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Chief Editor

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Articles, case studies or papers which any researcher wants published in this journal should be a thoroughly written material ranging from contemporary Public and Community Health (PCH) theoretical formalities, to new and modern methods and technologies applicable to Public and Community Health. If such research is descriptive, it should include abstract, introduction, background to the study, statement of problem, significance of the study as well as a review of literature pertinent to the study. Others are theoretical framework, design methodology, sample, sampling procedure, discussion of findings and recommendations.

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Chief Editor

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ASSESSMENT OF NURSE'S COMPETENCY IN IMPAIRED SENSORY PATIENTS PERCEPTION MANAGEMENT IN ACCIDENT AND EMERGENCY UNIT, UNIVERSITY OF PORT HARCOURT TEACHING HOSPITAL(UUTH), RIVERS STATE, NIGERIA

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ABSTRACT

This study was carried out to assess Nurses competency in patients with impaired sensory perception in accident and emergency department of university of Port Harcourt teaching hospital (UPTH). Nurse competency is a critical issue that is important for nurses, their organizations and their patients and empowers nurses in their practice. Three objectives were used to assess Nurses competency in patients with impaired sensory perception in accident and emergency department of university of Port Harcourt teaching hospital (UPTH), and responding three research questions were formulated to guide the study. A descriptive research design was used. The population of the study consisted of Emergency Trained Nurses at UPTH, P.H, and the sample consisted of 93 Nurses, Patricia Benner nurse theory was adopted. A Non-probability convenience sampling technique was used. A self-structured questionnaire was used to obtain data after ethical clearance and Results revealed that shows that Females 67(67.7%) while Males 30 (32.3%). shows the age distribution of respondents, out of 93 respondent studied 25 –30yrs 30 (32.3%) were age 31—35yrs 15 (16.1%) were 36—40yrs 13(14%), were 41 –45yrs 16(17.2%) were 46—50yrs, 8(8.6%) were 51—55yrs, 7(7.5%) were 56 –60yrs, 4 (4.3%) respectively. Educational Qualifications of the respondents RNM 30(32.3%) were AEN/NSNS, 46(49.5%) BSc/ BNSc, 30 (32.3%), MSc 16(17.9%) PhD 0 (0%). The Cadre of Emergency Nurses N01 30 (32.3%) SNO, 20 (21.5%) , PNO, 30(10.8%) , ACNO, 11 (11.8%) , CNO 17 (18.2%) ADN 5 (5.4%) respectively. The Years of working Experiences; 1—5yrs, 53(56.9%) were 6—10yrs, 25 (27.0%) and 11—15yrs 15 (61.1%) working experience respectively. Findings from this study shows that majority of emergency nurses have low level of competence in assessment of patients with impaired sensory perception. Conclusion Based on the findings of the study, the following Conclusions were made; Achieved competencies can be used as a reference for nursing education, application of nursing theories and practice in emergency. Recommendation Based on the findings from the study, the following are hereby recommended, a formal training on assessment of patient with impaired sensory perception is needed to offer nurses the skills required thereby increasing the competency level, emergency Nurses recorded less knowledge in the use of Glasgow coma scale than other area of practices and also recognized this as a global problem, thus requires its inclusion in educational programme for nurses in all areas of practice and in the curricular of nursing colleges, nursing work experience, in conjunction with managerial guidance, had a considerable influence on enhancing nursing capabilities. Thus Capacity building is crucial for newly graduated nurses who lack work experience, hospital managements should work against any mitigating factor on Emergency Nurses competency level of assessment in the care of patients with impaired sensory perception.

Keywords: Nurses Competency, Assessment, Impaired Sensory perception, University of Port Harcourt Teaching Hospital, Port Harcourt.

Introduction

Background to the Study: Professional competency is a fundamental concept in nursing, which has a direct relationship with quality improvement of patient care and public health, Nurses are the largest group of health professionals, and their competencies have a crucial role in the quality of health services (Fukada, 2018). Competency is a complex and multi dimensional concept that has different definitions. Understanding, knowledge, mastery of discipline, specific skills, ability to use sound professional judgement, adherence to professional standards and application of skills and knowledge have been defined as competency in nursing, Accordingly, healthcare and care provider systems are changing. For example, when a patient has an acute medical problem, the hospital is expected to provide short-term, intensive care. When the treatment is completed, home care is needed to provide support for treating the patient with dignity and respect until the end of his/her life. Thus, nurses must provide comprehensive care that meets patients' complex and diverse needs. Regardless of work setting, this is required of all nurses; presently, there is a growing expectation that nurses should be able to combine various sources of information and incorporate these into their decision-making and nursing practice.

Nurses are always challenged on how they can contribute to society as professionals. They are expected to take professional responsibilities for continuously providing direct care, protecting individual lives and supporting activities of daily living. To accomplish this, it is important for nurses to improve their nursing competency and utilize it in their daily practice. Competence is an ability acquired through experience and learning. The concept of competence is two-fold: 1) potential abilities that may work effectively under certain circumstances and 2) motivation to show one's usefulness using those abilities. On the other hand, competency is a behavioral characteristic that is based on one's interests and experiences influenced by his/her motivation and attitude. It is an optimal behavioral trait that likely leads to achievements. Competence (ability) is a premise for developing competency (behavioral characteristics). Here we reviewed the research on definitions and attributes of nursing competency in Japan as well as its structure, elements and evaluation. We further investigated methods for teaching nursing competency (Church, 2016).

Globally, the nursing profession is experiencing a shortage in manpower; this is particularly evident in highly specialized hospital units, such as emergency departments. In such wards, dealing with patients facing imminent life threatening situations is a common feature, the clinical competence of care providers is a concern. The competency of nursing staff in providing emergency care is a critical factor in patient care and safety. Furthermore, the quality of services provided in the Emergency Department is considered a hospital performance indicator (Tourani et al., 2019).

According to the national code of ethics, nurses are expected to be competent, have sufficient knowledge and skills to provide safe and quality care independently and assume accountability for their actions especially in physical, neurological assessment and evaluation of effective care (Zahedi et al., 2013). Globally, newly graduated nurses perceive low competency to work independently, requiring support and mentoring within the first few months of their practice as registered nurses (Baumann, Crea Arsenio, Hunsberger, Fleming Carroll, & Keatings, 2019; Spence Laschinger et al., 2019). Nursing competency can be divided into the following three theories: behaviorism, trait theory, and holism. Behaviorism refers to competency as an ability to perform individual core skills, and is evaluated by demonstration of those skills. Trait theory considers competency as individual traits necessary for effectively performing duties (knowledge, critical thinking skills, etc.). Holism views competency as a cluster of elements, including knowledge, skills, attitudes, thinking ability and values that are required in certain contexts. Nursing competency is generally viewed as a complex integration of knowledge including professional judgment, skills, values and attitude, indicating that holism is widely accepted. In nursing practice, nurses are required to apply their acquired knowledge, skills and innate individual traits to each situation and be able to adapt that knowledge and those skills to different circumstances. The clinical competence of nurses is a widely studied topic globally (Feliciano, Boshra, Mejia, Feliciano, & Maniago, 2019)

Statement of the Problem

Accident and emergency department is the center of excellence of any hospital and the first contact of the hospital by the patient and their relatives that suffer ailments, illnesses and any other condition that will warrant emergency management. Several patients with impaired sensory perceptions are admitted into the Accident and Emergency department (Adult and Paediatrics) on daily basis with both medical and surgical conditions.

The researcher observed during her minor and major clinical posting of part one and part two of the residency programme in the hospital, that most patients developed complications because they were poorly assessed, diagnosed and managed by the Accident and Emergency Nurses. Thus, this calls for the study: Emergency Nurses Competency Level in the Assessment of Patients with Impaired Sensory Perception in Accident and Emergency Department of University of Port Harcourt Teaching Hospital (UPTH).

Broad Objectives of the Study

The aim of this study is to evaluate Emergency Nurses Competency Level in the Assessment of Patients with Impaired Sensory Perception in the Accident and Emergency Department.

Specific Objectives:

1. To assess Emergency Nurses self-reported level of competencies on the sensory perception examination of unconscious patients in Accident and Emergency Department of University of Port Harcourt Teaching Hospital (UPTH).
2. To evaluate Emergency Nurses' level of competencies on the use of Glasgow Coma Scale using the three parameters in Accident and Emergency Department of University of Port Harcourt Teaching Hospital (UPTH).
3. To determine factors that mitigates against Emergency Nurses' competencies on assessment of patients with impaired sensory perception in Accident and Emergency Department of University of Port Harcourt Teaching Hospital (UPTH).

Research Questions:

1. What is the level of competency of Emergency Nurses regarding the assessment of a patient with impaired sensory perception in Accident and Emergency Department of University of Port Harcourt Teaching Hospital (UPTH)?
2. What is the level of competency of Emergency Nurses' on the use of Glasgow Coma scale for patients with impaired sensory perception in Accident and Emergency Department of University of Port Harcourt Teaching Hospital (UPTH)?
3. What are the factors that mitigates against Emergency Nurses' competence on assessment of patients with impaired sensory perception in Accident and Emergency Department of University of Port Harcourt Teaching Hospital (UPTH)?

Scope of the Study

This study is being delimited to all Accident & Emergency Nurses and Neurosciences Nurses working in both adult and pediatric Emergency in the University of Port Harcourt Teaching Hospital.

Significance of the Study

The benefits of this study are;

1. It will enable Emergency Nurses to assess their own competency levels for self-improvement and also for staff development.
2. Furthermore, it will serve as an important tool for nursing training to develop their competency skills, evaluate their effectiveness and conduct further research, which contributes to improving nursing quality.
3. Adequate knowledge and skills of sensory perception assessment in the care of unconscious patient will help to prevent complications like poor management of incomplete spinal cord injuries to complete spinal cord injuries, diagnosing concussion for contusion in head injuries, etc.
4. This study will add new knowledge, skills and implementation of standard nursing care to the Emergency Nurses, thereby making them to give competent care to Patients, hence, helping patients to save cost from prolonged hospitalization and unhealthy complications.

Operational Definition of Terms

- **Competency**: is the attainment of knowledge, intellectual capacities, practice skills, integrity, and professional and ethical values required for safe, accountable and effective practice.
- **Assessment:** is the process of gathering and discussing information from multiple and diverse sources in order to develop a deep understanding of what Nurses know, understand, and can do with their knowledge as a result of their educational experiences.

- ***Emergency Nurse:*** Is a trained Nurse specialty within the field of professional *nursing* focusing on the care of patients who require prompt medical and surgical attention to avoid long-term disability or death
- **Impaired sensory perception**: A change in the amount or patterning of incoming stimuli accompanies by a diminished, exaggerated, distorted, or impaired response to such stimuli" as those associated with the client's visual, auditory, tactile, gustatory, olfactory and kinesthetic responses to these stimuli.

Review literature

Nursing competency is a core ability that is required for fulfilling nursing responsibilities. Therefore, it is important to clearly define nursing competency in order to establish a foundation for nursing education curriculum. It is also important to identify the developmental process of nursing competency for continuous professional development after obtaining a nursing license. However, while competencies are important in improving the quality of nursing, the concept of nursing competency has not been fully developed. Thus, challenges remain in establishing the definition and structure of nursing competency, competency levels necessary for nursing professionals, training methods and so on. Therefore, further investigation is needed to establish a full concept of nursing competency. Clinical nursing practice is providing patient-centered care to achieve certain objectives. Nurses provide everyday care in fast-changing clinical settings using abilities acquired through knowledge and skill acquisition processes. An important aspect connecting knowledge and skills is clinical judgment. The clinical judgment process involves reflection, which connects one's own actions and their outcomes. This reflection is a component of clinical judgment.30 Integrating knowledge and skills in clinical settings is a feature of nursing competency and is associated with a core ability to provide care based on the needs of the person who is receiving the care. In other words, effective reflection is closely related to nursing competency improvement. Professional nursing practice includes making judgments, both as a care provider and learner, and reflecting upon one's actions as the care is being delivered, and after the care is completed. Nursing practice, by itself, is crucial for competency improvement. Nursing competency addresses the personal characteristics; cognitive ability; orientation to ethical/legal practice; engagement in professional development; collaboration with other healthcare professionals; providing teaching or coaching to patients and staff. The skills are grouped under five core competencies: communication, leadership, professionalism, knowledge, and business skills. Successful healthcare administrators apply the competencies on a day-to-day basis in healthcare organizations.

The competencies are organized in seven content domains: Management of Patient Health/Illness Status, The Nurse Practitioner-Patient Relationship, the Teaching-Coaching Function, Professional Role, Managing and Negotiating Health Care Delivery Systems, Monitoring and Ensuring the Quality of Health Care Practices the concept of core competence originated as a resource-based approach to corporate strategy, introduced by Praha lad and Gary Hamel., Personal core competencies can include: Problem-solving skills, analytical thinking, technical competency, conflict resolution and adaptability. Unconscious is an interruption of awareness of oneself and one's surroundings, lack of the ability to notice or respond to stimuli in the environment. A person may become unconscious due to oxygen deprivation, shock, central nervous system depressants such as alcohol and drugs, or injury. Unconsciousness is a state which occurs when the ability to maintain an awareness of self and environment is lost. It involves a complete or near-complete lack of responsiveness to people and other environmental stimuli (Fayaerts, 2017).

Loss of consciousness should not be confused with the notion of the psychoanalytic unconscious or cognitive processes (e.g., implicit cognition) that take place outside awareness, and with altered states of consciousness such as delirium (when the person is confused and only partially responsive to the environment), normal sleep, hypnosis, and other altered states in which the person responds to stimuli. (Miller, 2016). Unconsciousness may occur as a result of traumatic brain injury, brain hypoxia (inadequate oxygen, possibly due to a brain infarction or cardiac arrest), severe poisoning with drugs that depress the activity of the central nervous system (e.g., alcohol and other hypnotic or sedative drugs), severe fatigue, anesthesia and other causes.

Marcovitch (2011) "the brain is the organ of the mind" and it needs continuous adequate supply of oxygen and glucose in order to function normally. Interruption of either of them will lead to disturbances in consciousness and unconsciousness can be determined in several ways. Generally speaking, consciousness means awareness of oneself and the environment; it is the state of being aware of physical events and mental concepts. Awareness means the ability to combine the data in memory to the surrounding internal and external stimuli. When a person is conscious, he or she is awake, responds to his or her surroundings and behaves

meaningfully. Unconsciousness means lack of this awareness (Marcovitch 2011; Wester Gard 2009; Lindsberg & Soinila, 2015). In addition, consciousness can be roughly divided into the content of consciousness and the level of consciousness. The content of consciousness covers one's thoughts, experiences, sensations, imaginings and memories (Wester Gard, 2009). Concepts attentiveness and alertness are related to the level of consciousness (Lindsberg & Soinila 2015a). The level of loss of consciousness varies from drowsiness to a deep state of unconsciousness from which the patient cannot be awakened. (Nurmi & Alaspää, 2013.) According to the state of unconsciousness the patient may respond to different external stimuli such as pain. (Westergård, 2009).

Palmer (2014) Management of an unconscious patient is a medical emergency, requiring prompt assessment and the appropriate use of first aid and life support procedures. Nurses are always challenged on how they can contribute to society as professionals. They are expected to take professional responsibilities for continuously providing direct care, protecting individual lives and supporting activities of daily living (Ministry of Education, Culture, Sports, Science and Technology, 2017) (Bam, Diji, Asante, Lomotey, Adade & Akyeampong 2019). Takase and Teraoka6 developed the Holistic Nursing Competence Scale (HNCS) based on the definitions and attributes of nursing competency that are mentioned above, which consisted of 36 items with a five-factor structure that were retained to form the HNCS. These factors illustrate nurses' general aptitude and their competencies in staff education and management, ethical practice, provision of nursing care and professional development. This scale consists of 36 items and allows for the easy administration of periodic clinical nursing competency evaluations. The attributes of nursing competency identified through concept analysis are reflected onto the scale items without deviation from their original meanings. Therefore, HNCS can be considered as a holistic scale. Since this scale holds high reliability and validity, it is believed to be useful for clinical application.

The Five Core SELF Competencies

- Self-Awareness.
- Self-Management.
- Social Awareness.
- Relationship Skills.
- Responsible Decision-Making.

To accomplish this, it is important for nurses to improve their nursing competency and utilize it in their daily practice. Competency is an ability acquired through experience and learning. The concept of competence is two-fold: 1) potential abilities that may work effectively under certain circumstances and 2) motivation to show one's usefulness using those abilities (Bam, Diji, Asante, Lomotey, Adade & Akyeampong 2019). On the other hand, competency is a behavioral characteristic that is based on one's interests and experiences influenced by his/her motivation and attitude. It is an optimal behavioral trait that likely leads to achievements. Competence (ability) is a premise for developing competency (behavioral characteristics) (Japanese Nursing Association. Nursing clinical ladder, 2016).

Conceptual Review

Assessment and standard of care for patients with impaired sensory perception

Nursing Assessment/Health assessment is a key element in nursing process (Hanley, Higgins. 2005). These skills play a decisive role in assessing and determining the patients' health problems and caring needs and consequently have a crucial role in designing nursing care plans and determining the nursing interventions. The higher levels of health assessment skills would increase nurses' capability to monitor the changes in patients' health and contributes to make better judgments and nursing diagnosis (Lesa & Dixon, 2007). The more precise assessment, the better results would be obtained and the quality of patients' care would be improved. Thus, ensuring that the trained nurses and nurse students are competent in these skills is an important issue (Watson, 2002).

According to David McGuffin (2018), in order to effectively determine a diagnosis and treatment for a patient, nurses make four assessments: initial, focused, time-lapsed and emergency. One of the most important parts of nursing education, as well as the overall health care industry, is the group of routine procedures and processes involved with patient assessment and care. As a result, nurses and other health care professionals are able to

quickly assess and determine the best treatment for an ailing patient.

Initial Assessment: The initial assessment, also known as triage, helps to determine the nature of the patient's problem and prepare the way for the different assessment stages. The initial assessment is going to be much more thorough than the other assessments used by nurses. The components of the assessment may include obtaining a patient's medical history or putting him through a physical exam, or preparing a psychosocial assessment for a mental health patient. Other components of the assessment may include obtaining a patient's vital signs and taking subjective statements from the patient, as well as double-checking the subjective symptoms with the objective signs of the condition.

Focused Assessment: The focused assessment is the stage in which the problem is exposed and treated. Due to the importance of vital signs and their ever-changing nature, they are continuously monitored during all parts of the assessment. Depending on the malady, initial treatment for pain and long-term treatment for the root cause of the malady is administered and monitored. Part of the goal of the focused assessment is to diagnose and treat the patient in order to stabilize her condition. Focused assessments may also include X-rays or other types of tests.

Time-Lapsed Assessment: Once treatment has been implemented, a time-lapsed assessment must be conducted to ensure that the patient is recovering from his malady and his condition has stabilized. Depending on the nature of the malady, the time-lapsed assessment may span the length of one or two hours or a couple of months. During the time-lapsed assessment, the current status of the patient is compared to the previous baseline during and prior to treatment. Similar to the focused assessment, the time-lapsed assessment may also include lab work, X-rays or other diagnostic medical testing.

Professional nursing competency

Clinical and professional competency in nursing can be defined as a specific knowledge base, skill, attitude and value based and experience based intensive care. Clinical competencies can be divided into three while professional competency is divided into four domains. In clinical competencies, these are the principles of nursing care, clinical guidelines and nursing interventions. Professional competencies have the domains as ethical activities, decision making, development work and collaboration (Aari, Suominen, &Leino-Kilpi,2008).

According to Takase et al (2011), nursing competency can be divided into the following three theories: behaviorism, trait theory, and holism. Behaviorism refers to competency as an ability to perform individual core skills, and is evaluated by demonstration of those skills. Trait theory considers competency as individual traits necessary for effectively performing duties (knowledge, critical thinking skills, etc.). Holism views competency as a cluster of elements, including knowledge, skills, attitudes, thinking ability and values that are required in certain contexts. Nursing competency is generally viewed as a complex integration of knowledge including professional judgment, skills, values and attitude, indicating that holism is widely accepted. In nursing practice, nurses are required to apply their acquired knowledge, skills and innate individual traits to each situation and be able to adapt that knowledge and those skills to different circumstances (Takase, Teraoka & Miyakoshi 2011).

There are two definitions of holistic, integrated nursing competency: (1) By analyzing: a) graduation achievement goals as they relate to enhancing the development of nursing competency (the Conference for Nursing Education model). (2) the International Competency Standards Framework for general nurses (International Council of Nurses) and the Scope and Standards of Nursing Practice (American Nurses Association), Nakayama et al(2011), defined nursing competency as "the ability to take action by combining knowledge, skills, values, beliefs, and experience acquired as a nurse" and explained that, competency can be viewed as an integrated performance reflecting the professional nurse's feelings, thoughts and judgment; and Takase & Teraoka (2011) defined nursing competency as a nurse's ability to effectively demonstrate a set of attributes, such as personal characteristics, professional attitude, values, knowledge and skills and to fulfill his/her professional responsibility through practice. A competent person must possess these attributes, have the motivation and ability to utilize them and must effectively use them to provide safe, effective and professional nursing care to his/her patient.

These definitions were developed by referencing international standards and literature reviews of the concept

of nursing competency using domestic and international databases, clearly describing the structure of nursing and also leading to the development of evaluation methods. Therefore, they will play important roles in future research on nursing competency. On the other hand, in order for more nurses to evaluate and enhance their own nursing competencies in their practice, it is important to develop definitions of nursing competency and competency levels that are simple and easy to understand. The Japanese Nurses Association has been developing a standardized clinical ladder for nurses. As a result, the Association developed nursing competency indices that could be used across all areas of nursing practice (Japanese Nursing Association 2018). These nationally standardized indices were created to help nurses objectively evaluate their competencies, use them in different practice settings and situations and enhance the quality of nursing care. The Association defines core nursing competency as "the ability to perform clinical nursing care that is based on the nurse's ethical thinking and accurate nursing skills and that is provided to meet the needs of the cared." It also developed a rubric showing four core competencies for nurses (the abilities to understand needs, provide care, work collaboratively, and support decision-making) as a clinical ladder, with five levels for each competency as follows (I) following basic nursing care procedures and practicing nursing with needed advice; (II) practicing nursing independently based on a standard nursing care plan;(III) practicing individual nursing suited to care recipients; (IV) practicing nursing using predictive judgment with a broad perspective; and (V) in more complex situations, practicing nursing by selecting the best means for care recipients and increasing quality of life. Since the rubric shows objectives (including performance objectives) for each level, it helps many nurses evaluate their own skills, thus enhancing their competencies.

To acquire nursing competency, nurses must possess the skills and personal traits necessary to effectively perform their duties while integrating multiple elements including knowledge, techniques, attitude, thinking ability and values that are required in specific contexts. There are three categories into which these elements can be divided: personal traits necessary for nursing, professional attitudes and behaviors, and the ability to provide care based on professional knowledge and skills (Takase, Teraoka, Miyakoshi, & Kawada 2011).

Personal traits include affection, understanding, self-control, critical thinking and problem-solving ability. Professional attitudes and behaviors involve the following performance standards: taking up professional responsibilities, being autonomous, being aware of one's own limitations, providing explanations, respecting patient rights, promoting continuous learning and maintaining up-to-date knowledge and skills. Providing care based on professional knowledge and skills includes the ability to collaborate with other healthcare professionals, develop intrapersonal relationships, educate and instruct, manage nursing care, ensure safety and quality of nursing and expand the capacity of nursing. Thus, nursing competency attributes include a wide variety of abilities, and nursing competency can be referred to as performance traits explicitly demonstrated by a competent nurse who possesses these abilities.

In order to make nursing competency measurable, since it is a holistic and integrated concept, many researchers seek to identify its main components. Matsutani et al (2010) analyzed the definitions, attributes, elements and structure of nursing competency by reviewing articles in English about nursing competency. The present review produced a definition of nursing competency that included the ability to integrate knowledge and skills under particular situations or settings and traits that included core abilities necessary for ethical and effective nursing practice. Nursing competency is a holistic and integrated concept, which is constructed from complex activities. It is defined as a performance competency, which meets the standards expected from potential competencies. In addition, Matsutani et al (2010) categorized nursing competency into seven elements subsisting within three major components: i) the ability to understand people; applying knowledge, building intrapersonal relationships, the ability to provide people-centered care, providing nursing care, practicing ethically, and collaborating with other professionals; and the ability to improve nursing quality, expanding their professional capacity, and ensuring the delivery of high-quality nursing (Matsutani et al 2010).

Karasuda, Tsumoto, & Uchida (2014) conducted a study on the competency characteristics of nurses with 1 year of experience using the CNCSS. The results showed trends that where competent was high in areas of "ethical practice," "risk management," and "basic responsibilities" and low in "care coordination," "professional development," "improvement of nursing quality," and "health promotion." New nurses focus on the duties at hand, which inevitably increase the basic nursing abilities that are associated with ethics and responsibilities. However, it is difficult for them to provide individualized nursing care that supports patients' lifestyles and

engage in professional development while providing care. According Sasaki, Fukada, Okuda & Hatakeyama (2013) who examined competencies of nurses with < 5 years of clinical experience, nurses had a considerably high competency in direct, everyday care compared with the nurses with only 1 year of experience. They had acquired an ability to provide care that addressed individual health needs, including making appropriate clinical judgments, implementing planned nursing care, and evaluating outcomes. The ability that displayed the most improvement was care coordination, which involves practicing nursing as part of a team. Although improvements were seen in some of the nursing competency attributes during the fifth year of clinical experience, competencies in other areas were still low and required improvement even after the sixth year of experience.

Scales for measuring competency in nursing

Nakayama et al (2011) studied and organized processes for developing and evaluating nursing competency by collecting longitudinal and cross-sectional data on nursing competency from university graduate nurses who worked in hospital settings to discern the developmental processes that surrounded their competencies. They examined conceptual definitions and nursing competency frameworks through literature review of domestic and foreign articles and subsequently developed a competency structure with four concepts and 13 competencies. Further, Nakayama et al. created a list of questions for evaluating these competencies and developed a tentative measurement system called the Clinical Nursing Competence Self-Assessment Scale (CNCSS).The CNCSS measures the following four competency concepts: basic nursing abilities (basic responsibilities, ethical practice and supportive relationships); the ability to provide care that addresses individual needs (clinical judgment, planned nursing implementation, evaluation of care, and health promotion); the ability to modify care environment and collaboration systems [risk management, care coordination and nursing care management (fulfillment of responsibilities)] and the ability to devote time toward professional development in nursing practice (enhancement of professionalism, improvement of nursing quality, and continuous learning). This scale enabled the assessment of university graduate nurses' competencies and was initially used for nurses with 1–5 years of experience. However, the scale was later deemed useful for accurately measuring nursing competency in nurses with > 5 years of experience (Mihashi et al 2010).

Takase & Teraoka (2011) Conducted a concept analysis of nursing competency through a literature review of foreign articles published between 2000 and 2009. They then developed a scale based on the resultant definitions and attributes of nursing. The following ten attributes represent the characteristics of nursing competency addressed: personal characteristics; cognitive ability; orientation to ethical/legal practice; engagement in professional development; collaboration with other healthcare professionals; providing teaching or coaching to patients and staff; demonstrating management skills; ensuring quality and safety in care; establishing interpersonal relationships with patients and nursing staff; and managing nursing care. In addition, Takase and Teraoka (2011) developed the Holistic Nursing Competence Scale (HNCS) based on the definitions and attributes of nursing competency that are mentioned above, which consisted of 36 items with a five-factor structure that were retained to form the HNCS. These factors illustrate nurses' general aptitude and their competencies in staff education and management, ethical practice, provision of nursing care and professional development. This scale consists of 36 items and allows for the easy administration of periodic clinical nursing competency evaluations. The attributes of nursing competency identified through concept analysis are reflected onto the scale items without deviation from their original meanings. Therefore, HNCS can be considered as a holistic scale. Since this scale holds high reliability and validity, it is believed to be useful for clinical application.

To train nurses who can function in a wide range of facilities and settings, provide educational support and help maintain stable nursing workforce, the Japanese Nurses Association has been developing a "nursing clinical ladder (Japanese Nurses Association version)" as a nationally standardized index. This index is designed to be used in any nursing practice setting, and thus its use is not limited to the facilities with which individual nurses are affiliated; i)The nursing clinical ladder develops a standardized nursing competency index, applicable for all nurses regardless of practice setting and background and supports their competency development; ii) assures and secures nursing quality by properly evaluating nursing competencies, and iii) provides safe and trusted nursing care to patients and service users.

The clinical ladder is a system that shows nursing competency throughout different phases, displays target abilities for each phase and indicates nurses' abilities according to their achievement levels. It enables nurses to assess their own competency levels for self-improvement and can also be used for staff development. A core competency of nursing is "the ability to practice nursing that meets the needs of clients care and using logical thinking and accurate nursing skills." The nursing competency structure consists of four abilities: the ability to understand needs, the ability to provide care, the ability to collaborate and the ability to support decision-making. These four abilities are closely related and utilized in all types of nursing practice settings.

It is important to develop nursing competency training methods, evaluate their effectiveness and conduct further research, which contributes to improving nursing quality (Mihashi, Komatsu et al 2014). To provide seamless training from basic education to post-graduation clinical practice, many studies have focused on evaluating the nursing competency of university graduate nurses with < 5 years of experience (Mihashi, Komatsu et al 2014).

Tsuji et al (2007) developed a Likert-type nursing competency scale with seven domains and 31 items to evaluate the competencies of mid-level nurses. The results revealed a competency plateau phenomenon among mid-level nurses. In other words, nurses with 5–10 years of clinical experience showed almost no correlation between the years of experience and nursing competency scores. There were considerable differences among competency levels of these mid-level nurses, suggesting that there were nurses who strove for steady improvement of competency and ones who did not. Many studies use self-administered questionnaires for evaluating nursing competency. However, Kudo et al (2016) evaluated the competencies of average nurses with >10 years of clinical experience using management evaluation. They found that abilities evaluated highly by management were clinical judgment and planned implementation of nursing care. Abilities reported, but not included in the evaluation scale, involved the ability to respond, adjust, anticipate, and solve problems. That is, management expected these nurses to possess abilities to interpret situations, take action, and produce favorable outcomes.

Studies involving relationships among nursing competencies include relationships with critical thinking skills, (Hara 2013) sense of coherence and spirituality, development of social skills, and learning behaviors. Also, relationships with learning environments, (Kawamoto et al 2017), nursing care quality and current careers (Nanke, Usami, Arimatsu, Umeki, Kigo, & Taniguchi, 2005) have been studied. In all studies, nursing competency is referred to as an ability, which is a complex integration of knowledge including professional judgment, skills, values, and attitudes. These studies also investigated factors related to competency development. Further research should focus on identifying factors that affect nursing competency, which will help achieve insight into methods of training for nursing competency.

Training in Nursing Competency: Many studies on nursing competency training methods have focused on basic nursing education, Besshoet al (2013) and little has been studied on clinical nurses. For clinical competency training methods for students, scenario simulation, role-play and objective structured clinical examinations are often used. However, these methods view nursing competency from a behaviorist point of view, and the major focus is on performance in many clinical settings. Problem-based learning tutorial training is a well-known method where students work in small groups, present a nursing scenario with a problem and situation, create their own learning tasks and engage in active learning. This method involves student-centered learning; instead of active teaching, lessons that encourage active learning are crucial for training thinking skills. Therefore, future studies are needed to identify components of nursing competency and test each training method to verify which method is effective for training each competency. (Nakayama, 2012)

Clinical nurses' competency training methods. Clinical nursing practice is providing patient-centered care to achieve certain objectives. Nurses provide everyday care in fast-changing clinical settings using abilities acquired through knowledge and skill acquisition processes. An important aspect connecting knowledge and skills is clinical judgment. The clinical judgment process involves reflection, which connects one's own actions and their outcomes. This reflection is a component of clinical judgment. Ogata (2014) opined that integrating knowledge and skills in clinical settings is a feature of nursing competency and is associated with a core ability to provide care based on the needs of the person who is receiving the care. In other words, effective reflection is closely related to nursing competency improvement. Professional nursing practice includes making judgments, both as a care provider and learner, and reflecting upon one's actions as the care is being delivered, and

after the care is completed. Nursing practice, by itself, is crucial for competency improvement. To reflect on a particular clinical situation, it is important to understand the background of that situation. Once a nurse determines and shares the direction of the nursing care with the person receiving the care and explains the reasons and anticipated outcomes, reflection becomes a factor for competency improvement. Clinical judgment training through reflection is important for improving nursing competency; however, reflection by itself does not improve all competencies. Nursing competency includes a variety of components, such as knowledge, skills, attitudes, thinking ability and values; therefore, nursing competency training should incorporate various educational programs. To train all areas of nursing competency, it is necessary to understand the attributes and components of these nursing competencies as parts of the clinical ladder and develop training methods that address the order of competency acquisition. Moreover, in addition to evaluating nursing competency, further discussions and research are needed to examine the outcomes of competency improvement.

Factors Militating against Nurses' competency level

Nursing competency remains a considerable issue in health care (Yanhua & Watson, 2011). The assumption is that nurses have to be competent but perceptions are that this is not always the case (J.R. Garside). Nevertheless, nurses are expected to deliver quality care and services. It has been evaluated in many studies. It is defined as the ability to perform tasks that result in an anticipated outcome (Satu, Leena, Mikko, Riitta, & Helena, 2013). Nurses' competencies encompass all aspects of nursing, and include knowledge, attitude, and skills. In order to acquire optimal competencies, nurses must have critical thinking skills (. Chang &. Chang, 2011).

The competence of nurses has a significant impact on quality of care and is closely associated with job performance, satisfaction, and absenteeism (Numminen, &. Leino-Kilpi 2015). The dynamic development of nurses' competencies is influenced to a large extent by the environment It is critical that nurses develop competencies. Nevertheless, there are a myriad of factors, both internal and external, that might prevent nurses from acquiring competency. By contrast, some factors enhance the development of nurses' competencies.

Competence development is a continuous process of improving knowledge, attitudes and skills, and is influenced by a myriad of factors. Six factors were identified that affected the development of nursing competence in our systematic review: (1) work experience, (2) type of nursing environment, (3) educational level achieved, (4) adherence to professionalism, (5) critical thinking, and (6) personal factors. Work experience and education were shown to significantly influence the development of competency of nurses. Nurse managers need to support staffing competence through ongoing education, mentoring-preceptorship training, and case-reflection-discussion teaching programs.

Empirical Reviews

Abbasi, Bahreini, Yazdankhah Fard, & Mirzaei,(2017). Compare Clinical Competence and Job Satisfaction Among Nurses Working in Both University and Non-University Hospital in Bushehr in 2015. Nurses are the biggest component of the health care system in the world and their job satisfaction and clinical competence affect performance and success of the organization. This study is aimed to determine and compare the clinical competence and job satisfaction of nurses in both academic and non-academic hospitals in Bushehr in 2015.

Materials & Methods: In this cross-sectional study, 257 nurses were studied in two hospitals of Bushehr city selected by census method. Data was collected by using valid and reliable Nurse Clinical Competence and Job Satisfaction Inventory questionnaires. Data analyzed by using SPSS- 21, and descriptive statistics, t-test, and ANOVA and Pearson correlation coefficient. Statistical significance was set at $P< 0.05$.

Results**:** Findings showed that there were no significant differences between academic hospital nurses' job satisfaction with 126.96±29.34 and non-academic hospital with 128.31±23.26. Also, there were a significant difference between total score of nurses' clinical competence in academic hospital 62.18±18.09 and in non-academic hospital 67.78±17.64. There were a significant and direct association between the clinical competence and job satisfaction of nurses in both hospitals ($p\leq0.05$). Conclusion**:** Although nurses' clinical competence and job satisfaction in both hospitals were assessed at desirable level but both criteria were higher in non-university hospital nurses. It is necessary that Nurse Managers of academic hospitals should pay attention to assessment and improvement of nurse clinical competence and job satisfaction.

Afizu & Musah (2019) in their study assessed the knowledge of Ghanaian nurses about the Glasgow Coma

Scale and identify factors associated with their knowledge using a descriptive cross-sectional study involving a convenience sample of 115 nurses from a large teaching hospital in Ghana. Data was collected using a structured questionnaire and analyzed using descriptive statistics, Pearson's correlation, independent samples t-test, and one-way ANOVA. A little more than half of the participants (50.4%) had low knowledge of the GCS as a whole. However, with respect to basic theoretical concepts of the GCS, 62.6% of the participants had good knowledge about it, while only 5.2% demonstrated good knowledge on application of the basic knowledge in clinical scenarios. Working in Neurosurgical ward, female gender, and weekly performance of the GCS were associated with higher levels of knowledge. Academic qualification, years of experience as a nurse, and refresher training on GCS were not associated with knowledge. Conclusively, the findings from this study showed that nurses in Ghana have low levels of knowledge about the GCS. A more structured approach to teaching the GCS that is very thorough and done with demonstrations should be implemented to improve nurses' knowledge on the GCS.

Bae & Roh (2020) examined the training needs analysis of Korean nurses' neurological assessment competency. Result showed that Emergency department nurses reported lower neurological assessment competency when compared with ward and intensive care unit nurses. Despite the importance of neurological assessment, there is a lack of research directed at nurses' competency in performing these assessments. We aimed to identify nurses' competency levels in performing neurological assessments and prioritize their related training needs using importance–performance analysis. This survey research was conducted and reported based on the enhancing the quality and transparency of health research (EQUATOR) guidelines. A total of 213 nurses participated in a descriptive, cross-sectional survey study. Exploratory factor analysis identified seven factors that together accounted for 70.34% of the variance: cerebral function, signs and symptoms, pathologic reflexes, motor strength, assessment of an unconscious patient, reporting and documentation, and neurological assessment scales. [Correction added on 10 February 2020, after first online publication: the value of the variance has been corrected from '7.34%' to '70.34%' in the preceding sentence.] There were significant gaps between importance and performance for all seven factors. The importance–performance matrix identified the neurological assessment scales factor as a high priority for continuing education. Emergency department nurses reported lower neurological assessment competency when compared with ward and intensive care unit nurses. The analysis of training needs is beneficial for developing programs to enhance neurological assessment competency. Training in neurological assessment scales is a priority for nurses, and they prefer simulation- and practicum-based methods.

Chong, Thambinayagam, Zakaria & Yong, (2016) Assessment of level of consciousness using the Glasgow Coma Scale (GCS) is a tool requiring knowledge that is important in detecting early deterioration in a patient's level of consciousness. Critical thinking used with the skill and knowledge in assessing the GCS is the foundation of all nursing practice. This study aims to explore the knowledge and competence in assessing the GCS among staff nurses working in the Emergency and Outpatient Departments. This is a quantitative descriptive cross-sectional study design using the GCS Knowledge Questionnaire. Convenience sampling method was used. Nurses in these Departments were asked to partake in the survey. Data collected was analyzed using the Statistical Package of Social Sciences (SPSS) version 20. Descriptive and Pearson's chi square was used. Result showed that 55.56% of nurses had poor knowledge followed by 41.48% and 2.96% with satisfactory knowledge and good knowledge, respectively. The result on the association between knowledge and education level showed a significant association between the two variables ($X2 = 18.412$, $df = 3$, $n = 135$, and $p < 0.05$). There was also a significant correlation between knowledge and age group ($X2 = 11.085$, $df = 2$, $n = 135$, and $p < 0.05$). Overall, this study supports that good knowledge and skill are important in assessing GCS level.

Sok ,& Liaw (2013 Background: Preparing nursing students for making the transition to graduate nurse is crucial for entry into practice. Final year student nurses at the National University of Singapore (NUS) are required to undergo a consolidated clinical practice to prepare them for their transition to graduate nurse. Aim: To describe the development, implementation and evaluation of a simulation program known as Simulated Professional Learning Environment (SIMPLE) in preparing the final year student nurses for their clinical practicum in transition to graduate nurse practice. Method: A set of simulation features and best practices were used as conceptual framework to develop and implement the simulation program. 94 final year student nurses participated in the 15-hour SIMPLE program that incorporated multiple simulation scenarios based on actual ward clinical practices. Pre and post-tests were conducted to assess the students' preparedness for their

clinical practice in transition to graduate nurse practice. The students also completed a satisfaction questionnaire and open questions to evaluate their simulation experiences. Results: The student nurses demonstrated a significant improvement (t=12.06, p<0.01) on post-test score (mean=117.21, SD=15.17) from pre-test score (mean=97.86, SD=15.08) for their perceived preparedness towards their clinical practicum in transition to graduate nurse practice. They were highly satisfied with their simulation learning. Themes emerged from the comments on the most valuable aspects of the SIMPLE program and ways to improve the program. Conclusion: The study provided evidences on the effectiveness of the SIMPLE program in enhancing the students' preparedness for their transition to graduate nurse practice. A key success of the SIMPLE program was the used of simulation strategy and the involvement of practicing nurses that closely linked the students with the realities of current nursing practice to prepare them for the role of staff nurses.

Mattar, Liaw & Chan, (2015) Aims: The aim of this study was to examine nurses' self-confidence and attitudes towards the Glasgow Coma Scale (GCS). The GCS measures the depth and duration of impaired consciousness. However, there is an increasing evidence that problems are encountered in completing some aspects of the GCS. Design: This descriptive correlational study recruited 114 Registered Nurses (RNs) in one acute care hospital in Singapore. Methods: A set of questionnaires were given to the participants. The questionnaire had three parts, which collected data on demographics, attitudes and self-confidence. Results: Data analysis showed the type of clinical discipline (B=0.19), seniority in nursing (Staff Grade) (B=0.28) and higher attitude scores towards the GCS (B=0.41) were significant factors determining a nurse's confidence in using the GCS. A longer length of time working in a Neuroscience setting (B=0.21) and higher self-confidence scores (B=0.41) were significant factors determining a nurse's attitude towards the GCS. Conclusion: To ensure patient safety, the GCS has to be performed accurately. This study has shown there are differences in attitudes and self-confidence in using the GCS between nurses of different demographics, and that there are a variety of factors influencing their attitudes and confidence.

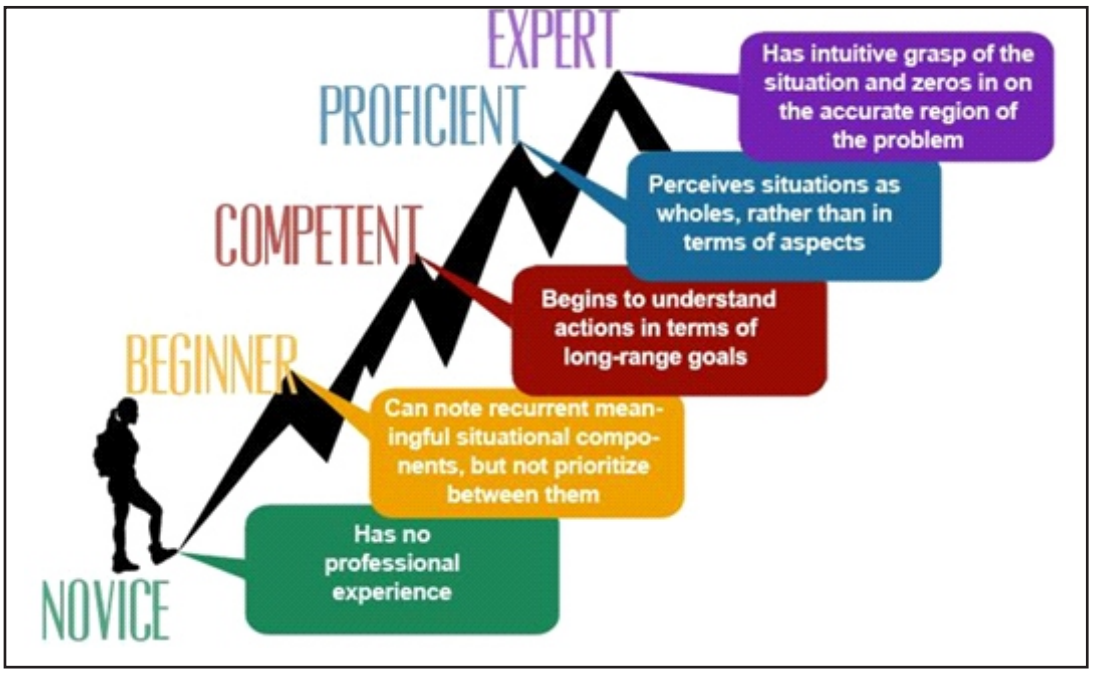
Al-Quraan & Abu-Ruz, (2016) assessed Jordanian Nurses' Knowledge to Perform Glasgow Coma Scale in Amman-Jordan. A non-experimental, descriptive cross-sectional correlational design was performed in four (3 private hospitals and 1 governmental) hospitals in Amman-Jordan using a self-reported questionnaire was answered by all (ICU, CCU, ER, and Telemetry) nurses who accepted to participate in the study. A total of 200 questionnaires were distributed to the participants with 90% response rate ending with 180 questionnaires in the final analysis. More than half of the sample (56.7%) was males. The participants were young nurses with mean age of 26.3±8 years. The total mean score for the whole sample was 7.38 ± 1.96. There was no relationship between experience, level of education, and training course and knowledge level. Nurses working in accredited hospitals and governmental hospitals recorded more level of knowledge than other hospitals. Emergency Room nurses recorded less level of knowledge than other area of practice. In conclusion, knowledge about Glasgow Coma Scale is a global problem. Jordanian nurses, as other nurses, have inadequate knowledge to perform Glasgow Coma Scale assessment. It is vital and necessary to include educational programs about Glasgow Coma Scale for nurses in all areas of practice and in the curricula of nursing colleges.

Motahareh, Musavi, & Ghahfarokhi (2014). The Comparative Study of Clinical Competence of Emergency Nurses Using Self-Assessment and Evaluation Methods by Head Nurses Abadan faculty of medical sciences. Clinical competency is the ability of nurses in playing a professional role in a clinical environment especially emergency department as the quality of the services provided. The present study aimed to compare the clinical competence of the emergency nurses using self-assessment and evaluation methods by head nurses. Method: The study was designed in a descriptive-analytical way, collecting self-assessment questionnaire and evaluation methods by head nurse's data. 70 nurses working in Emergency Departments of 3 Hospitals were selected and studied for 3 months based on entry requirements to the census. The instrument was a clinical competency questionnaire with questions in 7 functional fields and 63 skills. The data obtained from descriptive and inferential statistics were analyzed by SPSS-16. Result: The viewpoints of nurses and head nurses on the clinical competencies of nurses were assessed at a moderate level in the majority of domains. Nurses defined their clinical competencies at a significantly higher level compared to the head nurses (P<0.05). conclusion: The periodic assessment of emergency nurses as a critical part and the turning point of the hospital can guide the managers and nursing managers to pay attention to professional competence and promote continuing education programs for improving their competencies in this section.

Theoretical Framework

The Nursing theory to adopt in the study is Patricia Benner's (1982) which is in line with the study on emergency nurse's competency level of assessment care on a patient with impaired sensory perception. Benner introduced the concept that expert emergency nurses develop skills and understanding of patient care over time through a sound educational base as well as a multitude of personal experiences. She proposed that one could gain knowledge and skills ("knowing how") without ever learning the theory ("knowing that"). Patricia Benner developed a concept known as "From Novice to Expert." Benner's 5 Stages of Clinical Competence

Applications of Benner's nursing theory on Emergency Nurses competency level



Stage 1: Novice

This would be a nursing student in his or her first year of clinical education; behavior in the clinical setting is very limited and inflexible. Novices have a very limited ability to predict what might happen in a particular patient situation. Signs and symptoms, such as change in mental status, can only be recognized after a novice emergency nurse has had experience with patients with similar symptoms on patients with impaired sensory perception.

Stage 2: Advanced Beginner

Those are the new grades in their first jobs; emergency nurses have had more experiences that enable them to recognize recurrent, meaningful components of a situation. They have the knowledge and the know-how but not enough in-depth experience in the assessment with a patient impaired sensory perception

Stage 3: Competent

These Emergency nurses lack the speed and flexibility of proficient nurses, but they have some mastery and can rely on advance planning and organizational skills. Competent emergency nurses recognize patterns and nature of clinical situations more quickly and accurately than advanced beginners.

Stage 4: Proficient

At this level, emergency nurses are capable to see situations as "wholes" rather than parts. Proficient Emergency nurses learn from experience what events typically occur and are able to modify plans in response to different events.

Stage 5 Expert

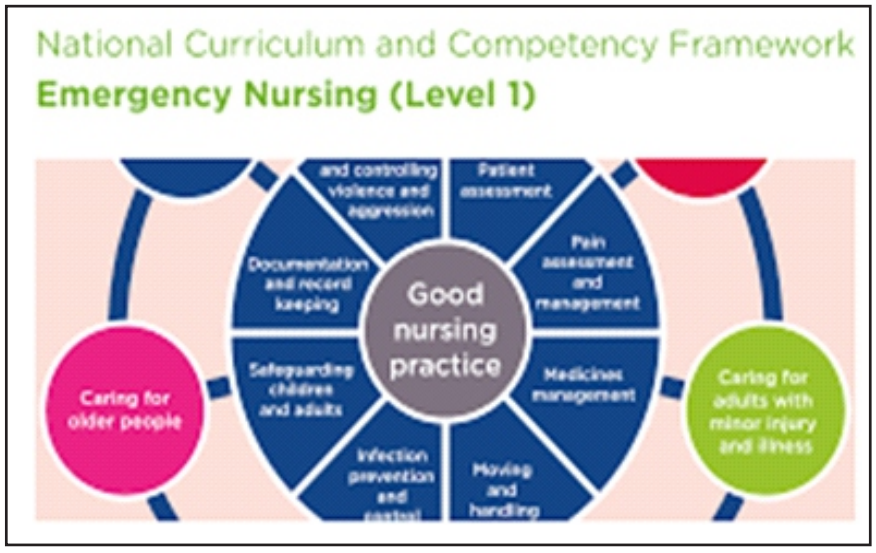
Emergency Nurses who are able to recognize demands and resources in situations and attain their goals. These emergency nurses know what needs to be done. They no longer rely solely on rules to guide their actions under certain situations. They have an intuitive grasp of the situation based on their deep knowledge and experience. Focus is on the most relevant problems and not irrelevant ones. Analytical tools are used only when they have no experience with an event, or when events don't occur as expected.

Conceptual Model

Patricia Benner's model stands on how a nurse develop nursing knowledge, skill, clinical competence and comprehension of patient care through complete theoretical training and experiential learning from novice stage to expert stage (Davis &Maisano, 2016; Homard, 2013; Walker-Reed, 2016). It outlines the values every Emergency nurse should work to, known as the 'six Cs'. This concept has caught the attention of caring staff everywhere. The six Cs - care, compassion, competence, communication, courage and commitment - are the core elements of our vision her model is one of the most useful frameworks for assessing nurses' needs at different stages of professional growth. This nursing theory proposes that expert nurses develop skills and understanding of patient care over time through a proper educational background as well as a multitude of experiences

Explanation of the conceptual model

Based on the study objective; to evaluate Emergency Nurses Competency Level in the Assessment of Patients with impaired sensory perception, Benner's novice to expert theory asserts that expert Emergency Nurses develop their knowledge of patient care and extensive skill set by obtaining experiences collected over a course of time as well as having an education background. Emergency Nurse is a specialty in which the Emergency Nurse cares for patients in the emergency or critical phase of their illness or injury, focusing on the level of severity and time-critical interventions. Whilst collaborating with members of the emergency team, the emergency Nurse plays a crucial role in the identification and care of patients with medical, surgical and injury related emergencies. The emergency nurse identifies life-threatening problems, prioritizes the care, carries out resuscitative measures with appropriate management and provides information and emotional support to the patient and his/her family within a supportive health care environment.



Patricia Benner's explanation of the conceptual model as five (5) levels of nursing experience as; Novice, Advanced beginner, Competent, Proficient and Expert

Novice as follows; Nurse Beginner with no experience need to be taught general rules to help perform tasks, should be guided with rules that are: context-free, independent of specific cases, and should be applied universally accepted standard, Rule-governed behavior is limited and inflexible and Ex. "Tell me what I need to do and I'll do it." with a supervisor.

Advanced Beginner has demonstrated acceptable performance are needed, has gained prior experience in actual situations to recognize recurring meaningful components and principles, based on experiences, begin to be formulated to guide actions.

Competent as Typically a nurse with 2-3years experience on the job in the same area or in similar day-to-day situations, more aware of long-term goals and gains perspective from planning own actions based on conscious, abstract, and analytical thinking and helps to achieve greater efficiency and organization

Proficient as; Perceives and understands situations as whole parts, more holistic understanding improves decision-making and Learns from experiences what to expect in certain situations and how to modify plans

Expert as; No longer relies on principles, rules, or guidelines to connect situations and determine actions, much more background of experience, has intuitive grasp of clinical situations and Performance is now fluid, flexible, and highly-proficient. Different levels of skills reflect changes in 3 aspects of skilled performance are: Movement from relying on abstract principles to using past concrete experiences to guide actions, Change in learner's perception of situations as whole parts rather than in separate pieces and Passage from a detached observer to an involved performer, no longer outside the situation but now actively engaged in participation

Significance of the theory; These levels reflect movement from reliance on past abstract principles to the use of past concrete experience as paradigms and change in perception of situation as a complete whole in which certain parts are relevant, each step builds on the previous one as abstract principles are refined and expanded by experience and the learner gains clinical expertise. This theory changed the profession's understanding of what it means to be an expert, placing this designation not on the nurse with the most highly paid or most prestigious position, but on the nurse who provided "the most exquisite nursing care and It recognized that nursing was poorly served by the paradigm that called for all of nursing theory to be developed by researchers and scholars, but rather introduced the revolutionary notion that the practice itself could and should inform theory.

Appraisal of Literature Review

Based on the study literature and theory drawn down to the objectives and the research questions of the study, the objective drawn inspiration from the literature reviewed. Benner theory of emergency nursing competency level is of standard. Benner's nursing theory explained its objective/principle in the competency level of care and its application to the clinicians; especially the accident and emergency nurse competency level, direct its effectiveness on the assessment of the patient. Literature review exposes the weakness of emergency nurses working in the accident and emergency department on their competency level of assessment. Al-Quraan & AbuRuz, (2016). Assessment of Nurses' Knowledge to Perform Glasgow Coma Scale. The most important assessment of neurological examination in the clinical setting is assessing level of consciousness. Motahareh, Musavi, Ghahfarokhi (2014) Clinical competency is the ability of the Emergency Nurses in playing a professional role in a clinical Environment especially emergency department as the quality of the services provided. Ying &Yupin (2018) holistic and behavior statements reflecting the skills, knowledge, attitudes, and judgment required for effective performance in the nursing profession. (ICN; Alexander & Runciman, 2003) identified 17 indicators within three domains of the generalist registered nurses' (RNs') competencies framework to advocate for global nursing competency. Today's nursing workforce represents various religions, nationalities, cultures, and generational cohorts (Meretoja, Numminen, Isoaho, & Leino Kilpi, 2015). Nurses' migration has resulted in requirements for comparable competencies (World Health Organization, 2009). Competence is context related and time specific (Garside & Nhemachena, 2013). (Mainland & Wilson, 2010). In healthcare settings, nurses have a common vision to protect and promote patients' health, no matter what the patient's nationality. Thus, it is required that nurses have adequate abilities to provide high quality services that meet international standards. Adaptation or implementation of these theories will be of great importance to the accident and emergency nurse/clinician.

From the literatures reviewed above, there is a GAP of empirical studies and application of Benner's nursing theory which is not implemented to acquire the competency level of care by the emergency nurses in the University of Port Harcourt Teaching Hospital to meet up the standard of care by the emergency nurses. Thus the need for this study; Emergency Nurses Competency Level in the Assessment of Patients with impaired Sensory Perception in Accident and Emergency Department of University of Port Harcourt Teaching Hospital, Port Harcourt

Methodology

Research Design: The study utilized a descriptive cross-sectional research design. Descriptive research design describes the characteristics of the population or phenomenon that is being studied, focuses more on the "what" of the research subject rather than the "why" of the research Subject (Shields & Rangarajan, 2013). It primarily focuses on describing the nature of a demographic segment, without focusing on "why" a certain phenomenon occurs. In other words, it "describes" the subject of the research, without covering "why" it happens

Area of the Study

This study was carried out in the Adult Accident &Emergency Department of University of Port Harcourt Teaching Hospital (UPTH) which is situated along East-West road at Alakahia Obio – Akpor Local Government Area of Rivers State. It commenced operation at its temporary site from 1980 and moved to its permanent site on Thursday, October12th 2006. It is an over 1200 bedded hospital with a staff capacity of more than 800 Nurses and 300 Doctors, composed of 48 departments. Renowned for its training and research abilities; the teaching hospital functions to facilitate effective care. This hospital is termed a five-star hospital, offering training of Nurses, doctors and students and a Centre for Research, point of referral for other levels of health care and health care facilities including neighboring states. The study department consist of eight Consulting rooms, Triage room, Resuscitation room, Nurses station, Conference hall, Sluice room, Pharmacy, Trauma theatre, Side laboratory, Record office, Account office, Plaster room, consists of 15 beds on female ward and 25 beds male ward.

Population of the Study

According to University of Port Harcourt Teaching Hospital Nursing Audit unit (2019) total number of Nurses are eight hundred and eighty-eight (888). Out of this number of nurses, ninety-three (93) are trained emergency nurses currently working in the Accident & Emergency Department. Therefore, the population for the study comprises of 93 trained Emergency Nurses working in Accident & Emergency Department of University of Port Harcourt Teaching Hospital.

Sample size

The entire nurses working in the adult and Paediatric Emergency Department of University of Port Harcourt Teaching Hospital formed the sample for the study.

Sampling Technique

The purposive sampling method was therefore employed by the researcher. In using this purposive technique, the researcher purposely selected all the nurses at the Adult and Paediatrics Emergency Department during the period of study.

Research Instrument

Questionnaires was used to collect data. It is divided into three sections. Section A; contains5 items on Socio Demographic data, Section B: assess nurses level of competence using the self-reported performance scale and the National Institutes of Health Stroke Scale (NIHSS), Self-Assessed Competency of Neurological Assessment Techniques. Section C examined the level of competence of nurses on the use of the Glasgow Coma Scale (GCS). This was presented on a five point Likert scale based on the Patricia Benner's Novice to Expert Theory.

Validity of the Instrument

Validity of the instrument was established through the judgment of expert nurses, two were drawn from neuro-science unit, two were drawn from Accident and Emergency Department, University of Port Harcourt Teaching Hospital. Questionnaire was submitted by the researcher to the two neuroscience validators same scrutinized the contents of the instrument and found it be able to measure the objectives of the study and there was no ambiguity identified. The instrument was also checked for the appropriateness of each item in terms of language use as well as the suitability of the questions for inclusion in the instrument and necessary corrections and suggestions by the experts was incorporated in producing the final version of instrument.

Reliability of the Instrument

The reliability was done using a Test –Retest method on 10 nurses working in the Accident and Emergency Department of the Rivers State University Teaching Hospital (RSUTH).

Procedure for data collection

Emergency Nurses working in Accident & Emergency Department were used for the study, and two research assistants were briefed on the procedure for the administration and collection of the questionnaires which lasted for three (3) weeks. Since it was a direct observational research design, data were collected on the spot.

Method of Data Analysis

Data obtained were cleaned, coded and entered using SPSS version 25.0. Descriptive statistics of mean criteria, frequency and percentages was used to summarize data. For decision to be taken, the mean for weighing of the response categories were found in

$$\frac{5+4+3+2+1}{5}=3$$

Objective one: this was answered using the modified 12 itemed Self-Assessed Competency of Neurological Assessment Techniques presented on a five-point scale based on Benner's Novice to Expert and rated 1, 2, 3, 4 and 5 with score ranging from 12 to 60. The individual mean scores were ascertained and categorized as follows: a mean score of 5 indicates Expert level, score of 4.00 – 4.99 termed Proficient level, score of 3.00 – 3.99 termed Competent level, score of 2.00 – 2.99 termed Advanced beginner while a score of less than 2 will be Novice (Gocan & Fisher, 2008).

Objective two: This answered using the Glasgow Coma scale presented on a five-point scale based on Benner's Novice to Expert and rated 1, 2, 3, 4 and 5 with score ranging from 15 to 75. The individual mean score will be ascertained and categorized as follows: a mean score of 5 will indicate Expert level, score of 4.00 – 4.99 will be termed Proficient level, score of 3.00 – 3.99 will be Competent level, score of 2.00 – 2.99 will be Advanced beginner while a score of less than 2 will be Novice (Gocan & Fisher, 2008).

Objective three; This answered the factors that mitigates against Emergency Nurses' competency level presented on a five –points scale based on Likert Strongly Agreed to Disagreed and rated 5, 4, 3, 2, and 1 on assessment of patients with impaired sensory perception by Emergency Nurses in Accident and Emergency Department (n=93)

Ethical Consideration

Authorization letter was obtained from the West African College of Nursing, and ethical approval letter and acceptance from ethical committee, University of Port Harcourt Teaching Hospital was obtained to carry out the study.

Data Analysis, Result and Discussion of Findings

This presents and discusses Data analysis, Demographic information of respondents and interpretation and Discussion of findings of the results of the study on the emergency nurse's competency level in the assessment of patients with impaired sensory perception in accident and emergency department of University of Port Harcourt Teaching Hospital, Port Harcourt. Ninety-three (93) copies of Direct Observational Structured questionnaires were used to assess the Competency level of Emergency Nurses on patients with impaired Sensory Perception and were used for the analysis. The results of this present study are organized and presented in three (3) Sections thus: socio-demographic characteristics of respondents were analyzed using simple frequency tables, chats, and percentages while Section B consist of Competent Clinical Skill items and Section C consist of Glasgow Coma Scale guide items and mitigating factors against the emergency nurse's competency level in the assessment of patients with impaired sensory perception, research questions were analyzed using weighted mean, simple frequency and Percentages.

Table 1: Socio- Demographic Characteristics of the respondents n=93

Variables	Category	Frequency	Percentages %
Gender	Females	63	67.7
	Male	30	32.3
	Total	**93**	**100%**

Age	25 – 30yrs	30	32.3
	31 – 35yrs	15	16.1
	36 – 40yrs	13	14.0
	41 – 45yrs	16	17.2
	46 – 50yrs	8	8.6
	51 – 55yrs	7	7.5
	56 – 60yrs	4	4.3
	Total	**93**	**100%**
Years of Experience	1 – 5	53	56.9
	6 – 10	25	27.0
	11 – 15	15	16.1
	Total	**93**	**100%**
Cadre of Nurses	NO1	30	32.3
	SNO	20	21.5
	PNO	10	10.8
	ACNO	11	11.8
	CNO	17	18.2
	AND	5	5.4
	Total	**93**	**100%**
Educational Qualification	RNM	30	32.3
	AEN/NSNS	46	49.5
	BSC/BNS	30	32.3
	MSC	16	17.2
	PHD	0	0

Table 1 shows the socio-demographic characteristics of the respondent, out of the 93 respondents studied, the age of the respondents showed that majority 30 (32.3%) are between the age group of 25 –30yrs, 15 (16.1%) aged 31—35yrs, 13(14%), aged 36—40yrs, 16(17.2%), 41 –45yrs, 8(8.6%), 46—50yrs, 7(7.5%), 51—55yrs, while 4 (4.3%) 56 –60yrs... Gender shows that majority are Females 67(67.7%), while Males are 30 (32.3%). Educational Qualifications shows that RNM 30(32.3%) AEN/NSNS 46(49.5%), BSc/BNSc 30 (32.3%), MSc 16(17.9%), Ph.D. 0 (0%) Years of working Experiences shows that majority had 1—5yrs 53(56.9%), 6—10yrs 25 (27.0%) and 11—15yrs 15 (61.1%)working experience. Cadre of Emergency Nurses shows that majority of the nurses were NO1 30(32.3%), SNO 20 (21.5%), PNO 30 (10.8%), ACNO 11 (11.8%), CNO 17 (18.2%), ADN 5 (5.4%)

Figure 1: Distribution of respondents according to gender

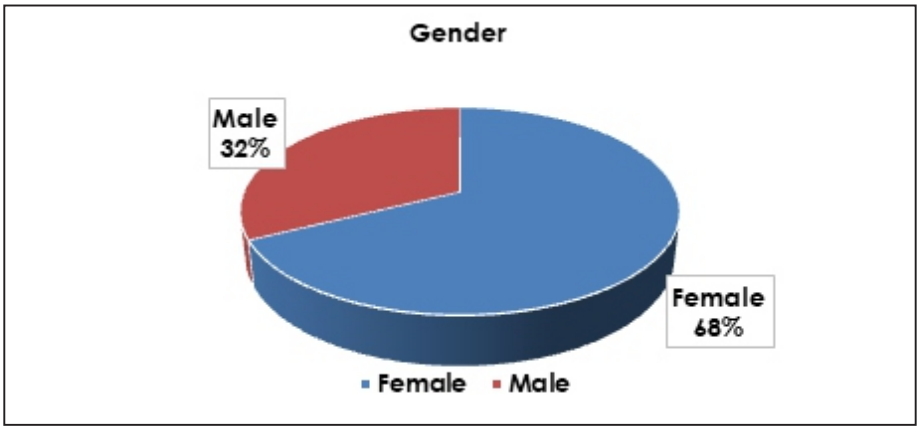


Figure 1: *Shows that Females 67(67.7%) while Males 30 (32.3%)*

Figure 2: Distribution of respondents according to age

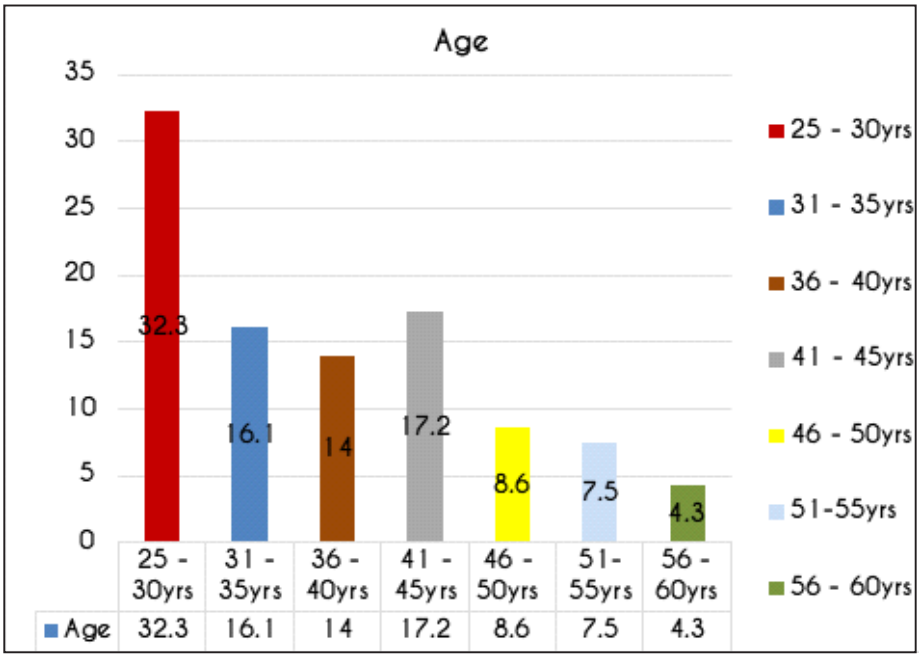


Figure 2 *shows the age distribution of respondents, out of 93 respondent studied 25 -30yrs 30 (32.3%) were age 31—35yrs 15 (16.1%) were 36—40yrs 13(14%), were 41 -45yrs 16(17.2%) were 46—50yrs, 8(8.6%) were 51—55yrs, 7(7.5%) were 56 -60yrs, 4 (4.3%) respectively.*

Figure 3: Distribution of respondents according to years of experience

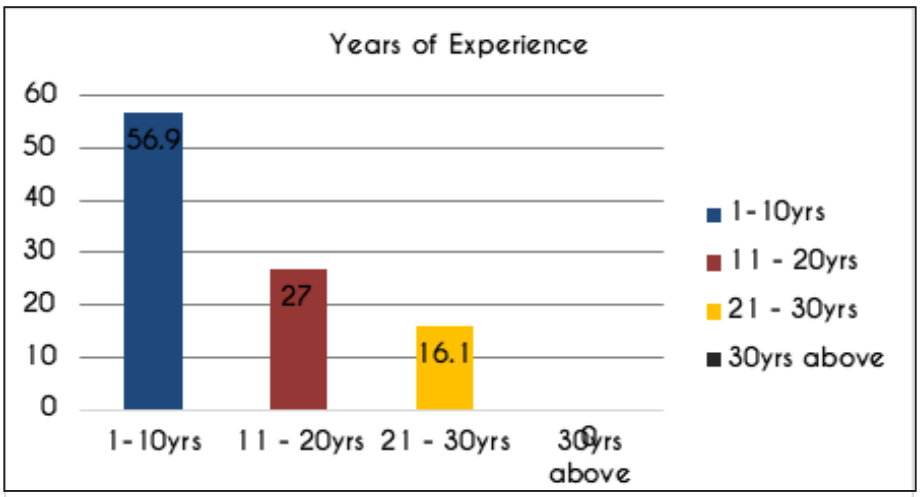


Figure 3 *Shows the Years of working Experiences; 1—5yrs, 53(56.9%) were 6—10yrs, 25 (27.0%) and 11—15yrs 15 (61.1%)working experience respectively*

Figure 4: Distribution of respondents according to Nurses Cadre

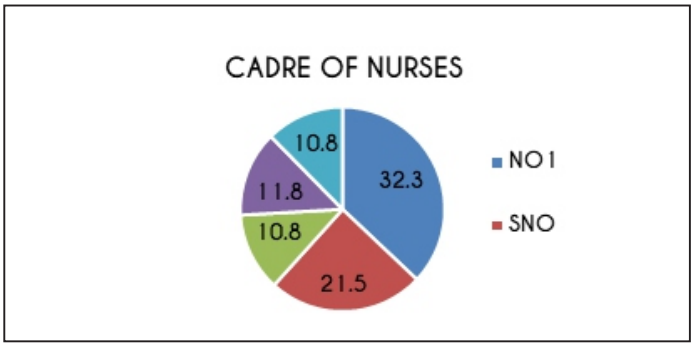


Figure 4 *Shows the Cadre of Emergency Nurses NO1 30 (32.3%) SNO, 20 (21.5%), PNO, 30 (10.8%), ACNO, 11 (11.8%) , CN0 17 (18.2%) ADN 5 (5.4%) respectively*

Figure 5: Distribution of respondents according to educational qualifications

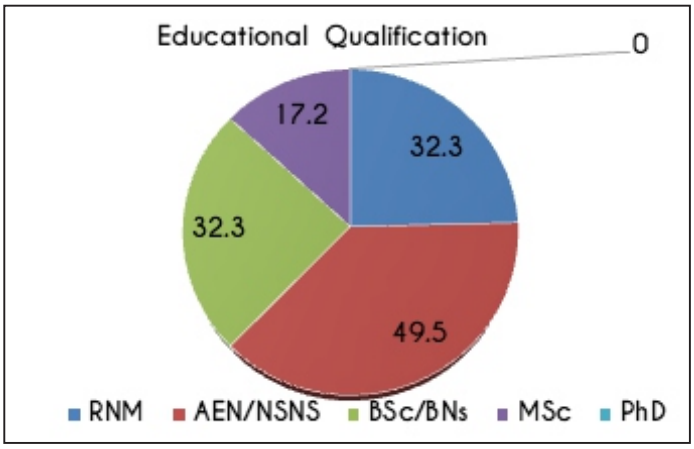


Figure 5 *shows the of the Educational Qualifications of the respondents RNM 30(32.3%) were AEN/NSNS, 46(49.5%) BSc/ BNSc, 30 (32.3%), MSc 16(17.9%) PhD 0 (0%).*

Research Question 1:
What is the level of competency of emergency nurses regarding the assessment of a patient with impaired sensory perception?

Table 2: The weighted mean on Emergency Nurses' level of competence in assessment of patients with impaired sensory perception (n = 93)

Section B: Emergency Nurses' level of competence in assessment of patients with impaired sensory perception Instruction: This section contains a modified 12 itemed Self-Assessed Competency of Neurological Assessment Techniques presented on a five-point scale rated 1, 2, 3, 4 and 5. Please tick [√] against the option that best indicate the level of competence.

12 Competency Clinical skills Items	Expert 5	Proficient 4	Competent 3	Advanced Beginner 2	Novice 1	Weighted mean	Remark
.Use of variety of assessment techniques to collect data	12(60)	20(80)	19(57)	12(24)	30(30)	2.6	Disagreed
2. Determination of accurate level of consciousness	10(50)	14(56)	11(33)	27(54)	41(41)	2.5	Disagreed
3.Incorporation of neurological examination techniques for	12(60)	21(84)	11(33)	17(34)	32(32)	2.6	Disagreed

comprehensive assessment of stuporous or comatous patient							
4. Accurate assessment of patient's mental status (e.g. orientation, awareness, attention and concentration level etc.).	15(75)	24(96)	28(84)	9(18)	35(35)	3.3	Agreed
5.Gaze and extraocular movements assessment (normal and abnormal response).	7(35)	10(40)	23(69)	20(40)	33(33)	2.3	Disagreed
6.Accurately assess facial palsy to determine motor weakness of the face.	9(45)	19(76)	28(84)	21(42)	16(16)	2.8	Disagreed
7.Assessment of motor strength and drift to determine subtle weakness and changes in the patients' motor strength.	11(55)	10(40)	15(45)	27(54)	30(30)	2.4	Disagreed
8.Assessment of limb ataxia to determine cerebellar impairment.	5(25)	8(32)	13(39)	30(60)	37(37)	2.0	Disagreed
9. Assessment of sensation using light touch as well as sharp/dull testing assessment techniques.	30(150)	25(100)	17(51)	15(30)	6(6)	3.6	Agreed
10.Assessment of expressive and receptive communication deficits.	7 (35)	5 (20)	20(60)	17(34)	44(44)	2.0	Disagreed
11.Assessment of patient's ability to understand the spoken and written word and to express thoughts orally and in writing	7 (35)	30(120)	28(84)	22(44)	20(20)	3.2	Agreed
12. Assessment of dysarthria (patients' clarity of speech).	19(95)	17(68)	11(33)	12(24)	34(34)	2.7	Disagreed

Table 2 showed the weighted mean on the Emergency Nurses' level of competence in assessment of patients with impaired sensory perception. Twelve (12) questionnaire items were used to address research question 1, out of which (3) three items were agreed as the weighted mean is greater than 2.9 (item 4, 9 and 11) were agreed with 9 items disagreed with (item 1, 2, 3, 5, 6, 7, 8, 10 and 12) weighted mean less than 3.0), this mean that majority have low level of competence in assessment of patients with impaired sensory perception.

Research question2: What is the level of competency of nurses on the use of Glasgow Coma scale for patients with impaired sensory perception? **Table 3:** The weighted mean on Nurses competency level on the use of Glasgow Coma scale for patients with impaired sensory perception (n = 93)

Section C: Nurses' competence in the use of Glasgow Coma Scale

Competency: Use of Glasgow coma scale	**Expert**	**Proficient**	**Competent**	**Advanced beginner**	**Novice**	**Weighted Mean**	**Remark**
	5	**4**	**3**	**2**	**1**		
Glasgow Coma Scale (Items)							
13.Assessment of eye opening and document appropriately: Recognition of							
Spontaneous eye opening Eye opening in response to verbal command Eye opening to pain only	30(150)	15(60)	7(21)	10(20)	31(31)	3.0	Agreed

Patient with no response to eye opening							
14. Assessment of verbal response and document appropriately: Recognition of							
Orientation (place, person and time), Confused conversation but able to answer questions, Inappropriate words, Incomprehensible speech	36(180)	26(104)	10 (30)	9(18)	9 (9)	3.6	Agreed
15. Assessment of motor command and document appropriately: Recognition of							
Movement to command, Purposeful movement to painful stimulus, Withdrawal in response to pain, Flexion in response to pain, Extension in response to pain, No response	15(75)	8(32)	3(9)	30(60)	37(37)	2.2	Disagreed

Table 3 shows the weighted mean on the nurses' competence in the use of Glasgow Coma Scale in the care of a patient. Three (3) questionnaire items were used to address research question 2, out of which (3) three items were disagreed as the weighted mean is lesser than 25), this means that majority disagreed on the use of Glasgow Coma scale in the care of patients with impaired sensory perception.

Table 4: The weighted mean on the factors that mitigates against nurses' competence on assessment of patients with impaired sensory perception (n = 93)

Mitigating factors	SA	A	U	SD	D	Weighted Mean	Remark
	5	4	3	2	1		
Factors that mitigates against nurses' competence							
15. Lack of sufficient motivation in nurses	50(250)	20(80)	10(30)	5(10)	8(8)	4.0	Agreed
16. occupational burnout	40(200)	30(120)	15(45)	3(6)	5(5)	4.0	Agreed
17. low quality and quantity of educational courses	30(150)	35(140)	7(21)	10(20)	11(11)	3.6	Agreed
18. lack of job satisfaction and professional interest	50(250)	30(120)	0(0)	8(16)	5(5)	4.2	Agreed
19. disproportionate recruitment of nursing staff in terms of number of patients	60(300)	20(80)	5(15)	5(10)	3(3)	4.3	Agreed
20. lack of clear standards for professional competency	75(375)	15(60)	0(0)	2(4)	1(1)	4.7	Agreed

Table 4 shows the weighted mean on the factors that mitigates against nurses' competence on assessment of patients with impaired sensory perception. Six (6) questionnaire items were used to address research question 3, all items were agreed as the weighted mean is greater than 2.5 (items15, 16, 17, 18, 19 and 20), this means that there are factors that mitigates against nurses' competence on assessment of patients with impaired sensory perception.

Discussion of findings

Findings from this study shows that majority of emergency nurses have low level of competence in assessment of patients with impaired sensory perception.

Research Question 1: What is the level of competency of Emergency Nurses regarding the assessment of a patient with impaired sensory perception?

The level of competence revealed that a significant proportion of the respondents accounting for a weighted mean of less than 2.5 disagreed with items on competency clinical skills, while a little proportion agreed which only accounted for a weighted mean greater than 2.9. This finding is surprising to the researcher as she would expect good level of competence in assessment of patients among emergency nurses due to their everyday encounter with such patients, thus this anomaly requires urgent attention. A formal training on assessment of patient with impaired sensory perception is needed to offer nurses the skills required thereby increasing the competency level. This study is in line with the study of Bae & Roh (2020) on the neurological assessment competency level of Korean Nurses where they reported that emergency nurses had lower neurological assessment level when compared with other nurses in the ward and ICU, and identified training needs of the nurses.

Research Question 2: What is the level of competency of Emergency Nurses' on the use of Glasgow Coma scale for patients with impaired sensory perception?

The result of this study also showed that majority of nurses disagreed on the use of Glasgow coma scale in the care of patient with impaired sensory perception. This is in agreement with Al-Quraan & Aburuz (2016) assessment of Jordanian nurses' knowledge to perform Glasgow coma scale which identified that emergency room nurses recorded less knowledge in the use of Glasgow coma scale than other area of practices and also recognized this as a global problem that requires its inclusion in educational programme for nurses in all areas of practice and in the curricular of nursing colleges.

Research Question 3: What are the factors that mitigates against Emergency Nurses' competence on assessment of patients with impaired sensory perception?

Findings regarding factors that mitigates against nurse's competence on assessment of patients with impaired sensory perception shows that lack of sufficient motivation, occupational burnout, lack of job satisfaction and professional interest, disproportionate recruitment of nursing staff and lack of clear standards for professional competency were identified as the main factors that mitigates against nurse's competency level.

Work experience helped to improve nurses' competencies. Nursing work experience, in conjunction with managerial guidance, had a considerable influence on enhancing nursing capabilities (Marshburn, Engelke & Swanson 2009.). Capacity building is crucial for newly graduated nurses who lack work experience. This ensures that the care that is provided is in accordance with the nursing ethical code and the organization's internal standards. It was found in one study that the competency level of nurses was higher for those with ≥ 5 years working experience compared to that for those who did not (Takase, 2012).

Education in this study referred to formal (tertiary) education, e.g., a diploma, Bachelor's degree and Master's degree. Our study showed that nurses from diploma degree had lower competences than that of nurses from bachelor degree (Salonen, Kaunonen, Meretoja, & Tarkka. 2007). Nurses with a Master's degree were well equipped to care for patients compared to those with a Bachelor's or diploma (Chang & Chang 2010). The role of education in developing nurses' competencies was shown to be vital in our study (Takase, 2012).

The ability to think critically was a contributory factor to the development of nursing competency and helped nurses to provide safe nursing care to patients. An increase in critical thinking abilities corresponded with an improvement in the competency level of the nurse (Forneris. 2012).

The provision of preceptorships and mentorships were an integral component of professional nursing care and nursing services. Preceptorships encouraged the nurses to develop enhanced capabilities, as well as professionalism. They also helped new nurses to gain basic knowledge, skills, and a professional attitude (Wangensteen, Johansson, Björkström, Nordström & 2012) and encouraged them to promote patient safety (Fater, Weatherford, Ready, Finn & Tangney and Lucas, 2014). Senior nurse mentorships helped to develop the abilities of new nurses (Komarata & Oumtanee, 2010). The mentorship programs also provided newly graduated nurses with increased nursing care experiences, while helping them to manage anxiety and improve their knowledge.

Male nurses were found to be more competent than their female counterparts in one study (Wangensteen, Johansson, Björkström, Nordström & 2012). This translated to better quality care being attributed to the male nurses and better quantity care being provided by the female nurses.

Age was another contributing factor to the development of nurses' competencies, primarily because it was usually a reflection of a longer working duration and learning experience. Senior nurses were found to have more working experience and better resultant competencies. Older nurses and those with more working experience were found to be more competent (Bahreini, Shahamat, Hayatdavoudi, & Mirzaei. 2011). Confidence was also seen to influence the advancement of nursing competence. By contrast, nurses with low self-esteem and anxiety were less ready to perform their duties and were not as competent in performing nursing care (Clow,. Ricciardelli, & Bartfay. 2015).

Summary

In summary, the study examined the assessment of the competency of emergency nurses in assessing patients with impaired sensory perception in the Accident and Emergency Department of the University of Port Harcourt Teaching Hospital (UPTH). The study was limited to nurses working in Accident and Emergency Department, on adult and pediatric patients only. Various literatures were reviewed based on the National Institutes of Health Stroke Scale (NIHSS), Self-Assessed Competency of Neurological Assessment Techniques, Glasgow Coma Stroke Scale (GCS), Patricia Benner Novice to Expert Nursing Theory. 93 emergency nurses were used for this study. Structured questionnaires were developed which were the bases for the assessment of nurses' competency in assessing patients with impaired sensory perception, and mitigating factors against nurses' competency level, using 5-point Likert Strongly Agreed to Disagreed ratings.

Examined and analyzed also are the socio-demographic characteristics using various statistical methods like frequencies, percentages, mean. The results show that majority of nurses assessing patients with impaired sensory perception in the Accident and Emergency Department of University of Port Harcourt Teaching Hospital, have low level of competency. This is as a result of lack of adequate exposure of emergency nurses to modern technology in assessing patients with impaired sensory perception, poor policies of hospital management, inadequate staffing, poor attitude of care givers

Conclusion

Based on the findings of the study, the following Conclusions were made; Achieved competencies can be used as a reference for nursing education, application of nursing theories and practice in emergency.

Recommendation

Based on the findings from the study, the following are hereby recommended:

- A formal training on assessment of patient with impaired sensory perception is needed to offer nurses the skills required thereby increasing the competency level.
- Emergency Nurses recorded less knowledge in the use of Glasgow coma scale than other area of practices and also recognized this as a global problem, thus requires its inclusion in educational programme for nurses in all areas of practice and in the curricular of nursing colleges.
- Nursing work experience, in conjunction with managerial guidance, had a considerable influence on enhancing nursing capabilities. Thus Capacity building is crucial for newly graduated nurses who lack work experience.
- Hospital managements should work against any mitigating factor on Emergency Nurses competency level of assessment in the care of patients with impaired sensory perception

Contribution to knowledge

1. The findings of this study have provided evidence on the emergency nurses competency level in the assessment of a patient with impaired sensory perception in the accident and emergency department of the university of Port Harcourt Teaching Hospital.
2. The study has portrayed that the nurses level of competency as a clinician should be of global recommended standard care of patients with impaired sensory perception to prevent further complications.

Suggestion for further studies

based on the findings of this study, it is suggested that:

Ø A similar topic of the research studies should be carried out by Emergency Nurses in Accident and Emergency Department in various Teaching Hospital in Nigeria/ Africa

Ø Emergency nurses should make use of adequate management guideline scales, neurological examinations,

application of nursing theories and proper use of diagnostic set in the assessment of patients with impaired sensory perception.

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THE CHANGING NEEDS AND EXPECTATIONS OF THE PATIENTS: THE ROLE OF THE 21ST CENTURY NURSE *BEING:* INAUGURAL LECTURE AT PAMO MEDICAL UNIVERSITY

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INTRODUCTION

Patient expectation in health care increasing, this is something that need to be managed adequately in order to improve outcomes and decrease liability. Understanding patients' expectations can enhance their satisfaction level. In medical and surgical nursing emergency units with acutely ill, serious, time-dependent issues and high level of stress, patients' expectations can indeed be challenging. This paper discusses patients' expectations and proposes implementation of elements of patient-centered care and value-based care into our existing health care systems today. There are transformative changes occurring in healthcare for which nurses, because of their roles, education, and earned respect are positioned to contribute and lead thus being major player in shaping these changes. They must understand the factors driving changes, the mandates for practice change, and the competencies (knowledge, skills, and attitudes) that will be needed for personal and system wide success. New health paradigm demands the nurse to be a full partner in relentless efforts to achieve the triple aim of an improved patient experience of care (including quality and satisfaction), improved outcomes or health of populations, and a reduction in the per capita cost of healthcare.

These changes focus on promoting, protecting and preserving the healthy lifestyles of the public., Preventing disease and health problems. Providing care and assisting in coping to clients with disability and terminal illness. As well as making sure that care provision is s safe, timely, effective, efficient, equitable and patient-centered.

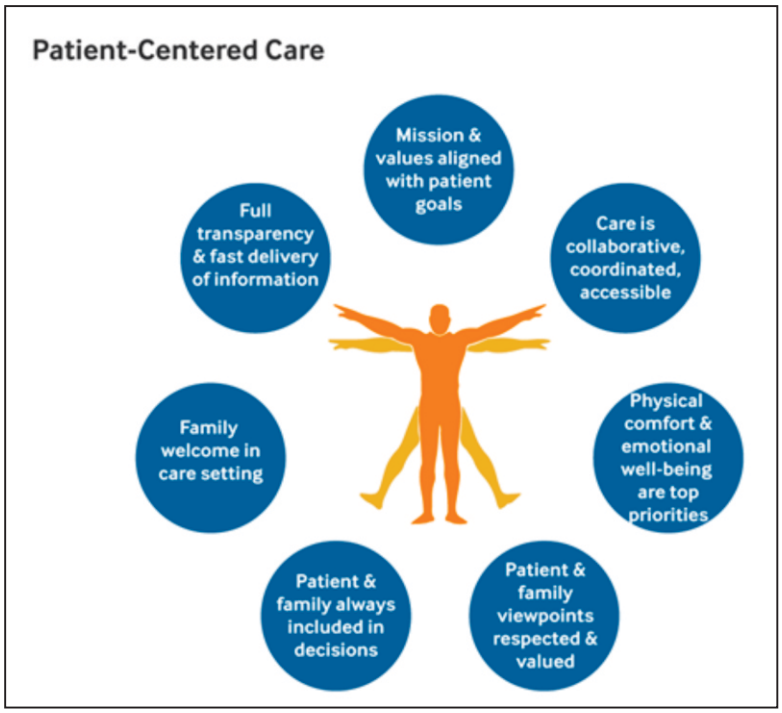


Fig 1: showing an illustration of patient centred care

Basic nursing care is concerned with helping a patient to meet his/her basic human needs. These needs vary according to age. general health condition, culture, physical and intellectual capacities or the particular pathologic state with which he\she is suffering. The main goal of nursing care understand is individual clients' conception of health and his/her health beliefs and practices. A nurse should be able to identify the factors influencing the client's behaviour and the impact of illness on the client and his family as successful nursing care depends on nurses' awareness of these.

The issue of patient's expectation about nursing care has been getting increased attention from policy makers, administrators, physicians, nurses and evaluators of health care. Patients with unmet expectations may never complain to the physician directly but instead they just will not return for ongoing and follow-up care.

Understanding and managing patients' expectations can improve patient satisfaction, which refers to the fulfilment or gratification of a desire or need. When we can "read" our patients, they are grateful. They will sense we understand them better because our responses are accurate and appropriate to what they expect and feel deep inside (Farooq, 2015). For patients in the emergency department, due to the acute and sudden nature of their problems, stress and anxiety levels are usually high. Managing the expectations of these patients and their families becomes even more challenging in an environment where many actions are time dependent these call for robust utilization of essential skills.

Essential Skills for Nursing in the 21st-centuryThere are indeed vital and essential skills pre requisites in this specialty care and include the following

Critical, Clinical and Ethical Thinking

- The global pandemic challenged nurses across acute care settings to be nimbler and self-assured in their nursing process. This includes interpreting observations, making nursing diagnoses, implementing nursing interventions and evaluating the effects of those nursing interventions.
- Among the essential 21st-century nursing skills will be sound critical thinking, clinical judgment and leadership, including an ability to reflect on actions taken, self-assessment, receiving feedback and improving one's ability to connect theory to practice over time and handle ethical dilemmas.
- New health challenges, whether pandemic or more isolated, will require nurses to team with other professionals in pursuit of rapid investigations and solutions. A key competency for future nurses and all health professionals will be to acknowledge the unknowns and to formulate strategies for to explore them.
- Remember the exam questions you had to answer in nursing school. The nursing profession doesn't always deal in black and white. Actually, I think it's safe to say they rarely deal in black and white. Much of the work we do is riddled in grey areas. When given a problem there are multiple right answers, but we're tasked to pick the most correct response Many times that requires thinking outside the box

Nurse and Machine Collaboration

- Nurses remain uniquely positioned to influence how technology is synthesized at the point of care. The emergence of collaborative intelligence and clinical analytics require both practical knowledge and a new mindset to welcome machines as an additional contributor to the care team. Imagine a clinical situation where a nurse is monitoring multiple patients for non-verbal signals of rising or falling pain levels, or changes in breathing patterns.
- Machine learning will help nurses and others improve clinical pathway prediction, disease progression prediction, health risk protection and predictive risk scoring. Collaborative intelligence will assist with the differential diagnosis of medical images and combine patient data with academic evidence and regulatory guidelines to help personalize treatment plans and improve treatment and outcomes.

Relationships + Interdependency

- The next generation of nurses will be asked to work in teams with other health professions, and with specialists trained in novel ways. Take, for example, Nursing and Midwifery Council of Nigeria (NMCN) using computer-based test (CBT) as a change and a need for both the patient and the nurses to achieve professional goals, aid recovery and improve standard of care. This is an inaugural ceremony of nurses graduating from PAMO Medical University, with CBT whose uniqueness is the high degree focused on critical thinking, decision making and evidenced based practice.
- At times, nurses will be asked to model various forms of services(servants) and transformational leadership as a means of everyone gaining a better understanding of the patient and circumstances. As technology assists more on the clinical side, nurses will play a larger role in research and in addressing health inequities. People-centered and integrated care will be within the reach of everyone with implementation of nursing languages in evidence- based nursing care and the core values of standard care.

§ Teamwork

Nurses never work by themselves. It's always in coordination with other nurses, doctors, and other multidisciplinary team members (e.g.-dietitian, respiratory therapist, and so forth). Each member plays a critical role in taking care of the patient. For these reasons, teamwork is a must-have nursing skill set.

§ **Compassion and Empathy**

Compassion and empathy are at the core of nursing. having sympathy or concern for one's suffering, and understanding patient's suffering is almost like putting oneself into the patients' shoes.

§ **Good Communication** ***Good communication is a must for nurses.***

You need to be able to communicate effectively with your coworkers and other members of the multidisciplinary team. Another often missed aspect of nursing communication (and why good communication is so important) is patient instructions and teaching. Nurses do a lot of patient teaching. As a nurse, you'll teach patients how to manage their diabetes. You'll teach them how to take medications appropriately. In short, you're giving instructions that have life and death consequences. To make communicating with patients even more difficult is when you're dealing with patients with low health literacy. To say that good communication is important for nurses is an understatement, it is essential to the core of what nurses do.

§ **Time-Management Skills**

As a nurse, you need to have good time-management skills. Nurses are constantly tasked to do many things and wear many hats. Time management is so important in the nursing profession. Here's the secret to managing time effectively used by some of the most successful people in their respective field. Time management skill is needed in all nursing specialties. One of the specialties I've worked in is gastrointestinal nursing. Even if you've never worked as a gastrointestinal Nurse/Endoscopy Nurse you probably still know that it's nothing like medical surgical. What you might not know is that there's a lot of time management skills that's needed, it just looks differently as a gastrointestinal Nurse than as a Medical Surgical Nurse.

§ **Paying Attention to Details**

Nurses make critical decisions each day that affects people's lives. From the instructions we give that can be much nuanced, to the intravenous drip we're titrating, misreading a number can be the difference between life and death. It's safe to say that attention to detail is not optional.

§ **Professionalism**

A Good Nurse is a professional nurse. When you're a professional nurse, you are responsive, humble and good-natured to patients and colleagues, do quality work, helpful to others, take pride in your work, being a professional in your work reflects well on your personal nurse brand and the profession of nursing.

§ **Physical Strength and Stamina**

Have you heard "no lift facility? Now that you're done laughing the truth of the matter is many nursing jobs especially the hospital direct patient care nursing jobs are very labor-intensive.
You're on your feet a lot. You're catching patients that are falling. All of this requires physical strength and Stamina.

§ **Ability to Manage Stress**

Nurses are constantly in stressful environments and situations. A nurse that can't find a way to manage the stress of their job will find themselves dealing with nurse burnout.

§ **Ethics**

Nurses should be ethical in their approach to their work. As the most trusted profession in the United States, the public and our patients have a high standard for nursing conduct (source). Because of that, we're called to practice ethically.

§ **Adaptability**

Healthcare is forever changing. New research continues to change practices that were once considered the gold standard. One of the most important basic nursing skill is the ability to adapt to those changes.

§ **Commitment to Career Development**

Remember when I said health care is forever changing. Good nurses don't fight the change but embrace it. One of the ways to embrace that change is to focus on developing your career as a nurse. This could be keeping up to date on the current best practice, or it could be going back and getting your graduate degree in

nursing.

§ **Ability to Delegate**

Nurses need to master the art of delegation. There's so much to do, and nurses can't do it by themselves. Therefore, nurses need to know when to delegate and how to delegate. You need to know when to delegate a task to a nurse aid. You need to know when to delegate work to another nurse.

§ **Prioritization**

Similar to what I mentioned above there's too much to do and so little time. You can't just not do them; they all have to get done. The question isn't which one can i not do. The problem is which one should i do first. That's where good prioritization skills come in handy. Because when presented between two patients. One is complaining about acute ankle pains, while another patient with a history of diabetes is all of a sudden very confused, Prioritization will help you figure out which patient you should see first.

§ **Strong**

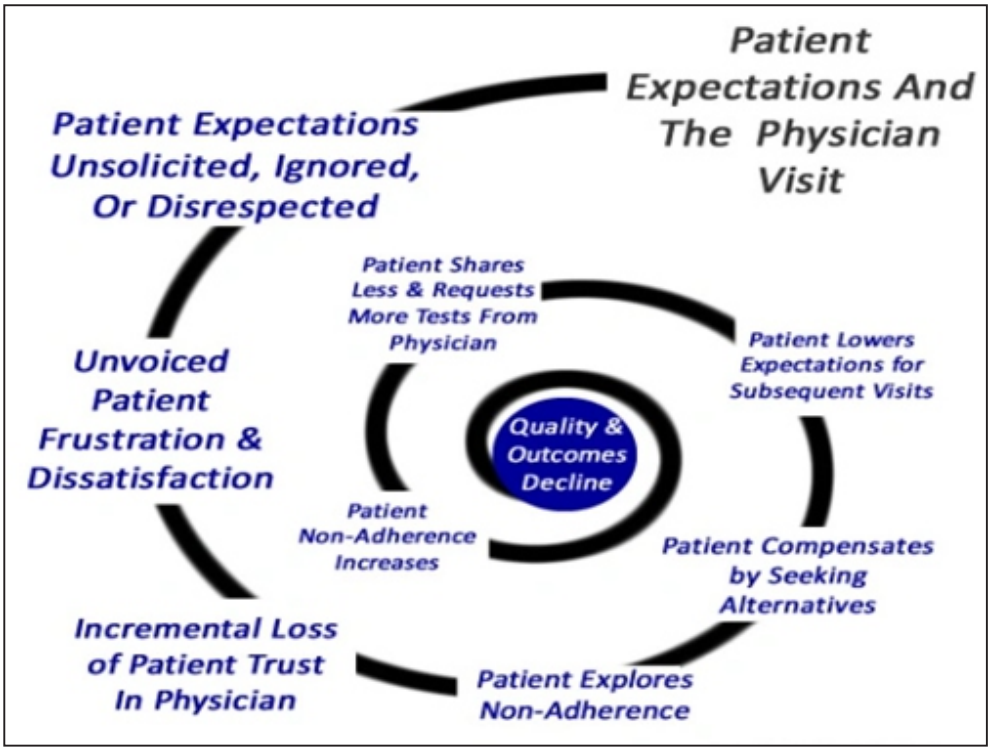
This is going to sound very cliché, but i thought its very appropriate. Nurses at times can be the punching bags for patients, doctors, and administration. When you're making a phone call to a doctor to report a problem with a patient, and they're yelling at you for doing your job… you have to remain strong. When family members start yelling at you because they're frustrated with what's going on with they are loved one you have to stay strong.

Patients Expectation

Expectations, with reference to healthcare, refer to the anticipation or the belief about what is to be encountered in a consultation or in the healthcare system. It is the mental picture that patients or the public will have of the process of interaction with the system. Patients come to a consultation with expectations which they may or may not be overtly aware of. These expectations may be openly presented or the physician may have to attempt to elicit them. Reactions to unmet expectations can range from disappointment to anger. Thus, knowing the expectations of our patients can help avoid these reactions, enhance their healthcare experience, and reduce our exposure to liability. Studies have shown that as much as 70% of litigation relates to real or perceived problems involving physician communications, which influences patients' expectations. Not meeting expectations can also result in non-compliance or suboptimal compliance and affect physicians' reputation in a community.

Fig 2. Patient with unmet expectations

Patients with unmet expectations may never complain to the care giver directly but instead they just will not return for ongoing and follow-up care. (Hoy, 2018), (Farooqi, 2015) Understanding and managing patients' expectations can improve patient satisfaction, which refers to the fulfilment or gratification of a desire or need. When we can "read" our patients, they are grateful. They will sense we understand them better because our responses are accurate and appropriate to what they expect and feel deep inside.



For patients in the emergency department, due to the acute and sudden nature of their problems, stress and anxiety levels are usually high. Managing the expectations of these patients and their families becomes even more challenging in an environment where many actions are time dependent. (Taylor, Kennedy, Virtue, & McDonald, 2005).

Fig 3. Patient expectations

As we plan to meet the increasing expectations, it becomes inevitable that the elements of patient safety will have to be considered as well. When addressing satisfaction issues, matters related to medication errors, falls and fall precaution, timely laboratory results review and procedural verification (which are closely linked to patient safety as well) are indeed very relevant.

In general, quality in healthcare has two dimensions: the objective and technical part as well as the subjective and qualitative part. Much as the former is important, as we continue to develop the state-of-the-art healthcare system and infrastructure, the latter is just as critical. What patients think of their experience with the healthcare system must matter to the healthcare planners, managers and policy makers because this experience, as much as the technical quality of care, will determine how people use the system and how they benefit from it. Somehow, technological innovations in medicine seem to have shifted some of the physicians' attention away from the personal care of patients. (Taylor et'al, 2005)

Managing Patient Expectations

Exploring patients' expectations is crucial for ensuring delivery of nursing care of the highest quality. Patients' expectations continue to increase. Therefore, a satisfactory balance should be achieved between patient expectations, Nurses' perceptions, and priorities set by healthcare planners. Every patient who comes for consultation has expectations based on his understanding of the illness, cultural background, health beliefs, attitudes, and level of understanding. Patient demographics and visit characteristics also contribute toward this. How far the nurses assess, implement, evaluate and reaches an understanding with the patient will also have an impact on the successful outcome of nursing care. The price healthcare providers and hospitals have to pay for dissatisfied patients and customers is indeed high, thus the investment of some time to understand this issue is certainly worth the while (Sun, Adams, Orav, Rucker, & Brennan, 2000).

Some of the general expectations of patients include:

- The need to be listened to
- The need to receive clear explanation and instructions about their condition
- To be treated by staff who show care/concern/compassion and
- To be treated by specialist and nursed by professional in their work (a trauma physician and emergency nurse, a paediatrician and a paediatric nurse) etc.

Some examples of unrealistic expectations of patients would include:

- wanting to discuss several major problems, all in one standard consultation
- prescription to be given without a consultation
- ability to call the physician 24hrs a day for any problems and
- thinking that the physician will always know the exact diagnosis at first consultation and start treatment immediately

To manage unrealistic expectations and unreasonable requests from patients, the nurse would know:

- that they should not allow patients to manipulate them with unreasonable demands
- they have to take a step back and assess why certain requests are put forth. This exploration can also enhance communications skills
- they need to explain clearly in simple terms, avoiding medical jargon, why certain treatment and management is necessary.
- they need to be clear as to why further tests and consults are needed
- that a patient's request for a second opinion from another physician is acceptable and,
- To make meaningful progress in enhancing patient care, safety, satisfaction, and quality, staff must listen and respond to patients and customers. Communications delays must be cut. Treating patients as individuals, managing their pain, and providing adequate information on treatment are all crucial, as are patient safety elements. The best approach would be to communicate well and try to develop a trusting relationship. At all times, we must strive to ensure patients understand the rationale for treatment and what to expect e.g., duration of therapy, side effects, costs, etc. Finally, we must always leave room for them to question, especially if there are concerns not addressed. (Stevens, Stagg, Mackay, 1977)

As we move into the future, the continuum of care for patients will continue to evolve and a paradigm change becomes inevitable in order to make patient care more meaningful, efficient and impactful. The focus will continue to be on improving patient care and the value of healthcare for patients. This is where approaches such as the value-based system of care and patient-centered care become relevant.

Patient-Centered Care

Patient-centered care is the practice of caring for patients (and their families) in ways that are meaningful and valuable to the individual patient. It includes listening to, informing and involving patients in their care. The IOM (Institute of Medicine) defines patient-centered care as: "Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.

Patient centered care (PCC) is an approach gaining much emphasis these days. It is one where we consciously adopt patients' perspectives, and mainstream them into all aspects of the healthcare system and its related processes. It involves navigating the healthcare system through patients' eyes. PCC represents customized patient care, viewed as a commitment to treat and manage patients as thinking and feeling persons with the ability to change and develop. It requires healthcare personnel to be open, flexible, and respectful in the provision of all aspects of care. It is also a partnership between patients and their healthcare providers. PCC is alignment with the 21st century, modern patients who are increasingly asking to be partners in their own care, highlighting also, ownership of their health, and healthcare.

The approach to PCC can be divided into three broad areas:

- Respect for patient values, preferences, and expressed needs
- The coordination and integration of care:
- Information, communications, and education

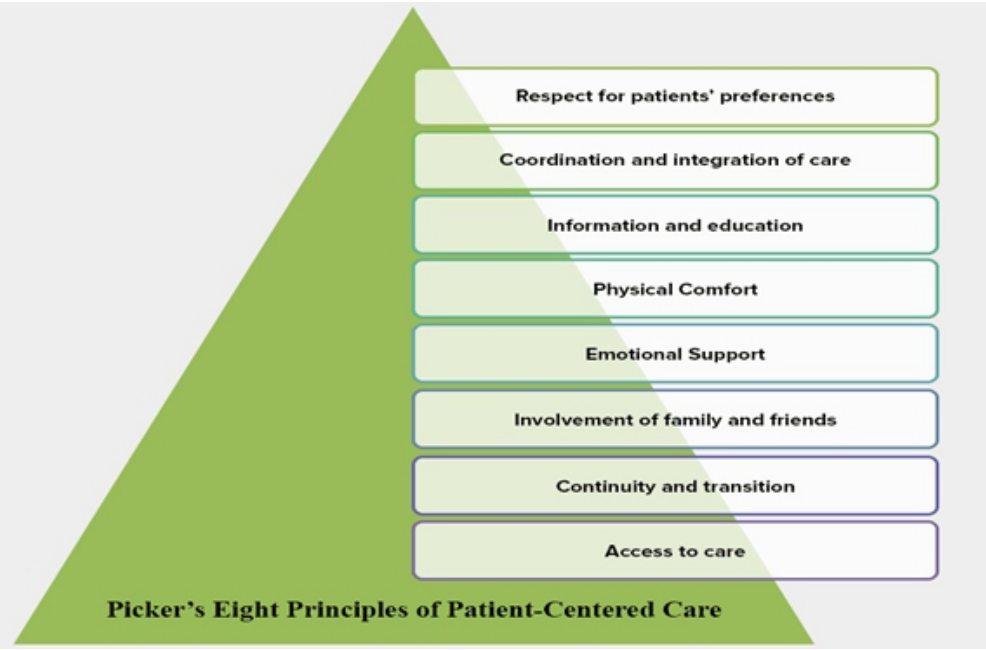
The quality of PCC in a hospital or institution is one that will transcend all other programs and activities. It represents the whole broad picture of institution-wide care and requires the "buy-in" from all levels of staff. It is one of the ways recommended to enhance, maintain, or even restore patients' trust and confidence. (Little, Everitt, Williamson, Warner, Moore, Gould, et al, 2011).

PCC must be a manifestation of an organization-wide culture, including the leadership, who must set the tone.

Having said that, large academic centres must also strive to find the balance to strike, considering the myriad of needs and interest of clinical specialists, nurses, medical educators, researchers, administrators, and other staff. (Davies, 2017)

With the understanding of PCC, it is certain that more time commitment will be required, especially pertaining to patient contact, care, and communications. In the busy emergency department, where resources such as manpower are already stretched to the maximum, this can add to the waiting time and overcrowding issues. These may delay care and certainly pose a challenge to front line emergency department staff. Moreover, in the ED, the lack of prior relationship between patients and the healthcare providers as well as the acute nature prompting ED visits can pose further challenges to the creation of a meaningful, effective partnership. Cases in the ED, such as violence and abuse, time-sensitive diagnoses, and resuscitation as well as sudden death, make it necessary to have thoughtful, advanced planning for the PCC approach. (Taylor, Kennedy, et al, 2016).

Principles of Patient Centered Care



1. **Respect for patients' values, preferences and expressed needs**

Involve patients in decision-making, recognizing they are individuals with their own unique values and preferences. Treat patients with dignity, respect and sensitivity to his/her cultural values and autonomy.

Fig 4. Principles of patient centred care

This is crucial as many patients feel that they lose their identity as individuals when they come to hospital and become "one of the cases." They feel the importance to be recognized as unique and to be actively involved in decision making relating to their care and treatment. Their cultural beliefs and practices too will be respected. This approach helps to preserve their dignity. It also helps to evolve their role from a passive one to a more active and knowledgeable one, in their best interest. It enhances their participation and thus empowerment. With the motivation, they will tend to be more compliant and pay greater attention to physicians' advice and communications and this is a step in the right direction toward enhancing patient safety and safe practice as well.

2. **Coordination and integration of care**

Patients feel vulnerable when they are faced with illnesses and they feel the need for competent and caring healthcare personnel. They need to make that "connection" and feel comfortable with all aspects of the care i.e. front line or acute care, auxiliary as well as support staff. The seamless patient and process flow will help with this objective and at the same time, enhance patient safety elements.

During focus groups, patients expressed feeling vulnerable and powerless in the face of illness. Proper coordination of care can alleviate those feelings. Patients identified three areas in which care coordination can reduce feelings of vulnerability:

- Coordination of clinical care
- Coordination of ancillary and support services
- Coordination of front-line patient care

3. Information and education

Adequate information must be shared with patients and this would include clinical, management, and even prognostic information. This is very relevant to increase the understanding of the concept for self-care and individual health promotion. Patient safety guidelines do emphasize this aspect of care as well. For example, with better communications and education, errors in prescribing and errors in omission can be gradually reduced, especially if we communicate better our intent, explain the effects of drugs, and why certain medications are required (or not required). (The Joint Commission, 2010). In interviews, patients expressed their worries that they were not being completely informed about their condition or prognosis. To counter this fear, hospitals can focus on three kinds of communication:

- Information on clinical status, progress and prognosis
- Information on processes of care
- Information to facilitate autonomy, self-care and health promotion

4. Physical comfort

The level of physical comfort patients report has a significant impact on their experience. Three areas were reported as particularly important to patients:

- Pain management
- Assistance with activities and daily living needs
- Hospital surroundings and environment

5. Emotional support and alleviation of fear and anxiety

Fear and anxiety associated with illness can be as debilitating as the physical effects. Caregivers should pay particular attention to:

- Anxiety over physical status, treatment and prognosis
- Anxiety over the impact of the illness on themselves and family
- Anxiety over the financial impact of illness

6. Involvement of family and friends

This principle addresses the role of family and friends in the patient experience. Family dimensions of patient-centered care were identified as follows:

- Providing accommodations for family and friends
- Involving family and close friends in decision making
- Supporting family members as caregivers
- Recognizing the needs of family and friends

7. Continuity and transition

Patients expressed concern about their ability to care for themselves after discharge. Meeting patient needs in this area requires the following:

- Understandable, detailed information regarding medications, physical limitations, dietary needs, etc.
- Coordinate and plan ongoing treatment and services after discharge
- Provide information regarding access to clinical, social, physical and financial support on a continuing basis.

8. Access to care

Patients need to know they can access care when it is needed. Focusing mainly on ambulatory care, the following areas were of importance to the patient:

- Access to the location of hospitals, clinics and physician offices
- Availability of transportation
- Ease of scheduling appointments
- Availability of appointments when needed
- Accessibility to specialists or specialty services when a referral is made
- Clear instructions provided on when and how to get referrals.

What do patients want from nurse

Fig 5. Aspects of patient satisfaction

They want to feel empathy and compassion. They want to know if they are safe. To effectively give patients the experience they deserve, they must be at the centre of care delivery and nurse leaders need to ensure a culture of service excellence that elevates the patient experience. This includes;

- ∅ Show respect
- ∅ Express gratitude
- ∅ Enable access to care
- ∅ Involve patients' family members and friends
- ∅ Coordinate patient care with other providers
- ∅ Provide emotional support
- ∅ Engage patients in their care plan
- ∅ Address your patients' physical needs
- ∅ Support your patients' mental health
- ∅ Help your patients manage their medications
- ∅ Deliver quality patient experiences
- ∅ Practice whole-person care
- ∅ Streamline Care Management with technology

Communication and Patient Safety: How Nurses Can Help

Nurses are of utmost importance in the chain of communication in any healthcare setting. The proper functioning of this communication chain directly impacts patient safety in various ways. Sometimes, healthcare providers make assumptions about what patients and their families know about health-specific vocabulary, such as anatomy and medication. A skilled nurse knows how to check for understanding and clearly explain important details in easy-to-understand language.

In some cases, especially in short-staffed facilities, nurses may not have enough time for questions after explaining a patient's diagnosis or medication regimen. This can have grave consequences, even endangering a patient's life. As the liaison between doctors and patients, nurses are a vital link between communication and patient safety, ensuring that patients truly understand the most important elements of their health.

Types of Communication

All the different types of communication can be put to work in a healthcare setting to maximize the quality of care. However, four key types of communication are important for nurses to understand and employ.

- Verbal communication: Verbal communication commonly refers to what a person says. Clear verbal communication includes the use of a strong speaking voice with appropriate volume and speed as well as the elimination of filler words, such as "um" and "like." Verbal communication also includes active listening skills to ensure that others understand. Nurses need to have strong verbal communication skills so patients can not only hear what they're saying but also understand.
- Nonverbal communication: Nonverbal communication includes gestures, body language, and facial expressions. Nurses can exhibit strong nonverbal communication by making strong eye contact; offering positive body language, such as good posture and a welcome, opening stance; and smiling when greeting a patient to develop rapport.
- Written communication: In written communication with patients or doctors, nurses should focus on simplicity. In communicating with patients and families, nurses should avoid medical jargon or terms that may be confusing, instead opting for concise, clear sentence structures. Other important aspects of written communication include attention to tone and thorough editing before sharing with others.
- Cultural awareness: Knowledge of cultural norms that may be outside of a nurse's own culture is key to

effective communication. For example, in many cultures, direct eye contact is seen as a sign of disrespect. If nurses understand this and other norms, they'll recognize that a patient may be avoiding eye contact to show respect — not because of anxiety or embarrassment — and they'll be better able to convey their own respect for the patient.

Patient Empathy: Putting Yourself in Their Shoes

Patient empathy involves understanding and sharing a patient's feelings. Empathy is a strong predictor of patient satisfaction and figures prominently into quality of care. Empathy includes three primary branches: affective, cognitive, and behavioral. In nursing, affective empathy means that a nurse recognizes patients as individuals rather than indistinct "customers." Cognitive empathy refers to interpersonal sensitivity and encompasses verbal and nonverbal communication that allows a nurse to get to know a patient on a deep level and create a space of comfort and kindness. Behavioral empathy refers to a nurse using a high degree of sensitivity to actively advocate for a patient to help relieve pain and improve health.

Nurses practice patient empathy every day by listening to patients, communicating verbally and nonverbally, and establishing a high level of advocacy and care. Maintaining patient empathy can lead to a syndrome called "compassion fatigue": physical and psychological exhaustion that helping professionals and caregivers often experience. Compassion fatigue can result in withdrawal, shifts in mood, and irritability. For nurses, who need to exercise a high degree of compassion on the job every day, it can be a serious condition. Taking time off, investing time in hobbies, and talking through stress and traumatic events with a trusted friend or professional counselor can help prevent burnout.

Empathy doesn't come naturally to all nurses, but they can develop it like any other skill. Studies have shown that about 70% of healthcare workers find it difficult to empathize with patients. Some ways to improve empathy on the job include practicing emotional regulation skills through mindfulness or meditation as well as finding a strong support system among co-workers. Healthcare facilities can reduce burnout in nurses and improve empathy by limiting the number of patients nurses see in a day and creating a positive workplace environment with reasonable hours and appropriate breaks. Patient empathy has tremendous benefits, creating a more positive patient experience. Patients who interact with empathic nurses are more likely to follow recommendations for at-home care. Studies have shown that cancer patients who experience patient empathy also exhibit less stress and depression during treatment, and expectant mothers experience less fear and anxiety prior to labor.

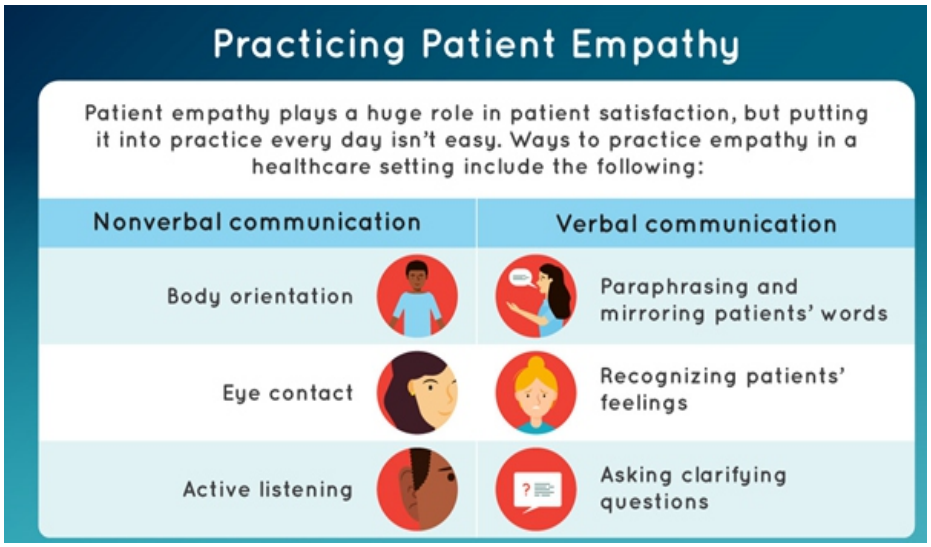


Fig 6. Practicing patient empathy

Person-Centered Healthcare Leads to Better Health Outcomes

Person-centered healthcare is an approach that views patients as equal partners in planning, developing, and monitoring care to meet their needs. In contrast to a task-centered approach that views patients as commodities or projects, person-centered care focuses on relationship building, patient empathy, and the core understanding that each patient is a human being with unique needs and wants.

Although not yet the norm, person-centered healthcare is becoming more widely practiced and has been linked to improved health outcomes. Person-centered healthcare requires a shift in thinking, approach, and service delivery. Often, large healthcare institutions take a task-centered approach because of the sheer

volume of patients entering their facilities each day. On a systemic level, institutions can begin to adopt a person-centered approach by reducing the number of patients that each provider sees.

Core Aspects of the Person-Centered Approach

The person-centered approach to healthcare includes several core aspects:

Respect and value: A person-centered approach values and respects patients as full members of society. Regardless of factors such as age, language, or socioeconomic status, nurses using a person-centered approach value patients and involve them as partners in their care.

Individualized care: Rather than simply treating a diagnosis, nurses taking a person-centered approach will provide individualized physical and emotional care spaces that align with their patients' changing needs.

Understanding: The person-centered approach requires that providers understand patients' perspectives in care and activities. Opportunities for engagement: Nurses using a person-centered approach work to provide opportunities for social engagement to encourage patient well-being. A person-centered approach can lead to higher patient satisfaction and better health outcomes because it creates a sense of mutual respect and collaboration. Person-centered care can play out in many ways; for example, a patient in a long-term care facility who's offered opportunities for social engagement may experience reduced loneliness, stress, or depression. A patient receiving cancer care may find comfort in a nurse who practices great communication and patient empathy. Patients with diabetes who encounter a nurse using person-centered tenets have been shown to more effectively manage their condition and experience overall improved health outcomes.

The approach to PCC can be divided into three broad areas:

1. **Respect for patient values,**
2. **Preferences, and**
3. **expressed needs** (the main needs of hospitalized patients are confidence, communication, information, education, self-care and support)

This is crucial as many patients feel that they lose their identity as individuals when they come to hospital and become "one of the cases." They feel the importance to be recognized as unique and to be actively involved in decision making relating to their care and treatment. Their cultural beliefs and practices too will be respected. This approach helps to preserve their dignity. It also helps to evolve their role from a passive one to a more active and knowledgeable one, in their best interest. It enhances their participation and thus empowerment. With the motivation, they will tend to be more compliant and pay greater attention to physicians' advice and communications and this is a step in the right direction toward enhancing patient safety and safe practice as well. The coordination and integration of care: Patients feel vulnerable when they are faced with illnesses and they feel the need for competent and caring healthcare personnel. They need to make that "connection" and feel comfortable with all aspects of the care i.e. front line or acute care, auxiliary as well as support staff. The seamless patient and process flow will help with this objective and at the same time, enhance patient safety elements.

Information, communications, and education: Adequate information must be shared with patients and this would include clinical, management, and even prognostic information. This is very relevant to increase the understanding of the concept for self-care and individual health promotion. Patient safety guidelines do emphasize this aspect of care as well. For example, with better communications and education, errors in prescribing and errors in omission can be gradually reduced, especially if we communicate better our intent, explain the effects of drugs, and why certain medications are required (or not required).

The quality of PCC in a hospital or institution is one that will transcend all other programs and activities. It represents the whole broad picture of institution-wide care and requires the "buy-in" from all levels of staff. It is one of the ways recommended to enhance, maintain, or even restore patients' trust and confidence. PCC must be a manifestation of an organization-wide culture, including the leadership, who must set the tone. Having said that, large academic centres must also strive to find the balance to strike, considering the myriad of needs and interest of clinical specialists, nurses, medical educators, researchers, administrators, and other staff.

With the understanding of Patient Centred Care, it is certain that more time commitment will be required, especially pertaining to patient contact, care, and communications. In the busy emergency department, where resources such as manpower are already stretched to the maximum, this can add to the waiting time and overcrowding issues. These may delay care and certainly pose a challenge to front line emergency department staff. Moreover, in the Emergency Department, the lack of prior relationship between patients and the healthcare providers as well as the acute nature prompting ED visits can pose further challenges to the creation of a meaningful, effective partnership. Cases in the ED, such as violence and abuse, time-sensitive diagnoses, and resuscitation as well as sudden death, make it necessary to have thoughtful, advanced planning for the PCC approach.

Value-Based Health Care

A value-based system is one where the focus is on value and in rewarding innovation that advances medicine. It strives to improve health and healthcare value for patients. Physician leadership is crucial as improving the value of healthcare for the patient is something only medical teams can do. The principles that need to be focused on would include the following.

Understanding that the goal is value for patients

This may appear very basic but our current practice does not stress on this sufficiently. In fact, success has always been defined as increasing revenue and operating surpluses. Insurers too want to be profitable and physicians want more patients in order to increase revenue for their practice. There will also come a time when many may move into private practice. Patients, on the other hand, want good health outcomes, not more visits, and increased cost. Improving value for patients is clearly the only valid goal for ethical reasons.

Medical practice should be organized around medical conditions and care cycles

Here is where health care delivery needs a revamp. Currently physicians tend to define their activities by their specialty. However, for patients, what matters is their medical condition. Organizing care around medical conditions rather than specialties is key to improving value to patients. A medical condition can be defined as a list of inter-related medical presentations that must be addressed in an integrated way, thus many specialists may have to come and manage the patient in an integrated way rather than the patients making various appointments, on different days to see each of these individual specialists. The current care "silos" would have to be broken down as it "fractures" patient care into various artificial segments. The more such segments a patient has to go through, the higher will be the chances of errors occurring (thus, patient safety consideration). This will come as a major change for healthcare personnel, but is worth implementing in strive toward seamless healthcare.

Results (such as risk adjusted outcomes and costs) must be measured.

This is important to monitor performance and chart the direction forward. To be most useful, outcomes should be measured over the complete care cycle. Physicians should lead the way in the development and use of these outcomes measures. The reasons for measuring must also be made known clearly to staff as many tend to view these as a threat. This perception can certainly affect performance. If it is led by physicians, it might be easier to overcome this misperception and thus may be easier for many to appreciate the power of these numbers to push for excellence. It is also known that motivated staff will gravitate toward areas that achieve true excellence.

In the area of patient safety for example, some of the statistics which matters include numbers of drug related errors, wrong site procedures, and falls whilst in the department. How then is value-based care appropriate to the practice of emergency medicine?

Understanding that the goal is value for patients

This is very relevant to the practice, as emergency care is acute and time-dependent care. Thus, there is the need to maintain high standards, be timely, efficient and at the same time provide satisfactory service, including communications. Patient satisfaction surveys done in emergency departments confirm that patients want these. Patient and public feedback is useful to be taken into account in evaluating service and care, and when introducing reforms.

The Nurses' Role in the 21st Century

Patient care

The primary role of a nurse is to be a caregiver for patients by managing physical needs, preventing illness, and treating health conditions. To do this, nurses must observe and monitor the patient and record any relevant information to aid in treatment decision-making processes. Nurses care for injuries, administer medications, conduct frequent medical examinations, record detailed medical histories, monitor heart rate and blood pressure, perform diagnostic tests, operate medical equipment, draw blood, and admit/discharge patients according to physician orders. Nurses also ensure patients' comfort, change bandages, report any changes in a patient's condition to other nurses or doctors, document patient activities, and assume other relevant tasks.

Nurses must often pay close attention to every detail of the patient's treatment and how they respond. If a problem is identified, nurses will often be the first to notice; thus, they must be able to quickly report a problem, particularly in the event of an emergency, to a physician. Throughout the treatment process, the nurse follows the progress of the patient and acts accordingly with the patient's best interests in mind. The care provided by a nurse extends beyond the administration of medications and other therapies. Nurses are often responsible for the holistic care of patients, which may encompass the individual's psychosocial, cultural, and spiritual needs.

Patient advocacy

In addition to their role as a clinician, nurses often provide emotional support for their patients and families. This can include ensuring that the patient understands and is prepared for their treatment, listening to patients and assessing their physical, emotional, cultural, mental, and spiritual needs. Nurses often help patients and their loved ones process their feelings and frustrations towards their illnesses. Through counseling and patient education, nurses may also be of assistance in explaining treatment options to patients and their family members, as well as advocating for the health and well-being of their patients.

A nurse often serves as a patient advocate in protecting a patient's medical, legal, and human rights. Since many sick patients may be unable to comprehend medical situations and act accordingly, it is often the nurse's role to support the patient. This may involve representing the patient's best interests, especially when treatment decisions are being made. Furthermore, nurses will often inform and support patients when they have questions or are apprehensive about treatments, procedures, or any other aspect of their care. Nurses may also make suggestions for patients' treatment plans in collaboration with the patient, their families, and other health professionals.

Planning of care

A nurse is directly involved in the decision-making process of treating patients. Thus, it is essential that nurses think critically when assessing patient signs and identify potential problems to make the appropriate recommendations. Although clinicians like physicians, physician associates, and nurse practitioners typically make final treatment decisions, nurses also have a crucial role in patient treatment plans. This is because nurses are typically most familiar with the individual patient, as they monitor their signs and symptoms on an ongoing basis. Thus, nurses should collaborate with other medical team members to promote optimal patient health outcomes.

Patient education and support

Nurses are also responsible for ensuring that patients can understand their health, illnesses, medications, and treatments to the best of their ability. This is particularly important when patients are discharged from the hospital and are responsible for continuing their treatments at home. A nurse should take the time to explain to the patient and their family or caregiver what to do and expect when they leave the hospital or medical clinic. Nurses should also ensure that the patient feels supported and knows where to seek additional information if needed. In every aspect of healthcare, nurses provide education, promote healthy practices, share their expertise, and help patients heal. By guiding patients and their families, nurses can also provide patients with appropriate referrals for other services, resources, and classes. In addition to when patients leave the hospital, nurses also educate patients about their care plan daily. This is essential for the success of the treatment, as patients must be prepared for all steps of their treatment and recovery. Nurses are also responsible for training and helping other nurses.

Summary

As healthcare is everyone's responsibility, health services are structures to a proportion accountability and incentives to patients, nurses, and other players. Coordination is the multiplier that transforms limited resources into effective health outcomes. Patients and nurses must have a relationship connected by open access to information, coaching, and support. Emergency physicians in Hong Kong have come up with a list of 10 Cs, helpful and applicable for quality care and risk management of patients: competence, confidence, comfortable, careful attitude, compliance with protocols, checklists, courtesy, being calm and controlled, compassionate, and considerate as well as timely and appropriate communications, the same values we all strive for.

Nurses need to provide high quality of care by following their policies and role descriptions. This is to equip them with the tools needed in order to deliver a good work ethic so that patients are cared for properly and enhancing their experience positively. Nurses need to maintain professional boundaries at all times in order to improve the quality of care being offered to patients while in the hospital or in their own home by respecting patients' dignity and autonomy at all time.

It is frequently claimed that nursing is vital to the safe, humane provision of health care and health service to our populations. It is also recognized however, that nursing is a costly health care resource that must be used effectively and efficiently. There is a growing recognition, from within the nursing profession, health care policy makers and society, of the need to analyse the contribution of nursing to health care and its costs. This becomes increasingly pertinent and urgent in a situation, such as that existing in global nursing care, where the current financial crisis has led to public sector employment delays, staff cuts and staffing deficits, combined with increased patient expectation, escalating health care costs, and a health care system restructuring and reform agenda. Such factors, increasingly common internationally, make the identification and effective use of the nursing contribution to health care an issue of international importance. This seeks to explore the nature of nursing and the function of the nurse within a 21st century health care system, with a focus on the Nigeria context.

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