PERCEIVED INFLUENCE OF PAUCITY OF NURSES ON QUALITY OF CARE AMONG PATIENTS IN A TERTIARY HEALTH INSTITUTION IN BENIN CITY, EDO STATE

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ABSTRACT

This study investigated the perceived influence of paucity of nurses on quality of care among patients in a tertiary health institution in Benin City, Edo State. The study's objectives are to assess nursing care quality, patients' perceptions of the impact of a shortage of nurses on nursing care quality, and suggestions for improving nursing care at the University of Benin teaching hospital in Benin. A descriptive cross-sectional survey design was used in the study. There were 243 patients in the medical surgical unit that made up the study population. Convenience sampling was used to choose a sample size of 151 respondents for the investigation. A well-structured questionnaire served as the data gathering tool. The research supervisor verified the instrument. To confirm the instrument's reliability, a test-retest procedure was used. Data was examined using descriptive statistics (frequency, percentages, mean score, and standard deviation) and inferential statistics (ANOVA) to assess study hypotheses at a p-value of <0.05. The findings reveal that patients have a positive opinion that standards/protocols for patient safety are in place, patients' rights are protected, and mistakes are immediately reported and rectified. It was also revealed that patients judged certain elements to have a beneficial impact on the quality of nursing care. This includes opportunities for nursing workers to advance and develop professionally. It was also revealed that providing enough facilities and equipment, employing nurses, enhancing nurses' well-being and quality, and encouraging nurses to attend update courses all help to improve the quality of nursing care. Based on the findings, it was concluded and recommended among others that Government at all levels; federal and state and local government should ensure that medical facilities under their care are adequately staffed and equipped in order to ensure quality nursing care.

Keywords: *Perceived Influence, Paucity of nurses, Quality of Nursing Care, Nursing Practice.*

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The nursing profession combines art, science, and humanitarian work in order to provide care for individuals, families, and communities,. Florence Nightingale is credited with founding contemporary nursing (Pfettscher, 2021). Nursing is recognised as a profession based on specific criteria. Porter-O'Grady (2021) lists these as having a systematic body of knowledge that provides a framework for the practice of the profession, standardised formal higher education, a commitment to providing services that benefit individuals and the community, the preservation of a distinct role that acknowledges autonomy, responsibility, and accountability, the obligation to regulate practice through standards and a code of ethics, evidence-based practice, and a dedication to members of the profession

When the demand for nursing professionals, such as Registered Nurses (RNs), exceeds the supply of RNs locally, nationally, or worldwide (for instance, inside a healthcare institution), a nursing shortage occurs. It may be measured using the nurse-to-population ratio, the nurse-to-patient ratio, and the number of available positions. Globally, both rich and developing nations experience this situation (Haddad et al., 2021). The World Health Organization (WHO) reported in 2021 that the demand for nurses will reach 12.9 million by 2035, and that there will be a shortfall of 7.2 million health workers to provide healthcare services globally.

Over a billion people worldwide are impacted by the nursing workforce shortage, particularly vulnerable groups like women and children who desperately require high-quality healthcare services (Aluko et al., 2021; Marć et al., 2021). Heijden et al. (2020), Leineweber et al. (2021), Matsuo et al. (2021), Valizadeh et al. (2021), Varasteh et al. (2021), Yun et al. (2020), and many other detrimental effects on patients' health-related outcomes as well as difficulties in combating diseases and improving health have resulted from the shortage of nurses.

Nursing personnel must be trained and educated in order to provide patients with proper care. Sadly, there is a severe lack of these employees (Machitidze, 2022). One of the biggest issues facing Nigeria's nursing profession is the scarcity of nurses. Due to societal and cultural restrictions, nursing is seen as a vocation dominated by women, which exacerbates the shortage. Another factor contributing to the nursing shortage is gender prejudice (Ndirangu et al., 2021). Unfortunately, due in part to media portrayals, the nursing profession has a bad reputation in Nigerian society, which deters individuals from thinking about pursuing it as a career. Over time, this unfavourable perception leads to a nursing shortage (Ndirangu et al., 2021).

The degree to which health services for people and populations raise the possibility of desired health outcomes and are in line with current professional knowledge is referred to as quality of care (WHO, 2021). It includes aspects like timeliness, efficiency, equality, safety, efficacy, and patient-centeredness. For patients, prompt, courteous, and evidence-based actions that enhance health outcomes constitute excellent care. The quantity and skill of nurses on hand to deliver critical services may have a big impact on the quality of treatment in a hospital environment.

Errors and higher rates of morbidity and death are caused by a lack of nurses. In comparison to facilities with lower patient-to-nurse ratios, hospitals with high ratios experience nurse burnout and discontent, which raises patient mortality and failure-to-rescue rates (Aiken et al., 2002). Therefore, the purpose of this study is to evaluate how patients at a tertiary healthcare facility in Benin City, Edo State, perceive the impact of a shortage of nurses on the quality of care they get.

1.2 Statement of the Problem

As the largest professional group in the healthcare system, nurses play a crucial role in providing high-quality healthcare services and helping to improve health outcomes for individuals, families, and communities through both preventative and curative measures (Alameddine et al., 2021; Drennan & Ross, 2022). A sufficient number of nurses is essential to strengthen the health system to improve health coverage and achieve all health targets because they are highly valued professionals and frontline healthcare workers in the global healthcare system not only in delivering effective quality care but also in improving the efficiency of the system (Aboshaiqah, 2021; Alameddine et al., 2021).

Although the nursing profession is widely acknowledged as being essential to providing healthcare services, one of the biggest issues facing the world today is the lack of nurses, which compromises the quality of healthcare services, improves global population well-being, and prevents universal health coverage (Adams et al., 2021; Alameddine et al., 2021; Kurjenluoma et al., 2023; Park & Yu, 2021; Yahyaei et al., 2022). This is because there are differences in the number of nurses who are now employed and those who are just starting

their careers and the number of nurses needed to address the demands of patients (Hudgins, 2021).

For example, the United States of America (USA) has a severe nursing shortage, with an estimated 12.9 million skilled nurses and midwives needed by 2035 (Adams et al., 2021; Yahyaei et al., 2022). The country will require about 3 million nurses to fill its nursing gap, a demand that is difficult to meet (Yun et al., 2020). Additionally, by 2025, the shortfall of nurses is predicted to surpass 500,000 (Valizadeh et al., 2020). The nurse-to-patient ratio is much lower than international norms in many Nigerian tertiary health facilities, including those in Benin City, Edo State. The World Health Organization (2021) states that one nurse to four patients is the recommended nurse-to-patient ratio in acute care settings.

Depending on the department and time of day, a single nurse may really care for 10 to 30 patients throughout a shift at several Nigerian tertiary hospitals. In addition to overstretching nurses, this severe understaffing causes missed treatments, care delays, decreased patient monitoring, a rise in medical mistakes, and lower patient satisfaction. The issue of caring as a crucial aspect of high-quality nursing practice is one of the main effects of this nurse shortage. Being present, receptive, sympathetic, and aware of patients' physical, emotional, and psychological needs are all components of providing care. Nurses may not be able to give the kind of individualised attention and empathy that characterises high-quality nursing care when they are overburdened, exhausted, and under pressure to care for too many patients at once.

Patients may feel disregarded, ignored, and unsatisfied with their hospital stay. Poor health outcomes can result from a breakdown in therapeutic connections and communication

between nurses and patients, which also erodes trust. There is still little empirical evidence on how patients themselves view this situation, particularly in tertiary settings, despite many publications emphasising the mounting difficulties related to nurse shortages in Nigeria's health sector. Because they are the ones getting healthcare services, patients are in a good position to evaluate how the shortage of nurses affects the standard of care they receive.

This study is, therefore, driven by the urgent need to examine the perceived influence of the paucity of nurses on quality of care among patients in a tertiary health institution in Benin City, Edo State. The findings will provide crucial insights into how staffing shortages affect the patient experience and may serve as evidence to inform health workforce planning, staffing policies, and resource allocation aimed at strengthening healthcare delivery in Nigeria.

1.3 Objectives of the Study

The main aim of this study is to examine the perceived influence of paucity of nurses on quality of care among patients in a tertiary health institution in Benin City, Edo State.

The specific objectives of this study are to:

1. identify the aspects of nursing care mostly affected by the paucity of nurses as perceived by the patients in a tertiary health institution, Benin City, Edo State.
2. determine nurse to patient ratio in a tertiary health institution, Benin City, Edo State.
3. ascertain the relationship between nurse to patient ratio and patients perception of nursing care in a tertiary health institution, Benin City, Edo State.

4. assess the perceived impact of nurses shortage on the quality of nursing care from the perspectives of patients in a tertiary health institution, Benin City, Edo State.

1.4 Research Questions

The following research questions are raised to guide the study:

1. What are the aspects of nursing care mostly affected by the paucity of nurses as perceived by the patients in a tertiary health institution, Benin City, Edo State?
2. What is the nurse to patient ratio in a tertiary health institution, Benin City, Edo State?
3. What is the relationship between nurse to patient ratio and patients perception of nursing care in a tertiary health institution, Benin City, Edo State?
4. What is the perceived impact of nurses shortage on the quality of nursing care from the perspectives of patients in a tertiary health institution, Benin City, Edo State?

1.5 Significance of the Study

The findings from this study will be significant in the following ways

Nursing Practice: Nurses are in the unique position to enlighten individuals, because they are always in contact with patients/client providing holistic care. For a nurse, to be able to give adequate information, she needs to have a thorough understanding on the influence of paucity of nurses on the quality of care given to patients. Nurses should endeavour to teach the students, as they have the right to this knowledge, which will enable them become a good nurse.

Nursing Education: This is what is hoped to be achieved at the end of the day. With good knowledge on the influence of shortage of nurses on the quality of nursing care given to patients, nurses will be better informed to give proper information to policy makers on ways to improve the conditions of service of nurses in order to retain the nurses.

Research: In aspect of research, it increases the awareness of the influence of nurses shortage on the quality of care given to patients and its researchability interest, by conducting more research to broaden their knowledge about quality of care.

1.6 Scope of the Study (Delimitation)

This study is delimited to the perceived influence of paucity of nurses on the quality of nursing care among patients in a tertiary hospital, Benin city, Nigeria. It is also delimited to the objectives that guided this study. This study is equally delimited to patients in University of Benin Teaching Hospital, Benin City, Edo State.

1.7 Operational Definition of Terms

Perceived Influence: In this study it means the effect shortage of nurses has on the quality of care patients receive in a tertiary hospital in Benin City.

Paucity of nurses: This is when there is a higher demand for nursing professionals, such as Registered Nurses (RNs), than available locally (e.g., within a healthcare facility), nationally, or globally.

Quality of Nursing Care: This is the degree to which nursing services provided to patients and families meet established, expectations, and needs, resulting in optimal health outcomes, patient satisfaction and well-being.

CHAPTER TWO

LITERATURE REVIEW

This chapter presents a review of related works. It shall be discussed under three sub-headings: Conceptual Review, Theoretical Framework and Empirical Studies.

2.1 Conceptual Framework

2.1.1 Concept of Nursing Care

Every human being needs health care since it is crucial to preserving their health and well-being. When someone feels ill, it's important to find a cure and become well again. Therefore, it is impossible to overstate the vital role that health care plays in any community. According to the WHO (2020), patients' entitlement to obtain treatment and care from a skilled professional may be the foundation for the vital character of health care. Second, healthcare is crucial because it is the duty of the government and organisations that oversee the industry to give the populace access to quality treatment. The skills and expertise of various health care professionals are often needed to meet the health care demands of individuals of any society. The tasks and duties of each discipline engaged in the provision of healthcare are distinct.

With a lengthy history spanning many years, nursing is one of the specialities and a significant part of the health care system. In essence, nursing involves a lot of care. There have been several definitions of nursing, all of which have tried to include aspects of nursing practice. The International Council of Nurses (ICN, 2019) defines nursing as an

autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well in all settings.

However, according to the American Nursing Association (ANA, 2020), nursing includes health promotion, sickness prevention, and care for physically and mentally ill, handicapped individuals of all ages in all healthcare and community settings. Furthermore, according to the Royal College of Nursing (RCN, 2018), the goal of nursing is to guarantee the delivery of safe, efficient, person-centred outcomes that assist individuals and their families in reaching the best possible state of health and wellbeing. It should be mentioned that different carers, such as RNs, practical (vocational) nurses, and nursing assistants, perform tasks related to nursing. Every one of these carers supports the nursing profession. In emphasizing the importance of nursing in the society, ICN (2021) stated that the need for nursing is universal and encompasses four essential roles; which include promotion of health, prevention of illness, restoring health and alleviating patient's suffering.

2.1.2 Objectives of Nursing

In actual practice, nurses do a variety of tasks and duties that are performed by experts in the industry. Nursing professionals make an effort to comprehend each patient's unique physical, emotional, and spiritual requirements when delivering care (Anuradha, 2019). Additionally, when giving patients care, nurses apply their professional judgement. In particular, a nurse's duties can range from simple to intricate, and they frequently involve treating injuries, performing routine medical exams, documenting thorough medical histories, giving medication, keeping an eye on heart rate and blood pressure, using medical equipment, and performing diagnostic tests, among other things (RCN 2021).

Additionally, they often report any changes in a patient's health, make sure the patient is comfortable, and take on other pertinent responsibilities.

The nurse monitors the patient's development over the course of treatment and takes necessary action in the patient's best interest. As a result, nurses are frequently in charge of providing patients with holistic treatment that takes into account their psychological, cultural, and spiritual requirements. Additionally, ethical rules serve as a guidance for nursing practice and are exemplified by several aspects. This Code of Ethics outlines the moral principles, duties, and professional obligations that direct nursing practice in the many positions that nurses take on (ICN 2021). Some of these include that a nurse'(s):

- primary responsibility is to people requiring nursing care and services now or in the future, whether individuals, families, communities or populations .
- duty involves promoting a care environment in which the human rights, values, customs, religious and spiritual beliefs of the individual, families and communities are acknowledged and respected by everyone.
- must ensure that the individual and family receive understandable, accurate, sufficient and timely information in a manner appropriate to the patient's culture, linguistic, cognitive and physical needs and psychological state on which to base consent for care and related treatment.
- must hold in confidence personal information and respect the privacy, confidentiality and interests of patients in the lawful collection, use, access, transmission, storage and disclosure of personal information.
- must demonstrate professional values such as respect, justice, responsiveness, caring, compassion, empathy, trustworthiness and integrity.

- should support and respect the dignity and universal rights of all people, including patients, colleagues and families.
- are active participants in the promotion of patient safety.
- must prepare for and respond to emergencies, disasters, conflicts, epidemics, pandemics, social crises and conditions of scarce resources. (International Council of Nurses 2021).

2.1.3 The Concept of Quality of Care

Quality service is a significant phenomenon since consumers are always looking for services that live up to their expectations. Because of this goal, companies all over the world view quality as an essential part of any service process. According to the American Society for Quality (ASQ, 2020), quality is the totality of a product or service's attributes that affect its capacity to meet a specific requirement. Quality is frequently defined using phrases like "value," "excellence," and "meeting and/or exceeding customers' expectations." In the medical field, quality is crucial. The Health Information and Quality Authority (HIQ, 2021) defines quality as achieving and beyond an acceptable performance level by offering a secure and efficient service.

A wide term that is essential to healthcare services is quality of care. For patients, their families, and medical professionals, it is crucial. It significantly affects patients' emotions and health results. The degree to which a health care service or product yields the intended result is simply referred to as quality care. The degree to which health services for people and groups enhance the likelihood of desired health outcomes and are consistent with current professional knowledge is what the US Institute of Medicine (2019) describes as

quality of care. According to the WHO (2020), quality care is defined as the extent to which patients receive exceptional care that satisfies their spiritual, emotional, social, physical, and environmental requirements. On the other hand, according to Potter and Perry (2021), quality care is the level of patient care services that raises the likelihood of desired results and lowers the likelihood of undesirable outcomes.

A three-part model consisting of structures (input), procedures, and results may be used to evaluate healthcare quality (Binder et al. 2020). The resources of the healthcare system that help it satisfy the population's healthcare demands are referred to as its structure. These resources include buildings, equipment, information systems, expertise, the availability of specialised staff, and financial resources. Conversely, process refers to how resources are used in providing and receiving care. It relates to what is actually done for the service user and how well it is done, whereas, outcome explains the state of health of the individual or population as a result of interaction with the healthcare system. Mainz (2021), in explaining outcome in health care quality posits that it is the effects of health care on the health status of patients and populations and comprises of final outcomes such as quality of life, mortality rate, morbidity as well as intermediate outcomes such as improved knowledge and others. It is noted that each component of the model is noted to be interdependent, such that good structures promote good processes and in turn, good processes promote good outcomes, vice versa. The WHO (2019) in explaining quality care noted that indicators such as effectiveness, efficiency, equitability, accessibility, patient-centered, safety could be used in measuring quality of care.

Effectiveness: According to WHO (2022), effectiveness is the delivery of evidence-based care to those in need in order to achieve the desired result. It offers data that is utilised to

decide what is best for both the healthcare system and each of its consumers. A care system's effectiveness is normally assessed by contrasting the resources (input) used in the system with the potential for benefit, which is commonly expressed in terms of an improvement in the health status of the person or group. Therefore, care that uses the evidence and resources at hand to get the greatest possible results may be deemed successful.

Efficiency*:* This refers to achieving desired results with the most cost-effective use of resources. Efficiency is defined by the Health Foundation (2021) as making the best use of the resources at hand to improve the quality of health outcomes while using the same quantity and kind of resources (staff, hospitals, and medical technology). The relationship between resource inputs (labour, capital, or equipment costs) and either intermediate outputs (numbers treated, waiting time) or final health outcomes (lives saved, life years gained, quality adjusted life years (QALYs)) is essentially what determines how efficient health care is. Resources are employed in an effective health care system to maximise the return on investment. Wasteful care is either directly harmful to health or is harmful due to the fact that inefficient care uses more resources than necessary, and care that involves waste is deficient and therefore of lower quality.

Equitable*:* According to Nall (2020), equity in care refers to making sure that each person has the chance to reach optimal health. Unquestionably, the WHO (2022) stressed that one aspect of high-quality treatment is that its quality is unaffected by the patient's gender, race, region, or financial background. According to the health equality concept, everyone should have equitable access to medical care. Everyone has a right to demand fair treatment in this regard. Therefore, the availability of treatment and the quality of services should be

determined by each person's unique requirements rather than by personal traits unrelated to the patient's illness or the reason for seeking care.

Accessibility: The availability of healthcare professionals (supply) and the local population (demand) have historically been used to gauge access to healthcare, and the distribution of the two variables is typically uneven. According to the Allegheny Health Department (2018), attaining health equity for all, preventing and treating disease, preventing needless disability and early death, and promoting and sustaining health all depend on having access to comprehensive, high-quality care services.

Patient-centered care (PCC)*:* According to Santana et al. (2018), PCC is the process of treating a patient with dignity, respect, and values while including them in all planning and decision-making around their healthcare. Unlike physician-centered treatment, it concentrates on the patient's views, choices, preferences, and requirements (Jayadevappa, 2017). PCC gives patients more authority and makes it possible for medical professionals to collaborate with patients to better achieve their objectives. It covers the patient's right to voice opinions, enquiries, and grievances regarding their medical treatment. Sharing choices with patients and assisting them in managing their health are two ways to demonstrate this. Delaney (2018) asserts that PCC practices have a major positive impact on patients because they enable them to better manage their health when they are interested, engaged, and supported.

Timeliness: Timelines describe how quickly patients can obtain services or care. Timeliness of care is defined by IOM (2020) as the ability of the health system to deliver treatment as soon as a need is identified. It is thought that a patient's health result improves

with prompt medical attention. Wait times, whether for an appointment or in a medical institution, can be a sign of timeliness. Therefore, timely care entails shorter wait times and occasionally detrimental delays for both carers and recipients.

Safety: Ensuring patient safety is essential to providing high-quality treatment. In essence, safety in healthcare relates to the avoidance of injury throughout the provision of medical care. According to Slawomirski et al. (2017), research currently available indicates that addressing safety failures accounts for 15% of hospital activity and expense, particularly in low-resource nations. The system of care delivery that avoids mistakes, learns from mistakes that do happen, and is founded on a culture of safety is emphasised in quality care. The Joint Commission (JC, 2021) listed seven patient safety goals that guarantee high-quality treatment, one of which is accurate patient identification. Staff members should employ at least two methods to confirm a patient's identity, such as name and birthdate.

This is seen to be a crucial method of lowering prescription mistakes and guaranteeing that patients receive the recommended therapy, protecting patients—particularly those who are unable to speak for themselves. Patient safety issues are frequently divided into three categories: clinical performance (prior to, during, and following intervention); patient management (failure in tracking, incorrect referral, or improper use of resources); and communication (failures between patient or patient proxy and practitioners, practitioner and nonmedical staff, or among practitioners).

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2.1.4 Quality of Nursing Care

The foundation of nursing is the idea of caring. According to Elayan and Ahmad (2017), nursing as a profession bears a great deal of responsibility for delivering high-quality care to those who require it. Quality care in nursing is defined by the American Nurses Association (2021) as "the degree to which nursing services for health care consumers, families, groups, communities, and populations increase the likelihood of desirable outcomes and are consistent with evolving nursing knowledge." It has been suggested that high-quality nursing care frequently manifests in a number of ways, such as shorter hospital stays, lower expenses, better patient outcomes, and improved patient satisfaction.

Nursing professionals' care and services have a significant impact on the quality of health care results. One of the most crucial factors in determining the quality of health care services is nursing care, which aims to reduce the patient's pain and discomfort (Edvardsson et al., 2017). Numerous ideas that are still applicable and essential to the practice have been employed to evaluate the quality of nursing care.

2.1.5 Indicators/Measurement of Quality of Nursing Care

Numerous roles and therapeutic situations are used in nursing practice. According to the ICN (2020), the goal of assessing nursing outcomes, or the quality of nursing care, is to comprehend initiatives that have been employed in the past and determine how they have affected nursing practice. It stated that the goal of healthcare delivery is to enhance aspects like patient safety, accessibility to care, and efficacy of care, among others, and that enhancing the quality of nursing outcomes is a global priority. Measuring the quality of nursing care becomes essential since its main goals are to maintain health, care for people

when their health is compromised, aid in recovery, and help people enhance their quality of life.

A number of indicators and instruments have been developed as benchmarks for evaluating nursing quality in general. Fifteen indicators were developed by the National Quality Forum (NQF, 2021) to gauge nursing care. It was created to evaluate how nurses in acute care hospitals support patient safety, a safe and professional work environment, and the quality of nursing care. Failure to rescue, pressure ulcer prevalence, falls, falls with injuries, urinary tract infections linked to urinary catheters, bloodstream infections linked to central line catheters, ventilator-associated pneumonia, smoking cessation counselling for acute myocardial infarction, smoking cessation counselling for pneumonia, smoking cessation counselling for heart failure, skill mix, and nursing hours per patient day are all included in the NQF-15. Nursing Work Index, Practice Environment Scale, and voluntary turnover (NQF, 2021).

Another tool that measures patient or family carer state, behaviour, or perception in terms of responsiveness to nursing treatments is the Nursing Outcomes Classification (NOC), which consists of 218 outcomes. These are divided into 24 classes, which are then divided into six domains. Functional health, physiological health, psychosocial health, health knowledge and behaviour, perceived health, and family are some of these dimensions (Moorhead et al., 2018).

The four nursing elements: nursing diagnosis, nursing interventions, nursing outcomes, and nursing intensity are also highlighted in the Nursing Minimum Data Set (NMDS). These factors are used to assess the standard of nursing care given in medical facilities.

Also, the American Nurses Association proposed the Patient Safety and Quality Initiative **(PSQI**). This instrument involves development, testing, storage and evaluation of indicators of nursing care and has as its major focus the association between nurse staffing and patient outcomes.

The California Nursing Outcomes Coalition (CALNOC), which was suggested by the American Nurses Association, is another metric used to assess the quality of nursing care. The Collaborative Alliance for Nursing Outcomes (CALNOC) is the new name for this database. It is a tool designed to gather information regarding patient outcomes that are sensitive to nursing care in order to advance advances in patient care. It has been used to determine how patient ratios affect staffing at the unit level, how frequently patients fall, how common hospital-acquired pressure ulcers are, and how often restraint is employed (CALNOC 2017). However, CALNOC is a regional database for measuring nursing quality that is mostly utilised in California, the state where it was proposed.

Furthermore, the American Nurses Association created the National Database of Nursing Quality Indicators (NDNQI) using the original National Quality Forum indicators, which are now known as the NQF-12 (Ganey 2021). It is also a helpful instrument for gauging nursing outcomes.

There are some components that are thought to be essential for nurses to provide high-quality nursing care. Patient safety, compassion, effective communication, empathy, meticulousness, and critical thinking/problem-solving abilities are some of these. Since the patient is the top concern, nurses are essential to patient safety. They are in charge of

providing patients with care that takes into account their psycho-social, developmental, cultural, and spiritual requirements (Yolanda, 2021).

A key component of any nursing care's success is compassion. A nurse needs to have an innate desire to genuinely care about their patients. Strong communication abilities are also essential for a nurse. Effective communication with other nurses, doctors, and other professionals from other units, patients, and their families is essential to a nurse's job. Medical mistakes may happen, patients may feel ignored or misinformed, and the care environment may suffer if communication is not properly interpreted and communicated. Furthermore, it is thought that demonstrating empathy for patients is a quality of quality nursing care. By showing empathy, nursing practitioners are more likely to focus on a person-centered care approach, rather than strictly following routine guidelines (Ghaedi, 2020). It is noted that when patients encounter this characteristic during nursing care, it adds positively to their experience.

Another trait linked to high-quality nursing care is attention to detail. In order to provide patients with the best care possible, nurses frequently under tremendous pressure to strike a balance between following doctor orders and applying their own knowledge, skills, and critical judgement. The necessity to care for a large number of patients may also be a factor; therefore, the nurse must be able to pay attention to details in order to lower the risk of medical error. Critical thinking and problem-solving abilities are also essential for providing high-quality nursing care. A nurse practitioner needs to have strong critical thinking and problem-solving abilities because they interact with patients one-on-one and are frequently in charge of making many decisions regarding their treatment.

It is mentioned that a nurse's poor decision-making could negatively impact the patient's health. Therefore, a nurse's capacity for critical thought and the general standard of care they deliver are key factors in their ability to implement clinical guidelines and best practices. Effective time management, the capacity to focus on duties, and the avoidance of mistakes are further traits of high-quality nursing care. It can be challenging to manage conflicting priorities, numerous patients, and a demanding care setting.

2.1.6 Challenges Associated with Nursing Practice

Several challenges have been associated with nursing practice. These ranges from inadequate staffing/shortage of personnel, risk of infection, injury and death, workplace violence, stress/twelve-hour shift.

***Inadequate Staffing**:* It has been observed that understaffing for brief periods of time is unavoidable in many organisations and circumstances, but in the nursing field, it can be a major obstacle with repercussions. According to reports, there is a 2.4 million nursing professional shortage globally (WHO 2021). Additionally, it was predicted that, under all circumstances, there might be an 18 million nursing professional shortfall worldwide by 2030. Increased burnout, an ageing population and retirement, and a lack of educational resources—especially in some nations—have all been blamed for this. It is thought that this shortfall could increase the pressure that currently exists.

Nursing personnel may have to work double shifts due to this scarcity, which could lead to exhaustion and medical blunders (American Nursing Association 2020). According to reports, between 17% and 30% of nurses quit during their first year of employment, and over 57% of nurses quit within the first three years. Additionally, one of the main obstacles

to nursing practice has been identified as specialisation (with the appropriate technical training and experience). It has been observed that a lack of expertise in some nursing specialities contributes to the nursing shortage. Furthermore, it has been seen that high patient ratios brought on by a lack of staff pose a problem for nursing practice, which frequently leads to subpar nursing outcomes. Of importance is the fact that in area such as the Intensive Care Unit (ICU), where patients requires utmost vigilance, the nursing professional may be responsible to patients higher than normal which could be a risk for medical errors.

Risk of Infection, Injury, and Death: A safe workplace is typically the result of a number of interrelated variables. According to the American Nursing Association (2021), safety-related concerns must be taken into account in order to improve workplace safety for nursing professionals. According to Joshua and Kakanda (2021), nurses are vulnerable to a variety of risks, such as back injuries from lifting patients and contact with dangerous materials and devices including chemicals and needlesticks. If a nursing practitioner is not sufficiently protected or informed, all of these could pose a risk. Legislation and education are seen to be crucial in lowering these hazards because they enable nurses and their employers to design work conditions.

Workplace Violence: Nurses may come into workplace violence while performing their duties. Essentially, violent behaviours such as bullying and verbal abuse from patients and their families, other nurses, or other healthcare workers could put them at higher risk of work-related assaults (Occupational Safety and Health Administration 2021). At other occasions, there may be severe reactions to the nurse, such as physical attack, which is quite dangerous. These could be detrimental to the nurse's emotional and physical health.

Stress/Burnout: One of the main concerns is the mental and physical strain that providing care for patients places on nurses. According to a poll conducted by ANA (2021), around 82% of nurses reported experiencing severe stress while performing their duties. The 12-hour shift, which is frequently linked to a taxing workload, the possibility of contracting an illness, and workplace violence, among other things, has been observed as the norm for nursing professionals in certain regions. This has been associated with weariness and an increased risk of medical errors, particularly among nurses who have a high patient turnover rate.

2.1.7 Quality of Nursing Care in Nigeria

There are an estimated 220 million people living in Nigeria. It is the most populous country in Africa and the seventh most populous country in the world. Nigeria's health sector was founded to offer basic medical treatment to all Nigerians, regardless of where they live inside the country's borders (FRN, 2020). The three levels of healthcare (primary, secondary, and tertiary) that are engaged in the creation, execution, and oversight of health policies can be used to describe the current healthcare system. In general, local governments oversee primary healthcare, state governments oversee secondary care, and the federal government oversees tertiary care, however state governments also have a part in this level of care

The Nursing and Midwifery Council of Nigeria (NMCN) oversees nursing practice in Nigeria. It is the only legal and administrative organization tasked with carrying out duties on behalf of the Nigerian Federal Government to guarantee that the country's citizens receive efficient and secure nursing and midwifery care (NMCN, 2022). It is also

responsible for maintaining the highest standards of professional nursing and midwifery practice and enforcing professional discipline. Furthermore, it outlines the norms and professional code of conduct that are expected of nurses. Some of these specifically include the requirement that the nursing professional take personal responsibility for the care they give their clients or patients. This suggests that he or she must cooperate with other professional peers and other members of the health team for ethnic procedures only, and that he or she is accountable for his or her acts and inactions regardless of instructions and advice from other health practitioners. Additionally, the nursing professional is required to contribute to the advancement of the nursing profession and science while considering the care environment and its psychological and social consequences on the patient or client (NMCN, 2022).

One of the main issues in public health is the quality of nursing care. It should be mentioned that many healthcare facilities struggle to provide high-quality nursing care and guarantee successful outcomes. It is difficult to provide high-quality nursing care in low-income nations like Nigeria. Inadequate training and retraining due to a lack of basic equipment, a poor working environment, resistance to change in the profession, leadership issues, a poor research culture, a lack of dedication to work, and general professional practice are some of the difficulties that Nigerian nurses face, according to Shehu (2018). Furthermore, Adepueju & Euphemia (2021) found that problems that hinder nursing care in Nigeria include a lack of possibilities for additional training, job overload and time limits, inadequate managerial support, and poor nurses' responsibility.

2.1.8 Patients' Perception of Quality of Nursing Care

In the provision of healthcare, nurses are essential staff members. They are a sizable fraction of healthcare workers that provide patient care, and their contacts with patients and the services they provide have a big influence on the patient's experience. Patients' viewpoints have been observed to drive the quality of care within the healthcare system since they continue to play a significant role in changing the healthcare delivery system (WHO 2021). One indirect but useful source of information on the perceived quality of health care delivery is patients' opinions of what makes for good care. Since nurses are the medical professionals that spend the most time with patients while they are in the hospital, the care behaviours of nurses may be the source of the sensation of care that patients perceive.

According to the Australian Commission on Safety and Quality in Healthcare (2021), nurses' contributions to healthcare quality go beyond delivering safe care that complies with the highest clinical standards. They also take part in larger organisational and system quality and safety frameworks. Therefore, nurses' understanding of the procedures involved in providing services as well as the results of those services based on patient satisfaction feedback can offer important insights into the perceived quality of care. The purpose of the healthcare system is to provide those who require care with the best possible care. It is the professional duty of nurses to assess, track, and document the suitability and efficacy of healthcare. Nursing and Midwifery Quality Care-Metrics (2021) listed seven care groups' worth of quality indicators. These include measuring systems that are unique to the care processes in individual care areas, tracking and evaluating performance against standards, providing real-time reports and a standardised system to

track the quality of care, quantifying trends and highlighting exceptional care and areas of risk that need immediate attention, enabling targeted action plans for improvement, providing guidance on healthcare staff education needs, and encouraging staff engagement and accountability for the quality of care.

2.2 Theoretical Framework

Quality Health Outcome Model (QHOM)

The Quality Health Outcomes Model (QHOM), developed by Mitchell and colleagues in 1998, will serve as the foundation for this investigation. According to the QHOM, the characteristics of patients and clients, health care interventions, and the health care environment (system) all interact to affect health outcomes (patient/client health). The model is an adaptation of Donabedian's classic structure-process-outcome framework, which postulates that, after accounting for patient characteristics, interventions or treatments directly result in anticipated outcomes. It anticipates a relationship between clients, interventions, and outcomes within the framework of care. The dynamic relationships with indicators that not only act upon but also affect the many components are what make the QHOM distinctive.

The physical and psychological settings in which care is provided make up the system, according to the QHOM. The physical environment includes things like manpower (both amount and quality) and infrastructure/equipment. Conversely, the psychological component includes elements like employee motivation, positive and supportive work environments, accountability, and efficient system monitoring.

Actions taken during the course of care are explained by intervention. Conversely, the unique qualities of the patient within the healthcare system are referred to as client characteristics. These consist of age, gender, and overall health. Moreover, outcome refers to the anticipated result of the patient's or client's interactions with the various components. According to the concept, a high-quality healthcare system should improve safety by reducing prescription errors, diagnostic errors, healthcare-associated infections, surgical errors, and safe transfusions.

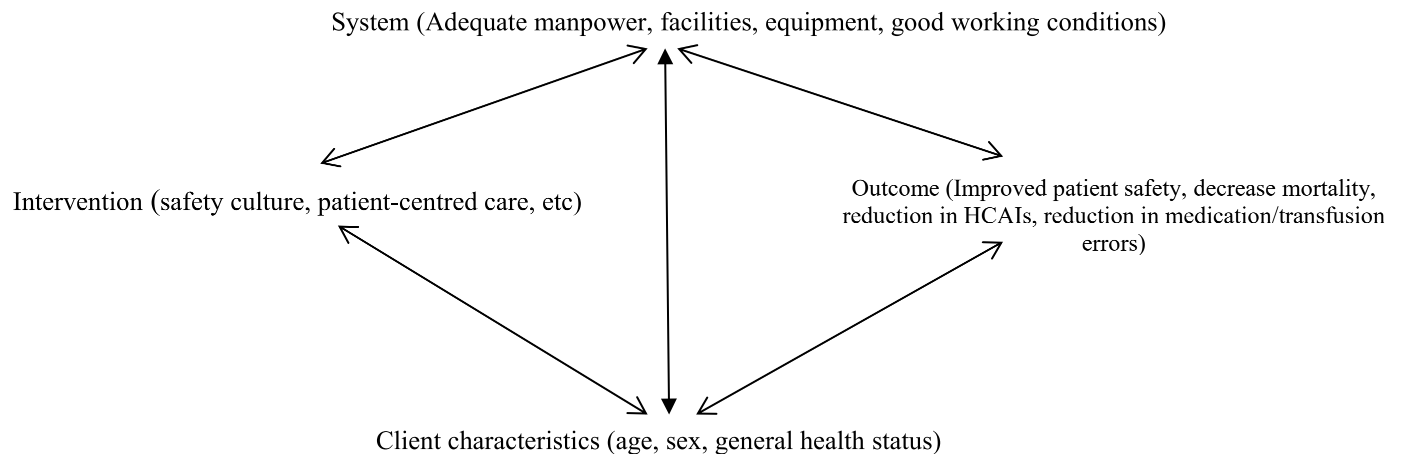

Figure 2.1: Quality Health Outcome Model (QHOM) (Mitchell et al., 1998)

Application of the Model to the Study

This study evaluates patients' perceptions of the quality of nursing care. The QHOM assumes that the quality of care obtainable depends on the structure of the care system (environment), interventions implemented in the healthcare process, and the characteristics of the patient. Nursing care is provided within the context of the health care system (environment). It can be assumed that adequacy in terms of facilities/equipment

availability, working conditions, quality and quantity of manpower may influence nursing care, which may then have an impact on interventions given during nursing care. More so, the characteristics of the client/patient such as state of health could also act to influence outcome.

Positive outcomes like safe transfusions, fewer medical errors, lower mortality, and fewer healthcare-acquired infections and disabilities are anticipated from quality nursing care. However, the quality of care that can be obtained is unsatisfactory in situations when the system (structure) and interventions offered are of poor quality, which results in unfavourable outcomes.

2.3 Empirical Review

Aspects of Nursing care affected by Nurses Shortage as Perceived by the Patients

Alikari et al. (2022) conducted a study on Perceptions of Caring Behaviours among Patients and Nurses, which included 310 patients and 329 nurses from six general hospitals in Greece who completed the Caring Behaviours Inventory-16. The Caring Behaviours Inventory-16 had a mean score of 78.94 (±17.85) for patients and 80.27 (±9.36) for nurses. The most important caring behaviours for patients were "Demonstrating professional knowledge and skills" (Mean: 5.45 ± 3.62) and "Treating my information confidentially" (Mean: 5.34 ± 1.06). The least important caring behaviours for patients were "Including me in planning care" (Mean: 4.36 ± 1.56) and "Treating me as an individual" (Mean: 4.55 ± 1.46). "Treating patients' information confidentially" (Mean: 5.43 ± 0.94) was the most essential caring behaviour for nurses, while "Returning to the patient voluntarily" (Mean: 4.57 ± 3.68) was the least important. The following items showed significant differences:

"Listening intently to me/the patient" ($t = -2.05$, $p = 0.04$), "Treating me/the patient as an individual" ($t = -7.82$, $p = 0.00$), "Being sympathetic or identifying with me/the patient" ($t = -2.80$, $p = 0.00$), and "Responding promptly when I/the patient calls" ($t = -2.01$, $p = 0.04$). The study found that while knowledge, skills, and safety were the most crucial caring behaviours for patients, respect, privacy, and dignity were the most crucial for nurses.

Ball et al., (2022) conducted a cross-sectional survey of 2917 registered nurses working in 401 general medical/surgical wards in 46 general acute National Health Service hospitals in England to investigate 'care left undone' during nursing shifts: associations with workload and perceived quality of care. According to the study's findings, the majority of nurses (86%) said that one or more care activities were left undone owing to time constraints on their last shift. The most common tasks left undone were soothing or chatting with patients (66%), teaching patients (52%), and developing/updating nursing care plans (47%). The number of patients per registered nurse is substantially linked with the occurrence of' missed care' ($p<0.001$). On wards assessed as 'failed' on patient safety, an average of 7.8 actions each shift were left undone, compared to 2.4 on wards rated as 'outstanding' ($p<.001$). According to the survey, nurses who work in English hospitals regularly say that care is left undone. Low nurse staffing numbers may be a contributing factor to poor quality and safety. A nurse-rated assessment of'missed care' could be used as an early warning measure in hospitals to identify wards with inadequate nurse staffing.

Additionally, Babapour et al. (2023) conducted a cross-sectional study with 115 nurses employed in two hospitals to examine the effects of occupational stress on nurses' quality of life and caring behaviours. The availability sampling approach was used to pick the nurses, and the Caring Dimension Inventory, job stress, and quality of life (SF12) questionnaires were used to gather data. The study's results showed that the mean (SD) overall scores for caring behaviour, quality of life, and job stress were 38.23 (9.39), 56.64 (18.05), and 2.77 (0.54), respectively. Total job stress scores were negatively correlated with both caring behaviours ($r = -0.26$, $P < 0.001$, Small effect) and quality of life ($r = -0.44$, $P < 0.001$, Medium effect). Job stress predicted 27.9% of changes in total quality of life score ($\beta = -0.534$, $SE = 0.051$, $R2adj = 0.279$, $P < 0.001$) and 4.9% of changes in total caring behaviours ($\beta = -0.098$, $SE = 0.037$, $R2adj = 0.049$, $P < 0.001$). The study showed that occupational stress had a negative impact on nurses' quality of life and health. It can also overshadow care performance and minimise such behaviours in nurses, which may be one of the variables influencing patient outcomes.

Perceived Impact of Nurses Shortage on the Quality of Nursing Care from the Perspectives of Patients

In Winter et al.'s (2022) study, "Nurse staffing and patient-perceived quality of nursing care: a cross-sectional analysis of survey and administrative data in German hospitals," 212,554 patients who were released from non-psychiatric, non-paediatric, and non-intensive hospital units after spending at least two nights there between January and October 2021 were included. 30,174 of them replied, resulting in a 14.2% response rate. The study's results showed that as (1) nurse staffing levels dropped (with diminishing

marginal effects) and (2) the percentage of assistant nurses in a hospital unit grew, all three characteristics of patient-perceived quality of nursing care dramatically declined.

Patients who were admitted to smaller hospitals, medical units, or were less clinically complicated showed a stronger correlation between nurse staffing levels and the quality of nursing care. The study's conclusions showed that, in addition to nurse staffing levels, nursing skill mix is essential for delivering the highest calibre of nursing care from the patient's point of view. Both should be taken into account when creating policies like minimum staffing requirements to raise the standard of nursing care in hospitals.

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A quantitative cross-sectional descriptive study design was used in a study by Mahmood et al. (2023) on the impact of staff nurse shortages on the quality of patient care in specialised hospitals in Lahore. This investigation was carried out in several healthcare environments in various geographical locations. The study's participants were chosen using a convenience sampling technique. In accordance with international recommendations, patients in contexts where there is a nurse shortage used and completed a questionnaire. According to the study's findings, most participants said that the lack of nurses had a detrimental effect on patient care. Reduced patient satisfaction with nursing staff service

was linked to the nursing shortage. Additionally, the study discovered that a lack of nurses frequently resulted in overworked and worn-out nurses, which reduced patient care quality and caused medical errors. The study came to the conclusion that patient care in healthcare settings is severely harmed by the nursing shortage. Patient death rates, longer hospital stays, lower quality of treatment, and lower patient satisfaction with care are all consequences of the nursing shortage. In order to improve patient outcomes and guarantee the delivery of high-quality healthcare services, it is imperative that the nursing shortage be addressed.

Cho et al., (2021) also conducted a study on the relationships between nurse staffing and patients' experiences, as well as the mediating effects of missed nursing care, which included 362 nurses and 208 patients from 23 nursing units across six hospitals in South Korea. The study used a cross-sectional study design to investigate the relationships between nurse staffing levels, missing nursing care, and patient experiences. The study found that lower perceived staffing sufficiency was associated with more missed nursing care, adverse events, and poorer communication, resulting in lower overall hospital evaluations from patients. The study concluded that increasing nurse staffing adequacy will reduce missed care and improve patient experiences. The study showed that proper nurse staffing is critical for minimising missed nursing care and improving the patients' experiences.

2.4 Summary of Literature Review

The literature on nurse staffing levels and healthcare quality shows a clear and continuous link between a lack of nurses and poor patient outcomes. Numerous global studies have found that when nurses are overloaded and understaffed, the quality of care provided

suffers dramatically. Nurse shortages have several serious effects, including increased mortality and morbidity rates, increased prescription mistakes, delayed treatment, diminished patient monitoring, and decreased patient satisfaction. These benefits are particularly visible in tertiary health institutions, where the complexity and number of patient cases requires competent and experienced nursing care.

In Nigeria, a nursing shortage has long existed, particularly in tertiary hospitals, which serve as the final point of referral in the healthcare system. Several studies have investigated the causes that contribute to this shortage, including bad working conditions, low pay, limited employment possibilities, a lack of professional development, and the migration of trained nurses to higher-paying nations. These factors not only restrict the quantity of available nurses, but they also contribute to increased workload, burnout, and low morale within the current staff, decreasing the quality of care offered to patients.

The World Health Organization defines quality of care as the extent to which healthcare services promote intended health outcomes while remaining consistent with current professional knowledge. It encompasses both technical and interpersonal components, such as effectiveness, safety, responsiveness, punctuality, and patient-centeredness. However, in the face of a nurse shortage, these components are frequently jeopardised. For example, nurses may not have enough time to speak properly with patients, give emotional support, or ensure that drugs and treatments are administered on time. This leads to a decrease in patients' overall happiness with their care experience, which may impair clinical outcomes.

While various studies have looked into the consequences of nursing shortages on healthcare personnel and institutional performance, there is little research that focuses

directly on patients' perspectives. The majority of existing material fails to convey the perspectives of patients, who are the primary recipients of nursing care. Furthermore, few research have investigated this topic in the setting of tertiary health facilities in Edo State, notably in Benin City. As a result, there is a shortage of localised data that may drive staffing decisions, healthcare policy, and focused initiatives to improve care delivery in this region.

Furthermore, existing research are primarily quantitative in nature, with an emphasis on statistical correlations and institutional performance metrics. There is a noteworthy lack of qualitative or mixed-method techniques that could provide deeper insights into patients' actual experiences, such as how they perceive and are influenced by the presence or absence of effective nursing care. The emotional, psychological, and interpersonal qualities of care—such as being treated with dignity, being listened to, and receiving prompt attention—are often neglected in quantitative data but are crucial features of quality treatment.

In conclusion, while the literature substantially supports the assumption that nurse shortages have a negative influence on patient care quality, considerable gaps exist. More patient-centered research is needed to better understand how patients perceive and experience the effects of low nurse staffing. There is also a need for research that focus especially on tertiary health institutions in Benin City to provide context-relevant evidence that can be used to improve healthcare delivery and policy formation in Edo State and other settings.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presented the procedures that employed in carrying out this study. It was discussed under the following sub-headings: research design, research setting, target population, sample size, sampling technique, instrument for data collection, validity of the instrument, reliability of the instrument, method of data collection, method of data analysis and ethical consideration.

3.2 Research Design

The cross-sectional descriptive research design was used for this investigation. This entails evaluating the topic of this study (quality of nursing care from the perspective of patients) across a section of patients who differ in particular parameters such as gender, age, educational level, marital status.

3.3 Research Setting

The study was carried out in the Medical and Surgical Unit of the University of Benin Teaching Hospital in Benin City, Edo State. It is a tertiary healthcare facility that opened in 1975. It is located in Ugbowo, Egor Local Government Area. It is really close to the University of Benin. UBTH is situated in a commercial district with a relatively dense population. It provides both clinical and diagnostic services, as well as a variety of services, making it a popular healthcare institution in the state, area, and country as a whole. It is believed that UBTH has over nine hundred and ten (910) beds. Its vision includes being the leader in providing quality healthcare solutions in West Africa, while its mission

statement is to work as a team to improve customers' health by integrating consistent quality care, education, and research in a compassionate atmosphere..

3.4 Target Population

The study's target population included all patients in the medical surgical unit of the University of Benin Teaching Hospital in Benin City. These individuals were chosen based on their direct experience with nursing care in a hospital setting, making them qualified to provide relevant insights regarding how a lack of nurses affects the quality of care they get. This demographic was chosen to ensure that replies are based on first-hand experience, hence increasing the validity and applicability of the findings to the issue of nurse shortages and quality of service in tertiary healthcare settings.

Table 3.1: Population Distribution

Units	**Ward**	**No of patients**
Surgical unit	A2	18
	A4	19
	B2	21
	B4	18
	ORTHOPAEDIC	22
	ORTHOPAEDIC	18
	NEURO-SURGICAL	19
Medical unit	A1	24
	A3	24
	A5	25
	RENAL	18
	ONCOLOGY	17
Total		243

(Source: Records Unit, UBTH)

3.1.1 Inclusion Criteria

- Only adult patients were included in the study to ensure that participants can provide informed consent and articulate their perceptions clearly.
- Patients who have received care for at least 48 hours (inpatients): This ensure that participants have had sufficient interaction with nursing staff to form an informed opinion about the quality of care received.
- Patients who were mentally and physically stable at the time of data collection. Only those in a stable condition will be included to ensure accurate communication and to avoid burdening patients in distress or crisis.
- Patients who were willing to give informed consent. Participation in the study was voluntary and based on informed consent.

3.1.2 Exclusion Criteria

- Patients who have spent less than 48 hours in the facility. These individuals may not have sufficient experience to evaluate the quality of nursing care.
- Critically ill patients or those in emergency conditions. Their participation may pose ethical concerns or interfere with urgent clinical care.
- Patients with cognitive impairment or psychiatric disorders that impair judgment or communication. These individuals may not be able to respond reliably to study questions.

These criteria was designed to ensure the collection of rich, reliable, and ethically sound data from participants who are most qualified to assess the perceived influence of nurse shortages on the quality of care received in the selected tertiary health institution.

3.5 Sample Size

Sample size refers to a subset of an entire set. It represents part of the whole population; hence it shares similar attributes with the entire population from which it is drawn. The sample size for this study will be determined using the Taro Yamme (1967) formula for sample size determination in order to ensure that proportionate sample which can reasonably serve as basis for which generalization is made for the entire population. The total number of patients sampled was approximate. The level of precision assumed was 0.05. The sample size was 224 calculated as thus:

n= sample size

N= population size

e= level of precision (e=0.05)

$$n = \frac{243}{1+243(0.05)}$$

n= 243

1+243(0.0025)

$$n = \frac{243}{1+0.6}$$

$$n = \frac{243}{1.6}$$

n=151

Therefore, the sample will be 151 registered nurses

3.6 Sampling Technique

A convenience sampling technique was used in selecting patients in selected wards for this study. Convenience sampling is a non-probability sampling method in which participants

are selected based on their availability, accessibility, and willingness to participate in the study at the time of data collection. This technique is commonly used in hospital-based studies, especially when access to a complete sampling frame is limited or when time and resources are constrained.

In the context of this study, convenience sampling involved selecting inpatients who meet the inclusion criteria—such as being 18 years and above, admitted for at least 48 hours, mentally and physically stable, and willing to provide informed consent. These patients will be approached during their hospital stay, and those who are readily available and agreeable will be recruited to participate. Although convenience sampling does not offer the same level of generalizability as probability sampling methods, it is appropriate for this study because it allows the researcher to collect data efficiently from a relevant and available subgroup of the inpatient population. It also facilitates the inclusion of participants who are directly experiencing care in an environment where nurse shortages may impact service delivery, which aligns with the objective of exploring patients' perceived influence of the paucity of nurses on quality of care. To reduce bias, efforts will be made to recruit patients from multiple wards (e.g., medical, surgical, obstetric) and across different times of day, ensuring a diverse and representative sample within the constraints of convenience-based access.

3.7 Instrument for Data Collection

This study made use of a questionnaire as instrument to elicit data from respondents. The questionnaire will comprise of three sections; A, B, C and D.

Section A consisted of items eliciting data on the demographic information of respondents (age, gender, academic qualification, marital status).

Section B comprised of items the quality of nursing care.

Section C: will include items on factors that can affect the quality of nursing care. The scale will be scored as follow: strongly agree 4, Agree 3, Disagree 2, Strongly Disagree 1. The mean of the respondents scores were determined and a value greater than 2.5 as a factor and a value less than 2.5 as not a factor.

Section D: comprised items on strategies that can promote nursing care

3.8 Validity of the Instrument

The instrument for data collection was scrutinized by the project supervisor. This is to ensure that the construction and arrangement of the items in the instrument is appropriate and able to measure the purpose for which it is intended for. Correction and comments made will be used in updating the instrument before it is administered. This will ensure both face and content validity. To establish construct validity, the questionnaire was structured based on a conceptual framework that links nurse availability to recognized dimensions of quality care. Items were grouped into logical sections based on these constructs, and questions were designed to align with specific indicator.

3.9 Reliability of the Instrument

Through the pilot study, the instrument's capacity to measure the study's objectives and yield reasonably accurate results was confirmed. In order to do this, copies of the instruments (10% of the sample size) will be pretested on a population that is different from the population under study but has comparable features. Fifteen patients from Central Hospital in Benin City will be employed in this instance. These were done twice in a row.

The reliability of the results was assessed using Cronbach alpha statistics. The outcome will demonstrate the instrument's dependability.

3.10 Method of Data Collection

Data were collected through face-to-face administration of the instrument to the respondents. Efforts were made to explain the purpose of the exercise to respondents, after which a copy each is handed to respondents who provides consent to participate. After completion of the instrument, it will be retrieved immediately in order to avoid incidence of loss.

3.11 Method of Data Analysis

The Statistical Package for Social Science (SPSS 22.0) was used to analyse the data. Both descriptive and inferential statistics will be used effectively in this case. Means, frequencies, and percentages are examples of descriptive statistics; the Chi-square test of association is an inferential statistic used to assess the study hypothesis. The significance threshold will be set at $p<0.05$. Based on the findings from the chosen sample, generalisations will be drawn.

3.12 Ethical Consideration

In carrying out a study of this nature, certain ethical procedures must be adhered to in order not to violate principles guiding research. Some of these include written permission/ethical clearance, Informed consent/voluntary participation, confidentiality/Anonymity and avoiding plagiarism.

Written permission/Ethical Clearance: Before embarking on this research, ethical clearance will be sought from the authorities in the studied area (University of Benin

Teaching Hospital). This is necessary so as not to violate standards and procedures in the stated healthcare facilities.

Informed Consent: From the population of study, samples that will be selected will be asked to provide informed consent on their willingness to partake in the study. Those who decline consent will not be forced to participate, whereas those who show willingness will be handed a copy of the instrument to complete. In essence nobody will be coerced or inconvenienced in participating in the study.

Confidentiality/Anonymity: In most research study such as this, the identity of the respondents must be protected. This will ensure that respondents provide sincere responses. At such, items that may personally identify the respondents will be excluded in the instrument.

Avoiding Plagiarism: It is expected that a research work should be original and a product of the researcher's findings. At such this study will as much as possible avoid plagiarism in form of subtle copying of another person's work. Where the views of others are expressed, appropriate citation will be provided.

CHAPTR FOUR

RESULTS

4.1 Introduction

This chapter presents the results obtained from analysis of data collected. It shall be presented in accordance with the research objectives

Table 4.1: Socio-Demographic Characteristics of Respondents (n = 151)

S/N	Variable	Frequency	Percentage
1.	**Sex**		
	Male	44	29.1%
	Female	107	70.8%
2.	**Age**		
	21 – 25 years	17	11.2%
	26 – 30 years	46	30.5%
	31 – 35 years	33	21.9%
	35 years and above	55	36.4%
3.	**Educational qualification**		
	RN	44	29.1%
	B.NSc.	89	58.9%
	M.Sc.	15	9.9%
	Ph.D.	03	1.99%
4.	**No of years of practice**		
	Less than 5 years	22	14.6%
	5 – 10 years	60	39.7%
	Above 10 years	69	45.7%
5.	**Current designation**		
	Chief Nursing Officer (CNO)	12	7.95%
	Assistant Chief Nursing Officer (ACNO)	15	9.9%
	Principal Nursing Officer (PNO)	16	10.6%
	Senior Nursing Officer (SNO)	24	15.9%
	Nursing Officer I (NO I)	48	31.8%
	Nursing Officer II (NOII)	36	23.8%

Source: Field work, 2023

Table 4.1 showed that majority (70.8%) of respondents are female, while 29.1% are male. Age distribution revealed that majority (36.4%) are within 35 years and above, 30.5% are within 26-30 years, 21.9% and 11.2% are within 31-35 years and 21-25 years respectively.

Educational qualification indicated that majority (58.9%) are holders of BNSc., 29.1% have RN certificates, while 9.9% and 1.99% have Masters and Ph.D. degrees respectively. Based on the years of practice, it was observed that majority (45.7%) have been in service for more than 10 years, 39.7% had been in service between 5-10 years, while 14.6% have less than 5 years practice experience. Current designation/rank of respondents showed that majority (31.8%) are Nursing Officer I (31.8%), while 23.8%, 15.9%, 10.6%, 9.9% and 7.95% are Nursing Officer II, Senior Nursing Officer, Principal Nursing Officer, Assistant Chief Nursing Officer and Chief Nursing Officer respectively.

Table 4.2: Perception of Quality of Nursing Care

S/N	Item	SA F(%)	A F(%)	D F(%)	SD F(%)	Mean	Std.D	Remark
1.	Protocols/standards that maintain patients' safety are in place.	37 (24.5%)	82 (54.3%)	19 (12.6%)	13 (8.61%)	2.95	.11	Agree
2.	Adequate support services afford nursing staff opportunity to focus on tasks.	20 (13.2%)	32 (21.2%)	56 (37.1%)	43 (28.5%)	2.20	.09	Disagree
3.	Patient's rights are upheld.	41 (27.2%)	50 (33.1%)	36 (23.8%)	19 (12.6%)	2.68	.35	Agreed
4.	Mistakes are promptly reported and addressed.	52 (34.4%)	39 (25.8%)	27 (17.9%)	13 (8.61%)	2.60	,44	Agreed
5.	There is enough time and opportunity to discuss patient care problems with other nursing staffs.	28 (18.5%)	33 (21.9%)	65 (43.0%)	23 (15.2%)	2.41	.67	Disagree
6.	There is time to teach patients on how to care for themselves.	57 (37.7%)	52 (34.4%)	22 (14.6%)	20 (13.2%)	2.97	1.04	Agree
7.	There is time to discover the fear of patients and try to relieve them.	49 (32.5%)	66 (43.7%)	31 (20.5%)	05 (3.3%)	3.05	.09	Agree
8.	There is enough time for treatment and medications with patients.	37 (24.5%)	49 (32.5%)	30 (19.9%)	33 (21.9%)	2.57	.32	Agree
9.	There is enough time to always protect the privacy of patients.	35 (23.2%)	21 (13.9%)	42 (27.8%)	51 (33.8%)	2.23	.03	Disagree
10.	There is adequate nursing staff-patient interaction/Providing emotional support to patient.	20 (13.2%)	36 (23.8%)	59 (39.1%)	36 (23.8%)	2.26	1.13	Disagree
11.	There is teamwork among various nursing personnel.	69 (45.7%)	56 (37.1%)	15 (9.93%)	11 (7.28%)	3.21	0.5	Agree
12.	Nursing supervisors/administrators consult with nursing staffs on daily concerns and procedures.	55 (36.4%)	72 (47.7%)	10 (6.62%)	13 (8.61%)	3.10	.08	Agree
13.	There is enough nursing staff to provide quality patient care.	35 (23.2%)	29 (19.2%)	24 (15.9%)	62 (41.1%)	2.23	1.31	Disagree
14.	There is enough time to render thorough nursing care.	29 (19.2%)	35 (23.2%)	44 (29.1%)	39 (25.8%)	2.30	.06	Disagree

15.	There is enough time to keep patient’s room neat and orderly.	44 (29.1%)	65 (43.0%)	20 (13.2%)	19 (12.6%)	2.85	1.05	Agree
16.	There is enough time to give patient as much information needed (e.g. treatment, hospital routine and test)	49 (32.5%)	52 (34.4%)	22 (14.6%)	28 (18.5%)	2.81	.06	Agree
17.	There is demand for high standard of care from supervisors/administrators.	73 (48.3%)	11 (7.285)	57 (37.7%)	07 (4.64%)	2.95	.01	Agree
18.	There are adequate precautions to prevent patient injuries.	63 (41.7%)	33 (21.9%)	36 (23.8%)	19 (12.6%)	2.92	1.02	Agree
19.	There are policies in place to prevent workplace violence on nursing staffs.	45 (29.8%)	51 (33.8%)	22 (14.6%)	30 (19.9%)	2.69	.06	Agree
20.	There are opportunities for nursing staffs to participate in policy decisions.	32 (21.2%)	30 (19.9%)	50 (33.1%)	39 (25.8%)	2.36	.04	Disagree
21.	Supervisors use mistakes as learning opportunities, not criticism.	33 (21.9%)	54 (35.8%)	32 (21.2%)	31 (20.5%)	2.58	1.10	Agree
22.	There is time to know individual patients needs.	57 (37.7%)	49 (32.4%)	21 (13.9%)	23 (15.2%)	2.91	.07	Agree
	Grand Mean					**2.67**		

$Benchmark = \frac{4+3+2+1}{4} = \frac{10}{4} = 2.5$ (Mean > 3.0 = agree/positive perception, Mean < 3.0 = disagree/negative perception)

Table 4.2 showed that mean responses for items 1, 3, 4, 6, 7, 8, 11 and 12 were 2.95, 2.68, 2.60, 2.97, 3.05, 2.57, 3.21, 3.10 respectively. Since these mean responses are greater than the benchmark (2.5) it infers that respondents agreed with these items (standard/protocols that maintains patients safety are in place, patients’ rights are upheld, mistakes are promptly reported and addressed, there is time to teach patients on how to care for themselves, there is time to discover the fear of patients and try to relieve them, there is enough time for treatment and medications with patients). Also, mean responses for items 15, 16, 17, 18, 19, 21 and 22 were 2.85, 2.81, 2.95, 2.92, 2.69, 2.58 and 2.91 were

respectively. Since these mean responses are greater than the benchmark (2.5) it infers that respondents agreed with these items (there is teamwork among various nursing personnel, nursing supervisors/administrators consult with nursing staffs on daily concerns and procedures, there is enough time to keep patient's room neat and orderly, there is enough time to give patient as much information needed (e.g. treatment, hospital routine and test, there is demand for high standard of care from supervisors/administrators, there is adequate precautions to prevent patient injuries, there are policies in place to prevent workplace violence on nursing staffs, supervisors use mistakes as learning opportunities, not criticism and There is time to know individual patients needs).

On the other mean responses for items 2, 5, 9, 10, 13, 14 and 20 were 2.20, 2.41, 2.23, 2.26, 2.23, 2.30 and 2.36 respectively. Since these mean are less than the 2.50 benchmark, it infers that respondents disagreed with these items (adequate support services afford nursing staff opportunity to focus on tasks, there is enough time and opportunity to discuss patient care problems with other nursing staffs, there is enough time to always protect the privacy of patients, there is adequate nursing staff-patient interaction/Providing emotional support to patient, there is enough nursing staff to provide quality patient care, there is enough time to render thorough nursing care, there are opportunities for nursing staffs to participate in policy decisions). A grand mean of 2.67 was obtained which implies that respondents had positive perception of quality of nursing care.

In a more descriptive ways, since the mean positive perception is 2.67 on a scale of 4, it infers that mean negative perception = 4 – 2.67 = 1.33.

Converting these two values into percentage:

Percentage positive perception $= \frac{2.67}{4} \times 100 = 66.75\% \approx 66.8\%$

Percentage negative perception = $\frac{1.33}{4} \times 100 = 33.25 \approx 33.3\%$

It means that 66.7% of the respondents had positive perception on quality of nursing care, while 33.3% had negative perception.

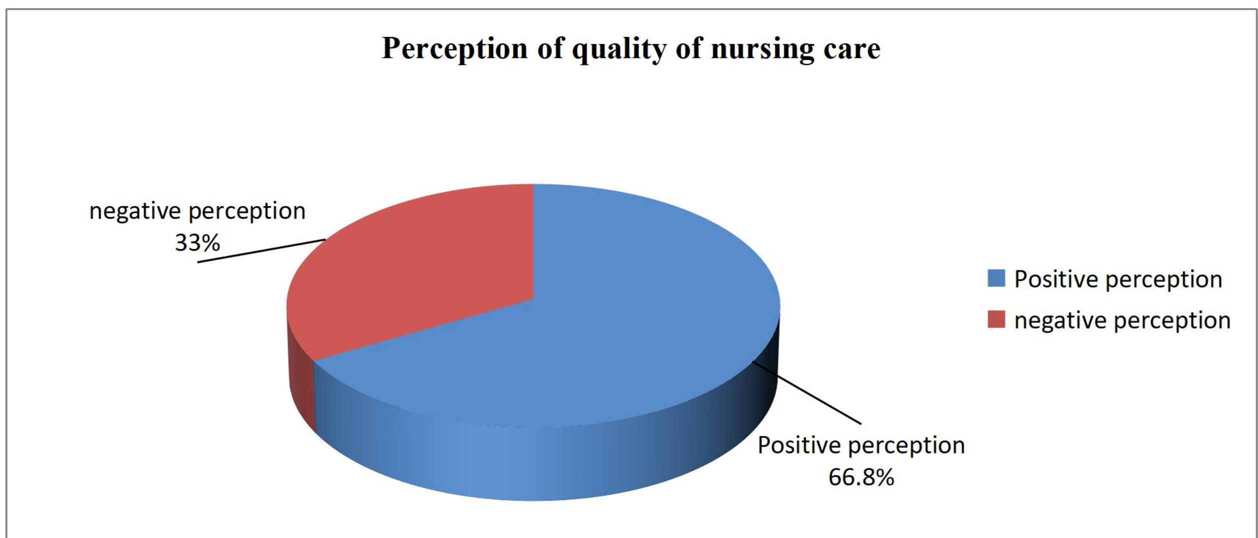

Figure 4.1: showing proportion of respondents on perception of quality of nursing care

Table 4.3: Perceived Influence of Paucity of Nurses on Quality of Nursing Care

S/N	Items	SA F(%)	A F(%)	D F(%)	SD F(%)	Mean	Remark
23.	Workload/Patient turnover is manageable.	18 (11.9%)	24 (15.9%)	49 (32.5%)	60 (39.7%)	2.01	Disagree
24.	Working hours/Shift are adequately organized.	35 (23.2%)	23 (15.2%)	45 (29.8%)	51 (33.85)	2.32	Disagree
25.	There is opportunity for professional advancement/development for the nursing staff.	51 (33.8%)	56 (37.1%)	23 (15.2%)	20 (13.2%)	2.90	Agree
26.	Equipment/supplies are adequate.	12 (7.95%)	25 (16.6%)	67 (44.4%)	46 (30.5%)	2.00	Disagree
27.	Infrastructure are adequate.	09 (5.96%)	33 (21.9%)	28 (18.5%)	81 (53.65)	1.80	Disagree
28.	Nursing staffs are adequately renumerated/adequate incentives.	12 (7.95%)	24 (15.9%)	64 (42.4%)	50 (33.1%)	1.97	Disagree
29.	Nursing personnel staffing is adequate.	31 (20.5%)	27 (17.9%)	47 (31.1%)	45 (29.8%)	2.28	Disagree
30.	There are training programme for newly recruited nursing staffs.	57 (37.7%)	80 (53.0%)	02 (1.32%)	12 (7.95%)	3.22	Agree
31.	There is enough time and opportunity to discuss patient care problems with other nursing staffs.	43 (28.5%)	55 (36.4%)	42 (27.8%)	10 (6.6%)	2.85	Agree
32.	Praise and recognition are in place for deserving nursing staffs.	34 (22.5%)	50 (33.1%)	40 (26.5%)	31 (20.5%)	2.61	Agree
33.	Nursing supervisors/administrators listens and responds to staffs concerns	67 (44.4%)	32 (21.2%)	16 (10.6%)	33 (21.9%)	2.84	Agree
	Grand Mean					**2.44**	

Table 4.3 showed that mean responses for items 25, 30, 31, 32 and 33 are 2.90, 3.22, 2.85, 2.61, and 2.84 respectively. Since these mean are greater than the benchmark (2.5), it implies that respondents agreed with these items (There is opportunity for professional advancement/development for the nursing staff, There are training programme for newly recruited nursing staffs, There is enough time and opportunity to discuss patient care problems with other nursing staffs., praise and recognition are in place for deserving

nursing staffs. nursing supervisors/administrators listens and responds to staffs concerns. On the other hand, mean responses for items 23, 24, 26, 27, 28, and 29 were 2.01, 2.32, 2.00, 1.80, 1.97 and 2.28 respectively. Since these mean responses are less than the 2.50 benchmark, it infers that respondents disagreed with these items (Workload/Patient turnover is manageable, working hours/Shift are adequately organized, equipment/supplies are adequate, Infrastructure are adequate, nursing staffs are adequately renumerated/adequate incentives, nursing personnel staffing is adequate). A grand mean of 2.44 was obtained, which infers that respondents disagreed with most of the factors enumerated as it relates to quality of nursing care. It could be inferred that since the items/statements were positively constructed and respondents disagreed with majority of the items, then these factors constitute challenges.

Table 4.4: Perceived strategies that can promote nursing care

S/N	Items	SA F(%)	A F(%)	D F(%)	SD F(%)	Mean	Std. d	Remark
34.	Provision of adequate facilities and equipment.	109 (72.2%)	11 (7.28%)	12 (7.95)	19 (12.6%)	3.40	.02	Agree
35.	Employment of nurses' staff	78 (51.7%)	54 (35.85)	09 (5.96%)	06 (3.97%)	3.30	.33	Agree
36.	Improving the wellbeing and quality of nurses	103 (68.2%)	46 (30.5%)	02 (13.2%)	00 -	3.67	.01	Agree
37.	Encouraging nurses to follow up with update courses to improve the quality of nursing care.	78 (51.7%)	65 (43.0%)	04 (2.65%)	03 (1.99%)	3.43	.03	Agree
38.	Encouraging nurses to engage in research.	56 (37.1%)	71 (47.0%)	10 (6.62%)	11 (7.28%)	3.10	.40	Agree
39.	Availability of effective healthcare team.	82 (54.3%)	60 (39.7%)	04 (2.65%)	05 (3.31%	3.45	.93	Agree
	Grand Mean					**3.40**		

Table 4.4 shows that mean responses for items for 34, 35, 36, 37, 38 and 39 are 3.40, 3.30. 3.67, 3.43, 3.10 and 3.45 respectively. Since these mean responses are greater than the benchmark (2.5), it implies that respondents perceive the items (Provision of adequate facilities and equipment, employment of nurses' staff, improving the wellbeing and quality of nurses, Encouraging nurses to follow up with update courses to improve the quality of nursing care, encouraging nurses to engage in research, availability of effective healthcare team).

A grand mean of 3.40 was obtained, which indicate that majority agreed on the items as possible strategies to improving nursing care.

In a more descriptive way:

Proportion that agrees = 3.40 on a scale of 4

Proportion that do not perceive the strategies as effective = (4 – 3.40) = 0.6

Converting it to percentage

Proportion that agrees = $\frac{3.40}{4} \times 100 = 85\%$

Proportion that do not agree $= \frac{0.6}{4} \times 100 = 15\%$

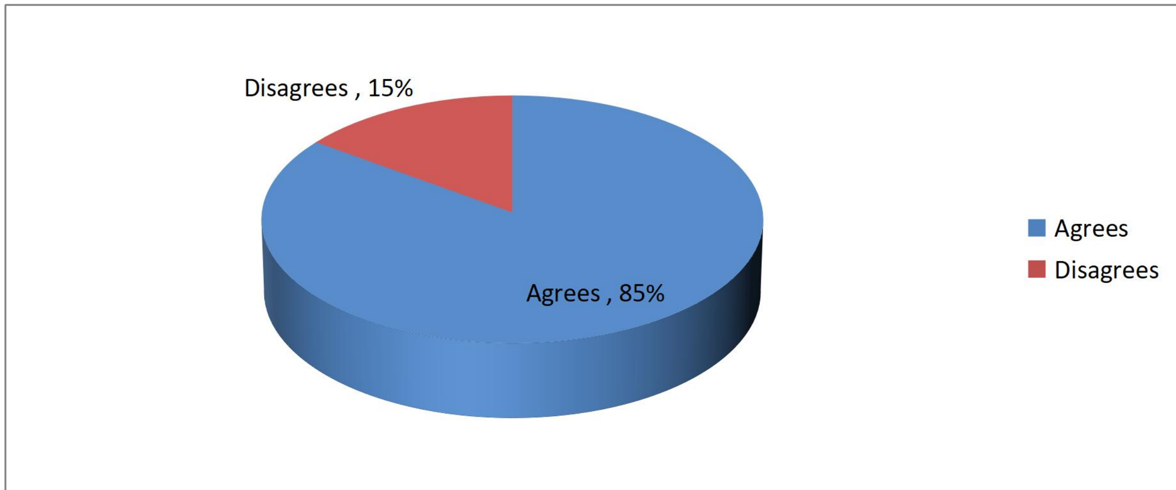

Figure 4.2: Proportion of respondents with mean responses to strategies on improving quality o nursing care

Table 4.5: Perceived Quality of Nursing care and years of practice (ANOVA)

Gender	N	Mean	Std. deviation	Standard error mean	F-value	p-value	Remark
Less than 5 years	22	2.70	1.08	.44	12.35	.01	Reject H_o
5-10 years	69	2.79	.76	.03			
Above 10 years	60	2.88	.05	.56			

Table 4.5 shows the analysis of variance in perceived quality of nursing care and years of experience of respondents. It is observed that mean perception for the different categories differs 2.70, 2.79 and 2.88 for less than 5 years, 5-10 years and above 10 years respectively. In other to ascertain, if this difference is significant an F-value of 12.35 and $p-$value of .01 were obtained. Since the p-value is less than $p < 0.01$, it infers that the null hypothesis is rejected, hence there is a significant difference in perceived quality of nursing care and years of practice.

Table 4.6: Perceived Quality of nursing care and gender (t-test)

Gender	N	Mean	Std. deviation	Standard error mean	t-value	p-value	Remark
Male	44	2.69	.07	.48	12.56	.07	Accept H_o
Female	107	2.65	1.03	.03			

Table 4.6 shows the relationship between perceived quality of nursing and gender. It is observed that male respondents had a mean response of 2.69, while female respondents had mean responses of 2.65, showing difference in mean responses. However, in order to ascertain if the difference is significant, a t-value of 12.56 and a p value of .07 were obtained. This implies that the null hypothesis is retained inferring that is no significant relationship between perceived quality of nursing care and gender.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the discussion of findings, implications to nursing practice, limitations of the study, summary, conclusion and recommendations

5.2 Discussion of Findings

This study evaluated at how patients in a tertiary health facility in Benin City, Edo State, viewed the impact of a nursing shortage on their quality of care. Results showed that the majority were female, 35 years and above, holders of B.NSc. with between 5-10 years' experience were Nursing Officer I. Results on research objective one, which sought to assess the perception of patients on the quality of nursing care, showed that patients had a positive perception that standards/protocols that maintain patients' safety are in place, patients' rights are upheld, mistakes are promptly reported and addressed, there is time to teach patients Additionally, they positively confirmed that there is teamwork among different nursing personnel, that nursing supervisors and administrators consult with nursing staffs on daily concerns and procedures, that there is enough time to keep patients' rooms tidy and orderly, that supervisors and administrators demand high standards of care, that there are adequate precautions to prevent patient injuries, that policies are in place to prevent workplace violence on nursing staffs, that supervisors use mistakes as learning opportunities rather than criticism, and that there is time to understand the needs of individual patients.

On the other hand, respondents expressed a negative opinion of adequate support services that allow nursing staff to concentrate on tasks, have enough time and opportunity to discuss patient care issues with other nursing staff, always protect patient privacy, and provide adequate nursing staff-patient interaction.Offering patients emotional support, having enough nurses to deliver high-quality patient care, having adequate time to give comprehensive nursing care, and giving nursing staff members the chance to take part in policy choices. Overall, over one-third of respondents had a poor opinion of the quality of nursing care, whereas over half (around seven-tenth) had a positive opinion.

This finding is similar to Fahim, et al. (2020) who reported positive perception of quality of care among nursing staff in primary health-care centers in Beni Suef Governorate However, it differs from Kakemam et al. (2021) who reported low perception of quality of care, especially safety culture among Iranian nurses.

Research objective two examine at how the lack of nurses was considered to affect the standard of nursing care. Patients' perceptions of the quality of nursing care were found to be positively influenced by specific characteristics. These include the chance for nursing staff members to grow professionally, a training program for recently hired nurses, and ample time and opportunity to discuss patient care issues with other nursing staff members.Nursing supervisors and administrators listen to staff problems and provide praise and credit for deserving nursing staff.

On the other hand, respondents disagreed with characteristics like workload because they believed that some elements had a detrimental impact on the quality of nursing care.Patient turnover being managed, working hours/shift being appropriately organised, equipment/supplies being adequate, infrastructure being adequate, nursing staffs being

adequately renumerated/enough incentives and nursing personnel staffing being adequate. Overall, it can be concluded that while some factors were acknowledged as limiting the quality of nursing care, others were viewed by nurses as contributing to it.

. This finding agrees with Uchendu, et al. (2020) who reported barriers to quality nursing care to include high workload, lack of protected breaks and shift-work among nurses in a sub-urban tertiary health facility in Nigeria. Also, it is in line with Odunaiya, et al. (2019) who reported that nurses considered poor staff strength, inadequate equipment and inadequate consultation with staff during procurement of medical supplies as barriers to quality nursing.

Furthermore, research objective three sought to ascertain perceived strategies that can enhance quality of nursing care. It was discovered that provision of adequate facilities and equipment, employment of nurses' staff, improving the wellbeing and quality of nurses, encouraging nurses to follow up with update courses to improve the quality of nursing care, encouraging nurses to engage in research and availability of effective healthcare team were regarded by majority (more eigth-tenth) as possible strategies to improve quality of nursing care.

A significant difference in perception of quality of nursing care and years of practice was observed in the study. This inferred that patients' perception of quality of nursing care base on years of practice differ between the three categories (less than 5 years, 5-10 years and above 10 years). Hence, it could be said that the number of years the respondents had been in the care system affected their perception. In addition, a significant difference was not observed between both genders in terms of their perception of quality of nursing care, which implies that both male and female nurses tend to hold the similar perception. This

result is different from Alotaibi, et al., (2020) who reported a significant difference in nurses perceived patient safety culture (quality of nursing) and gender among Saudi nurses.

5.3 Implications to Nursing

The outcome of this study has implications on nursing practice. These include:

1. Nursing administrators/directors should endevour to provide adequate support to nursing staff in order to enable them focus on tasks and hence the quality of care they provide.
2. Nursing administrators should ensure that nursing staffs are carried along in critical decision-making and policies so as to boost in their confidence in the care system of which they are part.
3. The Nursing and Midwifery Council should ensure that the mandate given to them to oversee the quality of nursing care is achieved through regular consultation and advising the government on the need to ensure that challenges such as staffing and remuneration are taken serious.

5.4 Limitations of the Study

The result from this study is subject to some limitations. One of such is the sample size utilized in this study, though proportionate, but it could have influenced the outcome, hence overgeneralization.

5.5 Summary

This study assessed the Perceived Influence Of Paucity Of Nurses On Quality Of Care Among Patients In A Tertiary Health Institution In Benin City, Edo State. Three research objectives and two hypothesis were formulated for the study. A review of relevant

literature was carried out under three broad sub-headings; Conceptual review, theoretical framework and empirical framework. Under conceptual framework, a review of related concepts as explained by authors was undertaken. Furthermore, the Quality Healthcare Outcome Model (QHOM) formulated by Mitchell et al., (1980) was adopted as model on which the study was explained. Furthermore, a summary of previous empirical works related to the objectives of this study was carried out. The study population was nurses in the Medical and Surgical Wards at the University of Benin Teaching hospital. A cross sectional descriptive research design was employed and data collected using a structured questionnaire. Data collected were analyzed and results presented.

5.6 Conclusion

This study concludes that for nursing care to be optimal, attention must be paid to both human and material resources (supplies, equipment, infrastructure) and the welfare of nursing staffs. It concludes that nurses in the studied area had positive perception of the quality of care, however they reported conditions that militates against quality of nursing care.

5.7 Recommendations

The following recommendations are made base on the findings of this study:

1. Government at all levels; federal and state and local government should ensure that medical facilities under their care are adequately staffed and equipped in other to ensure quality nursing care.
2. Non-governmental organizations (NGOs) should as a matter of responsibility contribute their own quota in addressing shortfall in terms of supplies and other necessities in public health facilities in other to ensure quality nursing care.

3. In other to address challenges confronting nursing care in Nigeria, government at all levels should endevour to put in place and strictly implement policies that addresses nursing staff remuneration and welfare.

5.8 Suggestions for Further Studies

The following topics are suggested for other researchers who may be interested in this area of study in other to add to the discussion.

1. Assessment of patients' perception of quality of nursing care in a tertiary health institution.

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APPENDICES

APPENDIX I: QUESTIONNAIRE

DEPARTMENT OF NURSING SCIENCE
SCHOOL OF BASIC MEDICAL SCIENCES
UNIVERSITY OF BENIN
BENIN CITY

PERCEIVED INFLUENCE OF PAUCITY OF NURSES ON QUALITY OF CARE AMONG PATIENTS IN A TERTIARY HEALTH INSTITUTION IN BENIN CITY, EDO

Dear Respondents,

I am an undergraduate of the above-named institution and department. I am currently carrying out a study on "**PERCEIVED INFLUENCE OF PAUCITY OF NURSES ON QUALITY OF CARE AMONG PATIENTS IN A TERTIARY HEALTH INSTITUTION IN BENIN CITY, EDO**". Please assist in completing this questionnaire so that the researcher can gather information for the study. Your responses will be treated with strict confidentiality.

Thanks

Section A: Demographic Information:

Instruction: Please tick (√) the option that applies to you

1. Sex: Male ( ), Female ( )
2. Age: 21 – 25 years ( ), 26 – 30 years ( ), 31 – 35 years ( ) 35 years and above ( )
3. Educational Qualification: RN ( ), B.NSc. ( ), M.Sc. ( ), Ph.D. ( )
4. Marital Status Single ( ), Married ( ), Separated ( ), Divorced ( )

Section B: evaluating the quality of nursing care

SA – Strongly Agree, A – Agree, D – Disagree, SD – Strongly Agree

S/N	Items	SA	A	D	SD
1.	Protocols/standards that maintain patients' safety are in place				
2.	Adequate support services afford nursing staff opportunity to focus on tasks.				
3.	Patient's rights are upheld.				
4.	Mistakes are promptly reported and addressed.				
5.	There is enough time and opportunity to discuss patient care problems with other nursing staffs.				
6.	There is time to teach patients on how to care for themselves				
7.	There is time to discover the fear of patients and try to relieve them				
8.	There is enough time for treatment and medications with patients				
9.	There is enough time to always protect the privacy of patients				
10.	There is adequate nursing staff-patient interaction/Providing emotional support to patient.				
11.	There is teamwork among various nursing personnel.				
12.	Nursing supervisors/administrators consult with nursing staffs on daily concerns and procedures.				
13.	There is enough nursing staff to provide quality patient care				
14.	There is always time to render thorough nursing care				
15.	There is time to keep patients' room neat and orderly				
16.	There is enough time to give patient as much information needed e.g. treatment, hospital rotiune and test				
17.	There is demand for high standard of care from supervisors/administrators.				
18.	there is adequate precatuions to prevent patient inuries?				
19.	There are policies in place to prevent workplace violence on nursing staffs.				
20.	There are opportunities for nursing staffs to participate in policy decisions.				
21.	Supervisors use mistakes as learning opportunities, not criticism.				
22.	There is time to know individual patients needs				

Section C: factors that can affect quality of nursing care

SA – Strongly Agree, A – Agree, D – Disagree, SD – Strongly Agree

S/N	Items	SA	A	D	SD
1.	Workload/Patient turnover is manageable.				
2.	Working hours/Shift are adequately organized.				
3.	There is opportunity for professional advancement/development for the nursing staff.				
4.	Equipment/supplies are adequate.				
5.	Infrastructure are adequate.				
6.	Nursing staffare adequately renumerated/adequate incentives.				
7.	Nursing personnel staffing is adequate.				
8.	There are training programme for newly recruited nursing staffs.				
9.	There is enough time and opportunity to discuss patient care problems with other nursing staffs.				
10.	Praise and recognition are in place for deserving nursing staffs.				
11.	Nursing supervisors/administrators listens and responds to staffs concerns				

SECTION E: strategies that can promote nursing care

S/N	Items	SA	A	D	SD
1.	Provision of adequate facilities and equipment				
2.	Employment of nurse’s staff				
3.	Improving the wellbeing and quality of nurses				
4.	Encouraging nurses to follow up with update courses to improve the quality of nursing care				
5.	Encouraging nurses to engage in research				
6.	Availability of effective healthcare team				

APPENDIX II: Reliability

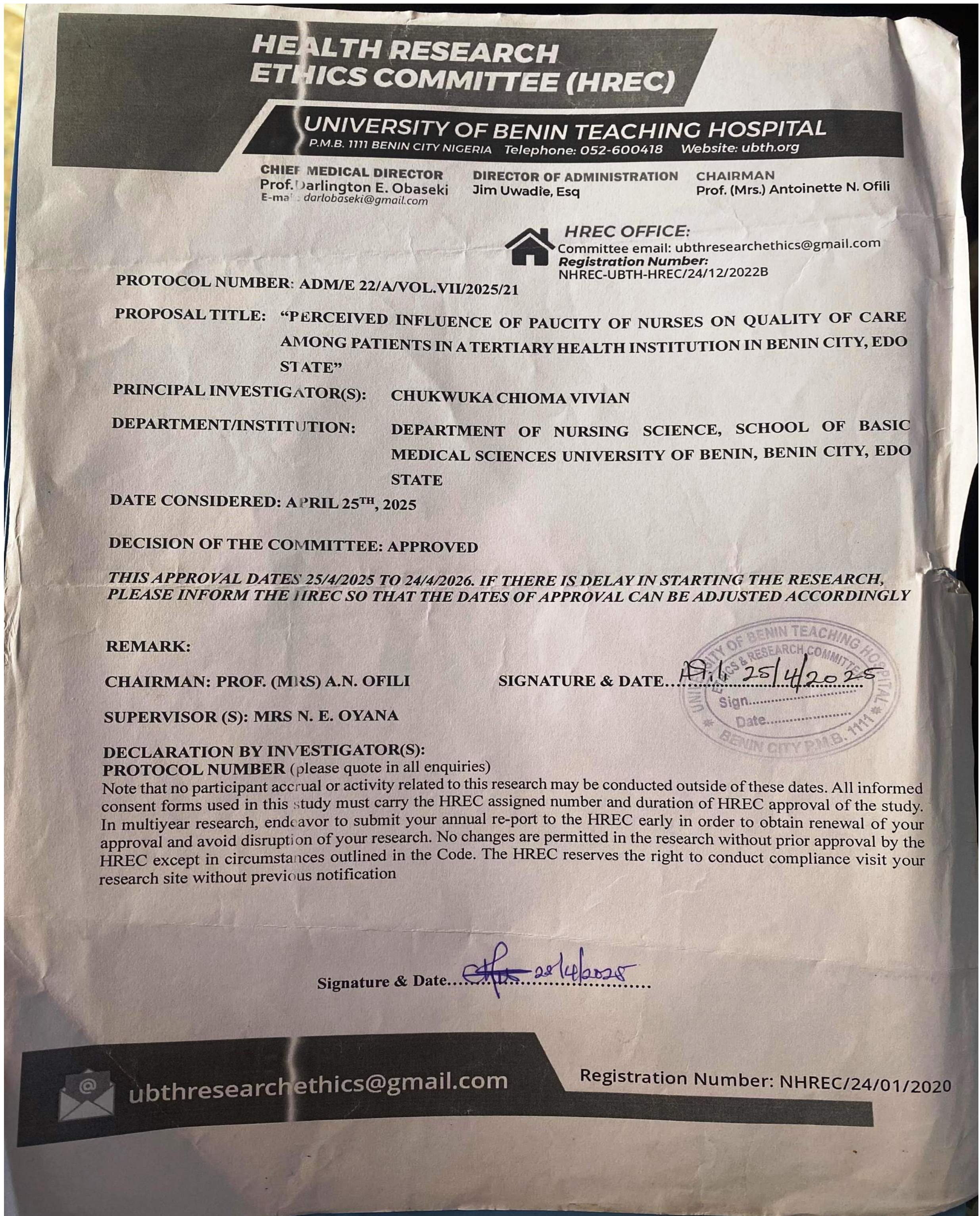
CRONBACH ALPHA RESULT

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.810	.794	18

Cronbach's Alpha = 0.810

APPENDIX III: Ethical Approval



HEALTH RESEARCH ETHICS COMMITTEE (HREC)

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Committee email: ubthresearchethics@gmail.com
Registration Number:
NHREC-UBTH-HREC/24/12/2022B

PROTOCOL NUMBER: ADM/E 22/A/VOL.VII/2025/21

PROPOSAL TITLE: "PERCEIVED INFLUENCE OF PAUCITY OF NURSES ON QUALITY OF CARE AMONG PATIENTS IN A TERTIARY HEALTH INSTITUTION IN BENIN CITY, EDO STATE"

PRINCIPAL INVESTIGATOR(S): CHUKWUKA CHIOMA VIVIAN

DEPARTMENT/INSTITUTION: DEPARTMENT OF NURSING SCIENCE, SCHOOL OF BASIC MEDICAL SCIENCES UNIVERSITY OF BENIN, BENIN CITY, EDO STATE

DATE CONSIDERED: APRIL 25TH, 2025

DECISION OF THE COMMITTEE: APPROVED

THIS APPROVAL DATES 25/4/2025 TO 24/4/2026. IF THERE IS DELAY IN STARTING THE RESEARCH, PLEASE INFORM THE HREC SO THAT THE DATES OF APPROVAL CAN BE ADJUSTED ACCORDINGLY

REMARK:

CHAIRMAN: PROF. (MRS) A.N. OFILI **SIGNATURE & DATE**........25/4/2025

UNIVERSITY OF BENIN TEACHING HOSPITAL ETHICS & RESEARCH COMMITTEE BENIN CITY P.M.B. 1111
Sign..........
Date..........

SUPERVISOR (S): MRS N. E. OYANA

DECLARATION BY INVESTIGATOR(S):

PROTOCOL NUMBER (please quote in all enquiries)

Note that no participant accrual or activity related to this research may be conducted outside of these dates. All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study. In multiyear research, endeavor to submit your annual re-port to the HREC early in order to obtain renewal of your approval and avoid disruption of your research. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code. The HREC reserves the right to conduct compliance visit your research site without previous notification

Signature & Date........28/4/2025........

ubthresearchethics@gmail.com Registration Number: NHREC/24/01/2020