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EXPLORING FACILITATORS AND BARRIERS TO IMPLEMENT PERSON AND FAMILY-CENTRED CARE IN A PRIVATE HOSPITAL EMERGENCY DEPARTMENT

FACULTY OF HEALTH SCIENCES

SCHOOL OF HEALTHCARE SCIENCES

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UNIVERSITY OF PRETORIA

Student name: Mari-Louise Joubert

Student number: U15381804

Supervisor: Prof N.C. van Wyk

Co-Supervisor: Prof R. Leech

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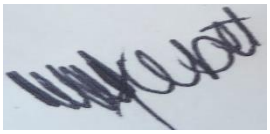
DECLARATION

I Mari-Louise Joubert U15381804 declare that this thesis: Exploring facilitators and barriers to implement person and family-centred care in a private hospital emergency department, is my original work. It has not been submitted to any other institution before for any degree or examination. All the sources used and quoted were acknowledged using complete references in the text and bibliography.



M Joubert — 29 November 2023

Signature: — Date:

DEDICATION

To my husband, Dolf Joubert and beautiful daughters, Allison and Abbygayle, thank you for supporting me through the good and the difficult times. Your unwavering confidence in me during the tough times and your words of encouragement, love and support carried me through, especially when it was getting tough.

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Accomplishing this research has been overwhelming because of all the challenges encountered along the way; however, the support and guidance from the following people contributed greatly to my successful outcome and completion of this project:

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ABSTRACT

BACKGROUND

In-person- and family-centred care, patients and their family members are involved in the planning, implementation and evaluation of care. The Registered Nurses' Association of Ontario developed best practice guidelines for person- and family-centred care in May 2015. Prior to the implementation of the guidelines in the emergency department of the designated hospital, possible facilitators and barriers regarding its implementation had to be explored and described. The research question was, therefore: "What were the facilitators and barriers according to the Consolidated Framework for Implementation Research that could influence the implementation of the person- and family-centred care guidelines of the Registered Nurses Association of Ontario in the designated hospital emergency department?

METHODOLOGY OF THE RESEARCH

A qualitative study in implementation science was conducted in a designated private hospital's emergency department in the Mpumalanga province through semi-structured focus group interviews with eight purposively selected nurse participants. The data was deductively and inductively analysed. The domains of the Consolidated Framework for Implementation Research served as a framework for the deductive analysis, and a thematic analysis was done in the inductive analysis.

FINDINGS

Possible contextual and interventional barriers and facilitators to the implementation of person- and family-centred care were identified. Important facilitators referred to the

existing endeavours to involve the patient and family in the care rendered in the department, the effective way the nurses previously implemented change and the empowering management of patient feedback. Possible barriers refer to the life-saving care required for severely injured patients that force the nurses to focus on physical care to the detriment of holistic care and the community's misuse of the department for primary healthcare, leading to poor patient and nurse ratios and thereby leaving the nurses with little time to build trusting relationships with the patients and family members.

KEY TERMS / CONCEPTS

Clinical best practice guidelines, Consolidated Framework for Implementation Research, Emergency department, Person-and family-centred care

TABLE OF CONTENTS

DECLARATION i

DEDICATION ii

ACKNOWLEDGEMENTS iii

ABSTRACT iv

TABLE OF CONTENTS vi

LIST OF TABLES ix

LIST OF FIGURES ix

CHAPTER 1 INTRODUCTION TO THE STUDY 1

1.1 INTRODUCTION 1

1.2 BACKGROUND TO THE PROBLEM STATEMENT 2

1.3 PROBLEM STATEMENT 3

1.4 RESEARCH QUESTION 5

1.5 AIM AND OBJECTIVES OF THE STUDY 5

1.6 DEFINITION OF KEY CONCEPTS USED IN THIS STUDY 5

1.7 CONTEXT / SETTING 7

1.8 PHILOSOPHICAL ASSUMPTIONS 7

1.9 THEORETICAL FRAMEWORK 8

1.10 DELINEATION 9

1.11 SUMMARY OF THE CHAPTER 9

CHAPTER 2 LITERATURE REVIEW 10

2.1 INTRODUCTION 10

2.2 PART 1: LITERATURE REVIEW OF PERSON- AND FAMILY-CENTRED CARE 10

2.2.1 Methodology of the literature search 11

2.2.2 Extraction of the data 14
2.2.3 Outcome of the literature review 24
2.3 PART 2: DESCRIPTION OF THE PERSON- AND FAMILY-CENTRED CARE GUIDELINES OF THE RNAO 28
2.4 SUMMARY OF THE CHAPTER 31
CHAPTER 3 METHODOLOGY OF THE RESEARCH 32
3.1 INTRODUCTION 32
3.2 RESEARCH DESIGN 32
3.2.1 Population 33
3.2.2 Sampling method and sample size 33
3.2.3 Data collection and organisation 35
3.2.4 Data analysis and interpretation 37
3.3 RIGOUR IN THE STUDY 37
3.4 ETHICAL CONSIDERATIONS 39
3.5 SUMMARY OF THE CHAPTER 40
CHAPTER 4 RESEARCH FINDINGS AND DISCUSSIONS 41
4.1 INTRODUCTION 41
4.2 DEMOGRAPHIC DESCRIPTION 41
4.3 THE RESEARCH FINDINGS 42
4.3.1 Domain 1: Intervention characteristics 43
4.3.2 Domain 2: Outer Setting 52
4.3.3 Domain 3: Inner setting 61
4.3.4 Domain 4: Characteristics of the individuals 77
4.3.5 Domain 5: Process of implementation 80
4.4 SUMMARY OF CHAPTER 87
CHAPTER 5 CONCLUSION, RECOMMENDATIONS AND LIMITATIONS 88
5.1 INTRODUCTION 88

5.2 AIM OF THE STUDY 88
5.3 SUMMARY 89
5.3.1 Categories relating to the outer setting 89
5.3.2 Categories relating to inner setting 90
5.3.3 Category relating to characteristics of individuals 91
5.3.4 Categories relating to interventional characteristics 92
5.3.5 Categories relating to the process of implementation....93
5.4 LIMITATION....94
5.5 RECOMMENDATIONS FOR PRACTICE IMPROVEMENT 94
5.6 RECOMMENDATIONS FOR FUTURE RESEARCH 96
5.7 CONCLUSION OF THE STUDY....96
REFERENCES 97
APPENDICES....112
APPENDIX A: PRIVATE HOSPITAL CONSENT (2022) 112
APPENDIX B: RESEARCH ETHICS COMMITTEE (2022)....114
APPENDIX C: PARTICIPANT'S INFORMATION AND INFORMED CONSENT DOCUMENT FOR A FOCUS GROUP INTERVIEW RESEARCH STUDY 116
APPENDIX D: SEMI STRUCTURED INTERVIEW GUIDE....123
APPENDIX E: TRANSCRIBED INTERVIEWS 128
APPENDIX F: FIELDNOTES OF FOCUS GROUP INTERVIEWS 156

LIST OF TABLES

TABLES		PAGE NUMBERS
Table 2.1	Core concepts of the literature review contexts and terms	12
Table 2.2	Eligible publications and findings	15
Table 3.1	Participant demographic information	34
Table 4.1	Participants' demographic data	42
Table 4.2	Summary of categories and sub-categories of the intervention characteristics domain of the CFIR	44
Table 4.3	Summary of categories and sub-categories of the outer setting domain of the CFIR	52
Table 4.4	Summary of categories and sub-categories of the inner setting domain of the CFIR	61
Table 4.5	Summary of categories and sub-categories of the characteristics of individuals domain of the CFIR	76
Table 4.6	Summary of categories and sub-categories of the process of implementation domain of the CFIR	79

LIST OF FIGURES

Figures		Page
Figure 2.1	PRISMA 2020 flow diagram for updated systematic reviews which included searches of databases	13

ABBREVIATIONS / ACRONYMS LIST

Consolidated Framework for Implementation Research (CFIR)

Emergency department (ED)

Person-and family-centred care (PFCC)

Registered Nurses Association of Ontaria (RNAO)

CHAPTER 1
INTRODUCTION TO THE STUDY

1.1 INTRODUCTION

Patient- and family-centred approaches are used in quality healthcare (Fitzsimons, Priori & Blomstrom-Lundqvist 2015:1602). It is, however, more appropriate to refer to person- and family-centred care (PFCC) as the word 'person' honours the uniqueness of the individual. The term 'patient' refers to a change in the person's identity once he or she becomes ill (Naldemirci, Wolf & Elam 2018:525). The person is an individual and must be respected as such. He or she belongs to a family (Lor 2016:223).

Families are diverse (Mitchell 2016:197), and so are their cultural backgrounds (Lor 2016: 224). The admission of a family member to a hospital can be very stressful for the whole family (Cattelan, Castellano, Merdji & Claude 2021:3). Therefore, nurses should not only attend to the needs of the patients but should also involve the family members in the planning and execution of their care. The illness of the family member may impact the well-being of the family, and the way the family reacts to the family member's illness may have negative consequences for the recuperation of the ill member (Bouchoucha and Bloomer 2021:133; Lissoni, Del Negro Brioschi, Casella & Fontana 2020:106; Taylor, Short, Asher, Taylor & Beidas 2020:108).

Much research has been done on person- and family-centred care. At first, clinicians in paediatric patient care started to involve the parents of children and family-centred paediatric care developed (Shields 2015:139). With time, other "centredness" approaches such as family-centred care, person-centred care, and child-centred care followed (Coyne, Padilla-Walker, Holmgre & Stockdale 2018:899). Person-centred care is also no longer limited to paediatric nursing. It is common in a variety of settings in mental healthcare (Gondek, Edbrooke-Childs, Fink, Deighton & Wolpert 2016:340), general hospitals (Cederwall, Olausson, Rose, Naredi & Ringdal 2018:37) and gerontology (Edvardsson, Watt & Pearce 2016:224).

Person- and family-centred care is aimed at "a mutually beneficial partnership" among patients, family members and healthcare professionals in the planning, delivering and evaluating of healthcare (Dudley, Bown, Ackerman & Snow 2015:257). In May 2015, the Registered Nurses Association of Ontario (RNAO) published clinical best practice guidelines for PFCC. The RNAO is a professional association representing registered nurses and nursing students in Ontario, Canada (RNAO 2015:84-86 and 23-40). To encourage family engagement, there must be a liaison between the healthcare worker, the family, and the person in need of care to communicate efficiently and clear all doubts in the family (Fernández-Martínez, Mapango, Martínez-Fernández & Valle-Barrio 2022:8).

Currently, the nurses in the designated hospital's emergency department do not implement person- and family-centred care. It is to the detriment of the patients, family members and themselves. According to implementation science, it is necessary first to explore and describe what facilitators and barriers may influence the implementation of best practice guidelines before the actual implementation is done (Glasgow, Vinson, Chambers & Khoury 2012:1275). This study thus aimed to explore and describe the possible facilitators and barriers prior to the implementation of the RNAO person- and family-centred care in the designated hospital emergency department.

1.2 BACKGROUND TO THE PROBLEM STATEMENT

Through PFCC, persons and their family members are empowered to collaborate in their healthcare (Hower, Venneday & Hillen 2019:115). Their unique needs and those of their family members are addressed, and the focus is not on disease (Delaney 2018:119). It also prevents the overuse of healthcare services (Senabye 2018:40-41).

Person- and family-centred care involves a deep interest in persons' healthcare needs, enabling nurses to deliver individualised care (Edvardsson, Watt & Pearce 2016:220). With a focus on the needs of individual patients and the design of their care accordingly, quality care is possible (Sharma, Bamford & Dodman 2015:107; Shields 2015:135).

Through PFCC, the values and beliefs of the individual and family members are acknowledged (Kvåle & Bondevik 2018:585), and care is delivered accordingly (Abukari, Acheampong & Aziato 2022:1). Patients are part of families. Therefore, families should be involved in the planning, delivery and evaluation of patient care (Olding, McMillan, Reeves, Scmitt, Puntillo & Kitto 2016:1198). Through the implementation of PFCC, information about the planned care is shared with patients and family members to their benefit (Giusti, Pukrittayakamee, Alarja, Farrant, Hunter & Mzimkulu 2022:17). It also entails a cooperative nurse-caregiver relationship to enable effective after-discharge care of patients (Malepe, Havenga & Mabusela 2022: 9).

Nurses may appreciate the family's contribution to quality care (Ngcoboa 2018:17), but they do not always know how to involve the family (Frivold, Dale & Slattebo 2015:239). When guidelines for evidence-based PFCC are implemented successfully, it enables them to deliver quality patient care (Kristensen, Nyman & Konradsen 2016:48). The RNAO developed the guidelines for PFCC after extensive research by a group of nurse experts. The guidelines have the potential to support nurses in delivering care focused on the unique individual as a member of a support system (family) and to involve him or her in the planning, delivering and evaluation of the care (RNAO, 2015:7). A study by Powell & Proctor (2016:26), however, proved that guidelines are not always in line with the context in which they are needed and that there are barriers that may influence its implementation. Systematic approaches are required to identify future factors that may negatively or positively impact the implementation (Baker, Comosso-Stefino, Gillies, Cheater & Flottorp 2015:111).

1.3 PROBLEM STATEMENT

In the designated hospital's emergency department, challenges with communication among patients, their families and the nurses existed. The patients kept coming back with worsening symptoms. They complained that they did not understand how to take the medication and implement the prescribed care, notwithstanding the patient education that they had received. They were dissatisfied with the care that they received and referred to

the department as a threatening environment. At times, they had to wait very long for a consultation and did not understand why the nurses could not always attend to them immediately. They clearly did not understand that the nurses had to attend to seriously injured patients first.

The researcher, a professional nurse in the designated hospital's emergency department, identified poor communication between the patients, their families and the nurses as a priority to be addressed. The PFCC guidelines of the RNAO address communication among nurses, patients and their families, as well as measures to involve patients and family members in the planning, delivering and evaluating of care. The implementation of the guidelines could bring an end to the complaints and ensure that personalised care is delivered. Organisations find it difficult to implement clinical best practice guidelines due to contextual elements that differ between services (David, Wertz, Barrientos & Allison 2018:767). According to Giusti et al. (2022:1), some nurses even require training in order to implement PFCC as they find it challenging to allow patients and their family members to do tasks that they consider to be the responsibility of nurses. It was thus necessary to first explore and describe the contextual and interventional facilitators and barriers prior to the implementation of the guidelines in the designated hospital's emergency department. When the guidelines are being implemented, it must be done in a way that the nurses find user-friendly and beneficial to use in everyday practice (David, et al. 2018:777).

The Consolidated Framework for Implementation Research (CFIR) describes five domains of contextual and interventional factors that may influence the use of evidence-based practice. The contextual domains refer to the inner and outer settings of the organisation as well as the characteristics of the individuals involved. The interventional domains focus on the intervention characteristics and the implementation process (Damschroder, Aron, Keith, Kirsh, Alexander & Lower 2009:50-51).

1.4 RESEARCH QUESTION

The research question was: "What are the contextual and interventional facilitators and barriers, according to the CFIR, that may influence the implementation of the PFCC guidelines of the RNAO in the designated hospital's emergency department?

1.5 AIM AND OBJECTIVES OF THE STUDY

The aim of the study was to explore and describe the contextual and interventional facilitators and barriers according to the CFIR that may influence the implementation of the PFCC guidelines of the RNAO in the designated hospital's emergency department.

The objectives of the study were to:

- Explore and describe the contextual facilitators and barriers that may influence the implementation of the PFCC guidelines of the RNAO in the designated hospital's emergency department.
- Explore and describe the interventional facilitators and barriers that may influence the implementation of the PFCC guidelines of the RNAO in the designated hospital's emergency department.

1.6 DEFINITION OF KEY CONCEPTS USED IN THIS STUDY

Person- and family-centred care: In PFCC, the focus is on the whole person as a unique individual with a life story and unique experiences of health. The person has relationships with family members who play definite roles in his or her life and health. The family members include all persons whom the individual identifies with. It may be nuclear family members, extended family members, friends, parents, and caregivers. It can even be extended to groups of people (RNAO 2015:8). The word person is preferred as the word patient refers to a change in the person's identity to become a passive receiver of care (Naldemirci, et al. 2018:524). In this study, PFCC referred to the involvement of the person and his or her family in the planning, delivering and evaluation of nursing care.

Implementation science refers to the study of strategies to encourage the use of research findings in practice. Implementation science focuses on what works under certain circumstances. Prescribed interventions need to be adjusted to be attainable in practice (Rabin & Brownson 2018:20). One can refer to implementation science as the scientific methods of study to encourage the implementation of findings and other evidence-based practices in everyday patient care (Kirk & Nilsen 2016:560; Olswang & Goldstein 2017:64). In this study, implementation science referred to the research methodology that applied. The researcher used a qualitative study in implementation science to explore and describe the facilitators and barriers according to the CFIR that may influence the implementation of the PFCC guidelines of the RNAO in the designated hospital emergency department.

Consolidated Framework for Implementation Research: The framework was developed from the constructs of 18 implementation theories. The developers used constructs from all the theories to develop one framework that, according to them, will enhance the implementation of research findings in practice (Damschroder, et al. 2009:50-51). The constructs are grouped into five domains namely, intervention characteristics, outer setting, inner setting, characteristics of individuals and implementation process (Keith, Crosson & O`Malley 2017:2). In this study, the domains were grouped in interventional facilitators and barriers (intervention characteristics and implementation process) and contextual facilitators and barriers (inner setting, outer setting and characteristics of individuals).

Best practice guidelines: Guidelines for best practice are systematically developed from research evidence and are aimed at assisting healthcare personnel to improve practice (RNAO 2015:6). In this study, the best practice guidelines refer to the guidelines that the RNAO developed for PFCC.

1.7 CONTEXT / SETTING

This qualitative study in implementation science was conducted in a designated private hospital's emergency department in the Mpumalanga province. The 221-bed multi-disciplinary hospital has an emergency department with three resuscitation, two high care, six consulting and two beds for wound care and suturing. Persons involved in motor vehicle accidents or industrial injuries in commercial and mining plants were treated in the department. As there were many farms in the vicinity, the workers who got injured on the farms were also treated at the department. The healthcare team consisted of two permanent doctors, five sessional doctors and permanent nursing staff (four trauma-qualified registered nurses, four general registered nurses, three enrolled nurses and two nursing assistants). Temporary nurses were employed when necessary. The team worked shifts of 12hrs, from 06h45-19h00 and 18h45-07h00. A shift was usually covered by one doctor, one to two professional nurses, one enrolled nurse and one nursing assistant. During March 2019, 458 adults were treated after trauma; 625 adults with medical/surgical conditions; 293 children with medical conditions; 265 adults after injuries on duty; 186 adults for follow-up assessments after injuries on duty and sixty-eight adults for wound care (Emergency Department Statistics for March 2019).

1.8 PHILOSOPHICAL ASSUMPTIONS

The paradigm of pragmatism was used. Pragmatism is a "matter of fact" perspective that acknowledges diversity in reality (Creamer 2018:49-52). It enables researchers to plan and execute research in a way that works for the study. Knowledge is context-specific (Creamer 2018:49-52), and in the case of this study, the context was the designated hospital emergency department. The researcher does not claim that the findings could be transferred to all emergency departments. The epistemology of pragmatism is supported as the researcher produced useful findings through close interaction with the participants (Creamer 2018:49-52). A hybrid inductive/deductive approach was followed in data collection and analysis. It is in line with the methodological assumptions of pragmatism (Creamer 2018:49-52). Through the study, the researcher endeavoured to contribute to

implementing research findings in practice. The axiological assumption of pragmatism was thus applicable as values play an important facet in the interpretation of results as the researcher gathers both objective and subjective points of view (Creamer 2018:49-52). Open coding was used to do data analysis in the implementation science (inductive analysis) according to a theoretical framework (deductive analysis) (Skillman, Cross-Barnet, Singer, Rotondo & Moiduddin 2019:284). For the researcher to be more flexible in the collection of data and the analysis of the data an ontology of pragmatism was applied. The research question is more important than the methods that were applied (Creamer 2018:49-52). The research question that relates to the contextual and interventional factors that influences the facilitators and barriers in the implementation of person and family-centred care in the emergency department were answered using a theoretical framework.

1.9 THEORETICAL FRAMEWORK

The CFIR was used to explore and describe the facilitators and barriers that may influence the implementation of the PFCC guidelines of the RNAO in the designated hospital emergency department. It consists of five domains (Keith, et al. 2017:2). The first domain relates to the intervention characteristics. It includes constructs that focus on the stakeholder's perceptions of the advantages of implementing the intervention. The second domain addresses the outer setting of the intervention and includes constructs that relate to the organisation. The third domain relates to the inner setting and has constructs that refer to the external context of the organisation. The fourth domain pays attention to the characteristics of the individuals involved with constructs about them, such as their knowledge about the intervention. The fifth domain focuses on the implementation process. Constructs referring to the planning, executing and evaluation of the intervention are addressed (Keith, et al. 2017:2). The theoretical framework was used in the interview guide and during data analysis. A deductive data analysis according to the framework, in addition to a thematic analysis, was done.

1.10 DELINEATION

The focus of the study was to explore and describe the facilitators and barriers according to the CFIR that may influence the implementation of the PFCC guidelines of the RNAO in the designated hospital's emergency department. The study did not include the implementation of the guidelines.

1.11 SUMMARY OF THE CHAPTER

In this chapter, the problem statement, aim, objectives, research paradigm and theoretical framework were described. The problem statement indicates the gap in the knowledge base that urged the researcher to conduct the study. In the next chapter, the knowledge base is described.

CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

In Chapter 1, the introduction to the study was done, and a brief description of the research problem and the aim of the study was provided. In this chapter, a review of the literature on person and family-centred care is described. Applicable previous studies were sourced, appraised, and integrated into the description.

In part one, the outcome of a literature review is described and in part two, the family- and person-centred care guidelines of the RNAO.

2.2 PART 1: LITERATURE REVIEW OF PERSON- AND FAMILY-CENTRED CARE

A literature review was conducted, and a rigorous approach was used to identify the best sources to be used in the review (Robbert 2018:893). To promote a holistic understanding of a research topic in healthcare, integrative reviews are often used. They consist of structured literature searches to ensure the reliability and validity of the findings of the review (Dhollande, Taylor & Scott 2021:427). Literature reviews are an integral part of research as they provide an overview of the research topic's theoretical background. Reviews assist researchers in identifying gaps in the existing knowledge. It can also be used to gain a deep understanding of the topic being researched (Coughlan & Cronin 2021:173).

A compulsory component of the research process is a literature review. It includes the selection of applicable articles on the research topic (Sajeevanie 2021:2713), the appraisal thereof and the description of the outcome of the analysis of the articles (Serenko 2021:1889). The outcome of a literature review is used to justify forthcoming research (Tlili, Altinay, Haung, Altinay & Olivier 2022:8). Literature reviews enable

researchers to describe what research has been done and what research should still be done (Aguilera, Marano & Tashman 2021:1468).

2.2.1 Methodology of the literature search

In this study, the researcher did an advanced search of literature through the use of the electronic databases of PubMed, MEDLINE, Science Direct, EMBASE, Google Scholar, Cochrane Library, CINHAL (Citation Index for Nursing and Allied Health Literature) and OVID. The keyword used for the search evolved as the review progressed, keywords were “patient centred care”; “family centred care”; “centred care in the hospital setting”; ‘person centred care in the emergency department’; “patient and family satisfaction of care in the health setting and or emergency department”; “perception of satisfactory care delivering in the hospital setting including the emergency department”. In the original search, she used the terms patient (person) and family-centred care. The researcher later added terms that related to the foundation, determinants, elements, and philosophy of person and family-centred care (Refer to Table 2.1). Even though the review was focused on person and family-centred care, the review included patient-centred care as researchers often use the term patient-centred instead of person-centred care. While reviewing the studies, the researcher noted that more studies were done on patient-centred care than on person-centred care. Journals and articles to be utilised had to comply with the inclusion criteria which were that it must be a published article with the focus on patient- or person-centred care in the hospital setting of the patient, person, and family, it had to be published between 2015 to 2023 to ensure the latest articles were used, and the research population had to focus on the patient, family, and healthcare providers. Policy reviews were excluded.

With the initial search from the selected databases a total of one thousand eight hundred and seventeen articles were produced. See Figure 2.1, page 23, for an explanation of how the articles were excluded to final 19 that was included for review purposes.

Table 2.1: Core concepts of the literature review contexts and terms

Patient- and family-centeredness	Contexts of Care	Patient and family involvement or participation
Patient-centeredness Family-centeredness Patient care Patient experience Family experience Patient-centred Care Family-centred Care Defined Measures Outcomes Improvements Services	Patient care Model of Health Care Frameworks of Care Person-centeredness Relationship centeredness Caring Dignity Patient care The family Quality improvement and indicators Quality care	Patient-centeredness Patient services Staff engagement Patients' narrative Patient's journey Quality improvement Professional behaviour Service improvement Patient's experience Family involvement

Wide-ranging results were found when the computerised searches were done, especially on patient-centred care. The challenge lay in the method of searching using different combinations of terms and scanning through the relevant titles and abstracts to reduce the outcome to a more manageable amount and still ensure that a comprehensive search was done. The scanning of reference lists and citations in published research reports provided additional information regarding philosophical, conceptual, and theoretical frameworks associated with patient-centred care. Articles were also gathered from the tables of contents of journals. Applicable books and publications of the South African National Department of Health, the Institute of Medicine and Healthcare Improvement were also searched for relevant information.

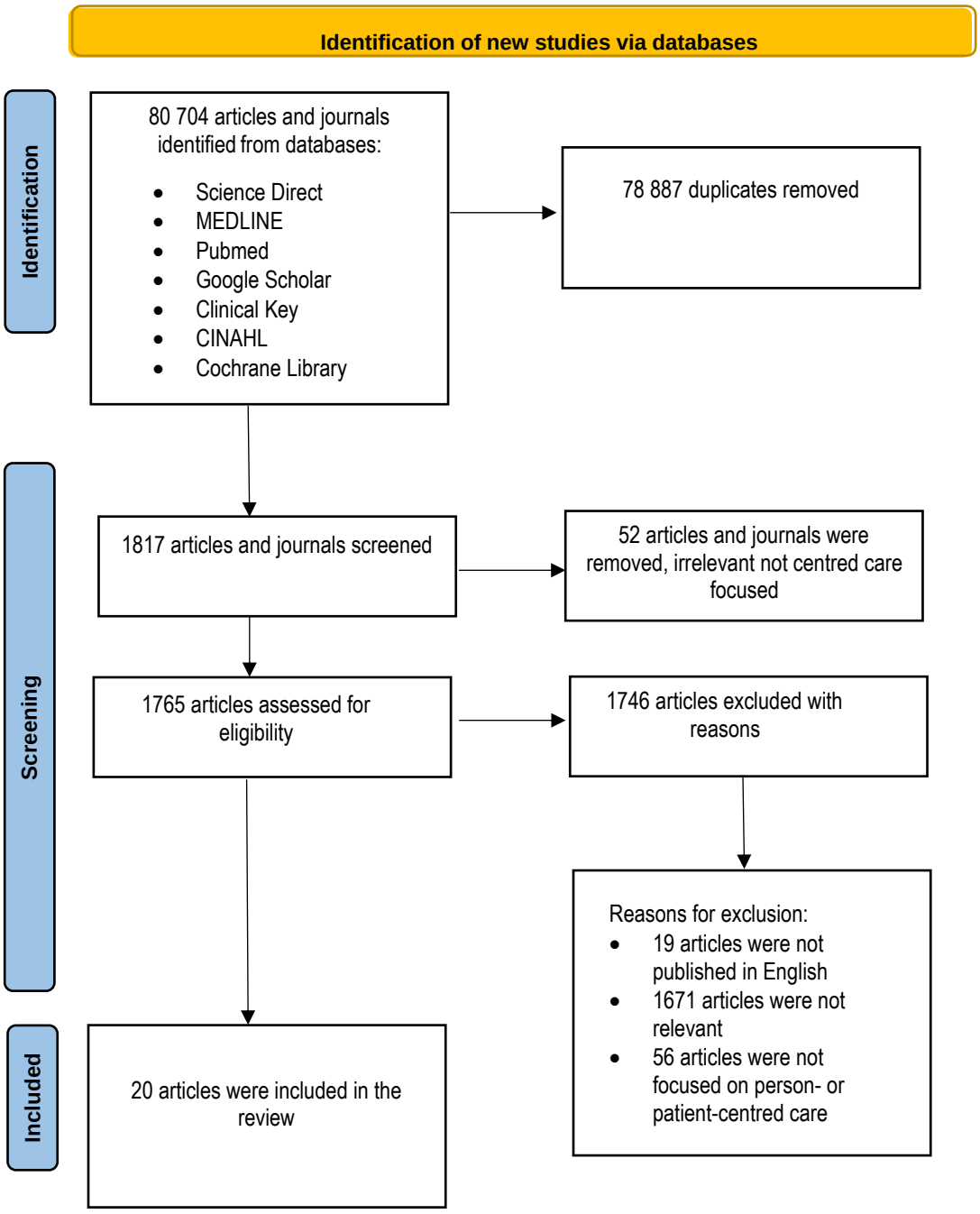

Figure 2.1 PRISMA 2020 flow diagram for updated systematic reviews which included searches of databases

2.2.2 Extraction of the data

Information was not restricted by any discipline, healthcare setting, patient diagnosis, age group or race. The eligible publications were evaluated regarding aims, designs, methods, participants, findings, and limitations (see Table 2.2). Once applicable publications were selected, the key findings were extracted and integrated into emerging themes to allow cross-referencing and analysis. Every effort was used to ensure that the literature review process was executed without bias and conducted with rigour. It was essential to prevent errors and to portray findings to be an accurate reflection of the review process. The selection of each publication was evaluated regarding its contribution towards this study (Aveyard & Bradbury-Jones 2019:5). The Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) 2020 diagram was used for the review to illustrate what the researcher did and what was found. The PRISMA aids to improve the reporting health research and to improve the quality of research applied in decision making in the healthcare setting (Page, Moher, Bosuyt, Boutron, Hoffman & Mulrow 2020:372).

Table 2.2 Eligible publications and findings

Authors and title of the article	Aims of the study	Research Methods	Key findings
Almaze, J., de Beer, J. (2017). Patient and family-centred care practices of emergency nurses in emergency departments in the Durban area, KwaZulu-Natal, South Africa. *Southern African Journal of Critical Care, 33*(2), 59-66.	To describe patient and family-centred care practices of emergency nurses in the emergency departments in the Durban area of the KwaZulu-Natal Province, SA, with the focus on the status of patient and family-centred care in the emergency department and the challenges in providing patient and family-centred care in the emergency department.	A descriptive, quantitative, non-experimental survey was done with forty-four emergency care nurses. A self-assessment inventory tool was used. It was adapted for a resource-constrained setting. Data analysis were done using the Statistical Programme for Social Science (SPSS), version 16 (IBM, USA).	The findings were that although PFCC is a challenge, the nurses acknowledge the importance of this model of care. The majority of emergency nurses (84%) acknowledged the importance of family participation in patient care, and 87% reported that family members were provided with information in a timely manner. The study showed that PFCC is a challenge. As much as the world is advancing in terms of medical technology, nurses should remember the importance of caring and communication. With the patient and their family members, which is essential for the nurse-patient-family therapeutic relationship.
Brickley, B., Williams, L.T., Morgan, M. *et al.* (2021). Putting patients first: Development of a patient advocate and general practitioner-informed model of patient-centred care. *BMC Health Serv Res*, 21(261):1-10.	To evaluate and advance a theoretical model of patient-centred care development in practice.	A qualitative description design was used. Participants were purposively sampled from six primary care organisations. Resulting in 15 patient advocates and three focus groups with 12 General Prattitioners. Focus group discussions were conducted. Data was analysed thematically.	The three main themes that emerged were that the model represents the ideal, the consideration of the system and collaboration in care and the optimising of the general practice environment. The general practitioners supported the credibility of the model and expanded its application beyond doctor-patient encounters.
Byrne, A. L., Baldwin, A., Harvey, C. (2020). Whose centre is it anyway? Defining person-centred care in nursing: An	To understand the current literature about person-centred care and identify a	An integrative literature review	It was found that the concept of PCC is well-known to nurses. The implementation of PCC is potentially hindered in the practice. Further

Authors and title of the article	Aims of the study	Research Methods	Key findings
integrative review. *PloS One*, *15*(3), e0229923.	distinct definition of the term person-centred care.		investigation is needed to determine how PCC is valued and operationalised through the practice and the measurement and reported outcomes that are required.
Cederwall, C. J., Olausson, S., Rose, L., Naredi, S., Ringdal, M. (2018). Person-centred care during prolonged weaning from mechanical ventilation, nurses' views: an interview study. *Intensive & Critical Care Nursing*, *46*, 32–37.	The aim was to determine, describe and discuss the three elements of person-centred that were present and to identify evidence of limitations and barriers of person-centred care during prolonged weaning from mechanical ventilation.	A secondary analysis of semi-structured interviews with nineteen critical care nurses were done using a theoretical thematic analysis.	Three themes were identified related to person-centred care. The three themes were finding a person behind the patient initiating the partnership phase and striving to restore patients' sense of control related to the working partnership phase. An additional theme, barriers to person-centred care, were also identified. Barriers to person-centred care were determined by the comprise of lack of team collaboration and resources. The facilitation of patients to be actively involved in the participation in decision-making during the weaning process may optimise weaning outcomes and require further research.
Curran, J.A., Gallant, A.J., Zemek, R. *et al.* Discharge communication practices in pediatric emergency care: a systematic review and narrative synthesis. *Syst Rev* 8 83 (2019). https://doi.org/10.1186/s13643-019-0995-7	The study aimed to examine how discharge communication works in a paediatric ED context and the development of recommendations for practice, policy, and research.	A systematic review process was done using textual summaries, content analysis, and conceptual mapping that assisted with exploring relationships within and between data.	The existing literature examined discharge communication. A theory-based approach to the intervention design is needed to improve the understanding regarding discharge communication in practice is recommended. Strengthening discharge communication in an ED presents a significant opportunity for improving health outcomes.
Delaney, L. (2018). Patient-centred care as an approach to improving health care.	To determine the effect of the patient-centred care on the evidenced-based approach.	Descriptive qualitative design discussing the concept of PCC and the benefits in all related	To consider the importance of the contribution of nurses to PCC and the enhancement of service delivery. In the

Authors and title of the article	Aims of the study	Research Methods	Key findings
in Australia, *Collegian*, 25(1), 119-123.		parties and the consideration of nurses' contributions towards PCC to enhance service delivery.	physical aspects of health care, the PCC approach acknowledges a patient's beliefs and values towards well-being. The advantage of using the PCC approach is the focus on enhanced patient satisfaction. Concerns were raised related to the effects of the PCC on the evidence-based care approach.
Dudley, N., Ackerman, A., Brown, K. M., Snow, S. K. (2015). Patient- and family-centred care of children in the emergency department. *Paediatric s*, *135*(1), e255–e272.	Patient- and family-centred care is about the approach to the planning, delivery, and evaluation of health care that is mutually beneficial in the partnership among patients, families, and health care professionals. Providing patient- and family-centred care to children in the emergency department setting presents opportunities and challenges.	A revised technical report was done, using previously published policy statements and reports, reviewing current literature, and describing the present state of practice and research regarding patient- and family-centred care for children in the ED.	It was determined that PFCCF should be considered in all phases of ED care. The health care team is responsible for patient and family needs and supporting the family and patient. Collaboration with the patient and family can lead to a more comprehensive medical record, a better sense of the patient as a person, and a better understanding of how the patient will function at home. Implementing a PFCC approach in adult patient care settings has led to improvements in patient safety, fewer medical errors, and lower cost of care.
Edgman-Levitan, S., Schoenbaum, S.C. (2021). Patient-centred care: achieving higher quality by designing care through the patient's eyes. *Isr J Health Policy Res* 10**,** 21.	The aim was to determine the solutions for familiar challenges to providing PFCC in the ED, an outline for a protocol for family member presence during invasive procedures, and resources for promoting institutional change.	A systematic scoping literature review were done of previous studies conducted.	It was discovered that a partnership with patients and their families in patient-centred care that matters will ensure that we deliver the care we all want and deserve.

Authors and title of the article	Aims of the study	Research Methods	Key findings
Edvardsson, D., Watt, E., Pearce, F. (2016). Patient experiences of caring and person-centeredness are associated with perceived nursing care quality. *Journal of Advanced Nursing*, *73*(1), 217–227.	The aim was to explore and determine the patient ratings of perceived caring and person-centeredness associated with perceived nursing care quality in a hospital sample of admitted patients.	A descriptive, non-experimental, and correlational design was used to do data collection and analysis of data from a sample of acute hospital inpatients.	It was found that patients experiencing caring and person-centeredness have an influential role in the extent to which patients experience the quality of nursing care. It also showed that knowledgeable and communicable staff timeliness of assistance and environmental support are the most significantly related to patient-perceived nursing care quality. Staff that showed knowledge and assisted by providing environmental support stood out as most related to patient-perceived nursing care quality.
Frivold, G., Dale, B., & Slattebø, Å. (2015). Family members' experiences of being cared for by nurses and physicians in Norwegian intensive care units: a phenomenological hermeneutical study. *Intensive & Critical Care Nursing*, *31*(4), 232– 240.	To illuminate the meaning of being taken care of by nurses and physicians for relatives in Norwegian intensive care units.	Thirteen relatives of critical ill patients admitted and treated in the intensive care unit were interviewed and data were analysed using a phenomenological hermeneutical method inspired by the philosopher Paul Ricoeur.	Quality in relations is described as crucial when relatives share their experiences of care by nurses and physicians in the ICU. Those who experienced informational and supportive care and who had the ability to participate expressed feelings of gratitude and confidence in the healthcare system. It was determined that those who did not experience the above-mentioned care, especially in terms of informational care, expressed feelings of frustration, confusion, and loss of confidence. However, patient treatment and care outweighed relatives' own feelings.
Hower, K. I., Vennedey, V., Hillen, H. A., Kuntz, L., Stock, S., Pfaff, H., et al. (2019). Implementation of patient-centred care: which organisational determinants	To determine the barriers and lack of comprehensive investigations on determinants of PCC across various health and social care organisations related to	A qualitative study of twenty-four participants in twenty semi-structured face-to-face interviews.	Similarities were identified by facilitating or obstructing the implementation of PCC in their organisational contexts. The results can help the implementation of PCC. They identified possible starting points for initiating the interventions and

Authors and title of the article	Aims of the study	Research Methods	Key findings
matter from the decision maker's perspective? Results from a qualitative interview study across various health and social care organisations. *BMJ Open*, *9*(4), e027591	constrained resources and to determine the barriers to the implementation of PCC.		implementation strategies and the redesign of policies to be more patient-centred.
Kirkpatrick, A.J., Cantrell, M.A. and Smeltzer, S.C. (2017). Palliative care simulations in undergraduate nursing education: An integrative review. *Clinical Simulation in Nursing*, *13*(9), 414-431.	The aim was to research the gaps and limitations indicated in the need for future PC simulation studies in relation to the effect of centred care.	An integrative review was used, summarised by the findings from nineteen studies focussing on the effects of simulation and the preparation of centred care from student involvement, identifying the gaps in the literature. Articles that were reviewed included three mixed method studies, ten quantitative studies, and six qualitative studies.	The outcomes supported the development of nursing student competence by providing meaning and context to the care they deliver. A recommended future investigation would be examining the relationships between PCC simulation, the student's role in simulation, and the effects on student knowledge, self-awareness, and clinical performance in providing PCC.
Ngcobo, A. (2018). *Knowledge, perceptions, and experiences of nurses towards family-centred care in adult intensive care units*. (Degree in Masters of Technology in Nursing in the Faculty of Health Sciences at the Durban University of Technology)	To explore and describe the perceptions of nurses towards family-centred care of adults in intensive care units.	Explorative, descriptive qualitative design at two public hospitals' intensive care units involving nine nurses in in-depth data analysis.	The findings of this study indicated that nurses have an accurate and correct knowledge of the concept of FCC, thus identifying and recognising their roles and responsibilities with respect to the components that enhance FCC. The perception founded towards facilitating family involvement in nursing care activities as part of FCC has revealed discrepancies due to the mentioned factors that cause a hindrance in family involvement. It showed that participants' experiences were as positive in relation to the family presence in ICUs. The relevance to clinical practice is that training and further research for nurses has been

Authors and title of the article	Aims of the study	Research Methods	Key findings
			proposed so as to better equip and encourage nurses with the necessary knowledge and skills required to improve family nursing in adult ICUs.
Olding, M., McMillan, S.E., Reeves, S., Schmitt, M.H., Puntillo, K., Kitto, S. (2016). Patient and family involvement in adult critical and intensive care settings: a scoping review. *Health Expectations*, *19* (6), 1183-1202.	To investigate the extent and range of literature on patient and family involvement in the critical setting.	Scoping review	Significant gaps in research on patient involvement in the critical setting emerged. Problems were identified that directly related to the scope, extent, and nature of patient involvement in intensive care settings, the broader socio-cultural processes that shape patient and family involvement, and the implications between patient/family involvement and interprofessional teamwork.
Santana, M.J., Ahmed, S., Lorenzetti, D., Jolley, R.J., Manalili, K., Zelinsky, S., Quan, H., Lu, M. (2019). Measuring patient-centred system performance: a scoping review of patient-centred care quality indicators. *BMJ Open*, *9*(1), p. e023596.	The aim was to identify quality indicators that can be used to measure patient-centred care.	Scoping review	It was determined that the identification of PCC quality indicators is a key first step in the groundwork to develop evidence-based PCC quality indicators. Research is needed to continue the development and implementation of patient-centred quality indicators for healthcare quality improvement.

Authors and title of the article	Aims of the study	Research Methods	Key findings
Senabye, J.S., (2018). *Family-centred care in an intensive care unit in Botswana: the views of families* (Doctoral Dissertation, University of Pretoria).	To describe the view of families regarding family-centred care and collaboratively develop strategies to enhance family-centred care.	A qualitative, contextual, and explorative descriptive research design was used. Ten family members of admitted patients in the ICU were selected and one on one interviews were done for data collection using an appreciative inquiry semi-structured and open-ended interview guide. Data analysis were using Tech`s eight-step method of data analysis.	Improvement in FCC in certain areas was identified, the workplace culture and the HCWs compassion. The support and family involvement in the care of the critically ill family member may improve family satisfaction, reduce complaints, and lead to positive health outcomes for the patient.
Sharma, T., Bamford, M. and Dodman, D. (2015). Person-centred care: an overview of reviews. *Contemporary Nurse*, *51*(2-3), 107-120.	To identify the components of person-centred care.	Literature review	Promotion of PCC is recommended by engaging in partnerships shared by decision-making. It was determined that the components associated with healthcare provider PCC behaviours and the organisational supports required for PCC are discussed. Findings stated that the HCP and organisations need to promote PCC care by engaging persons in partnerships and shared decision-making.
Shields, L. (2015). What is "family-centred care"? *European Journal for Person-Centred Healthcare*, *3*(2), 139144.	To identify evidence if family-centred care works and how it was implemented.	Scoping review	FCC needs commitment from leaders in HC. Educational training and policies need to be executed. Commitment from leaders of all health professions and managers of health services is needed. It will require education and the promotion of a policy. However, it needs the commitment of those who will use it - the health professionals, health service staff and children, young people, and parents for whom it is designed.

Authors and title of the article	Aims of the study	Research Methods	Key findings
Wong, E., Mavondo, F. and Fisher, J. (2020). Patient feedback to improve quality of patient centred care in public hospitals: a systematic review of the evidence. *BMC Health Services Research*, 20(1), 1-17.	The aim was to systematically review the literature relating to the interventions by patient feedback for improvement to the quality of care in hospital settings.	A systematic review	The outcomes of the study stated that patient experiences across various diverse dimensions, including communication, responsiveness, coordination of and access to care, or patient satisfaction with waiting times, physical environment, and staff courtesy. A recommendation was that the interventions to improve communication with patients, professional practices in the continuity of care and care transitions, responsiveness to patients, patient education, the physical hospital environment, use of patient feedback by staff and quality improvement projects were reported.
Zeh, S., Christalle, E., Zill, J.M., Härter, M., Block, A., Scholl, I. (2021). What do patients expect? Assessing patient-centeredness from the patient's perspective: An interview study. *BMJ Open*, *11*(7), e047810	The aim was to determine and explore the specific behaviours described in the model that are especially relevant for the high ratings in the previous studies,	Semi-structured interviews were conducted with twenty patients with chronic diseases. Data were analysed through content analysis.	The findings enriched the construct of PC by depicting essential aspects of PC from the patients' perspective. The results allow prioritising strategies to implement patient-centred care. Thus, this study helps to pursue the ultimate goal of fostering patient-centred healthcare delivery. Different aspects of PC emerged: the time-appropriate access to care, competence, empathy being taken seriously by healthcare providers, and their individual consideration of each patient's situation. Focus was reflected on taking a holistic perspective of the patient, patient-centred communication, the integration of multi-disciplinary treatment elements,

Authors and title of the article	Aims of the study	Research Methods	Key findings
			transparency regarding waiting time and the reduction of unequal access to care.

2.2.3 Outcome of the literature review

By analysing the data, content analysis was used to establish the prevalence of certain word, concepts, and themes in the qualitative data. The researcher applied content analysis to quantify and analyse the presence, meaning and hoe they relate to certain words, themes, and concepts. The source of data was from interviews. The researcher then analysed the text using content analysis by coding the text and breaking it down into manageable code categories for analysis to be used in code categories to summarize data even further for use (Serafini & Reid 2023:633).

The following themes emerged from the review:

Theme 1: Description of patient/person- and family-centred care

Patient/person-centred care is often not well defined; the way it should be implemented in practice is therefore not clear (Byrne, et al. 2020:2). Although much research has been done about patient/person-centred care and many conceptual frameworks have been developed, practical guidance on the implementation thereof is lacking (Delaney 2018:119). In patient/person-centred care, healthcare professionals prioritise what patients need and value when they plan and deliver care (Edgemar-Levitan & Scoenbaum 2021:1).

Communication with patients should be person-centred, and it requires that healthcare professionals be attentive to what patients say and that they should try to understand the meaning of what is said. In person-centred communication, the patient and his/her family are involve in enhancing his/her health and well-being (Kirkpatrick, Cantrell & Smelter 2017:425). Patients' families often appreciate opportunities to be involved in communication about the planning and delivery of care (Frivold, Dale & Slettebø 2015:232).

Although healthcare professionals may know about the advantages of family-centred care, it is not often applied in practice (Ngcobo 2018:57). When patient and family

perspectives are accommodated in the planning and delivery of care, they perceive the quality of care to be enhanced (Santana, et al. 2019:2). Patients and their families want to believe that their involvement may lead to an improvement of the quality of Care (Sharma, et al. 2015:115). Their involvement should not be limited to the planning and implementation of care. They should also be involved in the evaluation of the outcome of the care (Almaze, et al. 2017:59). The involvement of patients and their families in the planning, delivery and evaluation of care should happen in a mutually beneficial partnership with the healthcare professionals (Dudley, et al. 2015:255; Brickley, et al. 2021:1).

Theme 2: Challenges with the implementation of patient/person- and family-centred care

Challenges are experienced with the implementation of patient/person-centred care (Byrne, et al. 2020:15). It often relates to shortages in the number of healthcare professionals, deficiencies in their training and poor communication with patients and family members (Almaze & De Beer 2017:59). In emergency departments, the high number of patients and the urgency of treatment may contribute to the challenges experienced to render person- and family-centred care. Limited time is available to develop meaningful partnerships with patients and their family members (Dudley, et al. 2015:247). When too few healthcare professionals are available to render patient care, person and family-centred care is neglected (Hower, et al. 2019:111).

Involving patients and their family members in the planning and implementation of care takes time. When too few healthcare professionals are on duty, they may choose not to do it (Ngcbobo 2018:58). The same happens when the workplace culture does not support it (Senabye 2018:74). When healthcare managers view it as too time-consuming, they may not encourage the implementation of patient/person- and family-centred care (Edgman-Levitan & Schoenbaum 2021:2). The implementation of it should be the responsibility of the whole healthcare team (Cederwall, et al. 2018:35). All people involved in the care of patients should play their part to create and maintain an environment conducive to patient/person- and family-centred Care (Brickley, et al. 2021:161).

Nurses have the knowledge and skills to implement and practice patient/person and family-centred care but often lack the confidence to implement it (Ngcobo 2018:68). Once the structure for the implementation of patient/person and family-centred care is in place, additional training to empower the healthcare professionals may ensure that it is implemented (Shields 2015:134).

Theme 3: Benefits of the use of patient/person- and family-centred care

The unique healthcare needs of patients and their families are addressed when patient/person- and family-centred care is used. (Byrne, et al. 2020:5; Almaze & De Beer 2017:59). Family members are an important source of information that healthcare professionals require to plan and implement individualised patient care (Almaze & De Beer 2017:61). Patients' satisfaction with healthcare often increases when they receive care that addresses their unique needs (Wong, et al. 2020:530).

Efficient interpersonal communication between healthcare professionals, patients and their family members is, according to Wong, et al. (2020:530), important to improve patients' and family members' experiences of healthcare. Their sense of self-efficacy is improved (Byrne, et al 2020:12), and in general, the quality of healthcare is improved (Wong, et al., 2020:531; Edvardsson, Watt & Pearce 2016:6). Efficient interpersonal communication happens to the benefit of patients and their families' understanding of the prescribed treatment (Senabye 2018:53). A holistic approach to care is possible when all parties are involved in the planning, implementation and evaluation of care (Senabye 2018:53). It enhances accurate information sharing and supports the involvement of all parties (Almaze & De Beer 2017:61). Patients and family members do not only expect healthcare professionals to be skilful and knowledgeable (Zeh, et al. 2021:3), they should also be able to communicate effectively with others (Zeh, et al 2021:4).

Theme 4: Patient/person- and family-centred care in the emergency department

When healthcare professionals manage to develop optimal relationships with patients and their family members in emergency departments, fewer readmissions are often noted (Dudley, et al. 2015:257). Patients and family members experience the healthcare professionals as supportive when they are encouraged by them to participate in care planning and implementation (Frivold, et al. 2015:237).

According to Almaze & De Beer (2017:61), patients and family members want to be involved in the care that they receive in emergency departments. They prefer that the healthcare professionals should include them in caregiving partnerships (Shields 2015:141). It is, according to Dudley, et al. (2015:257), important to allow family members to support their loved ones during emergency care procedures as it usually eases their anxiety. Families require sufficient information about the sudden critical illness of their loved ones. They also need to know what treatment is prescribed and what complications may occur in future (Almaze & De Beer 2017:62).

The majority of patients requiring emergency care are discharged once the injury is treated. Empowering health education is, therefore, a key component of quality care. Healthcare professionals should equip patients and their families with the knowledge to manage the illness or injury after discharge effectively. Poor communication between the healthcare professionals and the patients and family members may contribute to a lack of comprehension of discharge information, which can result in recurrent visits to the emergency department and, in worst cases, the death of patients. A common intervention in emergency departments is health education, addressing a lack of information, and/or correcting wrong perspectives about the cause of injury and illness and the improvement of health and well-being (Curran, Gallant & Zemek 2019:83). Through patient/person-centred care, information is discussed that enable patients to be involved in their own healthcare (Edgman-Levitan & Schoenbaum 2021:1). It enables them to take control over their own well-being (Cederwall, et al. 2018:36).

Nurses play a liaison role between other healthcare professionals and patients regarding the sharing of information in emergency departments (Ngcobo 2018:69). When patients and their family members feel vulnerable, they need to be treated with respect, and their unique circumstances should be appreciated (Zeh, et al. 2021:3). Time is a limited resource in emergency departments. Unfortunately, healthcare professionals often view patient/person- and family-centred care as time-consuming (Zeh, et al. 2021:4). They, therefore, tend to focus on emergency procedures and forget to involve their patients and their patient's family members.

2.3 PART 2: DESCRIPTION OF THE PERSON- AND FAMILY-CENTRED CARE GUIDELINES OF THE RNAO

The guideline used in this study was developed by a systematic review of the original guideline, Client Centred Care (RNAO 2002), and a revision supplement guideline (RNAO 2006), guided by five clinical questions. The systematic review for the current guideline used relevant literature published between June 2005 and April 2014.

The Registered Nurses Association of Ontario (RNAO) are dedicated to ensuring that the best practice guidelines are based on recently available and related research. To fulfil the commitment, the guidelines that they develop are revised regularly by a panel of experts consisting of nurse specialists from a wide range of health sectors and healthcare practice areas.

The questions guiding the systematic review were:

1. What is person-centred care?

a. How can it be defined?

b. Components of person-centred care.

2. Healthcare provider behaviours towards person-centred care in service delivery (in the implementation process thereof).

3. They related evidence-based models demonstrating effective outcomes and support of person-centred care.

a. Person-centred care model components.
b. Enablers in implementing person-centred care models.
c. Barriers to implementing person-centred care models.
d. Satisfaction in care delivery and impact related.

4. Components to be included in the basic professional education programs.

5. Support from organisational or system structures for the implementation of person-centred care.

After the systematic review of the research reports (including articles) and the previous set of guidelines, the RNAO guideline development team's coordinators also asked a panel of experts to provide applicable guidelines. By utilising this search method and the appraisal of guidelines for research and evaluation instrument II (Brouwers, Rassenberg, van Weel, Laan & van Weel-Boumgarten 2017:1105), four critically appraised guidelines were selected to structure the process of developing PFCC guidelines:

- Alzheimer Society (2011). Guidelines for Care: Person-centred Care of people with dementia living in care homes. Retrieved from Health Education and Training Institute. (2012). Best practice governance framework for allied health education and training: Guidelines to support the development of allied health capabilities in the delivery of person-centred care. Retrieved from: http://www.heti.nsw.gov.au/resources-library/allied-health-best-practice-governance-framework/

- National Institute for Health and Clinical Excellence (2012). Patient experience in adult NHS services: Improving the experience of care for people using adult NHS services. Retrieved from: http://www.nice.org.uk/guidance/CG138

- National Institute for Health and Clinical Excellence (2014). Patient experience in adult NHS services: Evidence update 52. Retrieved from: https://www.evidence.nhs.uk/

- Richmond P.R.A. (2013). Good practice guidelines for person-centred planning and goal setting for people with psychosocial disability. A project report for Disability Care Australia. Retrieved from: http://www.ndis.gov.au/sites/ default/files/documents/ Project_Report_Final.pdf

Further website searches were conducted by members of the RNAO guideline development team for guidelines that were based on specific criteria related and focused on the topic of person-centred or focused-directed care, practices or different implementations, which included the defining of concepts, dimensions, facilitators, and barriers. It also had to refer to healthcare practices and/or behaviours and be published in English.

The team developed the following practice guidelines:

Assessment:

- Establishing a therapeutic relationship with the person using verbal and non-verbal communication strategies to build a genuine, trusting and respectful partnership.
- Build empowering relationships with the person to promote the person's proactive and meaningful engagement as an active partner in their healthcare.
- Listen and seek insight into the whole person to gain an understanding of the meaning of health to the person and to learn their preferences for care.
- Document information obtained on the meaning and experience of health to the person using the person's own words.

Planning:

- Develop a plan of care in partnership with the person that is meaningful to the person within the context of their life.

- Engage with the person in a participatory model of decision making, respecting the person's right to choose the preferred interventions for their health, by: 1) collaborating with the person to identify their priorities and goals for healthcare; 2) sharing information to promote an understanding of available options for healthcare so the person can make an informed decision; and 3) respecting the person as an expert on themselves and their life.

Implementation:

- Personalise the delivery of care and services to ensure care is not driven from the perspective of the healthcare provider and organisation by collaborating with the person on: 1) elements of care; 2) roles and responsibilities in the delivery of care; and 3) communication strategies.
- Partner with the person to tailor strategies for self-management of care that are based on the person's characteristics and preferences for learning.

Evaluation:

- Obtain feedback from the person to determine the person's satisfaction with care and whether the care delivered was person- and family-centred.

2.4 SUMMARY OF THE CHAPTER

In this chapter, the researcher described the outcome of a literature review and the RNAO guidelines for PFCC. In the next chapter, she describes the methodology of the research.

CHAPTER 3
METHODOLOGY OF THE RESEARCH

3.1 INTRODUCTION

Research methodology refers to the steps that researchers take to collect and analyse data in order to contribute to the knowledge base of the academic discipline, in this case, nursing science (Keith, et al. 2017:3). In this study, the researcher used a qualitative research methodology to obtain rich data about the studied phenomenon. She utilized the implementation science to explore and describe the facilitators and barriers according to the CFIR that might influence the implementation of the PFCC guidelines of the RNAO in a designated hospital's emergency department. Qualitative research can be done to explore and describe the factors that may have an impact on the implementation of evidence-based practices (Palinkas, Horwitz, Green, Wisdom, Duan & Hoagwood 2015:542). The researcher in this chapter described the methodology used in this study, consisting of the description of the study population, the sample, the sampling method, data collection and analysis processes and the interpretation of the findings (Polit & Beck 2017:557).

The researcher explored the facilitators and barriers in the implementation of person and family-centred care in a private hospital's emergency department guided by the contextual and interventional facilitators and barriers as discussed in the CFIR.

3.2 RESEARCH DESIGN

The researcher adopted a qualitative research design in implementation science and used the domains of the CFIR in semi-structured focus group interviews with nurse participants to explore and describe the facilitators and barriers that might influence the implementation of the PFCC guidelines of the RNAO. Qualitative research involves the engagement of researchers in a naturalistic setting with participants who can provide them with the relevant data (Bradshaw 2021:171). The researcher involved the nurses of

the designated emergency department as they are familiar with the context of the department and was also able to describe the possible facilitators and barriers that might impact on the future implementation of the guidelines. As the PFCC guidelines will be new to the nurses, the researcher presented lectures about the principles and practice recommendations of the guidelines prior to the interviews (RNAO 2015:84 and 23-40)

3.2.1 Population

Polit and Beck (2017:249) refer to study populations as the group of potential participants that meet the criteria to take part in the research. The study population consisted of all the participants who met the inclusion criteria (Polit & Beck 2017:249). The inclusion criteria referred to nurses from various categories with years' experience in the emergency department in the Mpumalanga province. An invitation to participate was sent out to twenty nurses in different nursing categories, as the implementation of person and family-centred care involves all nurse categories. They were identified as the study population due to their involvement in the emergency department and vast clinical experience.

3.2.2 Sampling method and sample size

A sample is the subset of a study population consisting of selected individuals (Polit & Beck 2021:275). The researcher used qualitative research, and these types of studies are generally focused on purposive sampling. She invited nurses from all categories who have had experience working in the emergency department to take part in the study. She assumed that they had sufficient knowledge about the working environment in the emergency department and would, therefore, be able to identify facilitators and barriers that might impact the implementation of the guidelines in the department. The research topic and relevant literature were given to the potential participants when they were invited to take part in the study (Palinkas, et al. 2015:522-525). Out of the twenty invited participants who formed the study population, only eight accepted the invitation to partake in the research, (N=20); (n=8) resulting in a 40% response rate.

Only after the Faculty of Health Sciences Research Ethics Committee of the University of Pretoria gave their approval for the proposed research 110/2020 see Appendix B, the management of the hospital group to which the designated hospital belongs, and the designated hospital general manager's written consent had been obtained did the researcher start collecting the data. The researcher invited the study population to be part of the research by explaining what the research entails and their role in the data collection. Two rounds of semi-structured focus group interviews were done. In the first round, six of the eight participants were present, and in the second round, all of the eight participants took part in the focus group interviews as the interview sessions were carried out as a whole continuing where the first session stopped Refer to Table 3.1 for information about the participants.

Table 3.1: Participant demographic information

Participants	Professional Qualification	Academic Qualification	Years in Nursing
NP1	Registered Nurse	Diploma in Nursing with a Degree in Emergency Nursing Science with Nursing Education	25
NP2	Registered Nurse	General Nurse with a Degree in Critical Care Nursing with Nursing Education	20
NP3	Enrolled Nursing Assistant	Certificate in Nursing	10
NP4	Enrolled Nursing Assistant	Certificate in Nursing	8
NP5	Registered Nurse	Diploma in Nursing with a Degree in Emergency Nursing Science with Nursing Education	25
NP6	Registered Nurse	Diploma in Nursing with a Degree in Neonatology	20
NP7	Registered Nurse	Diploma in Nursing with a Degree in Critical Care Nursing with Nursing Education	15

NP8	Registered Nurse	Diploma in Nursing with a Degree in Nursing Education	25

3.2.3 Data collection and organisation

The researcher discussed the participant information and consent leaflet (Referring to Annexure C: Participation information) with each of the participants to ensure that they gave voluntary informed consent to participate. The researcher is a professional nurse in the emergency department and, therefore, made sure that all the participants voluntarily took part in the study. She assured them that they could withdraw at any time without negative consequences. The participants were asked to keep all information that was shared during the interviews confidential.

The researcher compiled the interview guide in a table format and included the PFCC practice guidelines and the five (5) CFIR domains (intervention characteristics, outer setting, inner setting, characteristics of individuals that may be involved in the implementation and the steps of the process of implementation). Semi-structured interview guides can be used to help the researcher gather essential information (WASP 2019:53). The interview guide consisted of constructs of the domains of the CFIR (Refer to Appendix B for the interview guide). The interview guides were given to all participants one week prior to the focus group interviews to enable them to prepare themselves for the discussions. They were asked to make notes to be discussed and also to make notes throughout the sessions on their interview guides and to please make them available to the researcher if more information is required. The researcher received the notes from the participants and used them in the data analysis process.

The semi-structured interviews were done in a venue where the participants could feel free to take part in the interviews. The venue was comfortable, and no interruptions were experienced. The researcher aimed to create a therapeutic environment focussed on the needs of the participants in order to ensure their participation (Bana, Ribi, Kropf-Staub, Näf, Schramm & Zürcher-Florin 2020:3).

By using semi-structured interviews, the discussion of the participants was guided and not controlled to ensure optimal interaction between the participants (Barret & Twycross 2018:63). All participants were encouraged to take part. Open discussions enabled them to share their perceptions and to react to other participants' comments (Barret & Twycross 2018:63-64; Ruslin, Mashuri, Rasak & Syam 2022:24-25). The greatest advantage of group interaction is the rich, detailed accounts of the focal topics (Howard, et al. 2017:32). The interviews lasted up to an hour each session, and both sessions were audio recorded with the participants' consent.

Two sessions were held where a few participants were attending in the meeting room at the designated hospital and a few participants through Microsoft TEAMS to ensure all participants could attend. By using the Microsoft TEAMS application, it sent out an invitation for the day of the interviews, and participants could attend online. The application also recorded the sessions and automatically transcribed the recordings by using the Microsoft TEAMS application it created as a virtual meeting room. The sessions were scheduled at times the participants could attend and were convenient for the participants. The participants attending in person were in a meeting room away from disruptive nursing routines to limit interruptions. With session one, only six of the eight participants attended, and with session two, which was about three weeks after the first session, again, six participants of the eight attended, but the participants that weren't present in the first session were present in the second session.

Sufficient and rich data was gathered with the two focus group interviews. The researcher and one of her research supervisors (who listened online to the interviews) were aware of much repeating of participants' opinions in the second half of the last interview. No new data was presented that indicated the sufficiency of data (Tomaszewski, Zarestky & Gonzales 2020:3).

3.2.4 Data analysis and interpretation

Data analysis is the transformational process where raw data is transformed into something substantial and meaningful to provide a rich, logical, and insightful description of the studied phenomenon (Bingham & Witkowsky 2022:135). The researcher used inductive and deductive data analysis methods. The different domains of the CFIR were used in the deductive data analysis process. Framework analysis can be described as a systematic approach used in qualitative data analysis in implementation science that allows concepts of the CFIR to structure the analysis (Goldsmith 2021:2061; Breimaier, Heckermann, Halfrens & Lohrman 2015:4).

Data that could not fit the framework was inductively analysed. By using inductive data analysis, the researcher identified themes that emerged from the data not clearly guided by the domains of the CFIR. The researcher familiarised herself with the data collected by re-reading the transcripts and field notes and notes that the participants made on their copies of the interview guide and identified recurring themes (Azungah 2018:385). The themes were grouped to form the forming of codes, then sub-categories and categories. In the final phase of the data analysis, the outcome of the deductive and inductive data analysis was integrated. It concluded the stages of data analysis as described by Colon-Emeric, et al. 2016:3.

The researcher described the categories and sub-categories and thereafter discussed them with reference to applicable literature.

3.3 RIGOUR IN THE STUDY

The researcher applied the '8 big-tent' criteria as set out by Tracy (2010:830) throughout the study to ensure the rigour of the findings. The first criterion refers to the need to focus research on a **worthy topic.** The researcher focused the study on the exploration and description of the contextual and interventional facilitators and barriers that may influence the implementation of PFCC guidelines in the emergency department of the designated

hospital. The research topic is therefore relevant, and significant findings were delivered that may lead to the implementation of person- and family-centred care and thereby ensure an improvement of patient care.

The second criterion refers to the delivery of **rich data.** Data was collected until repetitions were observed. The researcher used an interview guide that was structured by the theoretical constructs of the CFIR to ensure that all possible facilitators and barriers associated with the future implementation of the PFCC guidelines were addressed.

The third criterion refers to the **credibility of the findings.** Through a detailed description of the data collection and analysis processes, the researcher strived to prevent biases. The reader of the report will get a good picture of how the data has been collected and analysed. The use of a guide for the data collection and a framework for the data analysis based on the constructs of the CFIR enhanced the credibility of the findings. The researcher provided a rich description of the data collection and analysis processes to enable readers to understand precisely how the research was done.

The fourth criterion refers to the **resonance of the findings.** The character of the study must influence the reader not only to relay the findings but also to move the reader to action (Tracy, 2010:840). The researcher strived to give the reader a comprehensive description of the methodology of the study to encourage similar research and the use of the findings of the study.

The sixth criterion refers to whether a **significant contribution** to the knowledge base and practice of the discipline was made. The researcher showed how she used the constructs of the CFIR to explore and describe possible contextual and interventional facilitators and barriers that may influence the implementation of evidence-based practice, which can lead to person- and patient-centred care that may result in improved patient care.

The seventh criterion refers to **research ethics.** The researcher, prior to gathering the data, obtained approval of the proposal from the relevant ethics committee and permission from the relevant hospital group manager to conduct the study in the designated hospital. All participants gave informed consent prior to the data collection. The researcher respected the participants and protected them from any harm that might be related to the research.

The seventh criterion refers to the **meaningful coherence of the study.** The researcher followed processes that researchers in implementation science recommended to fit the aim of the study and addressed the research question throughout the study, resulting in significant connections that are relevant to the study. The researcher described the methodology thoroughly to enable the readers to feel as if they had been present during the research.

3.4 ETHICAL CONSIDERATIONS

As described by Polit and Beck (2017:140), the rights of all participants must be protected. A full explanation of the study was given to the voluntary participants, verbally and through a written information leaflet. Written confirmed consent was gained from them. It was also stated clearly that the participants were free to withdraw at any time without any consequences. The research did not commence before the approval of the proposal by the Faculty of Health Sciences Research Ethics Committee of the University of Pretoria 110/2020 Appendix B, and the management of the applicable hospital group had given permission for the study to be done in the designated hospital. The participant information leaflet was discussed with the potential participants, and their informed consent was obtained.

The principles of the **Belmont Report** were adhered to throughout the research, and the researcher followed the principles by ensuring that ethical research was conducted.
There are three main principles in the Belmont report:

a. **Respect for human dignity:** The participants were given the chance to voluntarily decide to take part in the study, to withdraw at any time, and to refuse to give information. All the participants were treated with dignity and respect, and their diverse contributions towards the research were respected (Polit & Beck 2017:140).
b. **Beneficence:** The participants' right to freedom from harm and discomfort was protected. The researcher made sure that no exploitation of the participant happened (Polit & Beck 2017:139). The researcher ensured that all participants felt free to give their input during the focus group interviews. The input from all participants was appreciated.
c. **Justice:** The principle refers to the right to fair treatment and respect for privacy. Fairness involves treating all participants with equal respect. The participants were asked not to share personal information of the participants with others. The researcher did not include any information that may lead to the identification of a participant in the dissertation (Polit & Beck 2017:141).

Ethical approval was obtained from the University of Pretoria, Faculty of Health Sciences Research Ethics Committee (Ethics application approval number 110/2020, see Appendix B. Consent was also obtained from the designated hospitals' ethics committee (reference number 02122020/1 see Appendix A.

3.5 SUMMARY OF THE CHAPTER

In this chapter, the researcher described the research methodology and how the study was conducted, and in the next chapter, the findings and analysis will be described and discussed.

CHAPTER 4
RESEARCH FINDINGS AND DISCUSSIONS

4.1 INTRODUCTION

In chapter three of this dissertation, the focus was on the description of the research methodology. In this chapter, the findings and a discussion of the findings with literature are presented. With this study, the researcher sought to explore and describe the facilitators and barriers according to the CFIR that may influence the implementation of the PFCC guidelines of the RNAO in the designated hospital's emergency department.

The semi-structured interview guide was discussed over two focus group interview sessions; six participants each but a total of eight participants took part. In the second session, 2 participants could not attend the sessions. They were present either in person or via Microsoft Teams. Each interview lasted between sixty to ninety minutes. Data saturation was obtained with the two focus group interviews. Refer to Table 4.1 for the demographic information of the participants. After the data collection, the researcher used deductive and inductive analysis techniques to analyse the data. Categories and sub-categories were identified.

4.2 DEMOGRAPHIC DESCRIPTION

The participants were six professional nurses with advanced qualifications in either emergency nursing or critical care nursing and two auxiliary nurses. Complying with confidentiality and protecting the participants' identity, their real names are not used in the data description. See Table 4.1 below for the participant's demographic information.

Table 4.1: Participants' demographic data

Participants	Professional Qualification	Academic Qualification	Years of experience in nursing
NP1	Professional nurse	Diploma in nursing with a degree in emergency nursing science with nursing education	25
NP2	Professional nurse	Diploma in nursing science with a degree in critical care nursing with nursing education	20
NP3	Nursing auxiliary	Certificate in nursing	10
NP4	Nursing auxiliary	Certificate in nursing	8
NP5	Professional nurse	Diploma in nursing science with a degree in emergency nursing and education	25
NP6	Professional nurse	Diploma in nursing science with a degree in neonatology	20
NP7	Professional nurse	Diploma in nursing science with a Degree in critical care nursing and education	15
NP8	Professional nurse	Diploma in nursing science with a degree in education	25

The professional nurse participants had vast experience in clinical nursing and often served as mentors for their subordinates. They also had been exposed to the implementation of policies and guidelines. The two auxiliary nurses were selected due to their experience in acting as change agents in the emergency department of the designated hospital.

4.3 THE RESEARCH FINDINGS

The research findings were based on the data obtained during the focus group interviews and are presented based on the contextual and interventional factors of the CFIR. The first objective was to explore and describe the contextual facilitators and barriers that may influence the implementation of the PFCC guidelines of the RNAO in the designated

hospital's emergency department, referring to the individual characteristics, the inner setting and the outer setting according to the CFIR. The second objective was to explore and describe the interventional facilitators and barriers that may influence the implementation of the PFCC guidelines of the RNAO in the designated hospital's emergency department, referring to the intervention characteristics and the process of implementation according to the CFIR.

The five domains of the CFIR, as referenced by Breimaier et al. (2015:4), are:

- Domain 1: Intervention characteristics
- Domain 2: Outer Setting
- Domain 3: Inner setting
- Domain 4: Characteristics of the individuals
- Domain 5: Implementation process

The findings are discussed according to each of the CFIR domains.

4.3.1 Domain 1: Intervention characteristics

The constructs of the intervention characteristics in the CFIR refer to the following:

1. **Intervention source**, namely the organization that developed the innovation.
2. **Evidence strength and quality** that includes the feedback from the people who use the innovation.
3. **Relative advantage** refers to the belief that the use of the innovation will benefit the organisation.
4. **Adaptability** of the innovation refers to the extent to which it can be adapted to be of use in the organisation.
5. **The trialability** of the innovation refers to the possible benefits associated with the implementation of the innovation.
6. **The complexity** of the innovation refers to the degree of its complexity that may hinder the implementation of the innovation.

In Table 4.2, the categories and sub-categories of domain 1 are presented.

Table 4.2: Summary of categories and sub-categories of the intervention characteristics domain of the CFIR

	Categories	Sub-categories
DOMAIN 1: INTERVENTION CHARACTERISTICS	Guidelines match current practice	Individualised care
		Involve family
	Guidelines to enhance current practice	Trusting relationship
		Ensure privacy
		Communicating triaging

4.3.1.1 Category: Guidelines match current practice

The first category identified from the data obtained through the focus group interviews refers to the extent to which the PFCC guidelines fit the procedures and practices that were used in the emergency department. According to the data, it appeared that the existing hospital policies and the guidelines had much in common. It is important to note that guidelines should be aligned with the hospital's policies in order to enable nurses to render quality patient care.

a. Sub-category: Individualised care

Caring for patients not only involves their clinical treatment but also includes interventions that are focused on their well-being and their needs to be treated with respect, kindness, and compassion in collaborative relationships. The emphasis is focused on ways to support family- and person-centred approaches in the emergency department and to put patients at the centre of care delivery. When it is not done, patients often experience feelings of abandonment and enhanced vulnerability. They may feel dissatisfied with the care when they are not treated as valuable individuals and members of families. It often leads to negative patient experiences.

A holistic approach to care includes patient involvement and communication with patients and their family members by well-trained staff to attend to the patient's psychosocial, physical, and cultural needs. Unfortunately, acute care is delivered in emergency departments, and life-saving procedures are more important than the involvement of patients and their family members in decision-making. It is, however, possible to focus on the latter after the patients' conditions have been stabilized. Under these circumstances, the facilitation of the guidelines towards individualised care will increase the patient and family's satisfaction with the care. It will also improve the quality of care in the emergency department:

"And in that way, you try by all means to comfort them and do not judge them because it can also impact their health or their recovery" NP3[1]

"until you understand their stories, then you cannot judge them" NP 2

b. Sub-category: Involve family

Many patients and family members experience anxiety and emotional stress when acute care is needed and executed. Life-threatening situations occur in emergency departments that emotionally upset patients and their family members. When families and patients visit the emergency department, they are not prepared for what might happen and how serious the condition of the patients is. They are worried about their loved one's health and may, therefore, also need support from the nurses. At the same time, the nurses deliver acute care to the patients and have little time to attend to the family members' needs. The emergency department is a fast-paced and unpredictable unit, and the nurses have to deal with a variety of stressors simultaneously while still caring for the patients and the families involved. It is a difficult task to prioritise emergencies and to deal with family's anxiety. It is, however, essential to understand their needs and to address them effectively. An important component of quality care is the involvement of family members,

[1] Contributions by participants have been presented verbatim in the interest of authenticity and no changes have been made to grammar or use of language.

and by involving them, they can provide emotional support to patients. The participants were very positive about the implementation of the guidelines and came up with ways to implement it:

"...client liaison between the doctor and patients waiting, and he works from 9 to 9. And it is kind of like a client liaison, or he doesn't do any nursing work. He just goes from patient to patient. If the communication between the patient and family sitting in the waiting area, he builds the relationship". NP6

"…have one family member with the patient, but depending on how old the patient is like the baby would have both parents alternating each time". NP3

Discussion

According to Walsh et al. (2022:6), an imbalance between patients' and families' expectations of healthcare services and the care that is actually rendered may lead to their negative experiences. In such cases, the patients and families complain about their healthcare, notwithstanding the quality of care that they receive. It, unfortunately, impacts negatively on the working environment of nurses in the emergency departments.

In holistic patient care, with patients and families involved in the planning and execution of care, effective communication to share information with patients and family members during waiting times, triaging and health education, the quality of care and the satisfaction of patients and families are improved (Kuipers, Cramm & Nieboer 2019:19. Through the implementation of PFCC guidelines, every person visiting the emergency department is viewed as an individual, that is unique with his/her own unique needs. The person is recognised as a whole person and not only as a patient who requires immediate emergency care (Emmamally, Erlingsson & Brysiewicz 2020:40). When holistic care is provided, and the family is involved, patient and family satisfaction the quality care may improve (Baldwin & Harvey 2020:29). According to Senaby (2018:41) the delivering of holistic care in emergency departments requires an interactive culture between patients,

families and nurses to empower all stakeholders to feel free to engage decision making about the required patient care. Such involvement of patients and families in the care that is rendered in the emergency department and the continuation of the care after the discharge of patients from the emergency department may contribute to quality patient care (Walsh, et al 2022:33-36). Patients and family members are responsible for the care of patients after discharge from hospital and their involvement in the care of patients during their stay in hospital, may enable them to fully recover from illnesses and injuries leading to fewer re-admissions of patients (Malepe et al. 2022:9; Senabye 2018:40-41).

4.3.1.2 Category: Guidelines to enhance current practice

A critical factor for quality nursing care in the emergency department is nurses' advanced skills to deliver acute care without neglecting the holistic well-being of the patients and the involvement of their family members in their care. They are expected to save patients' lives and to create a supportive environment for the family members. It is accomplished by family involvement in the care of the patients after discharge from the emergency department. Patients' and family members' expectations should never be neglected, notwithstanding the fast pace of the functioning of emergency departments. The data revealed that the implementation of the PFCC guidelines could enhance the current practice in the emergency department.

a. Sub-category: Trusting relationship

Excellent interpersonal caring attributes and clinical competence of the nurses in the emergency department may positively contribute to trusting relationships between them and their patients and the family members of the patients. Negative attitudes and limited communication can result in a feeling of mistrust between nurses, patients and their family members. When mistrust is experienced, the possibility that a trusting relationship can develop is slim. The nurse participants considered the implementation of the PFCC guidelines as a means to ensure that trusting relationships between them and their patients are strengthened. It is important for the patients to experience their interaction

with the nurses positively. Efficient communication between nurses and patients is appreciated. Patients also prefer that their family members be allowed to support them in the emergency department. The nurse participants were aware of the family members' sensitivity to their nonverbal behaviour, such as their tone of voice. On the other hand, they feel confident that the nurses will help their loved ones when the nurses attend to their concerns. By implementing the guideline, the facilitation of trusting relationships can be enhanced:

"I believe that we can build a good, trusted relationship in our unit". NP4
"…creates a very good therapeutic environment for our patients". NP3

Unfortunately, it may be difficult to implement the guidelines when the emergency department staff has to attend to an overwhelming number of patients. A barrier identified is that there is sometimes not enough time to explain procedures before it is implemented:

"…we have a big unit and our emergency department…it's extremely busy. And to have a personal relationship with those patients is a big challenge in the unit for the staff". NP6

b. Sub-category: Ensure privacy

Securing patient privacy and confidentiality is an essential cornerstone of quality patient care in emergency departments. In the designated hospital's emergency department, the treatment bays are separated by curtains only, and it leads to the frequent infringement of the patient's rights regarding privacy. It also frustrates the nurses as confidential communication with patients is impossible. Sensitive information cannot be discussed, leading to either poor diagnoses or patient education. The outlay of the emergency department served as a barrier to the implementation of the PFCC guidelines:

"In the unit, we have private cubicles, but only divided by a curtain. So, you don't get to meet them unless it's in the results where you have to when the patient is normally you

are able to have a one-on-one talk with your patient or after the doctor has seen them". NP4

"you can hear the whole unit. You can hear the other person in the next room. So I think maybe closed doors would actually make it more private." NP3

c. Sub-category: Communicating triage

In an emergency department, patients and families require constant reassurance that the treatment will be successful. They, therefore, want the nurses to communicate with them even when they are busy dealing with other patients' emergency care. Ensuring patients' satisfaction with their treatment requires an understanding of the importance of ongoing communication with the patients and their family members. Enhancing informative and meaningful interaction between nurses, patients, and family members may lead to positive patient experiences. The implementation of the PFCC guideline should help nurses, patients, and family members to communicate in a manner that benefits all people involved. It is conducive to the appropriate care processes and needs that must be met.

Efficient communication in emergency departments relies on the nurses' ability to explain diagnoses and treatment in terms that the patients and family members understand. The patients' and family members' anxiety caused by the unfamiliar environment of emergency departments may contribute to communication problems. Effective communication can empower the patients and family members and thereby improve patient satisfaction with the care that they get in the emergency departments. The patients and their family members must understand why triaging is done. It may help them to understand why some patients have to wait longer than others before the nurses attend to them. The implementation of the PFCC guidelines may improve the communication between nurses and patients in the emergency department of the designated hospital:

"…it will help tell the family members in advance what's going on and also let them know what's going on with the persons in the unit. They will also be satisfied with the quality of service". NP1

"*having a triage nurse in the front, always updating the patients on what is going on inside, on the ER on the floor and also to immediately attend the people coming in to the EU."* NP3

Discussion

Holistic care is rendered when the patient is considered as a whole person being part of a family and a community, and his/her physical, psychological, emotional and spiritual needs are addressed in a trusting relationship with his/her nurses and other healthcare professionals (Walsh, et al. 2022:33). There is, unfortunately, limited time in emergency departments to build trusting relationships with patients and their family members. The emergency department is fast-paced, and an unpredictable working environment as emergency cases are admitted any time of the day and night, and the healthcare team should be able to work under enormous amounts of stress (Grover, Porter & Morphet 2017:92; Weaver, Hernandez & Olson 2017:50; Driskell, Salas & Driskell 2018:334:335). Patients who are admitted to emergency departments are also stressed about their chance to recover from severe illnesses and injuries, and so are their family members. They depend on the healthcare team to help them to manage their concerns and stresses (Almaze, de Beer, 2017:59). It is therefore according to Byrne et al. (2020:8), Greenway, Butt and Walthall (2019:5–6) important that the team communicates effectively in a non-judgemental respectful manner with patients and their family members to instil in them hope and faith that their loved ones will recover.

In the emergency department, patients should receive appropriate care at the appropriate time, and this is being done by triaging patients. Triaging is done to predict which patients need immediate care and which patients can wait for care, as their conditions will not deteriorate during a short waiting period (Hamzah, Hussein, Momani, Zghoul, Ahmed

Meri, Abdulwahhab & Jassim 2019:6). It is, however, important to reassess the waiting patients' needs ongoingly. The outcome of the reassessment should be communicated to both the patients and their family members to decrease their anxiety and stress levels (Hamzah, et al. 2019:8). Poor communication with patients and family members in the emergency department can result in medical errors due to delayed care (Rosen, et al. 2017:7).

The physical layout of the emergency department is often not conducive to maintaining privacy. If there is a chaotic environment, it makes it more difficult to create a suitable environment for communication in the department regarding maintaining confidentiality and privacy of patients' information. Such circumstances jeopardize opportunities to maintain trusting relationships with patients and their family members (Hartigan, Cussen, Meaney & O`Donoghue 2018:2).

4.3.2 Domain 2: Outer Setting

The constructs of the outer setting in the CFIR refer to:

- **Patient needs and resources,** including patients' expectations of service delivery and the prioritizing thereof, directly relate to quality improvement.
- **Policies** that may influence the implementation of innovation.

In Table 4.3, the categories and sub-categories of domain 2 are presented.

4.3.2.1 Category: Focus on emergencies; not the overall health status

The early identification and management of injuries or serious illnesses that can cause irreversible consequences or harm is the first priority of the nurses working in an emergency department. It does, however, happen that patients use the emergency departments of hospitals for non-emergency purposes.

Table 4.3: Summary of categories and sub-categories of the outer setting domain of the CFIR

	Categories	Sub-categories
DOMAIN 2: OUTER SETTING	Focus on emergencies, not the overall health status	Immediate emergency needs to take advantage
		Interaction with other units and services
	Obliged to render primary care	Replace general practitioners over weekends
		Replace other healthcare services
	Referral and transfers	Transfer patients
		Refer patients

a. Sub-category: Immediate emergency needs take advantage

At times, patients visit an emergency department for non-emergency purposes. They tend to view hospital emergency departments as consulting rooms of general practitioners and become very upset when they do not receive treatment upon arrival at the departments. According to the participants, they do not understand that patients with immediate emergency needs should always be attended to first. They do not understand triaging and the nurses' responsibility towards injured or severely ill patients:

"Usually when kids go to sports events, the parents sign consent saying that the children may be taken to the nearest facility for treatment…over weekends the emergency units are very busy… there are always the rugby clashes…there are very serious injuries…kids that actually died." NP8

When emergency care is delivered, the nurses may neglect the principles of PFCC due to attempts to save the lives of their patients. According to the participants, they found it difficult to focus on the families' needs to be updated about the patient's conditions. At the same time, they work under immense pressure to stabilize the patients' conditions:

"We focus on the patients, injuries and what had happened to him at this stage." NP1

"Even if the patient does not have medical aid and they come to our hospital first, and they need immediate attention, we will stabilize them first." NP3

The type of care that is delivered in emergency departments may serve as barriers to the implementation of PFCC. The participants were, however, convinced that they could do more to attend to the implementation of PFCC during the phase after the immediate emergency care was delivered. It can be done before the patients are transferred to critical care units or wards:

"The doctor in the emergency department follows up sometimes with the patients in the hospital or in the wards." NP1

b. Sub-category: Interaction with other units and services

The implementation of PFCC in emergency departments requires the involvement and effort of all other departments. It cannot be successfully implemented in one department of a hospital only. The involvement of patients and family members in the planning, execution and evaluation of care should be a priority of all units and services in the whole hospital. It should be the aim to render holistic care without compromising immediate emergency care in the emergency department. The participants advised that PFCC should not be limited to the emergency department as patients get transferred from the emergency department to other wards and units. The staff of those units and wards should be knowledgeable and skilled to continue with the care that commenced in the emergency department. The participants applauded the good communication between the departments of the designated hospital that, according to their opinion, could serve as a facilitator for the implementation of PFCC:

"…if you are on shift and you know this person, and you were concerned about the patients, you follow up and see if the patient is okay and fine and if the patient will be fine when they go home. And you can follow up with the nurses in the ward so that they can also follow up with the patient if there was a concern." NP2

"difficult to find placement for the patient at the government facilities, but we cannot withhold that treatment just because we know that we're going to have a problem. But so we do what we can and then we deal with what comes after." NP7

Discussion

Patients visiting an emergency department are triaged, and a colour code is provided reflecting the severity of their injuries and illnesses, thereby identifying the patients who need urgent medical care, especially when there is an influx of patients. Still, regardless of their medical prioritization all patients have the right to quality patient care (Tam, Chung & Lou 2018:1). A pre-requisite for a healthcare team to render quality care is, according to Rosen et al. (2018:430), Weaver, Walton, Hogden, Long, Johnson and Greenfield (2020:1) trust between all the members of the team and effective communication by all the members to the benefit of patients and their family members. They should be able to collaborate in order to reach a common goal, referring to optimal patient care (Driskell, et al. 2018:335).

Teamwork is optimised in emergency departments when healthcare professionals feel that their efforts to save patients' lives and to deliver holistic patient care with the involvement of family members are appreciated (Rosen, et al. 2018:430). Healthcare teams in emergency departments often have to do rapid assessments and render emergency care without hesitation in demanding working environments to attend to patients' immediate needs (Grover, et al. 2017:93).

4.3.2.2 Category: Obliged to render primary care

The participants agreed that they experienced a noticeable increase in patients visiting the emergency department to receive treatment for chronic conditions such as hypertension. It happened, according to them, especially over weekends and after hours when general practitioners' consultation rooms and primary healthcare clinics are closed.

Patient overloads are experienced that leave the staff with very little time to render PFCC. The management of patients with chronic conditions is not the main focus of the staff of emergency departments, and the influx of patients creates situations in which the nurses of the department find it very difficult to meet all the healthcare needs of the acute and chronic ill patients. According to the participants, patients who misuse emergency departments for non-emergency purposes pose barriers to the implementation of PFCC.

a. Sub-category: Replace general practitioners over weekends

The participants complained about the patients who believe that they should be treated in emergency departments for conditions that do not require emergency treatment. They do not view emergency departments as places where patients with life-threatening conditions are treated. When clinics and general practitioners' consulting rooms are closed, the staff of emergency departments are expected to replace the primary healthcare nurses and the general practitioners:

"They will come and during the night or on the weekends when there is really a staff shortage, and there really are critical patients in the unit." NP1

Patients with minor ailments and chronic conditions consult the emergency departments and demand the immediate attention of the nurses. Most minor and routine complaints are raised from patients with conditions that could have been treated elsewhere, causing a feeling of resentment from the nurses in the emergency departments because it takes time away from treating patients with actual emergencies:

"They've got this massive say headache, you know, go over the weekend, and now they didn't drink their blood pressure tablet for one day, so they go to the emergency department for it, you know where they will be seen." NP8

The participants complained about patients who diagnose themselves as severely ill or that their injuries require emergency treatment and that they, therefore, cannot wait until the general practitioners and primary healthcare nurses can attend to them on Mondays.

They demand to be treated as emergency cases over weekends at the emergency department of the designated hospital.

"So, the people that come with chronic stuff is, you know, you get your usual offenders." NP8

Due to the large number of patients that the nurses of the emergency department often have to attend to, little time is available for PFCC. It can serve as a barrier to the implementation of PFCC in the emergency department of the designated hospital.

b. Sub-category: Replace other healthcare services

According to the participants, the emergency department of the designated hospital is misused by the community. They are often expected to replace other healthcare services in the area. Some people who work for the mining industries in the area do not make use of occupational healthcare services but rather consult them at the emergency department:

"We are in a mining community. Therefore, there are a lot of occupational health clinics in our midst which attend to the workers. They follow them up and check them and so on." NP8

Some community members believe that the emergency department of the designated hospital is their sole point of care, and therefore, they do not make use of other healthcare services. The overcrowding of the emergency department is often due to the misuse of the department by people who refuse to use other healthcare services. Patients with chronic conditions require comprehensive assessments that are time-consuming. These patients take up the time that could have been used to resuscitate and stabilize patients who got severely injured in motor vehicle accidents, leaving the nurses to feel that they could not deliver the PFCC that the patients needed:

"…*we got the very wide community that we have to serve."* NP1

The participants were convinced that the misuse of the department by chronically ill patients served as a barrier to the implementation of PFCC. Instead of involving patients and their family members in the planning of care, they had no choice but to be task-oriented in order to attend to as many patients as possible in the minimum time.

Discussion

Gaughan, Kasteridis, Mason and Street (2020:210) recommend that each emergency department should be divided into a section for emergency care and a section for primary care, where general practitioners render care to patients who require primary care. It may have a positive effect regarding the improvement of primary care. Such an arrangement will also free the trauma healthcare team from having to take care of patients who require immediate care.

A variety of resources are required to render quality care in emergency departments as patients are admitted to who need diverse care. Some of the patients need primary care, and others require immediate emergency care. According to Owad, Samaranayake, Karim and Ahsan (2018:1060), limited resources and the misuse of resources may lead to failure to deliver quality care with detrimental effects on patients' health and survival. Effective management of the resources may prevent overcrowding of patients in the department and also enable quality patient care (Ahsan, Alam, Morel & Karim 2019:256).

4.3.2.3 Category: Referral and transfers

The referral and transfer of patients to another facility is time-consuming as complex processes have to be followed. It causes patients to wait very long to be transferred to other healthcare facilities, and while they are waiting, they occupy beds in the emergency department. Unfortunately, the number of beds in the department is limited and should have been reserved for patients who are severely ill or injured.

a. Sub-category: Transfer patients

The participants agreed that the transfer of patients to wards and units in the designated hospital added to their workload and caused chaotic situations in the emergency department. It urged them to focus on routine tasks instead of comprehensively assessing patients and family members in order to attend to their unique needs. They usually had very little time to build therapeutic relationships with patients and their family members, to the detriment of offering PFCC. The time that they could have spent on family- and person-centred care is used to arrange the transfers and accompany the patients to other wards and units. According to the participants, they are at the mercy of the receiving facilities when transferring patients for further care. At times, the wards and units are also overcrowded with patients, and patients can only be transferred to them after the discharge of patients. At the same time, patients keep on arriving at the emergency department for admission and care. The only way that the participants could manage the situation was by moving patients around in the emergency department. They also had to ask patients who did not need emergency care to wait in the waiting room to the patients' and families' dissatisfaction.

The participants explained the procedure that is followed when patients have to be transferred to intensive care units in the designated hospital:

"We do communicate once everything is done, stabilize the patient and everything we get clear guidelines from the case managers in terms of what is it going to cost. And for treatment in an intensive care unit with intubation or without intubation so that the family knows exactly what the cost is. They (the family) *make a decision on what to do."* NP7

When the participants had to transfer patients to other healthcare facilities, more challenges were experienced. All patients who need emergency care are admitted to the designated hospital, which is a private hospital, and only render care to patients who can afford to pay for the care or have medical insurance that will cover the costs. Once the patient's condition has been stabilized and they cannot afford to be transferred to an

intensive care unit or ward in the designated hospital, they have to be transferred to public hospitals. The participants explained that they usually spent much time to manage such transfers:

"The problem with transfers comes between the private and the provincial hospitals. When we want to transfer out of the medical intervention, if we then intubate the patient, it is very difficult to find placement for the patient at the government facilities. Still, we cannot withhold that treatment just because we know that we're going to have a problem. But so, we do what we can, and then we deal with what comes after." NP 7

"The doctor will decide if they have to be transferred to another institution or the nearest provincial hospital because the rule says you first. Your first priority is the patient, and then you can attend to the rest." NP 3

b. Sub-category: Refer patients

It is the responsibility of the healthcare professionals of the emergency department in the designated hospital to refer patients for follow-up treatment when necessary. The participants explained that they are obliged to facilitate the referrals and that continuity of care is ensured:

"The doctor, before discharge from the emergency department, can refer patients to the diabetic educator. And to the diabetic clinic, as well as, but obviously, all the nurses are also equipped to give some information regarding any medical issue." NP7

"Our general practitioners' offices are in the hospital as well as our surgeons' offices, everybody is here. So, if they come to our ER during office hours, we immediately can refer them to a, or we can call a specialist or come and see them in the department." NP7

The involvement of the nurses of the emergency department in arranging follow-up care for their patients serves as a facilitator for the implementation of the PFCC guidelines.

The participants agreed that they already focus on patient- and family-centred care. They, however, wished that they could have had more time to build empowering relationships with their patients.

Discussion

By discharging patients from emergency departments without providing them with sufficient information and skills, they and their family members may not be able to take care of them. The patients' conditions may deteriorate, and it might be necessary to re-admit them. It is, therefore, important that the healthcare team ensures that patients and their family members understand their medical conditions, how to take care of wounds if necessary and how to manage the medication if needed. According to Østervang, Lassen and Jensen (2022:7), when the healthcare team involves patients and family members in the planning and execution of care, they may enable them to work towards the improvement of the patients' health.

The transfer of patients to other healthcare facilities is often challenging, leaving the staff of the emergency department to function as a general ward rather than a department where immediate care is rendered. According to Gorodetzer, Alpert, Orr, Unger and Zalut (2020:6), the emergency departments get overcrowded, and the healthcare teams are overwhelmed due to the reluctance of ward and intensive care staff to admit the transferred patients to their wards and units. The same happens when the staff of other healthcare facilities delay the transfer of patients from the emergency departments to their hospitals.

4.3.3 Domain 3: Inner setting

The inner setting refers to the organisation's structure, networks, and communication channels, as well as the organisation's readiness to implement changes.

The constructs of the inner setting in the CFIR refer to:

- **Structural characteristics,** referring to the organisation's infrastructure and dynamics that may influence the response to change, such as the implementation of the PFCC guidelines.
- **Networks and communication,** referring to the communication between the staff and management of an organisation.
- **Culture of the organisation**, referring to the beliefs, values and assumptions that can affect the implementation of changes.
- **Implementation climate and readiness for change,** referring to the readiness of the staff and management to embrace changes.

In Table 4.4, the categories and sub-categories of domain 3 are presented.

Table 4.4: Summary of categories and sub-categories of the inner setting domain of the CFIR

	Categories	**Sub-categories**
DOMAIN 3: INNER SETTING	Teamwork within the department	Group cohesion of staff to enable adjustment to change
		Teamwork could support person- and family-centred care
		Cooperative reaction to policies
	High paced unit	Limited time to build relationships with patients
		Staff shortages may affect person- and family-centred care negatively
		Diminished sensitivity towards patients' needs
		Lack of privacy
	Traumatised patients are treated in emergency departments	Stressful situations are unavoidable
		Getting patient feedback to evaluate care
		Response to patient feedback
	Leadership	In-service training
		Communication facilitation

4.3.3.1 Category: Teamwork within the department

Efficient teamwork is required to implement change, such as the implementation of the PFCC guidelines of the RNAO to improve the quality of care in the emergency department of the designated hospital. It is important that staff functions as a cohesive team and that they collaboratively respond to policy changes, such as the implementation of guidelines to improve patient care.

a. Sub-category: Group cohesion of staff to enable adjustment to change

Productivity increases, and goal achievement occurs when teams functions cohesively. It may strengthen professional relationships and enable the team to collaboratively set goals and work towards attaining them. Good interpersonal professional relationships support effective communication between members of the team. When teams feel united, the members may experience satisfaction with the working environment. The participants experienced cohesion in the team of healthcare professionals working in the emergency department of the designated hospital. They communicated their satisfaction with the communication in the team:

"…the group cohesion was very good, we worked together and helped each other more. I think it was much better than before we work together and then talk to each other..." NP8

The group cohesion that the participants in the emergency department of the designated hospital experienced is a facilitator for the implementation of the PFCC guideline. The participants experienced the implementation of change in the recent past as non-disruptive:

"And also, there was the incorporate the whole lot of new staff quickly into the unit…we had to do very quick orientation and very quick group cohesion and to happen in order for things to be carried out." NP7

b. Sub-category: Teamwork could support person- and family-centred care

In a fast-paced working environment, such as what the participants experienced in the emergency department of the designated hospital, teamwork could be used to support PFCC. Effective teamwork is time-saving and enables nurses to secure time to attend to building therapeutic and empowering relationships with their patients and their family members to ensure personalized care that is not driven from the perspective of the nurses. The participants agreed that they prefer to engage with their patients meaningfully:

"We would actually have time to promote person-centeredness in a meaningful engagement and not only because they're just our clients, but she also remembering that they also have autonomy to their own health, and they have the right to decide what they also want. We cannot decide that ourselves or just include the healthcare team to be the ones deciding on their care." NP 1

The participants were eager to rearrange the workflow in the emergency department to accommodate the implementation of the PFCC guidelines and to involve patients and family members in the planning and execution of patient care:

"And by implementing this guideline, we will be focusing again on it. It will remind everybody about patient-centred care and that they are not just another number but a patient with family because we're not only treating the patient but also actually treating them as a whole." NP2

c. Sub-category: Cooperative reaction to policies

By implementing policies to maintain quality patient care, all staff contribute to the effective management of hospitals. The managers of departments in the hospital have delegated authority to ensure that policies are implemented. They are also responsible for the ongoing development of their staff to render evidence-based patient care. Hospital

policies should be updated when needed to be in line with the latest developments in patient care. The RNAO guideline for PFCC consists of recommendations regarding the planning, implementation and evaluation of PFCC. It is based on evidence and developed by a group of expert nurses to enable nurses to implement PFCC.

The participants were satisfied with the manner in which the nursing managers implement policies for quality patient care. They were not forced to implement policies but had opportunities to make recommendations regarding the implementation of the policies. They had also been invited to recommend changes to the policies:

"You get the policies, and then the nursing manager discussed it with us, and we discussed it, and if we did not agree, we could send it back to be changed as some proposed policies were not practical." NP1

The participants appreciated frequent meetings with the nursing managers. During these meetings, changes in practice and policies were discussed:

"And also, we have a daily meeting. That's how we get information about changes to policies, and the quality manager, the IPS and the service managers are present at the meetings." NP7

The manner in which the nursing managers and the nurses responded to the implementation of policies in the past serves as a facilitator for the future implementation of the PFCC guidelines.

Discussion

Lack of cohesion within the teams in emergency departments may lead to a decrease in the quality of care being provided and the safety of patients. Effective teamwork, on the other hand, may improve patient safety and the desired health outcomes and thereby also positively impact patient satisfaction with the care received (Buljac-Samardzic,

Doekhie & van Wijngaarden 2020:11). The functioning of teams can be improved through continuing professional development (Milton, Gillespie, Aberg, Erichsen Andersson & Oxelmark 2023:300-301).

In emergency departments, good inter-professional collaboration is a prerequisite for the delivery of quality patient and family care (Rosen et al., 2018:433; Vestergaard & Nørgaard 2018:185). When the quality of teamwork in the emergency department is improved, the quality of patient care may also improve (Martin & Ciurzynski 2015:484; Rosen, et al., 2018:444). Poor quality of care results from ineffective teamwork in the emergency department, with dire consequences for patients and their family members (Rosen, et al., 2018:444).

In emergency departments trusting relationships among the healthcare team and with the patients and family members may contribute to patients' adherence to treatment and thereby also to their improved health status (Ngcobo 2018:17). Professional values that support individualized care of patients to ensure that nurses attend to their health concerns and circumstantial variables are of utmost importance in PFCC (Kwame & Petrucka 2021:3). By rendering FPCC, nurses contribute to the improvement of patients' health and their satisfaction with nursing care (Moghaddasian, Dizaji & Mahmoudi 2013:197).

By applying evidence-based guidelines such as the PFCC guidelines of the RNAO in emergency departments, quality patient care is delivered (Shaikh, Stratton, Pardhan & Chan 2018:4). It does, however, require well-planned systematic incorporation of the guidelines into the current practice (Shaikh, et al. 2018:5).

4.3.3.2 Category: High paced unit

Life-saving care is rendered in emergency departments that require all staff involved to respond quickly to changes in the vital signs of patients. Stressful circumstances are

common, and the staff is aware of their immense responsibility to save families' loved ones. The departments are, therefore, often described as high-paced units.

a. Sub-category: Limited time to build relationships with patients

The nurses working in emergency departments are used to triage patients and respond to patients' needs accordingly. When life-saving procedures are required, their priority is not on building meaningful relationships with the patients and family members. It can only be done once they have successfully completed the life-saving procedures. The participants of the study acknowledged the need to treat patients holistically but also emphasized that in emergency departments, the time to build trusting relationships with patients and family members is limited:

"Actually, to make our patients feel welcomed and everything in the unit, because in most cases casualties are busy. So, our patient is not going to get one-on-one private session with the nurses compared to the wards. So, building this or implementing this (the PFCC guidelines) *would actually create a very good therapeutic environment for our patients."* NP3

"that we already stressed because they've got a family member not feeling well. The staff on the other hand, have been working at a very high pace and they've seen many patients." NP5

The high-paced workflow in the emergency department of the designated hospital is a barrier related to the implementation of the guideline as there sometimes is not time to do a comprehensive assessment to provide more holistic care. The focus is on the patients' immediate life-saving needs.

b. Sub-category: Staff shortages may affect person- and family-centred care negatively

When nursing shortages are experienced, limited time is available for the implementation of PFCC. Large workloads force nurses to resort to task-orientated routines in order to attend to all the patients. Patients are monitored for signs of physical and emotional distress, and treatments are done. The building of trusting relationships with patients and comprehensive assessments of their needs are then often neglected. The participants complained about shortages of nurses in the emergency department of the designated hospital due to the misuse of the department as a primary healthcare facility by patients and the challenges that they experienced in arranging transfers of patients to other healthcare facilities. The situation, unfortunately, had detrimental effects on the participants and the care that they delivered:

"Then it felt like you became numb. So, your sympathy levels are low, and every person that comes in doesn't feel like an individual anymore." NP6

"I think sometimes when it's rush hour in the emergency area, we tend to look unfriendly because even in your in your mind, you are triaging the patients to see who need emergency care, so if somebody's asking you to go to the bathroom and you are running towards someone else. I do not think that person is going to get the very nice response from you. So, they perceive us as unfriendly." NP7

Nurse shortages may hinder the implementation of the PFCC guidelines of the RNAO.

c. ***Sub-category: Diminished sensitivity towards patients' needs***

When patients arrive at the emergency department of the designated hospital, they are already anxious about whether they will recover. Their physical and psychological needs are equally important and should be addressed as quickly as possible. Nurse shortage may cause the nurses to focus on physical needs immediately as neglect thereof may be

life-threatening. The participants acknowledged that they often had to postpone emotional support and psychological care until they had time to attend to it. Unfortunately, it caused some patients to feel neglected, and they often complained that the participants were unfriendly and uncaring:

"I think what I can add to that, I don't think its people doing wrong in practice also, but I think COVID-19 probably also played a role because we were desensitized and any time that we are treating numbers and not patients and families." NP2

A possible barrier to the implementation of the PFCC guideline is the fact the nurses in the emergency department of the designated hospital are working under enormous pressure when the department is overcrowded, causing patients and families to wait for long periods of time before they are attended to. When nurses get the time to attend to a patient, they tend to focus on the urgent needs only and neglect the person-centredness in the care that they render:

"Not only that, it became, you know, we also became emotionally vested in the whole situation is where we don't anymore look at how the patient is feeling. "We just working because we get exhausted anyway, so we must go back, start the training knowing how to approach patients, how to talk to them and how to make them feel welcome because all the patients come to the casualty, you need one thing help. But if all the nurse also needs help, they are not going to be effective." NP4

d. Sub-category: Lack of privacy

The emergency department of the designated hospital lacks private spaces where nurses and patients can engage to build trusting relationships and render PFCC. There are no private areas where sensitive issues can be discussed. The participants complained about the curtains that divide cubicles where assessments and treatments are done:

"That is one of the big barriers for us in our emergency department because there's no private space where we can give the education, and sometimes there really is not time to do it because it's a very busy unit, and a lot of staff shortages, especially over weekends." NP1

"that there is not sufficient privacy. You don't often have cubicles, so it's really just the curtain between the two patients. And you have to discuss sensitive information with the family so." NP6

Discussion

Poor communication with patients and their family members and time constraints that cause patients to wait long for treatment may lead to medical negligence and patients' dissatisfaction with the care that they receive in emergency departments (Wang, Lee, Lee, Hsieh & Lee 2022:152). The time constraints are often related to staff shortages and high turnover of staff due to them being unhappy in the department (Haddad, Annamaraiu & Toney-Butler 2023:3). Staff shortages unfortunately often occur in emergency departments (Ramsy, Palter, Hardwick, Moskoff, Christian & Bailitz 2018:494).

The primary focus in emergency departments is on the delivery of immediate care required by patients with severe injuries and illnesses. It, therefore, often happens that the staff considers physical needs as more important than emotional and psychological needs. The latter becomes neglected, leading patients and family members to complain about the care that they receive in emergency departments. The implementation of PFCC may change the situation as the focus of PFCC is not only on the physical needs of patients. The involvement of patients and family members and endeavours to render individualized holistic care is emphasized (Phiri, Heyns & Coetzee 2020:1-2).

The healthcare teams of emergency departments are obliged to keep all information of their patients confidential (Hartigan, et al. 2018:5). Maintaining the privacy of patients and the confidentiality of information regarding their conditions can be hindered by the poor

physical outlay of the department. The situation gets aggravated when the department is overcrowded by patients due to delayed transfers and referrals of patients. It, however, remains the responsibility of the team to ensure the patient's privacy (De Steenwinkel, Haagsma, van Berkel, Rozema, Rood & Bouwhuis 2022:4).

4.3.3.3 Category: Traumatised patients are treated in emergency departments

Patients visiting emergency departments often are emotionally distressed and feel traumatized due to the need to be treated for a serious illness or injury. The accompanying family members experienced similar emotions. They may believe that their loved ones should be treated as a matter of urgency while all other families share the same expectations.

a. Sub-category: Stressful situations are unavoidable

The participants complained about the unrealistic expectations of patients and family members, but they also understood that the patients and family members were experiencing traumatic circumstances:

"We see here in our emergency department often people who are very emotional when they come in. So, because they've waited for a long time as well, it's an emergency unit, but it doesn't mean that turnaround time was forced or quick and that we already stressed because they've got a family member not feeling well." NP5

The participants described their own stress caused by the large number of patients that they had to attend to. They complained about burnout, sleep disturbances, and episodes of anxiousness and depression:

"The staff, on the other hand, have been working at a very high pace, and they've seen many patients. I think, yes, you can educate and share with them again what the care

that you need to portray and the compassion they should have. One sees many patients, but for the patient it is a new experience and a new place for the patient." NP5

Emergency departments are often experienced as stressful, but it should not be a barrier to the implementation of PFCC.

b. Sub-category: Getting patient feedback to evaluate care

When there is dissonance between the patients' and families' expectations of the care in the emergency department and the actual care that they receive, negative feedback is communicated. Patients who do not receive what they expect will complain about the care. The participants referred to the system that is used in the emergency department to get patient feedback. They were concerned about the patient's complaints and acknowledged the limitations that needed to be addressed:

"The most complaints are about education and the triage waiting time. The medication information. It's everything about communication and friendliness. Was the one big complaint, staff not explaining what they are doing." NP2

"So, you, it's more about the perception because the patient is patient-centred, and you are focussed on everybody in the cubicles, everybody in the results area." NP7

The feedback that the nurses and the nursing managers of the emergency department of the designated hospital ask from patients and their acknowledgement of the importance of the feedback is in line with the guidelines of PFCC. Feedback from the persons to determine the patient's satisfaction with the care that they received is the fourth recommendation of the PFCC guideline of the RNAO.

c. Sub-category: Response to patient feedback

Obtaining patients' and families' feedback regarding the care that they received in the emergency department of the designated hospital can assist the nurses in identifying limitations and addressing them appropriately. The participants appreciated the manner in which the nursing managers addressed patients' feedback:

"…if we if there's a serious reportable event, when we get it, the manager will receive a report regarding that or a serious topic, a serious complaint. And you receive it, and then you have to investigate it, and you have to have proof of your investigation. So, you discuss whether you have to have one-on-one discussions with the staff that was involved in the complaint, get their statements about what happened, from their perspective, you contact the patient as well, or the family member that's complaining and you need to get their understanding of what happened as well. And then you need to implement action plans to avoid." NP 7

"Written feedback on what our patients have said about a particular service that they received at the hospital and them certain in touch points that they comment on responsiveness of staff, the environment, friendliness, friendliness, the education that they received while they were at the hospital" NP1

The nurses and the nursing managers collaborated to address the complaints and to improve the care.

Discussion

Families and patients visiting emergency departments have heightened emotions of anxiety and stress. They are anxious about the possibility that the patients may not recover from their severe injuries and illnesses. They may, therefore, find it difficult to understand the healthcare teams' communication with them. Østervang et al. (2021:7) therefore recommend that the healthcare team should use understandable terms when

they discuss the required procedures with the patients and their family members. It is also necessary to repeat what has been said to remind the patients and family members about the initial explanations.

Patients who receive care in emergency departments are encouraged to rate the care and to give feedback to the managers of the department about their experiences. The feedback serves as valuable input that could be used to address deficiencies and improve the quality of care (Oyebile & Brysiewiez 2020: 254). It is also important to take cognisance of contextual factors such as the number of staff members employed in the emergency department, the physical space in the department and the resources of the department when measures are planned to address patients' dissatisfaction with the care (Austin, Blakely, Tufanaru, Selwood, Braithwalte & Clay-Williams 2020:55).

Management often responds to complaints from patients about the care that they received with in-service training of the healthcare team to improve the way they take care of patients (Ramsey, Sheard, Lawton and O`Hara 2019:44). Interventions to improve patients' satisfaction with emergency care should, however, be measured to determine its impact (Austin, et al. 2020:55). According to Santana et al (2019:8) performance quality indicators are needed to determine which improvement efforts had desirable outcomes.

4.3.3.4 Category: Leadership

Nursing managers of emergency departments have the daunting task of cultivating teamwork to deliver quality patient care in stressful situations. They have to support the nurses to attend to emergency situations and to patients who misuse the department for primary healthcare purposes.

a. Sub-category: In-service training

The participants appreciated opportunities to take part in in-service training sessions. They acknowledged the need to keep on improving their knowledge and skills in order to render quality patient care:

"Lots of in-service training in all the wards and in the emergency department as well. We are doing in-service training on certain objects for the specialised units and the normal wards, focusing on specific topics where there really is a need for." NP1

The implementation of the PFCC guidelines will require a series of in-service training of all the nurses who will be involved in the implementation of the guidelines. Fortunately, the nurses are used to attending such sessions, and they appreciate the opportunities to improve their knowledge and skills.

b. Sub-category: Communication facilitation

Utilizing tools to enhance interpersonal communication between nurses and nursing managers and between nurses and patients may contribute to the delivery of PFCC in the emergency department of the designated hospital:

"…sometimes you don't feel like you can communicate exactly the problem…then the managers…come and sit in with the meeting and discuss the issues, and they sort of facilitated communication so that it doesn't come off as punitive or bullying." NP7

"They help in this situations and they are also a backup because that also people in the incident investigation and ask questions and you also get involved with the family and the patient that have to help with the planning and action plans on how we are going to do it." NP2

Effective communication is important for the implementation of changes in the functioning of departments in hospitals. It will also be an important contributor to the successful implementation of the PFCC guidelines in the emergency department of the designated hospital.

c. Discussion

Managers of emergency departments often use in-service training to improve the collaboration of team members. It is important that the training should be re-enforced to improve the sustainability of teamwork strategies (DiMarino 2021:6; Lacerenza, Marlow, Tannenbaum & Salas 2018:517). In-service training should also be offered to help the healthcare teams of emergency departments to manage their stress effectively, to become familiar with innovation in emergency care and to implement evidence-based practices. It may improve their knowledge, skills and self-esteem to address patients' and families' needs (Glanz, Heimann, Zepeda & Ponticell 2018:353). Before the PFCC guidelines of the RNAO are implemented, the management of the emergency department will have to present training to all people who will be using the guidelines. They should be empowered to understand the PFCC concept, guidelines and related actions (Senabye 2018:40-41).

Informative collaborative meetings between the healthcare team and the managers of an emergency department provide the team with the necessary support to implement innovation to improve the quality of patient care (Blackburn, Ousey & Goodwin 2019:32). Adequate stakeholder engagement in the processes of policy and procedure development and implementation is crucial to guarantee successful implementation (Shaikh, et al. 2018:8).

4.3.4 Domain 4: Characteristics of individuals

The characteristics of the individuals who will be involved in the implementation of innovation refer to their knowledge and beliefs about the intervention, their feelings of self-efficacy to take part and their personal attributes.

The constructs of the characteristics of the individuals in the CFIR refer to:

- **Knowledge and skills about the intervention,** referring to the person's perceptions about the benefits that the implementation will bring to the working environment.
- **Individual stage of change,** referring to the general level of receptivity towards change of the persons who will implement the innovation.
- **Self-efficacy**, referring to the person's confidence that they will be able to implement the innovation.
- **Personal attributes,** referring to the values and norms of the persons who will be involved in the implementation of the innovation.

Table 4.5: Summary of categories and sub-categories of the characteristics of individuals domain of the CFIR

DOMAIN 5: CHARACTERISTICS OF INDIVIDUALS	Categories	Sub-categories
	Manage resistance to change	Address the rationale for change
		Enabling feedback required

4.3.4.1 Category: Manage resistance to change

People react differently to the possibility that their working environment may change. Some employees enjoy changes, and others may resist the planned changes. The managers who want to implement changes should be prepared to manage the staff who

may resist the implementation of change. If it is not done, the implementation will not be successful.

Change can only be effective when all employees are positive about it and are willing to take part in the implementation. The managers should lead them through the process of preparing for and taking part in the implementation.

a. Sub-category: Address the rationale for change

The participants agreed that they tend first to resist changes, but as soon as they understand the necessity of the proposed changes, they usually change their attitudes:

"We always resist at first because we have to ask why (is the change necessary)? *We are the relay between the upper management and then the workforce. So, we need to know all the why's, because the why's are going to be directed at us at the end of the day, and we need to actually know what we are talking about to have changes made."* NP7

The participants emphasized the importance of good communication to help the nurses understand why changes are important and how they will contribute to quality patient care. Changes should never be implemented in an autocratic manner. The participants should take part in the planning of change:

"So, sometimes you don't feel like you can be blunt and communicate exactly the problem. Then the managers or our direct managers come and sit in with the meeting and discuss the issues, and they sort of facilitated communication so that it doesn't come off as punitive or bullying." NP8

The participants' past experiences with the management of change may serve as a facilitator for the implementation of the PFCC guidelines of the RNAO.

b. Sub-category: Enabling feedback required

The implementation of initiatives such as the guidelines for PFCC ongoing feedback between the management and the nurses may facilitate positive responses from all persons involved. It is, however, important that the feedback be enabling and not blaming individuals for obstacles that are experienced. The participants mentioned that the focus of the feedback should be on achievements rather than on mistakes that had been made:

"…but I think it depends if this training is going to be for us and the patients. It's going to be something new, something good other than then doing something in the unit you always have to do, and do more with the patients." NP3

"…some of us are still old schooled and prefer things to be done according to them, when you introduce new things, it`s when they think, no you think you are better than them and that when they become negative." NP2

c. Discussion

Healthcare policies and procedures are developed to address identified problems and to improve patient care (Shaikh, et al. 2018:9). The whole healthcare team should be involved in the identification of the problem and the planning, implementation and evaluations of the measures to improve patient care. A prerequisite for the involvement of the team is their commitment to quality patient care and their willingness to use their energy to address problems (Stefánsdóttir, et al. 2022:444).

Responses to negative patient feedback regarding the emergency care that they received are influenced by the multiplicity of factors that could have contributed to the complaints (Buckley, Natesan, Breslin & Gottlieb 2020:450). It is nevertheless important that the management and the healthcare teams analyse the complaints and address it appropriately (Oyegbile & Brysiewics 2020:249).

4.3.5 Domain 5: Process of implementation

The process of implementation refers to the planning of the implementation, engagement of participants, the plan of execution and reflection to evaluate the implementation.

The constructs of the process of implementation in the CFIR refer to:

- **Planning**, referring to the plan to implement the innovation that includes the plan of action and the roles of implementation.
- **Engaging,** referring to the involvement of appropriate participants in the implementation of the innovation.
- **Executing,** referring to the plan of execution of the innovation.
- **Reflecting and evaluating,** referring to the feedback reports during and after implementation.

In Table 4.6, the categories and sub-categories of domain 5 are presented.

Table 4.6: Summary of categories and sub-categories of the process of implementation domain of the CFIR

	Categories	Sub-categories
DOMAIN 5: PROCESS OF IMPLEMENTATION	Complement current practice	Re-emphasize person-centredness
		Re-emphasize the importance of 'soft skills'
	Training for practice improvement	Address training needs
	Communication for guideline implementation	Learn from previous events
		Change management required
		Manage barriers to improvement

4.3.5.1 Category: Complement current practice

The implementation of the PFCC guidelines will complement the nurses' current endeavours to attend to the needs of the patients and family members. The participants were very eager to address limitations in their current practice and to develop strategies to enhance patients' and families' involvement in the care delivered in the emergency department of the designated hospital.

a. Sub-category: Re-emphasize person-centeredness

The implementation of the PFCC guidelines can be a valuable contribution to the care delivered in the emergency department. It will help the nurses to improve their communication with the patients and family members and to get them involved in the patient care rendered in the department. The participants were eager to build trusting relationships with the patients and their family members and to engage them in decision-making and continuity of care.

"And by implementing this guideline, we will be focusing again on it (PFCC)*, it will remind everybody about patient-centred care and that patients are not just another number but a person with family members. We are not only treating the patient, but we are also actually treating the family as a whole."* NP3

"*we get exhausted anyway, so we must go back, start the training knowing how to approach patients, how to talk to them and how to make them feel welcome because all the patients come to the casualty, you need one thing help. But if all the nurse also needs help they are not going to be effective"* NP4

b. Sub-category: Re-emphasize the importance of 'soft skills'

Although clinical care is of utmost importance in emergency departments where life-saving procedures are performed on a daily basis, nurses should also use their

interpersonal skills to treat patients with kindness, compassion, and respect. All nurses are trained to attend to patients as unique individuals belonging to families. It is only when nurses feel overwhelmed by shortages of nurses and overcrowded emergency departments that they need to be reminded that the patients are persons and that they need to be cared for in holistic ways. Not only patients' physical needs matter. Their emotional and psychosocial needs are as important as their physical needs. The participants were concerned about the fact that they often only focused on the immediate life-saving procedures. They were eager to re-emphasize the other needs of patients and therefore wanted to implement the guidelines to improve the care in the emergency department of the designated hospital:

"I think the staff in the emergency department… they need training again in soft skills." NP1

"We just have a problem just for them to do the basic things to introduce yourself to, to explain the triage process and the codes and to explain why are you going to wait and if you are a certain kind of the colour the amount of time that you likely to wait. I think the challenge is just the communication at the moment and never mind even I'm having relationship with the patient." NP4

c. Discussion

The 'soft skills' of the healthcare team in emergency departments are, according to patients and their family members, very important. They appreciate the empathy of the healthcare team and that they convey their understanding of the patients' and family members' anxiety and concerns about their loved one's conditions in the emergency department (Kwame & Petruckwa 2021:8). Barriers in emergency departments that may hinder the healthcare team from showing empathy to their patients and family members may include an overcrowded and chaotic environment and a lack of privacy. Such situations may prevent the patients and family members from expressing their healthcare needs (Al-Kalaldeh, Amro & Qtait 2021:29-35). In PFCC, the healthcare team should

create opportunities to invite the patients and family to become engaged in the planning and execution of care (Byrne, et al. 2020:9). Patients and family members should be enabled to practice their autonomy in deciding about the care that suits their cultural beliefs and family circumstances (Kim & Lee 2022:473). In PFCC, patient care is planned, delivered and evaluated in a mutually beneficial partnership of the healthcare team, patients and family members (Malepe, et al. 2022:1).

4.3.5.2 Category: Training for practice improvement

In emergency departments, highly skilled nurses are required to deliver care to seriously ill or injured patients. It is, therefore, important that they be exposed to continuing professional development.

a. Sub-category: Address training needs

Procedures and techniques to stabilize patients who had been severely injured in motor vehicle accidents or who suffered myocardial infarctions and pulmonary emboli have evolved and have improved through ongoing research. All nurse who work in emergency departments should attend workshops and conferences to improve their knowledge and skills. They are obliged to update their skills to do emergency care. The participants, therefore, were eager to learn new skills:

"I think the training would actually help a lot." NP3

"do daily trainings for new work procedures every day, almost because things are changing so rapidly" NP7

The participants' eagerness to improve their knowledge and skills serves as a facilitator for the implementation of the PFCC guidelines. In order to successfully implement the guidelines, the nurses will have to undergo some training in PFCC and guideline implementation.

b. Discussion

There is always a need to expand the knowledge and improve the skills of the healthcare teams of emergency departments. Through research, evidence-based practices are developed that healthcare teams should be familiar with to improve and maintain the care rendered in emergency departments. It is also important to strengthen the collaboration between the members of the department through in-service training. Leadership development can also be enhanced through training initiatives (Young, Patey, Norman, Chan, Hurley, Swab & Asghari 2022:840).

4.3.5.3 Category three: Communication for guideline implementation

Verbal, non-verbal and visual communication between all stakeholders is required to ensure smooth implementation of changes. Meetings to convey messages verbally, written notes to remind the stakeholders about strategies for the implementation and posters with descriptions of the steps of implementation should be used to support the implementation of the PFCC guidelines.

a. Sub-category: Learn from previous events

According to the participants, they are familiar with the implementation of changes to procedures and the workflow in the emergency department of the designated hospital:

"So, it was a whole rerouting of a lot of policies and procedures and we also had to do how a whole workflow change on every aspect…So, it was a big, big adjustment for the staff. We even had to do daily trainings for new work procedures every day, almost because things were changing so rapidly, especially in the first wave (of COVID-19) *when it was still unknown."* NP7

"We have to be reactive instead of proactive, but it has to be dealt with because it's on our statistics. So, we are also our held accountable for any interventions that we do. If we have a gap or if we have a missed opportunity." NP6

The participants' experiences with the implementation of changes in the emergency department that the outbreak of COVID-19 required may contribute to the smooth implementation of the PFCC guidelines.

b. Sub-category: Change management required

The implementation of changes in any working environment is challenging. When it is done in a fast-paced unit such as the emergency department of a hospital, extra efforts are needed to ensure that the staff does not become resistant towards the desired change. In the emergency department of the designated hospital, severely ill and injured patients are treated, and the working environment of the nurses is stressful. It is, therefore, important that the implementation of the guidelines should not be done in an autocratic manner. Participatory management is required. According to the participants, the nursing managers follow participatory approaches when changes are implemented in the emergency department of the designated hospital:

"You get the policies, and then the NM discuss it with us, and we discuss it, and if we don't agree, we send it back for change as some policies aren't practical." NP1

"then they need to go back to the whole staff group and explain to them what happened." NP7

The past involvement of the nurses of the emergency department in the adjusting of policies may, in the future, serve as a facilitator for the implementation of the PFCC guidelines of the RNAO.

c. Sub-category: Manage barriers to improvement

Not all stakeholders support the implementation of change. It is predicted that the same may happen when the nursing managers decide to implement the PFCC guidelines. They will experience barriers that will hinder the implementation of the guidelines. It is, therefore, important to be prepared to identify and manage the barriers that may occur. According to the participants, the training of nurses to gain knowledge and skills to implement the guidelines will not on its own be sufficient. They should be involved in each step of the planning for the implementation of the guidelines:

"…going back to the training part, people are negative already about training, doing a new thing is going to be difficult, to try and get positive participation." NP4

"the nurses must have the satisfaction that they are forming part of the guideline, to enhance the family centred care, the policy implementation, that sense of feeling that I have the skill and knowledge of how to be implanted, so that would be an incentive to me rather than getting a certificate." NP7

d. Discussion

Risks to patient safety in the emergency department can only be addressed after the identification of the underlying causes (Coggins, Santos & Zaklama 2020:9). It is therefore important that all members of the healthcare team be vigilant to identify possible situations that could lead to adverse events, delayed treatment and medical risks. Shared responsibility is of utmost importance in the emergency department. All the members of the team share the patients and are co-responsible for the safety of the patients (Amaniyan, Faldaas, Logan & Vaismoradi 2019:235). The successful implementation of measures to improve and maintain the quality of patient care should also be a shared responsibility of the healthcare team (Stefánsdóttir, et al. 2022:447).

Managing barriers to practice improvement entails the recognition of the lack of clinical knowledge and skills and the limited time that the healthcare team spend with patients and family members (Schofield, Rolfe, McClean, Hoskins. Voss & Benger 2022:4). To improve and maintain the quality of care provided in the emergency department an optimal working environment for the healthcare team is needed. It should be complemented with adequate resources and sufficient professional development opportunities (Anderson, et al. 2021:10).

4.4 SUMMARY OF CHAPTER

The findings were described and thereafter discussed with literature. In the following and last chapter, the conclusion, limitations, and recommendations of the study will be described.

CHAPTER 5
CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

Chapter 4 consisted of a detailed discussion and analysis of the data collected from the focus group interviews with nurse participants from the emergency department of the designated hospital. It explored and described the facilitators and barriers according to the CFIR that may influence the implementation of the PFCC guidelines of the RNAO in the department. Chapter 5 describes the aim of the study, summary, limitations and recommendations for practice improvement and future research as well as the conclusion.

5.2 AIM OF THE STUDY

The aim of the study was to explore and describe the facilitators and barriers according to the CFIR that may influence the implementation of the PFCC guidelines of the RNAO in the designated hospital's emergency department.

The objectives of the study were to:

- Explore and describe the contextual facilitators and barriers that may influence the implementation of the PFCC guidelines of the RNAO in the designated hospital's emergency department.
- Explore and describe the interventional facilitators and barriers that may influence the implementation of the PFCC guidelines of the RNAO in the designated hospital's emergency department.

5.3 SUMMARY

The first objective referred to the outer setting, inner setting and characteristics of the individuals according to the CFIR. The second objective referred to the interventional characteristics and the implementation process.

Objective one

5.3.1 Categories relating to the outer setting

When patients with severe injuries and illnesses are admitted to the department, they often require life-saving interventions. The aim is to stabilize their physical conditions as quickly and effectively as possible. During life-saving emergency care, interventions to stabilize the physical conditions of the patients are more important than endeavours to build trusting relationships with patients and family members. The general well-being of the patients gets neglected. These circumstances may hinder the implementation of PFCC.

In emergency departments, patients need to be transferred to other wards and units in the hospital or referred to other healthcare facilities once they have received initial treatment. The processes of referring or transferring patients are time-consuming and take up time that the nurses could have spent on delivering emergency care. On the other hand, the time that the patients spend waiting to be transferred or referred can be used by the nurses for PFCC. It, however, depends on the number of nurses who are on duty.

The emergency department of the designated hospital is obliged to admit patients who misuse the department for primary care. With a favourable patient-nurse ratio, PFCC can be delivered before the patients are discharged. When not enough nurses are on duty, and a significant number of patients with severe injuries and illnesses are admitted, the department gets overcrowded with little space and time to build relationships with patients and family members in order to deliver quality holistic care.

By creating a PFCC conducive environment throughout the whole hospital, the implementation of the RNAO guidelines will be enhanced. The PFCC that commenced in the emergency department will proceed after the transfer of patients to other units and wards. Holistic care based on the involvement of patients and their family members should not be limited to the emergency department. To continue the care provided in the emergency department, all nurses must be knowledgeable and skilled and practice good communication skills with colleagues from their own and other departments in the hospital.

5.3.2 Categories relating to inner setting

Group cohesion of the nurses employed in the emergency department requires effective communication, mutual trust and support, and feelings of being valued by others in the team. Conflict within the team may negatively impact the quality of care rendered in the department and, therefore, the patient's health outcome. Group cohesion may positively impact the productivity of the team, achievement of quality care goals, strong professional relationships and the satisfaction of patients and family members with the care received.

In a positive working environment characterised by respect between colleagues, patients and their family members, acknowledgement of each person's contribution to positive patients' health outcomes, the implementation of innovation associated with the PFCC guidelines of the RNAO is supported. If the team morale is low and a lack of participation in team activities occurs, it may reflect poor health outcomes for the patients.

In the past, the participants cooperatively implemented new policies, and they do not foresee that it will change in future. Their past experience serves as a facilitator for the future implementation of the PFCC guidelines of the RNAO. By implementing quality improvement policies successfully, patients and their family members benefit.

The emergency department is a stressful environment. Severely ill and injured patients are treated, causing their family members to be anxious. The nurses' primary

responsibility is to save the lives of their patients, leaving them with limited time to attend to the patients as human beings who are part of families. The participants acknowledged that they often found it difficult to build meaningful relationships with their patients and the associated family members. It may hinder the implementation of the PFCC guidelines.

Staff shortages in emergency departments may contribute to the neglect of the patient's needs to be assessed and treated as persons with unique needs and relationships. According to the participants, hospital managers should allocate staff according to the number of patients treated and the unique needs of the patients. It is, therefore, important that managers are cognizant of the challenges that a combination of critically ill patients and patients who require primary care for minor ailments cause when they are treated in the same department by the same nurses at the same time.

In emergency departments, a lack of patients' privacy may lead to the neglect of patients' needs to discuss sensitive issues with the nurses. It also contributes to challenges with the development of trusting relationships and the involvement of patients and family members in the care of the patients after discharge from the department. A lack of privacy serves as a barrier to the implementation of PFCC.

When nurses strive to deliver PFCC, it is crucial to receive feedback from the patients and to respond appropriately to the feedback. According to the participants, they already have a well-functioning system to get patient feedback. With the support of the nursing managers, the healthcare team of the department addresses the negative issues. The positive comments are celebrated. The way patient feedback is managed is a facilitator for the implementation of the PFCC guidelines of the RNAO.

The participants received in-service training to improve and maintain quality patient care. The existing system can be used for the implementation of the PFCC guidelines.

5.3.3 Category relating to characteristics of individuals

When all the nurses are positive to change, then only can it be effective and then only can implementation be successful. The nurses can experience a change in the working environment differently, and some can be resistant until they understand why the changes are necessary and how they will improve the quality of care. Training of the nurses and the involvement of the nursing managers may contribute to the successful implementation of the PFCC guidelines of the RNAO.

Objective two

5.3.4 Categories relating to interventional characteristics

Person-and-family-centred care refers to a holistic approach aimed at personalised, goal-oriented care according to the patient's preferences and needs and with their involvement in the planning, execution and evaluation of the care. In the emergency department, it consists of immediate physical care delivered with respect and kindness to the patients in collaborative relationships with both the patients and their family members. The patient should be at the centre of the PFCC, and he/she must be enabled to provide feedback regarding the care received. Although emergency care is focused on the immediate preservation of lives and positive clinical outcomes, once the patients' conditions have been stabilized, the use of the PFCC guidelines should be implemented to ensure the holistic well-being of the patients with the involvement of their family members.

Trusting relationships between nurses and patients and their family members enable the involvement of patients and family members in the care of patients and the emergency department. Patients and their family members mistrust nurses in the emergency department when they become aware of nurses' negative attitudes towards their involvement in the planning, execution and evaluation of care. Inadequate information from the nurses may cause breakdowns in communication with patients, resulting in non-trusting relationships. By implementing and practising the PFCC guidelines, trusting relationships can be formed and result in positive patient experiences and outcomes.

Patients' wishes must be honoured when it comes to the involvement of family members and the sharing of information related to their care. Although we know it can be beneficial to involve family members in the care processes of patients, it is the patients' choice to get the family members involved or not. In the emergency department of the designated hospital, it is difficult, due to the poor physical layout of the department, to adhere to the principles of confidentiality and protection of personal information when discussing the patient's health concerns and providing health education. The nurses must, by all means, try to adhere to the privacy policy of the designated hospital to prevent patient dissatisfaction and breakdown in trusting relationships.

Explaining the triage process to the patient and family members may create an understanding of why some patients may have to wait while others are treated immediately. When nurses keep the patients informed about delays and longer-than-expected waiting periods, the anxiety of patients and family members may be reduced. As processes are already in place in the emergency department of the designated hospital, it may serve as a facilitator for the implementation of the PFCC guidelines of the RNAO in the department.

5.3.5 Categories relating to the process of implementation

According to the participants, the principles of PFCC are already known to the nurses of the emergency department of the designated hospital. They are already implementing some of the aspects of the PFCC guidelines. It may, therefore, not be difficult to re-emphasize person and family-centredness in the planning and execution of patient care. The existing caring approach is aimed at involving the patient and family in the planning of long-term as well as acute care after the patients are discharged from the hospital.

The implementation of the PFCC guidelines requires the active involvement of the nursing managers and the training of the nurses in guideline implementation. It will also be necessary to emphasize the importance of using nurses' soft skills in rendering patient care. Providing care that is holistic requires nurses' endeavours to enhance the dignity of

patients and their family members. Empowering nurse-patient relationships should be cultivated.

Previous experiences with the successful management of change may enable the implementation of the PFCC guidelines. It will depend on the stakeholders' acknowledgement that training may be necessary. Implementing change can be challenging and even more so in a fast-paced unit like the emergency department of the designated hospital.

5.4 LIMITATION

The study was limited to the emergency department of one designated hospital where the researcher had permission to access the participations. Should any other researcher wish to utilise the findings and recommendations, they should do so with caution due to the small scale of the study.

5.5 RECOMMENDATIONS FOR PRACTICE IMPROVEMENT

The implementation of the PFCC guidelines of the RNAO in the emergency department of the designated hospital is recommended to guide and assist in the improvement of the quality of care to the patients' and family members' satisfaction and to ensure desirable health outcomes for all patients.

Recommendations for the implementation of the PFCC guidelines in the emergency department of the designated hospital:

- Manage facilitators and barriers identified in the outer setting domain of the CFIR by separating the severely injured and ill patients and the patients who require primary care. Divide the department into two sections, namely, an emergency care section and a primary care section. Manage the two sections separately and allocate to each section a complete staff establishment. Create a PFCC conducive environment

throughout the hospital to ensure that the care that is initiated in the emergency department is continued after the patients' transfer to other departments in the hospital. Enable the nurses in the emergency department to use the time spent on transferring and referring patients to initiate PFCC and to inform the staff who receive the patients after transfer or referral how to continue with the PFCC.

- Manage facilitators and barriers identified in the inner setting domain of the CFIR by empowering the nurses to develop strong group cohesion. Create a positive working environment for them to use their past experience with policy implementation to plan for and implement the PFCC guidelines of the RNAO. Enable them to use all possible opportunities to develop trusting relationships with patients and family members to the benefit of their involvement in the planning and execution of holistic care. Ensure the privacy of patients and manage patient feedback in such a way that the nurses are empowered, and the patients are satisfied with the care that they receive.
- Manage facilitators and barriers regarding the characteristics of the individuals who will be involved in the implementation of the guidelines to overcome any resistance towards the innovation through communication and training.
- Manage facilitators and barriers identified in the intervention characteristics domain of the CFIR by ensuring that the patient and his/her family are the centre of all caring activities. Explain the triaging process to patients and family members and keep all informed about the care that the patients receive and how they respond to the care. Once the life-saving processes have been successfully implemented and the patients' conditions have stabilized, the attention of the health team should shift from physical procedures to holistic PFCC.
- Manage facilitators and barriers identified in the process of implementation domain of the CFIR by using the knowledge and experience of the nurses in PFCC as facilitators in the implementation of the guidelines. Actively involve the nursing managers in the management of change and develop the nurses' skills in communicating with patients, showing empathy and respecting the dignity of patients and family members.

Recommendations for the implementation of the PFCC guidelines in the emergency departments of hospitals in general:

- Study the CFIR facilitators and barriers present in the functioning of the emergency department.
- Use the facilitators to support the implementation of the guidelines.
- Address the barriers to enable the implementation of the guidelines.

5.6 RECOMMENDATIONS FOR FUTURE RESEARCH

Further research is recommended to:

- Develop instruments to monitor the implementation of the guidelines
- Explore and describe the experiences of the people who implement the guidelines
- Explore and describe the experience of the patients and their family members regarding the implementation of the guidelines
- Develop instruments to measure the outcome of the implementation of the guidelines.

5.7 CONCLUSION OF THE STUDY

The researcher explored and described the facilitators and barriers in the implementation of person- and family-centred care guidelines of the RNAO in the emergency department of a designated hospital. She formulated recommendations regarding the use of the facilitators to enable the implementation and ways to manage the barriers. She recommended future research to monitor and measure the success of the implementation of the guidelines.

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APPENDICES

APPENDIX A: PRIVATE HOSPITAL CONSENT (2022)

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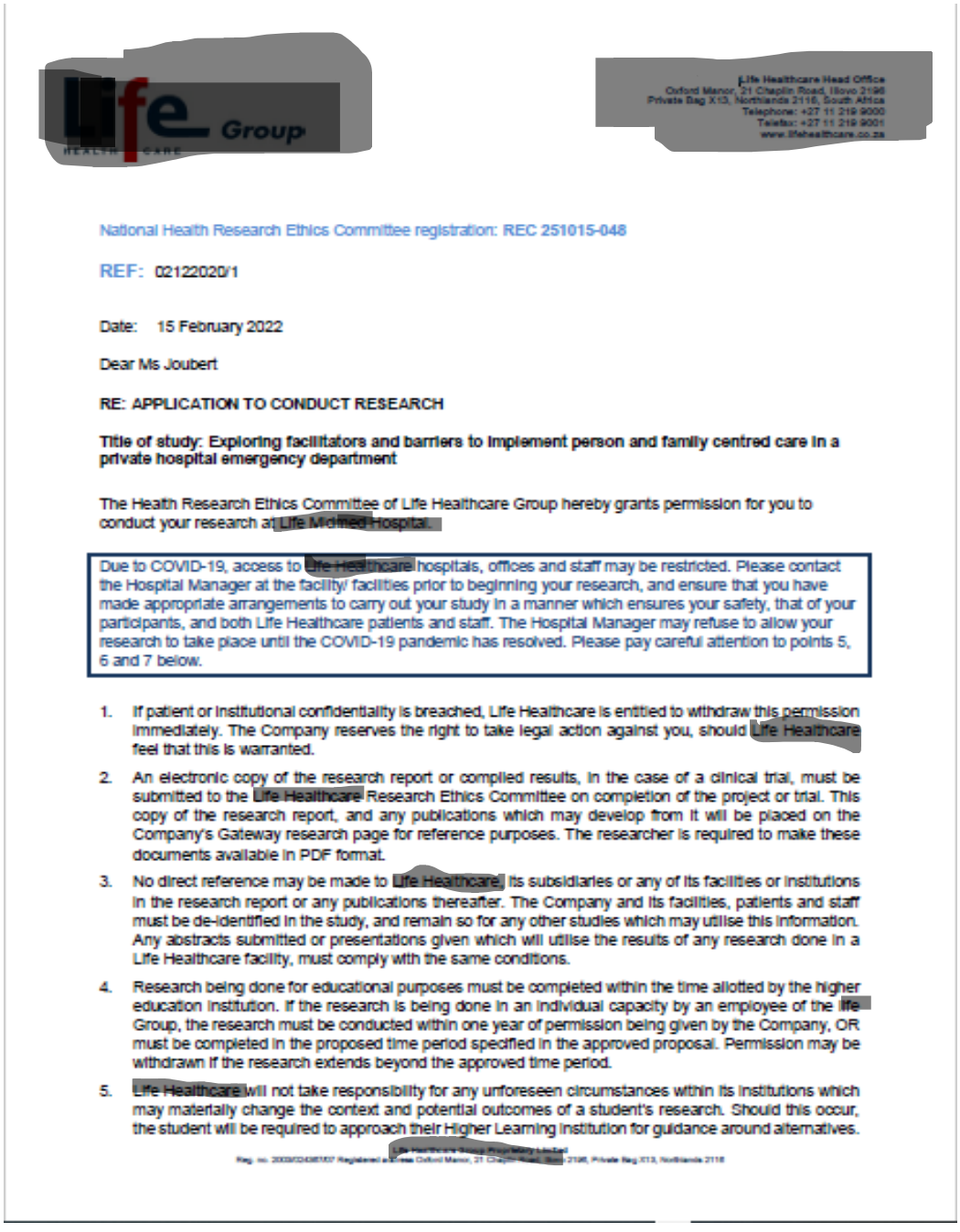

Life Healthcare Head Office
Oxford Manor, 21 Chaplin Road, Illovo 2196
Private Bag X13, Northlands 2116, South Africa
Telephone: +27 11 219 9000
Telefax: +27 11 219 9001
www.lifehealthcare.co.za

National Health Research Ethics Committee registration: REC 251015-048

REF: 02122020/1

Date: 15 February 2022

Dear Ms Joubert

RE: APPLICATION TO CONDUCT RESEARCH

Title of study: Exploring facilitators and barriers to implement person and family centred care in a private hospital emergency department

The Health Research Ethics Committee of Life Healthcare Group hereby grants permission for you to conduct your research at Life Midfield Hospital.

Due to COVID-19, access to Life Healthcare hospitals, offices and staff may be restricted. Please contact the Hospital Manager at the facility/ facilities prior to beginning your research, and ensure that you have made appropriate arrangements to carry out your study in a manner which ensures your safety, that of your participants, and both Life Healthcare patients and staff. The Hospital Manager may refuse to allow your research to take place until the COVID-19 pandemic has resolved. Please pay careful attention to points 5, 6 and 7 below.

1. If patient or institutional confidentiality is breached, Life Healthcare is entitled to withdraw this permission immediately. The Company reserves the right to take legal action against you, should Life Healthcare feel that this is warranted.
2. An electronic copy of the research report or compiled results, in the case of a clinical trial, must be submitted to the Life Healthcare Research Ethics Committee on completion of the project or trial. This copy of the research report, and any publications which may develop from it will be placed on the Company's Gateway research page for reference purposes. The researcher is required to make these documents available in PDF format.
3. No direct reference may be made to Life Healthcare, its subsidiaries or any of its facilities or institutions in the research report or any publications thereafter. The Company and its facilities, patients and staff must be de-identified in the study, and remain so for any other studies which may utilise this information. Any abstracts submitted or presentations given which will utilise the results of any research done in a Life Healthcare facility, must comply with the same conditions.
4. Research being done for educational purposes must be completed within the time allotted by the higher education institution. If the research is being done in an individual capacity by an employee of the Life Group, the research must be conducted within one year of permission being given by the Company, OR must be completed in the proposed time period specified in the approved proposal. Permission may be withdrawn if the research extends beyond the approved time period.
5. Life Healthcare will not take responsibility for any unforeseen circumstances within its institutions which may materially change the context and potential outcomes of a student's research. Should this occur, the student will be required to approach their Higher Learning institution for guidance around alternatives.

6. Life Healthcare will not be liable for any costs incurred during or related to this study.
7. In cases where a researcher is found to be guilty of misconduct, or in contravention of any national or international legislation or Life Healthcare policies or guidelines, permission to continue with the research will be withdrawn immediately pending investigation. In the case of student research, the higher education institution under which the researcher is registered will be notified. In the case of a clinical trial, The South African Health Products Regulatory Authority (SAHPRA) will be notified, as well as the trial sponsor and any other necessary parties.

Yours sincerely,

Dr Sharon Vasuthevan
Life Health Care HREC Chairperson

Prof Esmeralda Ricks
Research Associate

On behalf of the Life Healthcare
Health Research Ethics Committee

APPENDIX B: RESEARCH ETHICS COMMITTEE (2022)

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved old 22 May 2002 and Expires 03/20/2023.
- IORG #: IORG0001762 OMB No. 0990-0279 Approved for use through February 28, 2022 and Expires: 03/04/2023.

Faculty of Health Sciences **Research Ethics Committee**

11 February 2022

Approval Certificate
Annual Renewal

Dear Mrs M Joubert,

Ethics Reference No.: 110/2020 – Line 1
Title: EXPLORING FACILITATORS AND BARRIERS TO IMPLEMENT PERSON AND FAMILY- CENTRED CARE IN A PRIVATE HOSPITAL EMERGENCY DEPARTMENT

The **Annual Renewal** as supported by documents received between 2022-01-25 and 2022-02-09 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on 2022-02-09 as resolved by its quorate meeting.

Please note the following about your ethics approval:

- Renewal of ethics approval is valid for 1 year, subsequent annual renewal will become due on 2023-02-11.
- Please remember to use your protocol number (110/2020) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

On behalf of the FHS REC, Dr R Sommers
MBChB, MMed (Int), MPharmMed, PhD
***Deputy Chairperson** of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria*

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

Research Ethics Committee
Room 4-60, Level 4, Tswelopele Building
University of Pretoria, Private Bag x323
Gezina 0031, South Africa
Tel: +27 (0)12 356 3084
Email: deepika.behari@up.ac.za
www.up.ac.za

Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

RESEARCH ETHICS COMMITTEE (2023)

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 18 March 2022 and Expires 18 March 2027.
- IORG #: IORG0001702 OMB No. 0990-0278 Approved for use through August 31, 2023

Faculty of Health Sciences **Research Ethics Committee**

16 February 2023

Approval Certificate
Annual Renewal

Dear Mrs M Joubert,

Ethics Reference No.: 110/2020 – Line 3
Title: EXPLORING FACILITATORS AND BARRIERS TO IMPLEMENT PERSON AND FAMILY- CENTRED CARE IN A PRIVATE HOSPITAL EMERGENCY DEPARTMENT

The **Annual Renewal** as supported by documents received between 2023-02-01 and 2023-02-15 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on 2023-02-15 as resolved by its quorate meeting.

Please note the following about your ethics approval:
- Renewal of ethics approval is valid for 1 year, subsequent annual renewal will become due on 2024-02-16.
- Please remember to use your protocol number (110/2020) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:
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Research Ethics Committee
Room 1.69, Level 1, Tswelopele Building
University of Pretoria, Private Bag x323
Gezina 0031, South Africa
Tel: +27 (0)12 356 3084
Email: deapeka.behalf@up.ac.za
www.up.ac.za

Fakulteit Gesondheidswetenskappe
Lefapha la Litsebenzi tsa Maphelo

APPENDIX C: PARTICIPANT'S INFORMATION AND INFORMED CONSENT DOCUMENT FOR A FOCUS GROUP INTERVIEW RESEARCH STUDY

Study title: Exploring facilitators and barriers to implement person and family centered care in a private hospital emergency department

Principal Investigator: Mari-Louise Joubert

Supervisor: Professor Neltjie C van Wyk

Institution: University of Pretoria

DAYTIME AND AFTER HOURS TELEPHONE NUMBER(S):

Daytime number/s: 0827705122

Afterhours number: 0827705122

Date and time of informed consent discussion:

				:
date	**month**	**year**		**Time**

Dear Prospective Participant

1) INTRODUCTION

You are invited to volunteer for a research study. I am doing this research for Masters degree purposes at the University of Pretoria. This document gives you information in this document is provided to help you decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this document, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about what we will be discussing during the focus group discussion.

2) THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to explore or describe the facilitators and barriers to implement person and family centered care in a private hospital emergency department. Part of the study will be a focus group discussion. A focus group is where a few people – usually about 8 or 10 – get together with the researcher to discuss a specific topic. The discussion will be arranged at a time that is convenient to you and will take place on teams.

3) EXPLANATION OF PROCEDURES AND WHAT WILL BE EXPECTED FROM PARTICIPANTS

If you agree to participate, you will be asked to participate in a focus group discussion which will take about 90 minutes. You and the other participants will be asked some questions about your opinion about facilitators and barriers to implement person and family centered care in a private hospital emergency department. We will not ask any questions about your personal experience. With your permission, the discussions will be recorded on a recording device to ensure that no information is missed.

4) RISKS AND DISCOMFORTS INVOLVED

We do not think that taking part in the study will cause any physical or emotional discomfort or risk.

You do not have to share any knowledge you are not comfortable with. During the focus group discussion, you may find that some questions are sensitive; for instance, questions about facilitators and barriers to implement person and family centered care in a private hospital emergency department

5) POSSIBLE BENEFITS OF THIS STUDY

You will not benefit directly by being part of this study. But your participation is important for us to better understand the facilitators and barriers to implement person and family centered care in a private hospital emergency department.

The information you give may help the researcher improve a better understanding of facilitators and barriers to implement person and family centered care in a private hospital emergency department.

6) COMPENSATION

You will not be paid to take part in the study. There are no costs involved for you to be part of the study.

7) VOLUNTARY PARTICIPATION

The decision to take part in the study is yours and yours alone. You do not have to take part if you do not want to. You can also stop at any time during the interview without giving a reason. If you refuse to take part in the study, this will not affect you in any way. You will still receive standard care and treatment for your illness.

8) ETHICAL APPROVAL

This study was submitted to the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, Medical Campus, Tswelopele Building, Level 4-59, telephone numbers 012 356 3084 / 012 356 3085 and written approval has been given by that committee. The study will follow the Declaration of Helsinki (last update: October 2013), which guides doctors on how to do research in people. The researcher can give you a copy of the Declaration if you wish to read it.

9) INFORMATION ON WHO TO CONTACT

If you have any questions concerning this study, you should contact:
Professor NC van Wyk neltjie.vanwyk@up.ac.za or Mari-Louise Joubert 0827705122

10) CONFIDENTIALITY

We will not record your name anywhere and no one will be able to connect you to the answers you give. Your answers will be linked to a fictitious code number or a pseudonym (another name) and we will refer to you in this way in the data, any publication, report or other research output.

All records from this study will be regarded as confidential. Results will be published in medical journals or presented at conferences in such a way that it will not possible for people to know that you were part of the study. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Research Ethics Committee. All of these people are required to keep your identity confidential. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records. All hard copy information will be kept in a locked facility at the University of Pretoria, for a minimum of 5 years and only the research team will have access to this information.

Although all participants of the focus group discussion will be requested to keep the discussion confidential, the researcher cannot guarantee that they will do so. I therefore request that you do not disclose any information of a very personal or sensitive nature.

11) CONSENT TO PARTICIPATE IN THIS STUDY

- I confirm that the person requesting my consent to take part in this study has told me about the nature and process, any risks or discomforts, and the benefits of the study.
- I have also received, read and understood the above written information about the study.
- I have had adequate time to ask questions and I have no objections to participate in this study.
- I am aware that the information obtained in the study, including personal details, will be anonymously processed and presented in the reporting of results.

- I understand that I will not be penalised in any way should I wish to discontinue with the study and my withdrawal will not affect my treatment and care.
- If photos are taken it may only be used after I have seen it and agreed that it may be used.
- I am participating willingly.
- I have received a signed copy of this informed consent agreement.

_____ _____

Participant's name (Please print) Date

_____ _____

Participant's signature Date

_____ _____

Researcher's name (Please print) Date

_____ _____

Researcher's signature Date

I understand that the focus group discussion will be audiotaped. I give consent that it may be audio recorded.

YES

NO

AFFIRMATION OF INFORMED CONSENT BY AN ILLITERATE PARTICIPANT (if suitable)

I, the undersigned, ……..…., have read and have explained fully to the person, named …… , the participant informed consent document, which describes the nature and purpose of the study in which I have asked the person to participate. The explanation I have given has mentioned both the possible risks and benefits of the study and the alternative treatments available for his/her illness. The person indicated that they understand that they will be free to withdraw from the study at any time for any reason and without jeopardizing their standard care.

I hereby certify that the person has agreed to participate in this study.

_____ _____

Participant's name (Please print) Date

_____ _____

Participant's signature or thumbprint Date

_____ _____

Investigator's name (Please print) Date

_____ _____

Investigator's signature Date

_____ _____

Name of the person who witnessed

the informed consent (Please print) Date

_____ _____

Signature of the witness Date

APPENDIX D: SEMI STRUCTURED INTERVIEW GUIDE

Guidelines	**Intervention characteristics**	**Outer and inner setting**	**Process of implementation**	**Characteristics of individuals**
	Why do you think that the guidelines can be effective? How adaptable are the guidelines? Are the guidelines complicated?	Why do you think that the guidelines will fit your department? Does the hospital policy support PFCC? What resources do you have to implement the guidelines? Are you motivated to implement it?	Are you willing to take part in the implementation of the guidelines? Why do you think that you are capable of PFCC? What training is required? What barriers and facilitators may be experienced? How ready are the staff to implement PFCC? How can the staff be motivated? What incentives should be made available?	Do the staff have the knowledge and skills to implement PFCC? Do the staff believe in their capabilities? Are the staff eager to accept change? Does the department have staff who can act as change agents? How do the staff experience change?
Establish a therapeutic relationship with the person using verbal and non-verbal communication strategies to build a genuine, trusting, and respectful partnership:				

Nonverbal - active listening; convey sympathetic presence; give the person your full attention; display warmth and kindness; demonstrate respect; offer reassurance; display efficiency. **Verbal** - introduce yourself; explain your role; address the person by his name; get the person's agreement to proceed with care; explain care step by step; be respectful when you assess the person; be reassuring when they express their fears; do not rush the person; encourage the person to give input; use non-judgemental responses; accept, repeat and validate your understanding; adjust your tone of voice to accommodate the person; act as a resource; explore with the persons their concerns; provide clear and timely information; reflect on whether your manner and style of communication is meeting the person and family's needs.				
Build empowering relationships with the person to promote the person's proactive and meaningful engagement as an active partner in their healthcare: demonstrate an interest in the whole person; intentionally start with what matters most to the person; be respectful of each person's diversity; take the time to be present; listen attentively; learn about the person's values; encourage the person to tell his or her story; facilitate choices; support the person's autonomy; encourage the person to participate in decision-making; facilitate choices; provide information and education; encourage the person to voice concerns.				

Listen and seek insight into the whole person to gain an understanding of the meaning of health to the person and to learn their preference for care: ask questions about their strengths and health needs; what they are concerned about; what they wish to happen for care; what their priorities for care and services are; what they think about their ability to manage their own health; what they feel must be taken into consideration in their care; who they wish to involve in their care; what information they think they require.				
Develop a plan of care in partnership with the person that is meaningful to the person within the context of their life: appreciate the person's input; involve the person as active partner; keep the person's perspective central; address the person's unique needs and life circumstances.				
Engage with the person in a participatory model of decision making, respecting the person's right to choose the preferred interventions for their health, by: collaborating with the person to identify their priorities and goals for healthcare; sharing information to promote an understanding of available options for healthcare so the person can make an informed decision; respecting the person as an expert on themselves and their life.				

Personalize the delivery of care and services to ensure care is not driven from the perspective of the nurse and organization, by collaborating with the person on: elements of care; roles and responsibilities in the delivery of care; and communication strategies.				
Partner with the person to tailor strategies for self-management of care that are based on the person's characteristics and preferences for learning: determine the person's existing knowledge; share knowledge and information; avoid the use of medical jargon; explain information slowly; provide time for the person to absorb the information; help the person to accept new information.				
Obtain feedback from the person to determine the person's satisfaction with care and whether the care delivered was person- and familycentred: focus on the person's own experience of the care – the person was treated as a partner within the therapeutic relationship; there was respectful, truthful communication; the person felt safe, had their fears and concerns addressed, did not feel rushed; nurses delivered quality care to meet the person's needs as a whole person; the person was an active partner; nurses discussed evidence-based practices with the person in a way that helped the person understand the options of care and enabled them to make decisions.				

Educate nurses at a minimum on the following attributes of person- and family-centred care to improve the person's clinical outcome and satisfaction with care: empowerment; communication and decision making.				
Create an organizational culture that exemplifies its commitment to person- and family-centred care by: demonstrating leadership and commitment to this approach to care; involving the person in co-designing health programs; and building healthy work environments for all nurses.				
Design an environment that demonstrably improves the person's experience of healthcare by: creating healthy environments; being flexible and partnering to personalize care routines; improving access to care and services; enhancing the continuity and coordination of care and services during transitions; and providing continuity of nurses.				
Collect continuous feedback from the person to determine whether their experience with healthcare and services was person- and familycentred, and utilize this feedback to make improvements at all levels of the health system: select measures in partnership with the community as well as the staff to ensure consensus on elements associated with person- and familycentred care practices.				

APPENDIX E: TRANSCRIBED INTERVIEWS

Semi-structured interview: Session 1

4th April 2023

Attendees:

Participants	Professional Qualification	Academic Qualification
NP1	Professional nurse	Diploma in nursing science with an advanced qualification
NP2	Professional nurse	Diploma in nursing science with an advanced qualification
NP3	Nursing auxiliary	Certificate in nursing
NP4	Nursing auxiliary	Certificate in nursing
NP5	Professional nurse	Diploma in nursing science with an advanced qualification
NP6	Professional nurse	Diploma in nursing science with an advanced qualification

Intervention characteristics

Interviewer:

"Ok let us start. Can it work? You know, your ER, you know who visit your ER and you know how many people you have working; they are your resource you know the venue, how large it is, or how small it is, do you think that we can in that with the limited time, maybe you have enough time to create a good trusting relationship with each one or our patients coming in there?"

NP3

"Good Morning, I am Tsakane Mndawe, yes, according to what you see here, I believe that we can build a good, trusted relationship in our unit Actually, to make our patients feel welcomed and everything in the unit, because in most

cases casualties are busy. So, our patient is not going to get to get one-on-one private session with the nurses compared to the wards. So, building this or implementing this would actually make a very good and creates a very good therapeutic environment for our patients."

NP1

"We think if we can also integrate it, it will help tell the family members in advance what's going on and also let them know what's going on with the persons in the unit. They will also be satisfied with the quality of service."

Interviewer:

"OK. Do you have sufficient time to explain to everyone what your role is? And how you fit into the team?"

NP2

"I think it's also part of your introduction to the families and the identification to say who you are and what is your role in their care?"

NP5

"I think a current in our unit is we have a problem with it we have a big unit
and our ER and it's extremely busy.
And to have a personal relationship with those patients is a big challenge in the unit for the staff. Umm, then we just have a problem just for them to do the basic things to introduce yourself to, to explain the triage process and the codes and to explain why you are going to wait and if you are a certain kind of the colour the amount of time that you likely to wait. I think the challenge is just the communication at the moment and never mind even I'm having relationship with the patient."

Interviewer:

"It might not, and they one can maybe spent more time with the people, but when it's really like a crisis, one can't".

NP5

"Yes, I think if I can just mention that we have currently in our trauma unit is the doctors, not the hospital, but the doctor, that appointed a person, that is the client liaison between the doctor and patients waiting and he works from 9 to 9.

And it's kind of like a client liaison or he doesn't do any nursing work. He just goes from patient to patient. If the communication between the patient and family sitting in the waiting area. And he builds the relationship. So that's actually his job is doing that. And that was very well we get very good feedback. But the nurses themselves that that it's a lack, definitely a lack. I think so. I think really, he presents makes the relationship better, so he is an enabler. And so, it definitely it improved our feedback that we get from our patients."

NP1

"We recently got enrolled nurses also in our facility that's also doing that type of work and also help us with the triaging of the patients. (on now a trail started a few weeks ago as the feedback from patient were very poor, so a plan needed to be made)"

Interviewer*:*

"That is maybe a more realistic perspective. And sometimes you cannot be in a in a hurry, not rushing through the through the patients and of the situation, but luckily, I'm sure there are also times when you more time to speak that during the day."

Interviewer*:*

*"W*ould you say that his appointment is sort of an enabler?" And does it facilitate the process when not enough nurses are on duty? Maybe barrier"

NP1

"In in the front, before coming into the casualty department and that also helped a lot because that person also communicates between the doctor and the nursing staff in the casualty and with the family outside to tell them what these going on and what is going to happen. So that also helps a lot, and the patients really appreciate that so that they the family as well that they know what's going on with the family members."

Interviewer:

"OK, I'm glad you mentioned the family. To what extent are their families allowed to enter the unit and be with the person and take part in the decision-making."

NP3

"The unit normally would have one family member with the patient, but depending on how old the patient is, like the baby would have both parents alternating each time."

NP1

“Umm, with adults. Let's say elderly people who have that their children, maybe one daughter or son that will help give you the information or even reassuring the parent.”

NP1

“But normally in young adults. If they are stable, if I may stay or not
confused or anything they allowed to be there by themselves unless they need moral support from family.”

Interviewer:

“I see that I’ve listed here. Making sure that you’re on now non-judgmental. OK. And you know, sometimes we admit patients with home self-inflicted. And all people that is intoxicated or drunk. Is it difficult? Not to be judgmental? And when there are many other persons to look after.”

NP3

“OK, well, it depends on the situation you would get patients that tries to commit suicide and until you understand their stories, then you cannot judge them and say people have different problems out there and they all have different ways of dealing with their problem. But sometimes if you get a young adult just getting drunk for iPhone 20, I mean, sometimes you want to just express to them like, listen this there's more to life than just before that you want, but you get people meet adults where they put like and crisis they put financial problems, marital problems. And in that way, you try by all means to comfort them and do not judge them because it can also impact to their health or their recovery because as soon as you start judging them, then it feels to them that everyone is just against them.”

Interviewer:

“I think it’s a very important point that you are making” “Is it enough opportunity to do this in privacy?”

NP4

”Yes, in the unit we have private cubicles, but only divided by a curtain. So, you don't get to meet them unless it's in the resus area where you have to when the patient is normally

you are able to have a one-on-one talk with your patient or after the doctor has seen them.

Outer and the inner setting.

(the hospital policies, and do they allow you to build or enables you, or makes it possible for you to build a genuine, trusting respectful relationship)

Interviewer:

“Right. When we look at the outer and the inner circle. We need to talk about the hospital policies, does it allow you to do so or enables you not allow you in without hospital policy and makes it possible for you to both a genuine trusting, respectful relationship. Whether you have the resources in order to do that and you’ve already mentioned that you work in cubicles. So that my that’s a facilitate that you know that you have the cubicles available for something like that. And will get implemented so it’s a policy resources and the motivation to get it implemented.”

NP5

“If I can give my honest opinion, I've finished in the emergency unit for a few years.
And then to the towards the end before I started being a clinical facilitator.
Then it felt like you became numb. So, your sympathy levels are low and every person that comes in doesn't feel like an individual anymore. So, it then I still work from time to time over time in casualties and I've been out of practice now for more than five years.
And I can feel now that I have much more sympathy with my I would, I would listen to the story behind the story and I'm more willing to do that just because I'm not bombarded with it every day anymore. In practice, for too long you become numb.”

Interviewer:

“Thats it. Thank you for being honest with us because then I think that is very much possible that one can develop an insensitivity for all aspects that one has have to deal with while you are busy. Trying to work with me, but it’s at the same time so very ill and others not so ill.”

NP2

“I think what I can add to that, I don't think its people doing wrong in practice also, but I think covid probably also played a role because we were desensitized

And any time that we are treating numbers and not patients and families.

And by implementing this guideline, we will be focusing again on it, it will remind everybody about patient centred care and that they are not just another number but a patient with family because we're not only treating the patient, but we are also actually treating them as a whole”

Interviewer:

“Thats true” “Hospital policies that might be in English or barriers”

NP1

“Strict visiting times and because we can’t get the information over to family member if you don’t have someone to talk to the family being this if we don't have someone in the emergency unit that can give them any information to that will be a big barrier. If there's no one that can give information out.”

NP2

“And POPIA making people scared to talk to family. On what they can disclosed to the family, and they can’t.”

Interviewer:

“So, what is this? Or in your case, or actually barriers. Is it? How often do the family accompany the patient? The family members that do accompany the patients are they only the parents.”

NP3

“It depends on the condition and the age of the patient and how busy the unit is.”

Interviewer:

“Other resources that you have or that you think are lacking. Is there sufficient privacy?”

NP4

“Not really, because in the cubicles have curtains only.”

NP3

“Area between the other rooms is just a curtain, so you can hear the whole unit. You can hear the other person in the next room. So, I think maybe closed doors would actually make it more private.”

Process of implementation

Interviewer:

“We can move on to the process of implementation.” “According to your opinion, there was a hand of Natasha. (NP 5) you wanted to say something?”

NP6

“It's something that I see in our unit, and I actually support the previous person is that there is not sufficient privacy. You don't often have cubicles, so it's really just the curtain between the two patients. And you have to discuss sensitive information with the family so. Umm and I, I think it's not just in one specific facility. If you look at most of the emergency facilities that are set up in that way that there is not sufficient privacy to allow you that. The opportunity to discuss the information with the family itself.”

Interviewer:

“Let’s have a look at the process of implementation. Youve seen all of you have seen the guidelines. Do you think that we that it will be necessary to train the staff in the implementation? To do that, to implement this family and person centred. And healthcare guidelines, well, they require special training in order to do that. And this and now I interest is simply to a trusting respectful partnerships. Keeping also in mind that we treat patients from different culture cultural. And they are created by people from. A better idea of cultural needs and backgrounds. Do we have the sufficient knowledge in the ER? It would need to implement family and person-centred care.”

NP1

“I think the staff in the EU and hospital have to be trained how to, after covid as mentioned earlier on, because we get numb, and we not really explaining to the patient and family, and they need training again in soft skills. We are not really intuitive to explain to people something we must training soft skills again, how do? Different kinds of cultures and different kind of people when they want to explain something to them.”

NP3

“I think the training would actually help a lot, because taking also again of covid, it into consideration.”

Interviewer:

“OK. And anyone else who would like to contribute to the training, the necessity of training? And how willing will the staff be. to undergo the training, and what is your experience from the past? Do they enjoy in service or not?”

NP4

“Not only that, it became, you know, we also became emotionally vested in the whole situation is where we don't anymore look at how the patient is feeling. We just working because we get exhausted anyway, so we must go back, start the training knowing how to approach patients, how to talk to them and how to make them feel welcome because all the patients come to the casualty, you need one thing help. But if all the nurse also needs help, they are not going to be effective”

NP6

“I think what we see here with our EU often is people are very emotional ready when they come in. So, because they've waited for a long time as well, it's an emergency unit, but it doesn't mean that turnaround time was forced or quick and that we already stressed because they've got a family member not feeling well. The staff on the other hand, have been working at a very high pace and they've seen many patients. I think yes, you can educate and share with them again what is the role that you need to portray and the compassion they gain that it's their first time seeing you. You've seen many patients. And that just remind them, this is each time a new experience and a new place for the patient and that you communicate with this staff very often. That's the feedback we also get from our comment cards is if they just spoke to me or they just clarified more. So, remind them that not everybody that comes in understanding the terminology or the understand our turnaround times or anything like that and you actually teach the staff those principles again of speaking to the family or speaking with the patient so that the information comes through and then as far as possible to involve the in the in whatever decisions are going to be necessary for the for the patient.”

Interviewer:

“Thats a good, good comment. Good input ohm easily. Do the people in here or in your hospitals accept change?” You know this can be quite a big change for some of the

people because I might see an implementation of a guideline such as this as criticism on what they are doing at present, and they might feel they work very hard as it is. And now we come and say we want to teach you and we how to build a genuine, trusting, respectful relationship and how easy do you think will it be or them to make. They available for training and to be positive about the implementation and to accept that this might bring about some change in the way that they are working and doing every day."

NP4

"It just want to say it is not, a new way of doing things, especially nurses they are used to, they have experience it, and we can introduce a new way or a different way of doing things, it is not always received positively."

NP2

"I just want to say that it's not easy to bring in a new way of doing things, they need to be invested they believe that they were changing this. They know exactly how to do this, but they have experience is doing this. So, when you try. It's a new way of doing things. It's not always a positive feedback that you get from there, but if we continue and with the eventually, they will get used to it and then they will see the change if we guide them"

Interviewer:

"OK. Thank you. Thats a very positive perspective. And yeah, it will take time, but it's not impossible to get it done."

Interviewer:

"And not only being respectful and the relationship, but do we including making them active partners in healthcare so you? The admitted patient with one family member. And now you've both relationship, but now to make to bring that person into a partnership, making him in not just a recipient of care but a real partner, and you can have looked day on your guide that it says focus on what matters most through the person, work on the diversity. Weve started mentioning it. The diversity of our patients as well as the staff take time to listen attentively. What are the persons values? So, this is now not just the immediate need. And facilitate choices and let's speak the patient's autonomy. And provide sufficient information so that they can become actively involved. In the key that you give to him and that he or she will proceed with after discharge. You know, step by

step first look at the policies and then wave gone through all of this. How feasible is this? Is it possible? What will then facilitators or enablers and what might the barriers be? Something that I think of is communication. You know, if I can't speak the home language of the person, that can be quite a barrier to beat the person actively involved in the in his or her came."

NP4

"Yes, but I think we would actually have time to promote a person's centredness in a meaningful engagement and not only because they're just our clients, but she also remembering that they also have autonomy to their own health, and they have the right to decide what they also want. We cannot decide that ourselves or just include the healthcare team to be the ones deciding on their care."

NP3

"You also taking into consideration their beliefs and they use because people have different views, they have different values in terms of some patients will not be wanted to be nursed by a female nurse for an example. So maybe also helping our department in raising awareness of the different cultures in us with our communities would also help the patients because we get different patients that are still old school like the African culture, where the older male patient may not be nursed by a younger nurse"

NP2

"And I think with all the concern these days also that we need to obtain consent from the patient for all procedures, invasive procedures that actually do make them active partner in their care because you need to explain everything to them and they need to give consent, either verbally or written because that's part of the policies and procedures you must get consent from the family or the patient for any procedure that you do"

NP1

"I think if you continuously try and explain and provide information that's truthful
and explain what the next step in the treatment is. And they know what is going to happen to them, I think they will be more open to see what is going on because they are informed, and they get the necessary information for what is going to go on and what's going to happen."

NP5

I also think patients may have a resistance to actually be part of their own treatment plan if they do not have access to the information regarding whatever this. The patients that, for instance, a hypertensive patient, if you do not give him enough information, they just omit medication because they don't understand the need of it.

If we offer more and give information, is always key, so if you can give them more information, the outcomes might be better. No but as we do have like a form for concussion form, so we do give them information because its true at that moment, it's not the best time to actually give them education because they are scared or stressed."

Interviewer:

"Do you have written material day in your ER that you in in different languages? Maybe that you can provide them with the because they may be too stressed to remember what you are talking about?"

NP1

"We also have a back slap leaflet, but it's only available in English. It's not all the languages."

NP4

"But there's nothing about hypertensive care or asthmatic care, all those afterwards care in different languages even available."

Interviewer:

"Does it happen from time to time that there's really a language barrier that you don't have a nurse who speaks the language of the patient, and the patient does not understand English? All of the communication for that matter at all, and what do you do?"

NP1

"We have lots of patients coming in like Japanese and Chinese patients or visitors from the clear National Park that speaks foreign languages. So, we try to find a translator. Some of our therapist are translators."

NP3

"Yes, we do, but mostly the African cultures like Tsonga, Zulu, Swati, etc.

Then the most nurses are actually from different ethnic groups. So, we do have it that we try to communicate in their language."

NP1

"We try but it is not always possible."

Interviewer:

"Good. Then let's have the next one, which is meaning of health to the person and learned about the preferences of care and looking into the person more and focus on more than just like a hand injury do you have you attend to? How important is his or her hands or in his or her occupation? Thats just a very simple example, but is it possible to attend to that? Because that's part of person and family centred care to look at the person as a as a human being not only a person who`s injured."

NP3

"Looking at our casualty unit, it depends on what's the injuries of the patient. I would say maybe what happened? That evidence? Yes, we do try to look at helping the patient, especially when they're maybe defaulting on their hypertension medication or diabetes medication. Then you would want to know with whom the patient is staying with, who is taking care of them is it a person that is informed on how to help the patient giving medication or giving the correct diet? And then you go to the extent of checking if it's possible for the question to be on diet for whatever sickness, because now that becomes a challenge as well because our economy people don't get to afford everything. So that's one of the major things. But with most injured patients, I don't know if we actually go to that extent because we see to our immediate need from the patient and then we transfer them or to different units where they will be referred to specialist. Then from there that is where they get more information and knowledge how to treat their injuries or needs go to those experiences where we can get through, follow up or sit the patient, it is sometimes just too busy and short staffed"

NP1

"We focus on the patients, injuries and what had happened to him at this stage. The doctor in the EU follows up sometimes with the patients in the hospital or in the wards, and if you are on shift and you know this person and you were concerned about the

patient's, you follow up and see if the patient is an okay and fine and if the patient will be fine when they go home. And you can follow up with the nurses in the ward, so that they can also follow up with the patient if there was a concern."

NP6

"Yeah, I think much of the time actually goes into the immediate needs of the patient, especially if they are charged to go home. I do think that's an area that would actually need attention and that that is not you try to give discharge information, but it doesn't mean that you really assist, whether the patient is able to actually maintain what you've shared with them as well. Yeah, I agree. If we actually admit the patient in the hospital, there is a whole process that is followed. But I think if its discharge time, I don't think we basically I don't think we look at them holistically."

Interviewer:

*"*Let's talk domestic violence what happens then? How does one render person and family care in the case of domestic violence and the person is not injured to the extent that they should be admitted?*"*

NP4

"OH, first we have to prove if it's domestic violence because now it has to be the recurring and be proven. Because normally if you get the patient that comes once maybe hurt or injured you can't prove that it's been abuse. But if it's something that is recurring, then that is where our doctors and our unit managers will take a step forward into helping that patient or involved because we do have some social workers in our hospital that actually assists us with that"

NP2

"We are quite vigilant on child abuse because we involved the paediatrician. If we suspect, we report to the social workers as we are very close to with the social workers."

Second Session:

13th April 2023

Participants	Professional Qualification	Academic Qualification
NP1	Registered Nurse	Diploma in Nursing with a Degree in Emergency Nursing Science with Nursing Education
NP2	Registered Nurse	General Nurse with a Degree in Critical Care Nursing with Nursing Education
NP3	Enrolled Nursing Assistant	Certificate in Nursing
NP4	Enrolled Nursing Assistant	Certificate in Nursing
NP7	Registered Nurse	Diploma in Nursing with a Degree in Critical Care Nursing with Nursing Education
NP8	Registered Nurse	Diploma in Nursing with a Degree in Nursing Education

***Interviewer**:*

*"*I remembered that we all had to make major changes during COVID. So how was that managed? Try to remember what you've done in your preparation for COVID day in the ER and what changes was made were made. And how did the people react to that? Was it easy? Was it difficult? What were the emotions?"

NP1

"In our hospital we didn't let the family come in with the patient, who will see the patient off given over to the casualty department and the patient was alone in the department. If the patient was discharged, the patient got the information and was discharged without any family contact from the nurses. When the patient was admitted. We let the family know. But they were not allowed into the hospital. So, it was really problematic for the family as well as the patient, so people only see the family when they were discharged."

NP8

"OK, there was a lot more required from the staff in terms of communication with the families because on a daily basis they had to phone and make telephonic calls to all the

patients family members to give them an update on the condition of the patient and so on. So, it was also very difficult in terms of the POPIA act and staff to these actions and who is the actual person that you can share information with and all that."

NP8

"Yes, because. In actual fact, during the covid, our turnover was so weak, and the staff were under pressure a lot and then they still had this additional duties that they had to carry out during the day and also, they work most of the time they were actually short staffed."

NP7

"I think in the first wave, the staff were sick, and seen how their peers is getting sick one by one, it was also very stressful and the certainty surrounding the situation was not nice."

Interviewer:

*"*And how was it? How did you get to know about the arrangements and about COVID? Did the nursing service manager come and discuss it and was your input ask? And was it the top down approach? How was it done?"

NP8

"On the initially it was a daily meeting. And as we progressed, it was a daily meeting with the CEO, the nurse manager and all the unit managers. As well as the IPC infection prevention as well as the quality manager, in order to discuss all the new policies as well as the, how can I say the get arounds with difficult situations so that we could discuss it with the staff. So that they knew what to do in various situations, a patient being discharged which route they should take. What to do with the patient? What must they do with the file afterwards? Must it be in the unit? What must they do with the medication? Because the pharmacist manager was also invited to this.
So it was a whole rerouting of a lot of policies and procedures and we also had to do how a whole workflow on every aspect in terms of covid workflow on every aspect in terms of covid with how to do this, how to manage intubations. How to resus during, if a patient is called with positive or negative or PUI waiting for results. So, it was a big, big adjustment for the staff. We even had to do daily trainings for new work procedures every day, almost

because things were changing so rapidly, especially in the first wave when it was still unknown".

Interviewer:

"OK, did it? Did the group feel? Was it more group cohesion because of that? In the between the staff or that it actually contribute to stressful relationships in the in the group?"

NP7

"I think the group cohesion was very good, we worked together, helped each other more. I think it was much better than before we work together and then talk to each other. And all the people with the meetings like. Even you know, they discussed it and they burst into tears, and it was a very emotional."

NP8

"And also there was the incorporate the whole lot of new staff quickly into the unit. So, because we were getting staff even as far as KZN to coming assist us. So, we had to do very quick orientation and very quick group cohesion and to happen in order for things to be carried out."

Interviewer:

"OK. Yeah, that's how you manage the change that you had to bring about during COVID. And do you still have a when we now or go? Luckily, we through COVID. OH, the biggest problem surrounding COVID, but do you still have regular meetings with your nursing service managers, and do they appreciate your input during these meetings? Or do you more or on the other hand, do you know if that doesn't happen, do you just get sort of a written policy document that you have to implement? Or in what way do the nursing service managers communicate?"

NP1

"You get the policies and then the NM discuss it with us, and we discuss it, and if we dint agree we send it back for change as some policies isn't practical."

NP8

"And also, we have a daily meeting. That's how we get information about changes to

policies and the quality manager, the IPS and the service managers are present at the meetings."

NP8

"So, you get an opportunity to also voice your concerns."

Interviewer:

"These suit both ways in which you a document that tells you this is how you do the triage, and these patients go there and those go there and those get discharged and or it's a standard procedures in your in your unit"

NP3

"Yes, professor, it's participant 3. We do have a triage plan in the emergency unit, and it also has colour coding of where you know which patient is a P1 or P2 or P3 and how you should handle P1 P2 and P3 in that manner. It does work well, even though sometimes we do get patients that are P3, that wants to be considered P1s to get immediate attention. But yes, it does work."

NP8

"Yes, but currently we also working on a project in the EU to improve that feedback from the patients in terms of having a triage nurse in the front, always updating the patients on what is going on inside, on the ER on the floor and also to immediately attend the people coming into the EU."

Interviewer*:*

"And should you not agree on the way things are done and you would like to implement to make to recommend changes, do you feel free to do that?"

NP8

"Yes, yes, definitely. We are always resisting at first, (laughing). We always resist at first because we have to ask why I all circumstances, because remember we are the relay between the upper management and then the workforce. So, we need to know all the whys, because the whys are going to be directed at us at the end of the day and we need to actually know what we are talking about to have changes made."

NP1

“OK. So, we have, it's kind this and we do have a post discharge survey which is previously known as the patient experience feedback, experience management as well as the customer relationship management that we also do so on a weekly basis we get feedback. Written feedback on what our patients have said about a particular service that they received at the hospital and them certain in touch points that they comment on responsiveness of staff, the environment, friendliness, friendliness, the education that they received while they were at the hospital, things like that on a monthly basis. We receive or actually every two weeks we receive the post discharge survey, which gives us an indication of whether we are meeting targets on those touch points and then on a monthly basis. We get the full report for that previous month, which we also have to communicate to the staff and give them any targets that will not meet and the focus areas for the next month.”

NP8

“Yes. And also, we do have a family meetingworks procedure also that if there should be any serious implications for the patient that the doctor, the family, the UM of the unit where the patient is in as well as the managers all sit in, and they discussed the plan forward for the patient.”

NP8

“It's not always possible, but we try our best some of the time. We have to be reactive instead of proactive, but it has to be dealt with because it's on our statistics. So, we are also our held accountable for any interventions that we do. If we have a gap or if we have a missed opportunity.”

***Interviewer*:**

“OK. And informed consent and informed decision-making important aspect and but when it is a lifesaving situation and there is no family, how is it managed?”

NP8

“Ok, if it’s a P1 emergency patient, when it comes to being intubated, unfortunately if the there is no family accompanying the patient the doctor take the executive decisions to save their live and then after the facts if the patients family comes or can be reached, we

will involve them or informed them, of the actions and the further planning of care for the patient. Going to ICU, but when it comes to patient that has to go for emergency theatre, we have an on-call list of the doctors, surgeons, the orthopaedics, all of them. So, they will have to come in immediately, assess the patients need for theatre, prepare the patient, and informed of the theatre need for emergency theatre. They get all the theatre staff together and then there's also, again, if there's a family member available to speak to, they will speak to the family member, but it's a family member, is not available, they will have to make an executive decision between the two medical practitioners to take the patient to theatre without consent."

NP5

"I think also it doesn't show that a lot of our patients or from old age homes and there's often a DNR. And then we end up resuscitating a patient that has a DNR, because the communication wasn't there, or maybe the family didn't arrive yet or the old age personnel didn't tell the ambulance personnel that there is a DNR. And then we end up with a situation where you've intubated the patient that actually didn't want to be intubated."

NP5

"No, because often you have to make that decision very quickly and then you know it's a matter of life and death. And then, yeah, you end up Doing something that was against the patients will. Yes, what I've sometimes also experienced is that the family don't all agree on what could have happened so There's a DNR, then some of them. That's what they mean. And the rest of them will actually say go all out thing that you can. So yeah, I that's also another challenge that we have. But The thing is, if it's the if it was the patients wish and there is a DNR in place in, that's what you have to respect. But then often that communication is lost."

NP5

"Exactly. The thing is what I just also they these things tend to happen at night. And I also think then during the night communication is also not that good. Maybe I don't have permanent staff. So that's another challenge."

NP7

“Usually when kids go to these sort of things. I'm talking about sport events; the parents sign consent saying that the children my take into any to the nearest facility for treatment. So, I think if it's for you know, if you look at weekends in the emergency, units are very busy and with a more than southern part of Mpumalanga, there is always the rugby clashes and big sports things. If you can't see serious injuries, it was quite there a few very serious injuries, injuries and kids said that actually died, so yeah.No, I think there's usually there is consent.”

NP1

“The patients comes immediately come to the nearest thing there, and that will be treated, and they will be stabilized and then the family with the doctor decides on what's going back into the patients. So, the question is not transferred before the family had decided they can pay, or they cannot pay. We’re not going to check first in the medical card, we check the patients first.”

NP3

“Yes, prof its [name of participant] even if the patient does not have medical aid and they come to our hospital first and they need immediate attention, we will stabilize them first and then only then the doctor will decide if they have to be transferred to another institution or to the nearest provincial hospital because the rule says you first. Your first priority is the patient and then you can attend to the rest.”

NP8

“And also, we have we have a, we do communicate once everything is happened, stabilize the patient and everything we get clear guidelines from the case managers in terms of what is it going to cost. And for treatment in an ICU with intubation without intubation so that the family knows exactly what is, what is the cost for initial? And then they make it a decision on what to do. The problem with transfers comes between the private and the provincial hospitals. When we want to transfer out of the medical intervention. If we then intubated the patient is very difficult to find placement for the patient at the government facilities, but we cannot withhold that treatment just because

we know that we're going to have a problem. But so, we do what we can and then we deal with what comes after."

NP8

"Of course when we triage the patient, you need to know the full medical history, surgical history. What medication they are using because it's usually linked to the reason why they actually come into the emergency department the first place. And the doctor, OK, the only it's more indirect where you won't see the diabetic educator at the emergency department, but the doctor before discharge from the emergency department can refer you to the diabetic educator. And to the diabetic clinic, as well as, but obviously all the nurses are also equipped to give some information regarding any medical issue. As well as they do have access to the EIDO, should the patient for some reason goes straight to theatre from the emergency department, they can they, we do have an EIDO project in place which gives you information about most of the procedures carried out at this hospital. So, we can give them information and we can give the family members as well as the patient if they're if they're able to browse through what will, what is the procedure for specific operation that needs to be done."

Interviewer:

"To implement it, you have all the feedback that discharge feedback that you've seen, and I think you are already doing a person-centred care, but the barrier in an ER is we will have to keep attack that into cognition. And remember its always the possibility that it's a real emergency and that can serve as a barrier for the implementation of person-centred care."

"Health education of the person. Is it feasible and in in an emergency department? And how do you? How what do they do? You inquire what they know about their health and their illness, and then you work with that when you plan out education."

NP7

"You know, I think most of the patients, do understand it. What we have seen is, you know, we can measure it actually. Now if you look at your comebacks on and now say the hip placement that wasn't successful due to patient not understanding of the discharge. So, I think yes, they do understand."

Interviewer:

“What is you experiencing that the majority of the patients are capable of understanding the leaflet and capable of helping themselves after discharge? Or do they just acknowledge that they’ve received it? Do you have people who come back again and again with the same symptoms and same concerns?”

NP3

“I think because we are in Mpumalanga and it's quite a large province, we see variety of cultures, languages, races, in one area. So sometimes some language barrier can also put. The other problem, as well as cultural issues, because now you give education to the actual patient regarding the management of a wound of colostomy, bag or whatever, but in actual fact the patient is not the person that's going to be looking after that. And so, the husband or the aunt or the brother or sisters is actually, the one that's going to be the actual care giver of this patient's, it's far for them sometimes to travel to the hospital to receive that education before discharge of the patient. If they did not accompany the patient to the emergency unit. Those factors actually result in the patient just commenting, No, they never received discharge information.”

NP8

“Yes especially when it's a lot of physical things that have to happen, they need to know how to change the colostomy bag. They need to know how to empty, they need to know what to do when it's leak. Also, the vac dressings that we do, they have to have, they need a lot of detail in a short period of time on how to manage this thing at home.”

Interviewer:

“Do you have sufficient time to do the health education? Is there a space in the ER where you can do the health education and the patient can concentrate on what you are talking about or is it done in between where other people are waiting?”

NP1

“That is one of the big barriers for us in our casualty department because there's no private space where we can give the education and sometimes there really is not time to do it because it’s a very busy unit, and a lot of staff shortages especially over weekends.”

NP8

“And I think that increases actually our admissions because it emergency care. So, a septic wound is not going to have a quick fix. So, the best option is rather to admit the patient to get actually progressive long-term care, rather than just to patch the wound and send the patient home and expect them back the next day with the bleeding leaking wound.”

NP1

“Especially because they stay far and like Candice said, we got the very wide community that we have to serve, they will come and during the night or on the weekends when there is really a staff shortage and there really is critical patients in the unit”

NP7

“You know that we don't really have our doctor's work our GPs. The GPS are not open. It's office hours on a Saturday so maybe they are open two or three hours. But not on a Sunday or public holiday, so there's not really 24-hour services for chronic patient problems”

NP8

“And also, our community wait until the half in a coma before they access the emergency unit, or they are coming from far and he goes if we are fetching them with whatever for the longest time. Right now, the abdominal wall is falling out. Then they come and actually check and see.”

Interviewer:

“Yeah, it’s really a crisis for the ER. I’ve seen in one of the hospitals here, Pretoria, that group of GPs opened actually a practice in the hospital and then for chronic conditions or for just the minor ailments such as a child crying because of year ago, whatever. And then patients can consult them instead of going to the ER for. And then in the ER is left for only real emergency cases.”

NP2

“I think also the one thing that we were problem in our casualty is over weekend sometimes parents and people working on the mines along time they think the casualty

department is the GPs of, so they come with the small stuff, and they sit, and they want the GPs. So, we can't always in the casualty environment provide the needed attention that they seek form a GP consult, so it's not due to the staff not being enthusiastic as they should be, because it is not really that serious, and with the hours its more comfortable for the patients to come at that hours"

NP8

"So it's exactly the same as our setup because our GP's offices are around the hospital as well as our physician surgeons, everybody is here. So, if they come to our ER during office hours, we immediately can refer them to a or we can to a given to a specialist or come and see them in the ER department."

Interviewer:

"OK. We talked about personal satisfaction or patient satisfaction already. Let me just see you mentioned it earlier today, whether I have more questions. You said you try and treat them really as individuals and not just as numbers or and you have a survey that they can complete, and they can put all the complaints' theme. And you said it communicated with you every on the two weekly basis and also once a month it worked out, I suppose in percentages. OK. And if I may ask, what is your percentage of satisfaction?"

NP8

"Yeah. So, I can only speak for the wards now or only casualties? OK. This it was in the 80s. Yeah, it's it fluctuates low and up. It's between 70 and 80%."

NP2

"The most complaints is about education and the triage waiting time. The medication information. It's everything about communication and friendliness. Was the one big complaint, staff not explaining what they are doing."

NP1

"Because we are here to deliver a service and because I know we all got problems at home, but we are here to deliver a service and the patient's seeking help is sick they won't feel the need to talk to us and they won't feel open to talk to us or disclose something because we are unfriendly, and they can't speak to us."

Interviewer:

“OK. Do you think its valid to complain about friendliness or unfriendliness?”

NP8

“Sometimes I think not. I think sometimes when it's rush hour in the emergency area we tend to look unfriendly, because even in your in your mind, you are triaging the patients to see who need emergency care, So if somebody's asking you to go to the bathroom and you are running towards a P1. I don't think that person is going to get the very nice response from you. So, they perceive us as unfriendly.”

NP8

“Yes. So, you it's more about the perception because the patient is patient centred and you are focussed on everybody in the cubicles, everybody in the resus area. So, you are divided by them have all the time in the world to think about themselves, while they are lying the in the emergency cubicle or area.”

Interviewer:

“How do your, uhm, do your manager respond to say they said decrease in the percentage of satisfaction of versions? Do you have a meeting? Do you analyse the statistics? Do you discuss them? How to bring about improvement? Maybe in the way that the ER is managed?”

NP8

“OK, if we if there's a serious reportable event, when we get it, the manager will receive a report regarding that or a serious topic, a serious complaint. And you receive it and then you have to investigate it and you have to have proof of your investigation. So, you discuss whether you have to have one-on-one, discussions with the staff that was involved in the complaint, get their statements about what happened, from their perspective, you contact the patient as well, or the family member that's complaining and you need to get their understanding of what happened as well. And then you need to implement action plans to avoid.”

NP8

“The same problem from happening again in that when you come, when it comes to the development of action plans. It's very important to involve your staff because they need to buy into the action plans because it's no use you are planning, but the staff are not

willing to do it, or they don't understand the reason for doing it differently.So, you have to have at the end of the day when you finish with your investigation, you need to go back to the whole staff group and explain to them what happened.What do they think? How we can improve? We agree on action plans to do to implement in the future and also.At the end of that following month, you need to review and see whether your action plans that you've implemented have improved your score or not. Then we have to go back to the assessment part, the planning, the implementation again."

NP1

"They help in this situation, and they are also a backup because that also people in the incident investigation and ask questions and you also get involved with the family and the patient that have to help with the planning and action plans on how we are going to do."

Interviewer:

"You are giving us very valuable information for the research because should they be a decision to implement. And these specific guidelines you actually explained now a way in which it can be done, and you also tell us that the group that in the group of the team in the in the ER is actually used to making changes and to implement. And I want to ask a next question on when you get a report of a from a dissatisfied patient. Do you feel that your management is supportive or more? Punitive that you get blamed and accused and sort of."

NP8

"They also they give you a bird's eye view, because sometimes we are very involved, we very close knit with our staff. So, sometimes you don't feel like you can be blunt and communicate exactly the problem. Then the managers or our direct mangers come and sit in with the meeting and discuss the issues and they sort of facilitated communication so that it doesn't come off as punitive or bullying."

NP7

"No, I can't even remember of a complaint. Our complaints are surrounding time, and that they had to wait."

NP1

"And patient information and communication."

Interviewer:

“Education thing, education of Inservice education of the nurses. Do you have regular in service and lectures, or are you and are you obliged to go? And how is it implemented and to see whether and do that is they control whether you go or not to the in service training and whether there’s an outcome in your practice. Once you’ve attended an in service training is it implemented? Is there a person checking on that?”

NP1

“Yes, we got them. Lots of Inservice training, all the wards and in the casualty department as well. We are doing in service training on certain objects, subjects that they are lacking in and then we do record on that that and then there I am CTS for the specialised units and the normal wards, and a CTS for the EU and they focus on specific topics where there really is a need for.”

Interviewer:

“So should the hospital decide to, let's say, implement these guidelines that you have the in front of you, this is specific way of training the nurses to do it, you you've done it in the past to implement specific strategies and it can be done again.”

All

Yes, yes.”

***Interviewer*:**

“Do patient and the follow-ups is done in EU or elsewhere.”

NP8

“Because once the patient leaves the hospital, the file is completely closed and we don't revisit that file every time you come to us, you get a new file with new information.”

NP2

”In some cases, if you've got a specific patient you would like to receive feedback, but not all cases”

NP8

“But not all cases and also in the patient with the revolving door syndrome and they always be returning for the same problems then you like you want to know what is being discussed with the patient.”

NP8

“At the external service, because now obviously the information is not going in because they still coming every second week for the same problem. So, they think it’s a follow up.”

NP8

“Yes, yes, they do. But they also don't have unlimited funds. So, when they really going to need admission to an ICU or anything like that, it's going to be difficult for them to do so”

NP7

“I think a lot of you know, we are in a mining community. So, there's a lot of occupational health clinics in our midst, which mostly attend to the workers. Or they've gone problems and follow them up and check them and so on. So, the people that come with chronic stuff is, you know, you get your usually offenders.”

NP7

“I think a lot of them know, they've got this massive say headache, you know, go over the weekend, and now they didn’t drink their blood pressure tablet for one day, so they go to the ER for it you know where they will be seen. And there's a lot of holiday resorts around us as well. And so yeah. Yeah. So, you know, a lot of those people, you know, kids gets hurt at the holiday place. You know that needs emergency care.”

APPENDIX F: FIELDNOTES OF FOCUS GROUP INTERVIEWS

Date:	4th April 2023 Thursday Morning	13th April 2023 Thursday Morning
Time allocated	2 Hours	2 Hours
Method of attendance:	Microsoft TEAMS and in person	Microsoft TEAMS and in person
Participants attended:	6/8 NP 1-6 Attended	6/8 NP 1-4 and 7-8 attended

The interview were conduction in two sessions, where one half of the interview guide were discussed in the first session and then the second half of the interview guide in the second session. The sessions were facilitated by the researcher, M Joubert and overseen by Professor N van Wyk. It was using Microsoft TEAMS as some participants could not attend in person, so the program recorded the interview and transcribed it. Participants invited included nursing categories that works and have worked in the Emergency Department. Two participants couldn't attend the first session but attended the second session. Two participants attended the first session but couldn't attend the second session. Participants were welcomed and the reason for the interview discussed, they were once again assured that they can please speak freely as it is all private and confident, participant has also submitted their signed consent forms before participation. An Interviewed guide was used and made available to the participants a week before the agreed upon date to familiarize themselves.

Participants answering the questions honestly and interaction between participants were good and the general understanding of the topic was good, this led to richer answers.

Participant 4 agrees with the other participants instead of answering the questions. It may be due to the fact that the participant in a junior nurse between senior nurses. Participant 3 and 8 commented the most on the questions asked. Participants were very outspoken and debated the questions answered. When asked about the hospital policy of patient centred care not everyone was aware of it.

After interviews were concluded, the researcher checked the transcripts for correctness and then removed all the unnecessary numbers and symbols inserted by the TEAMS transcribes (original transcripts is available upon request), the rescher then took all the notes and started to code the sub-categories and categories.