses at the Trauma and Specialist Hospital – Winneba.

3.5 Inclusion criteria

The nurses who participated in the study were nurses who had worked for at least a year and above at the bedside. These were nurses working in the various wards of the hospital such as the male medical, male surgical, the female medical and surgical, the paediatric ward, the maternity ward, the accident and emergency and the recovery ward. Working in the ward for a year and above provided the nurses with the experience needed to participate in the study. The kind of exposure these nurses had gave them insight into the continuity of patient care.

3.6 Exclusion Criteria

The study excluded all student nurses and midwives, theatre nurses, Ear Nose and Throat (ENT) nurses, Eye nurses and nurses at the Out-Patient Department (OPD) because their patients are usually not on admission. Others who were excluded were nurses at the nursing administration and community or public health nurses.

3.7 Sample Size and Sampling Method

The sample size of a qualitative research is achieved when the researcher does not get any new concept or idea after repeatedly interviewing participants (Trotter, 2012). The size of the sample depends on the researcher getting the quality of information and experiences from participants. The researcher continued to interview the participants until there was saturation of data; that is the answers kept on repeating and there were no new answers. The researcher used a sample size of 15 because the data saturation occurred with the 15th participant.

Sampling is the means by which participants are selected from the population to take part in the study to be able to obtain essential information from them (Rosenthal, 2016). The researcher used the purposive sampling technique to select the sample for the study which

ensured that only those who qualified were included. The researcher's aim was to select people who could give the information needed (Moen & Middelthon, 2015). To do this, several wards such as the Male and Female Medical, Male and Female Surgical, Paediatric, Accident and Emergency and Maternity were visited to explain the processes, purpose and objectives of the study to the heads of these units. Notices of request to join the study was sent around for those interested to join the study. Those interested were contacted and recruited in the study as they met the inclusion criteria. The researcher contacted the nurses personally on a one-on-one basis to ask them to join the study voluntarily.

3.8 Data Collection Tool

A semi-structured interview guide was used to collect the data. The interviewees' responses were probed to help get more information (Hyland, 2016). The interview guide was formulated taking into consideration the objectives of the research. The interview guide was made up of two sections which were A and B (refer to appendix A). Section A was the demographic data of the participants and Section B was the main interview questions (Appendix A).

3.9 Data Collection Procedure

The researcher sought permission from the hospital and sought consent from the nurses. Nurses who consented could participate in the study. Participants were encouraged to answer the questions as they desire but not on compulsion. The participants read the information sheets (Appendix C) and cleared all misunderstandings and signed the consent form (Appendix B) before proceeding with the interview. The interviews were started on May 31st, 2017 and ended on June 7th, 2017 according to the convenience of the participants. All interviews were conducted at the hospital premises. The interviews lasted

between 30 and 60 minutes. The interview involved a face to face interaction between the researcher and the interviewees. The place for the interview was decided by both the participants and the researcher within the facility.

The interviewer interviewed nurses who understood the situation and could provide meaningful information (Moen & Middelthon, 2015). Two of them took place at the in-charges offices and the rest at the nurses' restrooms in the various wards. The interviews were recorded using a voice recorder with the consent of the participants. The researcher recorded notes to ensure there is no disparity in the audio tape. The researcher stopped the collection of the data when there were no more different answers being generated. Participants were supplied with a snack. Participants were informed about further interview sessions for clarifications when necessary.

3.10 Piloting of Instrument

Two pilot interviews were done with nurses at the Ga South Municipal Hospital, Accra. The semi- structured interview guide was used to test the participants' understanding of the questions and to enhance the skills of the researcher. This was also done to check if there was the need to revise the questions. The interview was audiotaped and later transcribed. All anomalies with the interview guide were corrected before subsequent interviews were conducted. The data for the pilot test was not added to the main findings in this study.

3.11 Ethical Considerations

An ethical clearance was sought from the Institutional Review Board (IRB) of the University of Ghana at the Noguchi Memorial Institute for Medical Research. (See Appendix D). An introductory letter was given by the School of Nursing and Midwifery at the University of Ghana to be taken to the facility for permission. (See Appendix D).

These letters were sent to the hospital Management through the Medical Director, Trauma and Specialist Hospital Winneba where the study was conducted to inform them about the study and to recruit participants. The researcher introduced herself and explained the aim, the benefits and the potential risks of the study to the participants through the participant's information sheet (see Appendix C).

3.11.1 Consent

The study was explained to the participants to ensure that the participants understand. The researcher sought the consent (Appendix B) of the participants and those who consented were allowed to participate. The participants were free to ask questions for any clarification about the study. The researcher assured the participants that, they had the freedom to quit the interview at any time.

3.11.2 Confidentiality/ Privacy

Participants were informed that the interview will be audiotaped and transcribed verbatim.

Participants were assured of their privacy during the interview and the interviewee was protected from any harm. The participants' identity was made anonymous. Participants were told that the information they provided will be kept by the researcher under lock and key for five years after which the information would be destroyed. The information would also be stored on an external hard disk o protect it.

3.11.3 Risks /Benefits

The participants were told there will be no known risk attached to this study. They will be protected from any possible harm. In case the participant is not comfortable with any of the questions being asked, he or she has the right to overlook the question. Being involved

in the study will not benefit them financially but will go a long way to benefit anybody who visit the health care facility or is admitted into the hospital.

3.12 Rigour

Rigour in Qualitative Research constitutes the measures for the trustworthiness of data collection, analysis and interpretation which are often compared with reliability and validity in a quantitative research (Prion & Adamson, 2014). According to Lincoln and Guba (1985), cited in Prion and Adamson (2014), rigour is described under four areas which are: Credibility, Transferability, Dependability and Confirmability.

3.12.1 Credibility:

The credibility of the study is looking at how true the study is and the subsequent interpretation of the data (Prion & Adamson, 2014). To achieve this, the researcher learnt about the setting and established rapport with the interviewees, briefing them on everything about the study. The researcher interviewed only nurses in the inclusion criteria and then ensured that adequate time was given to each interviewee between 30-60 minutes. The researcher asked questions that enabled the participants to bring out all that they knew. The Same interview guide was used to ensure similar answers were given by the interviewees. The researcher also debriefed the participants to ensure that what was transcribed was the same as what they had said. Participants were assured of anonymity and confidentiality of their responses.

3.12.2 Transferability:

Transferability indicates how the result of the study could be used in other settings similar to the original setting of the study (Trotter, 2012). This, the researcher did by giving a good description of the research methodology. The researcher also described the setting, the sampling method and the sample size. The researcher established rich descriptions that

could be applied by other researchers. Data collection and content analysis were performed concurrently. The primary researcher listened to the tape. The interview guide and the study processes be well described in case another researcher would want to replicate the study.

3.12.3 Dependability:

Dependability shows how consistent the research can be when applied many times and can be called the research audit (Prion & Adamson, 2014). The researcher gave a detailed description of the research design, the sampling method, the data collection tool, the analyses used and how it was interpreted. Each interview was audiotaped, transcribed and analysed to arrive at the themes and the sub-themes. All other activities were recorded and kept for anyone who may want to follow it up. Dependability was maintained by examining the context of the findings, as well as how each interview contributed to the finding of the study.

Confirmability:

Confirmability is how the researcher prevents biases and removes assumptions so that when another researcher analysed the same data, the same result is achieved (Murphy & Yielder, 2010). This, the researcher did by seeking in-depth knowledge of nurses on their perceptions of continuity of patient care. The researcher will confirm the data by listening to the audiotape repeatedly. The researcher will take additional note as the audio record to ensure adequacy in the interview. Data were collected until there was saturation. The researcher contacted participants to confirm what they said and debriefed them of the analyses and interpretation.

3.13 Analysis of Data

This is the method by which the researcher takes the reader into the content and context of the study and gives deep descriptions of the data (Rosenthal, 2016). The researcher analysed the data concurrently with data collection. Data was transcribed as precise as recorded from the audio recordings. The researcher listening to the audio tapes (confirmability) assisted in validating the content of the interview and correct any ambiguous speech made by the interviewee. The researcher used content analysis to analyse the data and the data was managed by the NVivo software version 11 (Rosenthal, 2016). In the process, each aspect of the data including words, phrases, statements and sentences made by the participants were all analysed. The researcher read over the transcripts several times and notes were formulated to familiarise herself with the data (Moen & Middelthon, 2015). Through discussion, the researcher generated codes from the transcripts. The codes were grouped into themes and sub-themes. The themes were reviewed, and the researcher collapsed the themes that did not have adequate data to support them. The researcher used verbatim quotes to support findings (Moen & Middelthon, 2015). The researcher also considered the feelings, perceptions and thoughts of the participants and not her own feelings (Rosenthal, 2016).

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CHAPTER FOUR

4.0 FINDINGS OF THE STUDY

4.1 Introduction

This chapter presents the findings from the data gathered from participants in the study on the perspectives of nurses on continuity of patient care at the Trauma and Specialist Hospital in Winneba, Ghana. Analysis of the data took into consideration the field notes that helped in the understanding of the data generated. The various themes and sub-themes are presented with verbatim quotations from the participants and their anonymity was maintained using pseudonyms. The demographic characteristics of participants are also provided.

4.2 Demographic Profile of Participants

15 participants (nurses) from different units at the Trauma and Specialist Hospital in Winneba were interviewed. 7 of them were males and 8 were females. 8 of the participants were in the age range of 22 years to 28 years, 6 were from age 30 years to 35 years and one person was 40 years. Out of the 15 participants, 9 were married and 6 were single. With their educational background, 10 participants had a diploma in nursing, 3 had a Bachelor of Science in nursing and one had a post graduate degree in nursing. Among them were 5 Nursing Officers, 4 Senior Staff Nurses, and 6 Staff Nurses. These nurses were working in the various units of the hospital. 1 was working at the Paediatric unit, 2 each at the maternity, male medical, female medical and surgical, male surgical, and recovery ward and the rest, which were 4 at the emergency ward.

4.3 Organization of Themes

The themes realised from the study were organised to provide answers to the research questions. The themes were; techniques of ensuring continuity of patient care by nurses, nurses' documentation of patient care, the use of oral communication in the continuity of patient care and teamwork during a shift. Table 2 in Appendix E shows the various themes with their corresponding sub themes.

To answer the first research question, "In what ways do nurses provide continuity of patient care?" One major theme emerged that was; techniques for ensuring continuity of patient care by nurses.

4.4 Techniques for ensuring continuity of patient care by nurses

Almost all the nurses said nurses continue to give patient care until the patient is well again or the patient dies. To do this, the nurses used techniques such as reading of previous patient reports and folders, educating the patients about their diseases and performing routine and specific care for the patients. Three sub-themes emerged. These were familiarisation with patient care, rendering nursing care as a continuum and support of patients during care.

4.4.1 Familiarisation with patient care

Almost all the nurses showed that, they continued care of their patients by establishing rapport with them. Nurses who come on duty greet their patients and charts with them to build relationship with them.

"If the patient is a new patient on the ward, when we get to the patient, the staff who are taking up greet the patients and introduce themselves to the patients that I am nurse this, I am taking up from this shift so after they are gone I am the one in charge of you. we mention the patients name, the complaint, the doctor who admitted the patient and the diagnosis." ***N15***

*"When I come on duty, normally I greet the patients on admission". **N7***

A nurse said getting near the patients allowed them to know the needs of the patients to further continue care.

*"Then I will know who needs another care. So, through greeting, I get to know those that have been catered for and those that need help**". N7***

Some other nurses stated that the next staff coming on duty need to read everything about the patient to be able to continue to care for the patient effectively.

*"When I come on duty, I read whatever thing that has been done previously on a patient for me to know where to continue from". **N14***

*"The next staff taking up will go through the report, the A (admission) and D (discharge) book for them to know if there are any new admissions or discharges and they will go through the folder as well as the bedside sheets which contain the treatment sheet, the TPR (temperature, Pulse and respiration charts) sheet and the nurses' notes before we can start to hand over the patients to them". **N7***

Furthermore, others said they always must read the folders and the reports to update themselves on the progress of care and fill in the gap in care prescribed by the doctors that the previous staffs were unable to do.

*"If the doctor came in the morning and I came on night duty, I need to read the folder to see what the doctor wrote. Sometimes the morning staff might have forgotten about it. It does happen it's not intentional as it is a human institution, those errors are bound to happen?" **N11***

*"I like reading a lot. First, I need to read the report book to know my patient and my folders, I don't joke with them because reviews are done daily, and I need to read to know what the updates are". **N12***

Moreover, some nurses said they involve their patients in the care they are rendering by giving them updates on their diseases.

*"I normally talked to my patients because some of them are afraid that being a diabetic is the end of their life". **N8***

*"In nursing, you need to explain everything to the patients when performing procedures. So ideally, we involve them because you cannot just go and stand there that we want to do something for the patients so definitely we explain the procedure and explain the rationale behind what you want to do". **N7***

4.4.2 Rendering nursing care as a continuum

The nurses said nursing care was provided by nurses through running of shifts.

*"In nursing, we run shift so for instance if a group come for a shift in the morning those taking over from them must ensure they continue what the morning staff did". **N13***

*"In nursing, we come in shifts. So, let assume the morning shift came and then gave the care but were not able to finish, the afternoon staff will come and continue in that manner. Then the afternoon staff will also hand over to the night shift and then it continues like that. **N7***

All the nurses said they run three shifts which were morning, afternoon and night.

*"We come on different shifts. We come on morning afternoon and night shifts. When you come on morning shift everything, that has been done for a patient or all the patients on the ward must be continued". **N15.***

*"We run morning, afternoon and night shift**". N10***

Some nurses said they hand over in their units all the time. From one shift to the other care could be continued well when patient care is handed over to the next staff.

*"If everything is ok, we move from patient to patient and then hand over whatever thing that has been done for each patient, and everything we have done on the ward**". N15***

*"Continuity of patient care in my understanding is handing over the patient to the next person to take over". **N8***

Also, a nurse said they used the nursing process to care for the patient. This involved patient assessment, planning, implementation and evaluation.

*"We use the nursing process in caring for our patients on the ward, this includes planning, implementation, and evaluation of the care and so we go through all the processes**". N3***

Furthermore, all the nurses said, there were some of the care that were done in all the shifts and that was the routine care.

*"There are things that run through the entire shifts, like checking of vitals and giving of medication, run through every shift". **N13***

*"Whatever they did for the patient you must continue as in serving of medication, feeding, checking of vitals, personal care for the patient like bed bath, oral care". **N10***

A nurse also said there were some of the nursing cares that were specific to the shift the nurse was running and the disease of the patient.

*"We have some care that becomes specific to shifts like cleaning of the patient. In some of the shift, if a patient does not soil himself you can't just go and say I want to clean you. but if the patient soil himself then, whatever the shift maybe you will have to clean and make sure the patient is comfortable". **N13***

*"Here, we manage cases like jaundice. So, if I come for morning, I make sure the baby is comfortably under the phototherapy machine and the shade is not removed from the baby's eyes because the phototherapy has effects on the eyes. We also manage patients with neonatal sepsis and we use medications". **N9***

However, some nurses said the resources that they needed to render proper care were sometimes lacking.

"Sometimes the basic logistics you will need to work with will not be available. So, when it's time for dressing you will have to wait for the patient to go and buy them before you can dress the wound". **N10**

4.4.3 Support of patients during care

The nurses also revealed that care for their patients had a lot to do with supporting patients and relatives throughout the care.

*"We always support the patient in our care**". N15***

*"When we have a patient that the relatives don't visit we try to call the social welfare to come and locate where the patient is staying and then we will get the relatives to visit the patient". **N3***

Some of the nurses said the support could be by providing basic needs of the patient and their babies since some relatives left the patient in the hospital alone.

*"If the patient needs something like the bed pan or feeding we do give assistance to the patient". **N5***

*"For instance, with the Caesarian section mothers, the babies are referred alone here with either the midwife or the nurse. So, we must be changing the diapers and cleaning the baby for the relatives and if there is anything else to be done, we have to do it**". N9***

Other nurses said they supported their patients by spending their own money on them since the patient may not have the money or have been neglected by the relatives.

*"Sometimes we use our own money to buy drugs for them. We care for them as we should by making sure they take their drugs, feed them and do the basic things that need to be done". **N10***

*"Some patients are neglected by their relatives, so we do almost everything for them**". N12***

Moreover, others said they supported their patients as though they were their own relatives.

*"In fact, there are times we sometimes get emotional especially when we realise that this patient could have been helped if early medical attention was sorted it could be prevented but then she comes in the last stage and that is sad". **N12***

In answering the second research question, "How is nursing documentation done during the continuity of patient care" one major theme emerged, nurses' documentation of patient care.

4.5 Nurses' Documentation of Patient care

Almost all the nurses said they documented patient care when they rendered care to the patient. This they did during the care or after the care depending on the condition of the patient at the time of care. In documenting care, there were many forms that they used, and the style of documentation sometimes differed from unit to unit even in the same facility. Three sub- themes emerged, and these were; materials needed for documenting care, the content of documenting patient care and barriers to the documentation of patient care.

4.5.1 Materials needed for documenting care

From the participants, nurses record on different sheets and books after they had given care to the patients. Some of these were the Temperature, Pulse and Respiration sheet (TPR), the Blood Pressure Chart, the medication sheet, fit chart, fluid chart, the nurses' notes, the folder, the report book and the admission and discharge book.

*"We have the fluid chart, TPR chart, the nurses' note and the treatment sheet in which we document care. If it is fluid, then we put it on the fluid chart, if a baby or a child comes twitching or then we document in the fit chart". **N5***

*"We document in the treatment sheet, medication sheet, T.P.R sheet, and input and output chart". **N7***

Other nurses said the area of documentation depended on what kind of nursing care the nurses gave to the patients.

"We have the admission papers including the front index, fluid chart, fit chart treatment sheet, nurse's note, TPR sheet and others. So as and when the patient's condition demands you can even improvise a chart". ***N12***

Furthermore, some nurses said after recording everything , they record a summary of the care rendered in the nurses' notes.

"Whatever we did for the patient and documented in the TPR sheet, medication sheet and others we also document them in the nurse's notes". ***N15***

"Any procedure that we do for a patient, we do document in nurse's notes". ***N15***

However, some nurses also said they document electronically using the computer.

"We use the computer, we use the HAMS". ***N14***

Others said the computer they used for records was for only admission and discharge and medication administration.

"We key in only admissions and medications on the computer". ***N1***

A nurse said they used the computer alongside the paper folder and charts.

"We use in this ward the HAMS. But we use it alongside the paper folders". **N1**

However, some of the nurses said comparing the computer with the paper folder, they preferred the paper folders.

"I prefer the paper folder because if the network is bad, you cannot even get drugs for the patient. A patient was admitted and the network was bad, so we could not get drugs and patient was suffering". ***N10***

"I prefer the writing because with the writing, I go faster than typing on the computer". ***N14***

Other nurses said they also preferred the computer to the paper folder

"I think e-folder is the best. Using the computer is better than writing everything". ***N6***

"I will prefer the electronic because in the electronic folder the information will be accurate and intact than the paper one". N7

Furthermore, other nurses said the computer was laudable, but it is time-consuming when dealing with emergencies.

*"Attending to emergencies and typing on the computer is difficult, unless you finish everything. The computer will be more efficient in the ward, not an accident and the emergency unit****". N5***

Still others preferred the paper because if the network fails care is disrupted.

"Sometimes the system may be disturbing or the network maybe off. Then the one recording must go to a different unit to enter a patient drug before pharmacy can dispense the medication. So, for me I prefer the writing to the computer". ***N15***

4.5.2 Content of patient care documentation

Almost all the nurses said there is no format for documenting care in their unit but the person who performed the procedure document care as it was done.

"Documentation is everybody's work and as far as you render the care, you are supposed to document". ***N13***

"When you perform a procedure, you the person who performs the procedure on the patient must document and put his or her name on it". ***N10***

Some of the nurses said documentation was in such a way that the next person understood what they meant.

"We should write it in plain words, not for the layman but for other colleagues to understand what you have written down. If I take it and I don't get meaning out of it I can't continue care". ***N14***

Some of the nurses showed that everything done for the patient was recorded. These included the personal information of the patient, the date, the name and signature or initials of the one recording the care.

"We document the patient's name, the sex, the indication and if it is an operation that we have done and need continuity of care, we write the indication and the surgery performed" ***N4.***

"You start by writing the date, the time the procedure that was done for the patient, then you write your name and sign". N9

A nurse said they wrote whatever they did to build the trust of the people in their care.

"For me, I think anything we do for the patient we have to document because some of the patients are vigilant. They know the times for their medication and they can prompt the nurses, so, when you give you must document". ***N8***

However, some of the nurses said they wrote the procedures done and interventions given, such as interventions for a reduction in temperature.

"If it is vital signs we indicate the figure. For instance, when the BP is high we must indicate the figure then the intervention that was given, then we sign". ***N12***

"In your documentation, you write temperature was previously 38 or 39 so the patient was sent to the bathroom, tepid sponging was done and suppository paracetamol 1g b d given. After, that temperature rechecked was reduced. So, the documentation should include the date, time, procedure, medication that was given then you sign". ***N11***

Others also said they wrote what they did, how they did it and the things they used for the work.

"If you have done the dressing you should document that the wound has been dressed. Dressing with what? whatever things that you used because you know some of the wounds you must put on it hydrogen peroxide to remove some of the sloughs sometimes you need to cover it for some time and so anything at all that was done should be written." ***N14***

Nurses said documentation should be accompanied by initials or signature.

"When taking the nurses note, for instance, you must make sure, all the areas are filled including the date time, name of the patient. write every care that was rendered for the patient and then sign. But most of us use initials.". ***N13***

4.5.3 Barriers to documentation of patient care

Some nurses stated that there were barriers that did not allow them to document as should have been done. Some of the things they identified as barriers were low staffing levels.

"For staffing, we don't have much staff which is a challenge so when we come to work we suffer a lot. We do tedious work.". ***N9***

A nurse said some of her colleagues refused to sign or put down their initials after documentation**.**

"I always complain about it, even for the night nurses report book, they are supposed to write their names and sign against them, but they only write their name and leave" ***N3***

However, some other nurses said one of the disturbing things was when stationery got finished in the facility and nurses did not have the sheet to document their care.

"When I came on night the changes book was finished, it was weekend too, so I had to remove a sheet from a notebook and fix before I continued the procedure" ***N9***

*"I mean sometimes we don't have the nurses' notes available, so we take the treatment sheet, turn it then we write at the back to continue the notes****". N14***

To answer the third research question "in what ways do nurses use oral communication in the continuity of patient care", one major theme was obtained and that was the use of oral communication in the continuity of patient care.

4.6 The use of oral communication in continuity of patient care

The study findings revealed that the nurses used oral communication to ensure continuity of care for their patients. In doing so the nurses discussed the care of the patients among themselves to enable them to share ideas. During patient handover, the nurses give information verbally to each other. Three sub-themes emerged, and these were: discussing vital information of patients, confirming patients' information about the care given and transferring of detailed information.

4.6.1 Discussing vital information of patient

Some of the nurses said that everything about the patient is written but there were some pieces of information that were given orally to the next staff.

*"I am saying we talk to each other, in case a patient's is given a new diagnosis, even though we have written everything, when we get to the nurses' station we stand and talk about it". N**15***

Another nurse said, normally the language nurses used during their discussions was English but sometimes used "Twi".

*"Among nurses we use "Twi" and English, these are the basic language we use. But we normally speak English with the doctors and "Twi" with the patient because that's the language they most speak and understand". **N10***

A nurse said every incident that happened on the ward must be discussed among the staff either at the bedside, the nurses' station or office.

"*Like if there had been incidences in the ward, maybe a patient was refusing drugs or something, that we don't usually encounter, we discuss them at the nurses table because there are some of the things that we can't discuss at the bedside. it may be quite sensitive, so we discuss such things here at the nurses table and then go to the ward to take up****", N3***

Some nurses also said that, the confidential information was often discussed at the nurses' station.

"We don't say everything at the patient bedside, things like retro cases. But if there are further information that the nurses need to know, we say that at the nurses table" ***N5***

"There is certain information we say it at the nurse's station before we hand over care. When we get to the patient we are not supposed to discuss vital information". ***N8***

Moreover, a nurse said that they sit down at the nurses' station because it made them relaxed to give detailed and vital information.

"When you stand, and you are talking it wouldn't be like when you sit. When you sit down you are relaxed and comfortable. So, you can say everything that you need to say even though you have written it". ***N15***

"We say everything that we need to say even though it is written. because when you sit down you give proper details of whatever really happened verbally". ***N15***

Some of the nurses revealed that sometimes they communicated by calling themselves on phones or by WhatsApp.

"If the person is not on duty, but you want him to do something for you, it is either you call or you WhatsApp the person" ***N4***

"We have various media that we channel information through. We have the WhatsApp group, and at times the nurse in- charge sends SMS on specific information to the staff". ***N13***

Other nurses said, they normally discussed the care given that they did not understand so they could share ideas.

"We hand over care and if there is anything that the doctor wrote, and we don't really understand, we discuss among ourselves on how to go about it before we continue the care." ***N2***

4.6.2 Confirming patient information about given care

Some of the nurses said even though the information was passed on to them orally they confirmed the information by reading through the written document and from other staff and patients.

"*Usually we discuss at the nurse's table, but we sit and look through the folders one by one before we go to the ward and hand over, just like what we do in the morning".* ***N3***

"Although I notify the person what I did, the person will read and make sure everything has been documented. Sometimes we say something that had not been recorded in the chart.". ***N4***

Moreover, others said they must know the patients they are to manage to avoid mistakes.

"Let those taking up from you know the name of the patient and the patient condition. The medication the patient is being managed on then if the patient is an old patient". ***N13***

"At times, we sit down to share information depending on the condition. It may be an emergency case". ***N5***

4.6.3 Transfer of detailed information from staff

Some of the nurses said to continue care effectively the information transferred from one nurse to the other must be detailed.

"Each shift that we run is like a circle so wherever we start from is where we will end. So, if I tell the morning shift the condition of the patient, it runs through all the other shifts" ***N15***

"We say everything that we need to say though we have written it in the nurse's note but when you sit down, proper details of whatever really happened verbally is given". ***N15***

Other nurses said the transfer of detailed information was not done in the presence of the patient.

"Based on the information to be given, if it concerns the patient then we hand over publicly at the bedside. But for the confidential information, we do that at the nurses station". ***N7***

Some nurses said to get detailed information nurses asked themselves questions so that they could understand exactly what was to be done for the patient.

"When am handing over to my colleagues and they ask questions about whatever have been done, then I explain to them". ***N9***

To answer the fourth research question which was: "How do nurses exhibit teamwork during shift work", one major theme emerged and that was teamwork during a shift.

4.7 Teamwork during a shift

The study found that for continuity of patient care to be ensured, there must be a kind of unity among the nurses. The interview revealed that this unity must be in the form of nurses relating to each other well, having good behaviour towards each other and the leader showing leadership abilities. Three sub-themes emerged. The sub-themes were relationship among nurses, leadership roles of nurse in-charges and positive and negative behaviour of team members.

4.7.1 Relationship among nurses

Some of the nurses interviewed were of the view that, teamwork was optimal in the hospital in terms of the nurses caring for the patient.

"As for my ward, the teamwork here is one of the best". ***N5***

*"I think the team work here is very good". **N8***

Some other nurses said teamwork made them work as friends and family and so they often understood themselves.

*"We have very good relationship with ourselves; we understand each other". **N15***

*"I think the teamwork in A&E is just like a family; me that is how I see it**". N6***

A nurse said teamwork helped them cover each other and prevent issues that will not be pleasant.

*"There is teamwork because when there is an issue even without the in-charge's knowledge we bring it up and then solve it". **N7***

Others said to achieve their goals of satisfactory patient care they collaborated with each other.

*"I think the teamwork here is very good. Like when RTA (Road Traffic Accident) comes we all gather. Someone will be setting the infusion line, whiles others will be passing catheter. Coming together to do something for a patient is teamwork". **N8***

*"A staff may approach another staff and complain that he or she needs help and because there is cordial relationship we will accept and help each other". **N9***

4.7.2 Leadership roles of charge nurses

A nurse leader reported that nurses ensure teamwork by their involvement in the nursing work of their unit.

"I involve myself in the work; I have the belief that for you to be an effective leader you should participate, do it for them to see.". **N4**

However, some of the nurses said the leader showed support for them as nurses by standing by them where there were issues.

*"When there is an issue, definitely she will stand by the staff***". *N7***

Moreover, a nurse said for a nurse leader to foster unity she encouraged the staff even if their attitude was not the best.

*"As a leader, you will come across all kinds of staff and you should know the work and make sure there is unity among your staff. Because if there is no unity there is no teamwork.". **N8***

Others said the leader must create the enabling environment for staff to share ideas with him or her.

*"She is very approachable whenever the need arises, and you call for a discussion with her, she is ready.". **N9***

Another nurse said, the leader was expected to take initiative and be resourceful at work.

*"There is a saying that to whom much is given much is expected. So, I expect my leader to take the initiative". **N10***

Moreover, others said the nurse leader must appreciate the staff and avoid partiality.

*"For her, if you need to be praised she will praise you and if you need to be rebuked she will do that. If you need to be corrected you will be corrected, she brings us together and whoever you are if you are wrong you will be rebuked". **N13***

4.7.3 Positive and negative behaviours of team members

Some nurses said that the behaviours of nurses were both positive and negative during care. The positive behaviours fostered teamwork

"They know how to sacrifice, that is one thing that I like about them, even though they are supposed to close, they over stretch themselves all the time". **N4**

*"They all cooperate**". N2***

Other nurses also said their colleagues exhibited bad behaviours in the team which discouraged other team members.

*"Some of the nurses feel reluctant to work. When they come unless you tell them what to do they will be sitting down". **N15***

*"Some of us come with our juniors and leave the whole work on them. They are doing more work than us and we get more pay than them". **N12***

Furthermore, a nurse said there was a nurse who was rude to the staff and patients.

*"We even have one staff the way she will even talk to you. When she comes on duty, all the relatives will be complaining about her rudeness. We have talked to her to change". **N8***

Almost all the nurses said one of the major negative attitudes of nurses was lateness to work.

*"It is about punctuality when you come on duty early and the next person does not relieve you on time, it is bad. We have been talking about it". **N11***

*"Punctuality is a problem but some of them when you tell them, they become angry but now it is better". **N13***

4.8 Summary of Findings

From the study, techniques used in ensuring continuity of patient care, nurses documentation of patient care, the use of oral communication among nurses and the use of teamwork in ensuring continuity of patient care were discovered during the content analysis.

The sub-themes that emerged were familiarization with patient care, rendering nursing care as a continuum, support of patients during care, materials needed for documenting care, content of patient care documenting, barriers to documentation of patient care, discussing vital information of patient, confirming patient information about given care, transfer of detailed information from staff, relationship among nurses, leadership roles of charge nurses and positive and negative behaviours of team members . The above sub-themes showed in detail the views of nurses on the continuity of patient care. These were supported by quotes from participants that were interviewed.

The major findings of the study were: nurses continued care by running shifts for 24 hours. Nurses read folders, nurses' notes and report book before continuing care. Nurses document in appropriate books and charts such as fluid chart, temperature, pulse and respiration chart among others. Most nurses did not sign or write their initials after documenting care; nurses always discussed detailed information at the nurses' station before moving to the patient bedside. Some behaviours of nurses such as lateness to work, rudeness and laziness were what affected their continuity of patient care.

4.9 Summary of themes

The themes and sub-themes that emerged showed in detail the views of nurses on the continuity of patient care. These are shown in the table below:

Table 1: Summary of themes and subthemes

Themes	**Subthemes**
Techniques of ensuring continuity of patient care by the nurse	• Familiarization with patient care • Rendering nursing care as a continuum • Support of patients during care
Nurses documentation of patient care	• Materials needed for documenting care • Content of patient care documentation • Barriers to documentation of patient care
The use of oral communication in the continuity of patient care	• Discussing vital information of patient • confirming patient information about given care • Transfer of detailed information from staff
Teamwork during a shift	• Relationship among nurses • Leadership roles of charge nurses • Positive and negative behaviours of team members

Source: Field survey, 2017

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS

5.1 Introduction

This chapter discussed the findings of the study with references to the relevant literature. The study was to explore the perspectives of nurses on continuity of patient care. The discussion was on the main themes which included techniques of ensuring continuity of patient care by the nurse, documenting patient care, the use of oral communication in the continuity of patient care, teamwork during a shift. The summary of the discussion is also provided.

5.2 Techniques of ensuring continuity of patient care

Continuity of patient care is a means of caring for patients over a period. Studies show that it is in three forms. These are relational, management and informational continuity (Aller et al., 2013; Freeman & Hughes, 2010; Haggerty, Freeman, & Beaulieu, 2013). These forms of continuity are interrelated and must be used together in the healthcare facilities to achieve the goal of reducing patient revisit to the hospital (Hill et al., 2014; Nam et al., 2016)

Nurses in the study, were of the view that to continue care for the patient, they were to familiarise themselves with patients and relatives. They said that they did so by visiting the patients' bedside and talking to the patients to establish rapport. The above finding is supported by Poremski et al. (2016), that a strong relationship between the care giver and the client and the support given to the patient will yield good care. This relationship was enhanced when the incoming nurses introduced themselves to the patients in the units. Every nurse that came on duty ensured that he or she knew the patients by name, the date

of admission, the physician who admitted the patient, the diagnosis given to the patient, the state in which the patient came and the initial vital signs of the patient and what other care was to be given. According to Lafferty et al. (2011), to know the patient means to know the history and the care given. That means that the patient is the focus of healthcare and that every need of the patient must be considered and care provided (Starfield & Care, 2011). This strong relationship between the caregiver and the patient ensures reduction of patient mortality and frequent revisit to the hospital (Lustman, Comaneshter, & Vinker, 2016).

Furthermore, the nurses said they read the folders and the nurses' notes to know what was previously done for the patient and what was supposed to be done. By reading about the patient, the nurses got adequate information that they needed to know about the patient. This is consistent with the findings of Uijen et al. (2010), that care givers can only continue care if they are informed about the previous care received. Reading of the folders confirmed the information about the patient concerning the name, the care received since admission, what care has been done, and others which had been overlooked and what needs to be done. This promotes information flow and ensures care is continued. Care givers know what they are about and are able to give quality information to their patients (Renholm et al., 2016). However, information flow to the patients was not enough because from the study, the nurses shared information among themselves but less of that information was told to the patients. This is consistent with the findings of Hill et al., (2014), that the least used form of continuity is the informational continuity. If nurses have much information, it boosts their confidence and the patient with enough information is able to cope well with the disease (Rathor et al., 2011). There are limitations to the extent to which staff will get information since getting internet access in most facilities is difficult (Park et al., 2016).

Looking at the above finding, it implies that every nurse that comes on duty should take time to go to the patient's bedside to talk to the patient to establish rapport and to read everything about the patient in his or her care. It is by so doing that the nurse will know the needs of the patient which have not been met. This was not often so as the nurses complained of shortage of staff and work overload. This agrees with Enns, Sawatzky, Manitoba, (2016), findings that workload, lack of time, staffing issues, shift work, and lack of self-care are some of the issues that mitigate against the continuity of care.

Caring for the patient was the core business of the nurses when they are on duty. The nurses in the study said they run three shifts in 24 hours and that was morning, afternoon and night. This was consistent with (Griffiths, Morphet,Innes, Crawford & Williams, 2014), that most nurses run an 8hour shift. Each shift had its own activities. This also agrees with (Griffiths, Ora, Simon & Ball, (2014) findings that nurses run different shift systems in different countries and that nurses' shift must not exceed 12 hours. This, they said is because nurses who work for more than 12 hours do not produce quality work due to stress. Moreover, the study findings revealed that the care given by nurses were either routine or specific. This agrees with the findings of Enns, Sawatzky, Manitoba, (2016), that care for the patient is holistic and nurse must advocates for patients when rendering care.

From the above, it is apparent that, the nurses while caring for the patient used more management continuity and relational continuity than informational continuity of patient care even though, nurses did not mention the three forms of the continuity of patient care. This is inconsistent with the findings of Naert, et al (2017), that the most frequently used continuity of patient care is the management and the relational continuity. Therefore, nurses must know about all the forms of continuity of patient care and enhance the use of the informational continuity of patient care.

5.3 Nurses' Documentation of Patient care

Nursing care is rendered if there is evidence that work has been done on a patient. Most of the nurses showed that care given to patients were often recorded. The findings revealed that whatever was done for the patient was recorded and that nurses had so many materials for documentation (Ogoe et al., 2014). The study revealed that the materials for documentation that nurses used were papers and computers. Some of the paper materials that nurses recorded care in were the temperature pulse and respiration charts, the blood pressure charts, the fluid charts, the admission and discharge book, the report book, the fit charts among others, according to the type of care being given, This is inconsistent with the findings of Ogoe et al., (2014), who said that the use of the computer enhances data retrival which makes it easy to use the data. This will ensures continuity of patient care.

Also, the findings showed that for nurses in this study, the computer was not used much for documentation in nursing folders or charts but only for admitting and discharging patients and serving medications to the patients. Most nurses admitted that they preferred writing on paper to typing on the computer. A few said they will choose the computer. This findings is not supported by Ogoe et al., (2014) ;Wang, Yu, & Hailey, (2015) who showed that the use of a software for documentation was the best after their intervention study with Smart-Med software. Using the computer to keep records of patients is the best as it ensures quality care in keeping correct and up to date data. Nurses will avoid the issue of missing diagnosis or signs and symptoms. Patient information is easy to retrieve which makes the patient build confidence in the healthcare personnel.

The nurses who did not choose the computer, attributed it to the network being inconsistent and that they were slow in typing when there was the need to care for patients. However, Teviu et al. (2012), noted that, the use of the paper folders has become a problem to nurses because of the lack of space, the items to use in recording, untrained

staff and the type of systems used in filing. From the findings, it is inferred that nurses need to be trained on the use of electronic gadgets for documentation of care as well as getting backups for the computers to prevent loss of data during power outages (Lindo et al., 2016).

Furthermore, the study revealed that nurses documenting care was not just writing whatever they did but how the procedure was done, what was used to do the procedure, the outcome of the procedure together with the name of the patient, the date, the age and the name and signature of the one who performed the procedure. Moreover, other nurses said the records should be written in plain words, and clear for others to understand. These suggestions agree with the findings of Machudo & Mohidin (2015), who said nursing record should be precise, full of information deemed to be important; the nursing records should be written on time and very accurate and clear to all to avoid doubt. A few of the nurses did not have date and time since some nurses forgot to document and others documented but did not sign their names or append their signature. This is consistent with the findings of Heikkilä et al. (2016), who found out in their study about postoperative documentation that care documented was not up to standard. This is also consistent with the findings of Asamani et al., (2014), who said most nurses do not record care (46%); others do not write in the nurses' notes (63%) whiles others do not sign after documentation (57%). For nurses' record on paper to be accepted, there should be a date, time and signature, and what was done for the patients. The above implies that nurses should be supervised and monitored to be able to follow the standard way of documenting care. This was also said by Nakate et al. (2015), that there should be constant supervision, monitoring and support by the leadership of nursing .

Other findings were that documentation was most of the time difficult because of other things that serve as hindrances. Many of the nurses blamed their lack of complete

documentation on their level of staff on duty per shift. Some lamented that supposing they were two or three on duty with emergency cases they would prefer concentrating on the care and by the time they had finished they would be too tired to do document. To solve this problem, (Asamani, Amenope, Babanawo & Ofei, 2014), suggested that putting policies in place and training staff on documentation will help. Moreover, nurses can be available and ready to document but there would be the unavailability of materials that the nurses would use to document care such as stationery and sometimes even pens. The nurses said on so many occasions they had to tear sheets and improvise, or they had to borrow from other units. Nonetheless, they always ensured they did their best to record care rendered. This is inconsistent with the findings of Nakate et al. (2015), who said lack of nursing documentation was often blamed on a shortage of staff, workload, and oversight while to others, it is a lack of experience and little knowledge about what to document, how to document and where to document .

This implies that nursing documentation needs to be looked at in a broader view in terms of the policies, staff supervision and monitoring. Adequate staffing must be given to units and facilities to reduce staff burnout. This is consistent with the findings of Heikkilä et al. (2016), who said policy guidelines on how to document are some of the recommendations to nurses on patient care . Nurses must pay attention to time, workload, support from nurse leaders and knowledge about documentation. Electronic documentation can help improve nursing documentation.

5.4 The use of oral communication in the continuity of patient care

Nurses at the health care facility did communicate among themselves to care for the patient effectively. There are many forms of communication which the nurses used but the study findings showed that the nurses used both oral and written forms of communication (Freeman & Hughes, 2010). The nurses revealed that they communicated

among themselves concerning issues of care. The nurses discussed patients and their condition, their diagnoses and interventions that the previous nurses gave at the nurses' station before getting to the bedside. This is consistent with the findings of Sedgwick & Garner, (2017), who said joining in team discussions help share opinions about the work. They search for information and use the information to calm, reassure and give opinions during care.

The findings showed that if there were any vital and confidential information to be shared among staff such as diseases of stigmatisation (retroviral diseases) and terminal diseases (cancers), they were deliberated on by the nurses at the nurses' table. A patient with a critical condition which needed much attention was also discussed orally to enable other colleagues to initiate care quickly. This is inconsistent with the findings of (Fathi et al., 2016), who said that communication among nurses is seen most in in-patient information sharing, proper documentation of patient information and the transfer of this information. It was also shared from the minds of the nurses and sometimes through discussions and nurses are careful to share patient vital information, not at the bedside (Liu et al., 2012). This implies that continuity of care was effective if nurses took time to discuss issues of importance to the care they render. This would enable them to gain much confidence and to give quality care with fewer errors (Nam et al., 2016).

Another finding was the use of social media by the nurses. The nurses said if there were things that the previous staff did, and they did not understand, they used the social media such as "WhatsApp" to communicate with one another. According to Chung et al., (2015), the use of informal discussion has an influence on the social media. Also, according to Sharpe & Hemsley, (2016), the use of mobile technology can enhance communication among staff . This implies that departments should have a mobile phone for staff to use as an emergency and this should be loaded with credits for nurses to use to

clarify issues not well understood. In his study Dare,(2009) found out that using mobile phones can enhance staff communication but it lacks policy guidelines and may lack confidentiality of the messages.

Furthermore, the findings showed that all pieces of information that were given to colleagues orally were supposed to be cross-checked with other documents such as patients' folder and nurses' notes. Nurses took the time to go through the folders to note whether all that the colleagues said had been written down for evidence sake. By reading the patient folder, the nurses got to know their patients well enough to avoid mistakes and to fill in the gap in the management of the patients. This is consistent with the findings of Manser and Foster, (2011), that there are times information about the patient is given verbally which does not augur well for the management of the patient.

Moreover, the information that is shared among nurses must be detailed enough from one shift to the other. The study findings revealed that information shared is circulated for all the staff to note. This is to avoid the information being distorted from one nurse to another. Proper and detailed information of what happened must be shared so that complete information may be given out. Even though the information would be given out verbally, nurses said they write it as well to ensure that the information does not lose its value (Abraham, Kannampallil, & Patel, 2012). To get detailed information, the nurses said they sat down, relaxed and then asked questions for clarification and better understanding. These findings agrees with that of Thraen, et al. (2012), that patient information must reach the next caregiver or the facility by way of communication and feedback must be received to be able to continue care.

From the above, it is implied that information sharing is very important. Nurses should make it a point to share information through verbal communication or by writing them down.

5.5 Teamwork during a shift

The study findings revealed that the relationship among the nurses were encouraging because these nurses saw themselves as families and cared for one another. They worked together in unity supporting each other to avoid exposing the weaknesses of one another. The study findings are consistent with the findings of (Montgomery, Spanu, Adriana & Panagopoulou, 2015) who said teams are effective if they participate a lot. They taught themselves, especially when it comes to helping the new ones to be able to work as team members independently. Grover et al., (2017), also said that when members feel connected to each other there is success in their practice. Also, training of team members enhances the roles of each member.

Another finding revealed that the leader of the team must be supportive and can take initiative with the care for the patient. The leader must be knowledgeable, tolerant and hard working to win the nurses to work well. This agrees with Belling et al., (2011) that good decision making and supporting the staff will influence continuity of their patient care but at the same time is challenged with low staffing levels. The leader must be able to create an enabling professional environment by encouraging the nurses even when there is a challenge with both material and human resources. This is consistent with the findings of Cummings et al. (2010), that enhancing one's leadership styles helps the leader to support the staff and then create an environment which increases job satisfaction and increased work output. The leader must be able to appreciate staff to enable them to put up their best in caring for the patient. This agrees with observations of Nelsey and Brownie, (2012) that teams are influenced by their leaders and the leader must be able to mentor the

staff, create an enabling environment for them to work and be able to solve conflicts when they arise.

However, teams are enhanced when every team member is committed to the work. Every team had a goal which was to ensure that patients care was continued in their shift. The study findings showed that even though some of the team members were committed to achieving their aim others were not bothered. According to Montgomery et al. (2015), failing to engage staff affect teamwork in the facility. The findings showed again that some of the nurses were co-oporative and were ready to sacrifice even if it meant staying after the normal duty to care for patients or replace other nurses who may be indisposed. This is consistent with the findings of Nelsey and Brownie, (2012), that when teamwork is enhanced in a facility, nurses refuse to absent themselves and they are retained at the facility. Others did not even care, and they exhibited rude behaviours towards patients and staff and would not heed to advice to come to work early to be part of the team that took up. These behaviours affected teamwork which further affected the continuity of patient care. This is consistent with the findings of Kalisch and Lee, (2010), that lack of teamwork account for the missed nursing care patients receive.

The above implies that the nurses had not been trained in team dynamics and that was why the members did not see their importance in the teams. Nurses need to be trained in team dynamics and communication to be able to play their part well (Deneckere et al., 2012). The nurses planned schedule for each shift and need to consider roles and skills of each team member. These roles and skills when ignored can affect the team work in the continuity of patient care (Grover et al., 2017). This shows that communicating among members at work and the leadership skills of the charge nurse will ensure effective teamwork.

5.6 Summary of discussion

In summary, many studies looked at continuity of patient care in terms of three forms namely: relational, informational and management (Abraham, Kannampallil, & Patel, 2012; Cornwell et al., 2012; Haggerty, Freeman, & Beaulieu, 2013). Most of these studies were on the perspectives of the patients and the study were quantitative. This study is a qualitative study that looked at the perspective of nurses on continuity of patient care in documentation, teamwork and communication among the nurses. The findings were consistent with other findings and showed that even though nurses perceived that they were providing care, there is the need for training to be done in the areas of nursing documentation, the need to work as teams, how and what to talk about in communicating with each other. Again, every nurse must be trained on the forms of continuity of patient care (relational, informational and management) and how to achieve it. Also, it is necessary to train nurses on how to use the computer to create folders for the patients. Finally, the Ministry of Health can institute policies that will ensure that all nurses have a format in documenting patient care.

CHAPTER SIX

6.0 SUMMARY, IMPLICATIONS, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter is centred on the summary of the study, implications of the findings for nursing practice, nursing education and nursing research. The limitations of the study, conclusions and recommendations are also presented in this chapter.

6.2 Summary of the study

The study explored the perspectives of nurses on continuity of patient care at the Trauma and Specialist hospital, Winneba. The study used an exploratory descriptive qualitative design using purposive sampling technique. Data collection began after ethical approval was obtained from the Institutional Review Board of the University of Ghana; Noguchi Memorial Institute of Medical Research. The instrument for data collection was a semi structured interview guide which was pre-tested at Ga South Municipal Hospital, Accra to avoid any ambiguity and to ensure that the instrument was in line with the objectives and purpose of the study. Fifteen participants were involved in the study. All participants who agreed to be part of the study signed a consent form. With the permission of participants, each interview was recorded on a voice recorder and transcribed verbatim. Content analysis was employed to analyze the data.

There were six major findings of the study namely; nurses continued care by running shifts for 24 hours. Nurses read folders, nurses' notes and report books before continuing care. Nurses documented care rendered in books and charts such as fluid chart, temperature, pulse and respiration chart among others. Most nurses did not sign or write their initials after documenting care. Nurses always discussed detailed information at the

nurses' station before moving to the patient bedside. Some behaviours of nurses such as lateness to work, rudeness and laziness were what affected their continuity of patient care.

6.3 Implications

The findings of this study revealed some implications that must be attended to. The implications are related to nursing education, nursing practice and nursing research.

6.3.1 Nursing Education

The findings of this study have several implications for nursing education. It is important to train staff on documentation of nursing care, sharing of patient information through communication among staff and how to work in teams. The nursing profession or practice is largely dependent on the training one acquires from school. It is thus necessary to enhance the curriculum in nursing training to expand the content on continuity of patient care, especially the three forms of continuity of patient care namely, relational, information and management continuity of patient care. Health tutors at the Nursing and Midwifery training colleges must guide students in acquiring the necessary knowledge in documentation of patient care, communication among nurses and teamwork.

6.3.2 Nursing Practice

Findings of the study revealed a gap in the documentation of nursing care, communication among nurses and patients and teamwork among nurses. However, nurses are supposed to use these skills to ensure there is continuity of patient care. Nurses must establish good interpersonal relationships, acquire good record keeping skills and learn to share detailed information to enhance continuity of patient care.

6.3.3 Nursing Research

This study explored the perspectives of nurses on the continuity of patient care. In the future, this study can be repeated in other hospitals in Ghana to further explore nurses' perspectives on continuity of patient care. However, the perspectives of other health workers and patients on continuity of care are important to be investigated.

6.4 Limitations

It is possible that other nurses with different backgrounds could have different perceptions on continuity of care. Nonetheless, the study can be repeated within similar context to allow for transferability. To generalize the findings of the study, a quantitative or mixed method approach could be used with a larger sample in the future.

6.5 Conclusion

Continuity of patient care is the most important factor in reducing patient mortality and patients' revisit to the hospitals. The forms are relational, informational and management continuity of care. Enhancing relationship with the patient, documenting nursing care, transferring information to both staff and patient and supports to patients will improve continuity of patient care. However, low levels of nursing staff, lack of materials for patient care and negative behaviours of nurses affect continuity of patient care. It is therefore necessary to train staff on nursing documentation, communication and teamwork to enhance continuity of patient care.

6.6 Recommendations

Based on the findings of the study, recommendations were made to the following; Nurse, leaders, Ministry of Health and the Trauma and Specialist Hospital, Winneba.

6.6.1 Nurse Leaders

- Nurses should acknowledge the forms of continuity of patient care (relational, informational and management) and apply them in their care.
- Nurses should be trained through workshops and in-service training on the need for nursing documentation, communication and teamwork.

6.6.2 Ministry of Health

- The Ministry of Health should collaborate with the stakeholders of nursing education in Ghana to revisit the curriculum for training nurses to include more on nursing documentation, communication and teamwork.
- The Ministry should develop policies on nursing documentation, communication and teamwork and ensure their full implementation

6.6.3 The Trauma and Specialist Hospital

- The nurses at the hospital must be trained on the three forms of continuity of patient care (relational, informational and management continuity of patient care) through workshops and in-service training.
- Policies, Protocols, and checklists for nursing documentation, communication and teamwork should be developed and disseminated in all the units of the hospitals.
- Nurse leaders must supervise nurses to ensure nurses document nursing care and practice teamwork.

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NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH (NMIMR)
COLLEGE OF HEALTH SCIENCES, UNIVERSITY OF GHANA, LEGON

INSTITUTIONAL REVIEW BOARD

Data Collection Instruments
INTERVIEW GUIDE

SECTION A

Age: .....

Gender: .....

Educational Level.....

Marital status: .....

Rank: .....

Ward: .....

Many years' experience: .....

SECTION B

1.Kindly share with me the care you provide for the patients?

Probes:

Nursing care

Support to patient and family

Information to patients

2. Please share with me your thoughts on communication on the ward?

Probes

Interaction among staff

Meetings/ discussions

Folders

3. How do you transfer information from one shift to the other?

NMIMR-IRB Form A (Students Only)
Version Date: May, 2016

1

APPENDIX A

Probes

Verbal

Checklist

Group discussion

4. What can you say about teamwork in your ward?

Probes

Leadership role

Cohesion

Attitude of staff

5.Please tell me how you document your care?

Probes

Who does it

Paper

Computer

Nurses note

APPENDIX B

Consent Form

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH (NMIMR)
COLLEGE OF HEALTH SCIENCES, UNIVERSITY OF GHANA, LEGON

INSTITUTIONAL REVIEW BOARD

Consent Form

Title: Perspectives of nurses on continuity of patient care: At Trauma and Specialist Hospital, Winneba

Principal Investigator: Josephine Okine. MSc. Nursing Student

Address
School of Nursing University of Ghana, Legon

General Information about Research

The main purpose of the study is to explore how nurses perceive continuity of patient care. The study will dwell more on nursing documentation, communication and teamwork.

the results and recommendations is expected to be useful in informing training of nurses and midwives on the importance of continuity of patient care. Furthermore, it is expected that, the hospital will establish protocols in respect to sharing of patient information, keeping of accurate and adequate records and working collaboratively.

To achieve this, nurses working at the bedside will be interviewed. The interviews will last between 30minutes to one hour. The interview will be based on your time and convenience.

Possible Risks and Discomforts

There will be no known risk attached to this study. You will be protected from any possible harm. In case you are not comfortable with any of the questions as they are being asked, you may refuse to answer any of them.

Possible Benefits

Being involved in the study will not benefit you financially but will go a long way to benefit anybody who visit the health care facility or is admitted into the hospital. However, during the interview, if any portion of the study makes you feel sad, you can refuse to answer.

NMIMR-IRB Form A (Students Only)
Version Date: May, 2016

1

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VALID UNTIL
02 MAY 2018
APPROVED DOCUMENT

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COLLEGE OF HEALTH SCIENCES, UNIVERSITY OF GHANA, LEGON

INSTITUTIONAL REVIEW BOARD

Confidentiality

Your privacy will be maintained. Your name will not appear on the transcript and no identifying information will be included. The interviews will be audiotaped and write out. These will be kept for at least five years after the study in my custody.

Compensation

You will be given snack after the interview

Voluntary Participation and Right to Leave the Research

The interview will be based on your time and convenience.

You will be required to sign a consent form. You may refuse to join in the study because it is not compulsory.

If even you join you may withdraw at any point in time that you feel like doing so.

Contacts for Additional Information

You can contact me at the school of Nursing, University of Ghana, Legon or these phones numbers 0243111979 and 0507879632. In case you have any concerns, you may contact: Dr. Lydia Aziato: Head of Adult Health Department, School of Nursing, University of Ghana or Ms. Linda Norman Faculty member, (Adult Health) School of Nursing, University of Ghana, for any further clarification.

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant, you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.ug.edu.gh

NMIMR-IRB Form A (Students Only)
Version Date: May, 2016

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2

APPENDIX C

Volunteer Agreement Form

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH (NMIMR)
COLLEGE OF HEALTH SCIENCES, UNIVERSITY OF GHANA, LEGON

INSTITUTIONAL REVIEW BOARD

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title *(*Perspectives of nurses on Continuity of patient care: A study at the Trauma and Specialist Hospital, Winneba*)* has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

Date _____ Name and signature or mark of volunteer _____

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

Date _____ Name and signature of witness _____

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research has been explained to the above individual.

Date _____ Name Signature of Person Who Obtained Consent _____

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0 2 MAY 2018
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NMIMR-IRB Form A (Students Only)
Version Date: May, 2016

3

APPENDIX D

Ethical clearance

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Established 1979A Constituent of the College of Health Sciences
University of Ghana

INSTITUTIONAL REVIEW BOARD

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E-mail: nirb@ngochi.ug.edu.gh
Telex No: 2556 UGL GH

Post Office Box LG 581
Legon, Accra
Ghana

My Ref. No: DF.22
Your Ref. No:

3rd May, 2017

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824 **IRB 00001276**

NMIMR-IRB CPN 092/16-17 **IORG 0000908**

On 3rd May, 2017, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : **Perspectives of nurses on continuity of patient care: A study at the trauma and specialist hospital, Winneba**

PRINCIPAL INVESTIGATOR : **Josephine Okine, MSc cand.**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

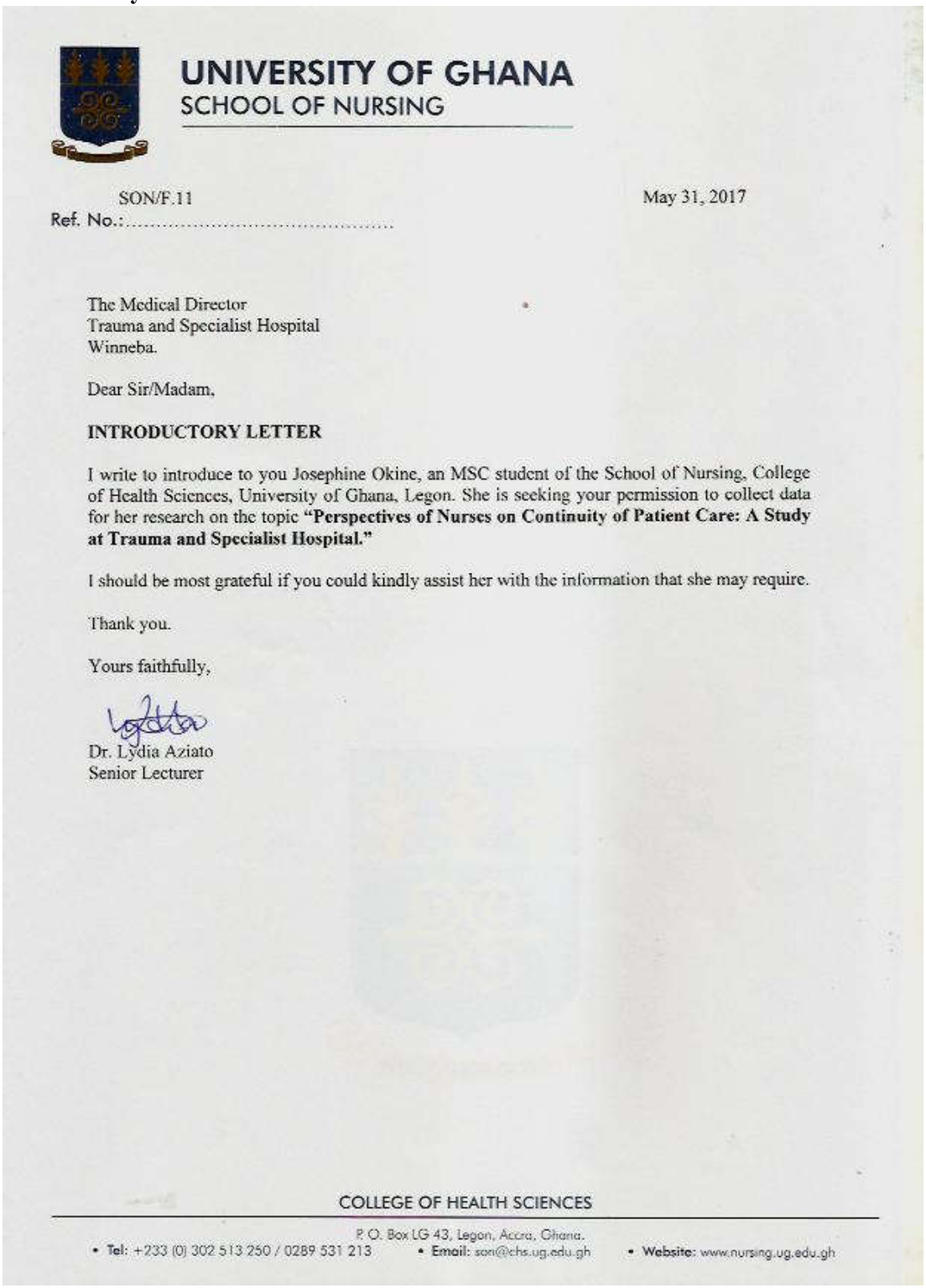
Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 2nd May, 2018. You are to submit annual reports for continuing review.

Signature of Chair: .....
Mrs. Chris Dadzie
(NMIMR – IRB, Chair)

Introductory Letter



UNIVERSITY OF GHANA
SCHOOL OF NURSING

SON/F.11 May 31, 2017
Ref. No.:.....

The Medical Director
Trauma and Specialist Hospital
Winneba.

Dear Sir/Madam,

INTRODUCTORY LETTER

I write to introduce to you Josephine Okine, an MSC student of the School of Nursing, College of Health Sciences, University of Ghana, Legon. She is seeking your permission to collect data for her research on the topic **"Perspectives of Nurses on Continuity of Patient Care: A Study at Trauma and Specialist Hospital."**

I should be most grateful if you could kindly assist her with the information that she may require.

Thank you.

Yours faithfully,

Dr. Lydia Aziato
Senior Lecturer

COLLEGE OF HEALTH SCIENCES

P. O. Box LG 43, Legon, Accra, Ghana.
• Tel: +233 (0) 302 513 250 / 0289 531 213 • Email: son@chs.ug.edu.gh • Website: www.nursing.ug.edu.gh

APPENDIX E

Table 1: Characteristics of Participants

Pseudonym	Age (yrs.)	Gender	Educational Level	Marital Status	Rank	Ward
N 1	25	Male	Diploma in Nursing	Single	Senior Staff Nurse	Male surgical
N2	22	Female	Diploma in Nursing	Married	Senior Staff nurse	Male Surgical
N3	35	Female	Master of Nursing	Married	Nursing Officer	Female
N4	30	female	Adv Diploma in Critical Care Nursing	Married	Nursing Officer	Recovery
N5	27	Male	Diploma	Single	Staff Nurse	Recovery
N6	30	Female	Diploma in Midwifery	Married	Staff Midwife	Maternity
N7	40	Female	Diploma	Married	Staff Midwife	Maternity
N8	27	Male	Diploma	Single	Staff Nurse	Emergency
N9	35	Female	Diploma	Married	Senior staff Nurse	Emergency
N10	25	Male	BSc Nursing	Single	Nursing Officer	Emergency
N11	30	Female	BSc Nursing	Married	Nursing Officer	Emergency
N12	30	Male	Diploma	Married	Senior Staff nurse	Pediatric
N13	28	Female	Diploma	Single	Staff nurse	Female
N14	25	Male	Diploma	Single	Staff nurse	Male Medical
N15	26	Male	BSc Nursing	single	Nursing officer	Male Medical