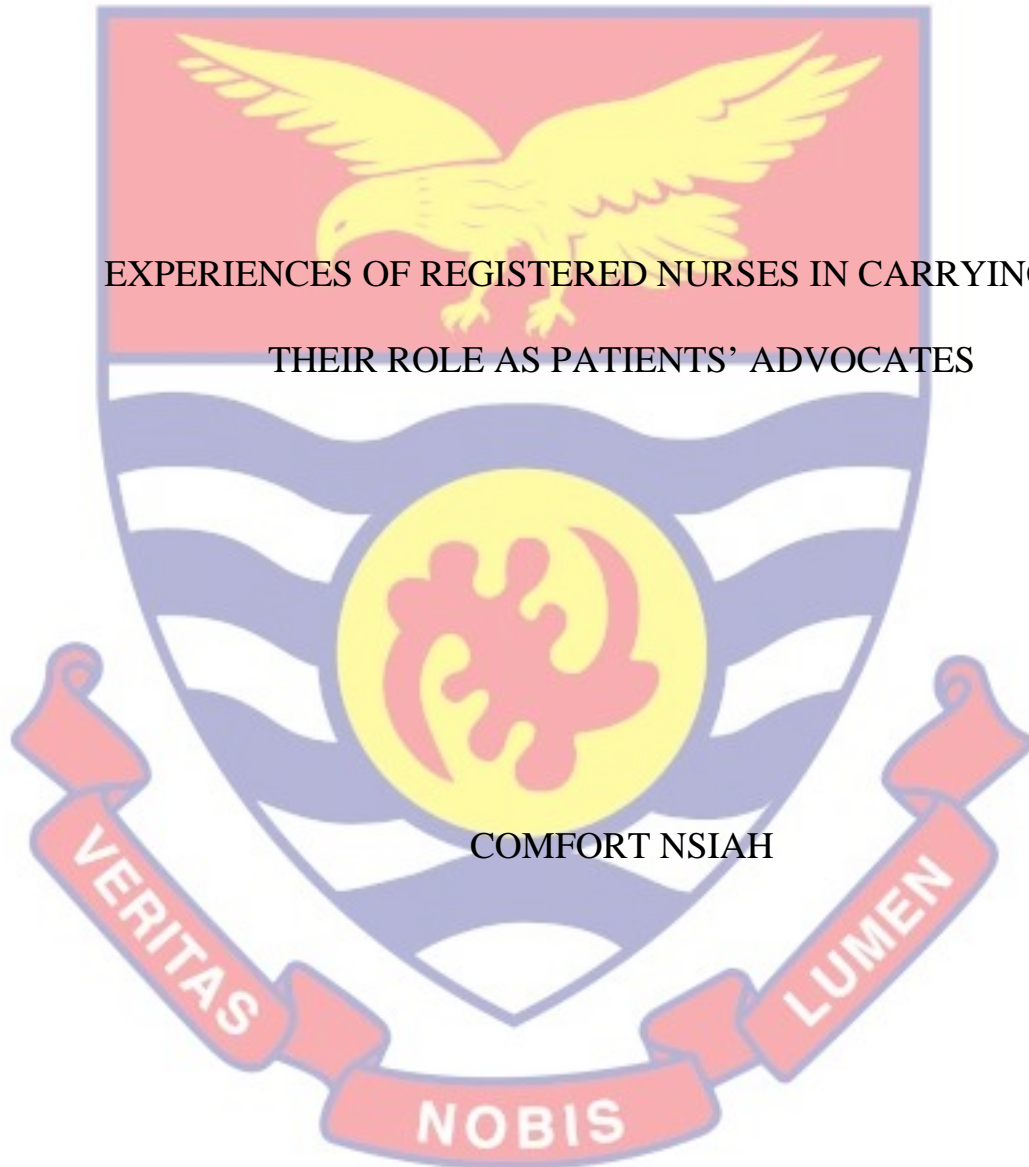


# UNIVERSITY OF CAPE COAST

EXPERIENCES OF REGISTERED NURSES IN CARRYING OUT  
THEIR ROLE AS PATIENTS' ADVOCATES



COMFORT NSIAH

2017

UNIVERSITY OF CAPE COAST

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ROLE AS PATIENTS' ADVOCATES



BY

COMFORT NSIAH

Thesis submitted to the School of Nursing and Midwifery, of the College of Health and Allied Sciences, University of Cape Coast, in partial fulfilment of the requirements for the award of Master of Nursing degree.

JANUARY 2017

## DECLARATION

### Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this University or elsewhere.

Candidate's Signature ..... Date: .....

Name: .....

### Supervisors' Declaration

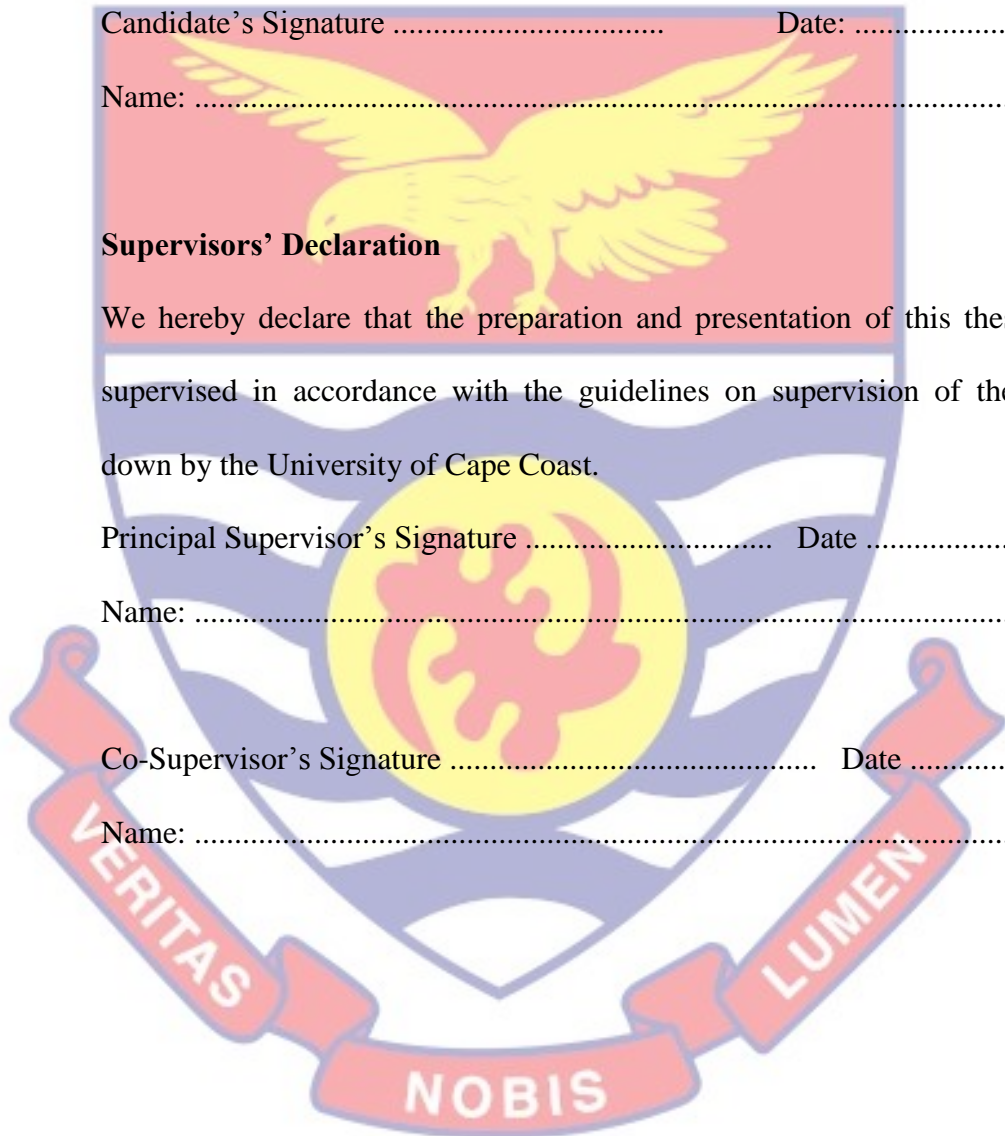
We hereby declare that the preparation and presentation of this thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

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

Name: .....

Co-Supervisor's Signature ..... Date .....

Name: .....



## ABSTRACT

Patient advocacy plays a critical role in promoting patient safety and quality care. Yet, there is little or no data documenting the practice of patient advocacy among nurses in Ghana. This study explored and provided an in-depth description of experiences of registered nurses in carrying out their role of patient advocacy within the Ghanaian context at the Cape Coast Metro Hospital (CCMH). A qualitative approach with descriptive study design was used to meet the set objectives. The study was guided by Peplau's interpersonal relations theory. Purposive sampling technique was used to select twenty-five registered nurses who were willing to participate in the study. Data were collected from the twenty-five research participants through a semi-structured interview. Interviews were audio taped, transcribed and analysed using qualitative content analysis. Key findings based on this study revealed that the nurses had adequate understanding of the meaning of patient advocacy and were willing to advocate for their patients. Yet, advocating for the patients within the clinical setting was practically difficult owing to several existing barriers. These barriers included the health institution, physicians, patients, anticipated negative outcome of advocacy, fear of loss of job, limited communication and poor inter-personal relationships. Nurses who overcame the existing barriers succeeded in advocating for the patients, enjoyed positive physical, emotional, psychological and professional experiences as well as positive effects on the health institution. The contrary, however, occurred when the advocacy activities became unsuccessful. Based on study findings, recommendations were made for improved patient advocacy.

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My very special thanks go to my dear husband, Dr. Francis Nsiah, and my children, Samuel and Gloria. Dear Francis, thank you for your patience, special love, encouraging words and support offered throughout my studies. Samuel and Gloria, I will forever remember your special welcome and smiles that brought relief after a hard day's toil. I also thank my brother Samuel Kyereh and my mother for her foresight and moral support. I thank my family, my in-laws and all church members both in Ghana and in Canada for their support.

I am extremely grateful to Dr. and Mrs. Agyenim Boateng and their family, Mr. and Mrs. Victoria Kukuiah for their support. If I forgot to mention your name please bear with me and accept my thanks.

DEDICATION

To my husband, Dr. Francis Nsiah, my children, Samuel and Gloria Nsiah,  
and my mother and mother in-law



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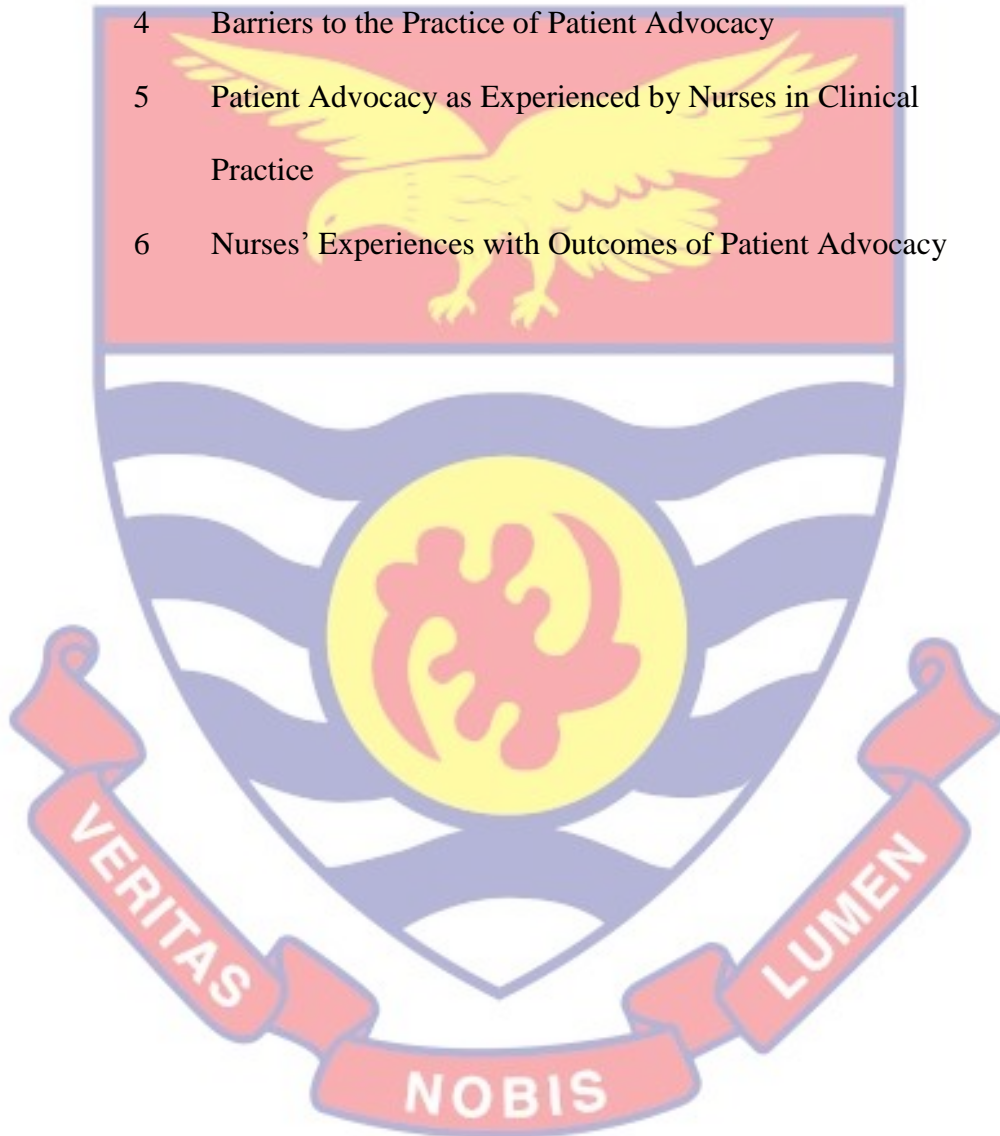
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## LIST OF ABBREVIATIONS

CCMH	Cape Coast Metropolitan Hospital
CCTH	Cape Coast Teaching Hospital
CS	Caesarean Section
DDNS	Deputy Director of Nursing Services
GHS	Ghana Health Services
IRB	Institutional Review Board
MN	Master of Nursing
MOH	Ministry of Health
NHIS	National Health Insurance Scheme
NMC	Nurses and Midwifery Council
PA	Patient Advocacy
PIN	Personal Identification Number
RN	Registered Nurse
UCC	University of Cape Coast
USA	United States of America
WHO	World Health Organization



## CHAPTER ONE

### INTRODUCTION

#### Background to the Study

The key goal of every health care facility is to ensure patient safety and quality care. Yet, as Black (2011) ascertained, this goal cannot be achieved effectively without nurses carrying out their advocacy role. Advocacy has been described as speaking up on behalf of somebody who cannot speak for him or herself (Amidei, 2010). Similarly, Abbaszadeh, Borhani and Motamed-Jahromi (2013) have described patient advocacy (PA) as standing in on behalf of the patient in terms of the patient's needs, interests, care and preferences. Advocating for a patient is a process or a strategy containing a series of particular actions for protecting, representing and safeguarding patient's rights, best interests and values.

Patient advocacy has been an essential component of professional nursing ethics since the time of Florence Nightingale. Attree (2007) affirmed that patient advocacy is the essence of professional nursing and it promotes patient safety, ensures less complication, increases satisfaction and leads to quick recovery of the physical, mental and spiritual health of the patient. Patient advocacy is highly practiced in Iran, Sweden, Australia, United Kingdom, Canada, United States of America and other developed countries across the globe due to its benefits (Black, 2011; Attree, 2007). The role of the nurse as patient advocate is very beneficial to the patient, the nurse, the health institution and the nation as a whole. For instance, studies by Amidei (2010), Black (2011) and Attree (2007) have shown increased infections, more complications, readmissions due to relapse and unnecessary patients deaths of

individual patients in facilities where nurses were not empowered to advocate for patients.

According to Negarandeh and co-workers (Negarandeh, Oskouie, Ahmadi, Nikravesh & Hallberg, 2006), patients admitted into healthcare facilities are vulnerable and must be advocated for to enhance their safety and quality care. Besides, the Patient Charter introduced by the Ghana Health Services (GHS) mandates all practicing nurses in Ghana to advocate for their patients in healthcare facilities (GHS, 1992). Yet, it does not clearly define the advocacy role or provide the practicing nurse with a guide to carry out such role. The goal of this study is therefore to explore and provide an in-depth description of experiences of registered nurses in carrying out their role as patients' advocate. This study also sought to provide empirical evidence with regard to the practice of patient advocacy by nurses in healthcare facilities. Outcomes from the study will increase understanding of registered nurses' (RNs) role in patient advocacy and also promote nurses' ability to develop an effective approach to undertake their advocacy role to enhance positive patient outcomes. Outcome of the study will further inform nursing education institutions, healthcare authorities and policy makers as to the support and policies needed to be put in place to ensure quality nursing care.

### **Statement of the Problem**

Current emphasis on patient safety has increased the awareness of the critical role advocacy plays in promoting safe clinical practice. For instance, a study by Black (2011) revealed an increased in hospital acquired infections due to the nurses' inability to advocate for their patients. Yet, there seems to

be little documentation about how nurses experience and carry out the advocacy role in Ghanaian health care settings.

Norman et al. (2012) seem to suggest that patients suffer complications and in some cases die in some Ghanaian hospitals not because of their sickness but rather as results of physicians or health professionals' refusal to attend to the patients in time. A study by Abekah-Nkrumah (2010) also found that most nurses in Ghana (61.8%) demonstrated better knowledge of the patients' charter but did not carry out their responsibility under it. Abekah-Nkrumah (2010) noted complaints of impolite treatments of patients from hospital staff. Another assertion of the author that gave further credence to patient advocacy was that health workers including nurses had been disrespectful towards patients during the course of receiving health services.

In addition, an exclusive interview a midwife at the Cape Coast Metropolitan Hospital granted the Ghana news Agency on January 1, 2015, disclosed that advocating for patients' rights and ensuring patient's safety and quality care was a challenge for nurses at the CCMH. However, some studies have indicated that absence of patient advocacy has negative consequences. It limits the possibility of addressing patient's safety issues such as, patient education, medication errors, and the use of aseptic techniques that promotes healing and quality care (Amidei, 2010; Black, 2011; Attree, 2007). Further consequences of limited patient advocacy include more complications, readmissions, unnecessary deaths, and expensive health care cost (Amidei, 2010; Black, 2011; Attree, 2007; Choi et al., 2014).

Furthermore there are several definitions and nurses' experiences in patient advocacy in nursing literature. However, one may question whether or



not this role is similar to reality in the Ghanaian context. Answer to this question can only be obtained through empirical evidence. Abbaszadeh et al. (2013) have supported the idea that the nurse's sense of confidence, values, empathy, assertiveness, and persistency determines the effectiveness in patient advocacy. There seems to be knowledge gaps with regards to nurses' role as patients' advocate in Ghana.

This study would assist in identifying nurses' understanding of their role as patient advocate and how they experience and carry it out in practice at the Cape Coast Metropolitan Hospital (CCMH). It is the belief of the researcher that this study will help to identify challenges related to nurse's role in patient advocacy at the CCMH for an improvement in patient safety and quality care.

#### **Statement of Purpose**

The purpose of the study is to provide an in-depth description of the experiences of registered nurses in carrying out their role in patient advocacy within the Ghanaian context at the Cape Coast Metropolitan Hospital.

#### **Specific Objectives**

The specific objectives guiding this study were to:

1. Explore the registered nurses' description of patient advocacy.
2. Describe how registered nurses carry out their role as patients advocate.
3. Describe experiences of nurses in acting as patient's advocate in clinical practice
4. Explore barriers to the practice of patient advocacy among registered nurses.

### **Significance of the Study**

The significance of this research is to increase understanding of the complex phenomenon of patient advocacy. The study will also contribute to efforts aimed at improving nurse's role as patient advocate and maintaining the quality of patients care and safety within the Ghana health care system.

The study is expected to reveal the strengths and shortcomings of nurses in carrying out their advocacy role. Results from the study will inform nursing educational institutions, healthcare authorities and policy makers as to the needed changes in curriculum, support and policies needed to be put in place to ensure an improvement in patient advocacy, safety and quality nursing care.

The study outcome will potentially facilitate nurses' ability to develop effective improvement approaches to undertake their advocacy role to enhance patient safety and quality care. Patients will then experience fewer complications, reach discharges quickly, attain satisfaction with health care delivery and more importantly resume normal activities earlier. Findings from the study will also promote high quality care that can prevent illness, promotes optimal wellbeing, and results in decreased healthcare cost and ensures a healthier nation.

### **Delimitations**

All individuals who fell outside the inclusion criteria and or refused to sign the inform consent form were excluded from the study. Only registered nurses (RNs) who have had the opportunity to advocate for patients were interviewed for the study. A Registered Nurse in this study refers to nurses who possesses diploma certificate and above in nursing and are deemed qualified by the Nurses and Midwifery Council (NMC) and have been given

personal identification number (PIN) to practice in Ghana. This inclusion criteria was because RNs work closely with patients, which places them in the right position to recognize the vulnerabilities and needs of patients, listen, support, voice, and advocate for the appropriate care for their patients (Negarandeh et al., 2006). The registered nurses were also selected based on the criteria that they have been practicing as nurses for at least one year in the health facility. This criteria ensured uniformity and consistency, because the RNs were expected to have received same training, knowledge and the requisite skills needed to provide effective patient advocacy. The study was carried out only within the CCMH.

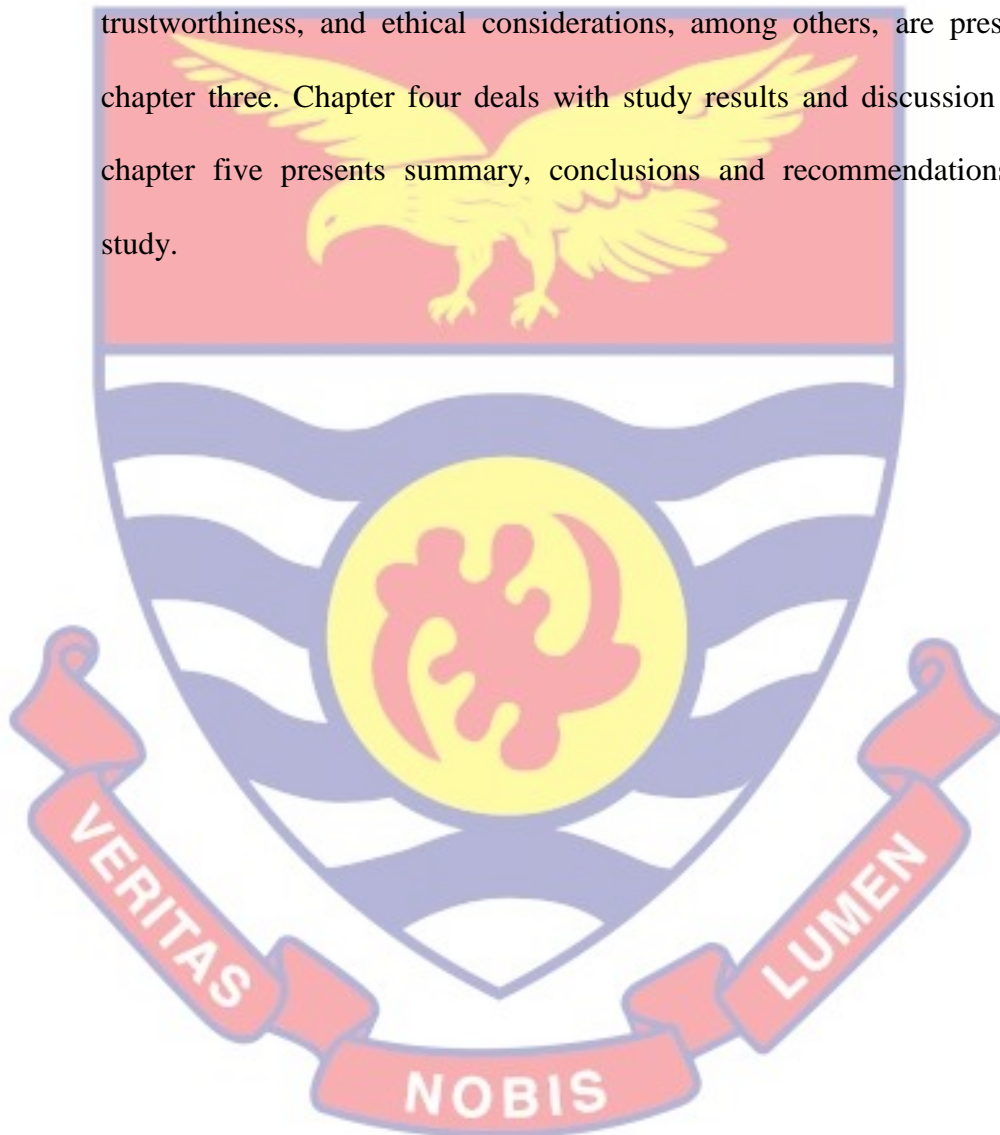
### **Limitations**

The first limitation of this study was the limited scope of the study to one health facility due to timeline for thesis submission and the lengthy time required to obtaining ethical clearance. In addition, the study participants should have included both physicians and patients as well since nurses formed only part of the individuals involved in the patient advocacy activities. Notwithstanding these challenges, the goal of qualitative research is to discover rather than verification and generalization (Creswell, 2007). The purpose of this study is to provide a rich description of the phenomena under study from the participant's perspective.

### **Organisation of the Study**

The study is structured in five chapters. Chapter one provides a background to the study, statement of the problem, statement of purpose, specific objectives, significance of the study, as well as, delimitations and limitations of the study. On the other hand, chapter two reviews literature on

the concept of patient advocacy, empirical review of related studies, related theoretical models of patient advocacy, theoretical framework of the study, and a summary of the chapter. Methodology of the study detailing the research design, study setting and population, sample size, sampling procedure, data collection instrument and procedure, data processing and analysis, trustworthiness, and ethical considerations, among others, are presented in chapter three. Chapter four deals with study results and discussion whereas chapter five presents summary, conclusions and recommendations of the study.



## CHAPTER TWO

### LITERATURE REVIEW

This chapter reviewed available previously published literature on patient advocacy and how nurses experience their role in carrying it out in other part of the world. It also includes empirical review of existing research similar to the topic under study. This review was undertaken to assist the researcher to find out knowledge gaps and to compare consistency and possible reasons for any inconsistencies that might exist in those studies. It is also aimed at enhancing the researcher's understanding of concepts and theories on the topic being studied (Creswell, 2007).

The literature was reviewed from database, such as Cumulative Index to Nursing and Allied Literature (CINAHL), Medical Literature on Line (MEDLIN), EBSCOHOST and Educational Resource Information Centre (ERIC). Other sources used included textbooks, journals and open access articles. This literature review has been presented under seven main sections. These sections include: (1) description of the concept of patient advocacy, (2) description of how nurses carried out their role in patient advocacy, (3) the implications of nurse's role in patient advocacy on patient safety and quality care, (4) barriers to the practice of patient advocacy in healthcare settings, (5) empirical review of related studies (6) related theoretical models of patient advocacy, and finally (7) theoretical framework of the study.

#### **Description of the Concept of Patient Advocacy**

Advocacy is a concept that has been widely acknowledged in other professions besides nursing. For instance, the law firm describes advocacy as pleading the cause of a client in the court of justice, while supporting and

protecting the interest and rights of individuals in constituency meant advocacy in politics (Graham, 2012). According to Graham (2012), advocacy in nursing is unique from all other careers in that it strives on a giving off of one's self (the nurse) to an individual (the patient). Advocacy in healthcare environment focuses on health conditions, health care resources, patient needs, and that of the public as well.

However, the exact interpretation of what nurses perceive as advocacy differs in the literature. Abbaszadeh et al. (2013) described patient advocacy as an action taken to attain goals on behalf of one's self or others. The authors further defined nursing advocacy as speaking up for individual patients who are unable to speak for themselves. On the other hand, Vaartio and Leino-Kilpi (2004) viewed the concept of advocacy as a philosophical principle in the nursing profession. Vaartio et al. (2004) also argued that the concept of advocacy is an embedded component of nursing practice. Hence, nurses are expected by their professional code of ethics to intercede on behalf of patients in situations of ethical dilemma.

A study conducted by Bu and Jezewski (2007) in an attempt to clarify the concepts of advocacy concluded on three core attributes of the concept. These attributes were safeguarding patient's autonomy, acting on patients' behalf and championing social justice in the provision of healthcare. These attributes support the fact that advocacy enhances patients' safety and ensures quality of patient care (Vaatio et al., 2004). Historically, patient advocacy has been an ethical responsibility for nurses. Most nurses viewed their daily activities and measures taken on behalf of a patient as being patient advocate. O'Connor and Kelly (2005) revealed patient advocacy in terms of the nurse

utilizing his or her professional knowledge effectively to advocate for their patients, as well as, challenging the traditional healthcare power structures. Other authors like Vaartio et al. (2006) viewed patient advocacy from the perspective of empowering patients to advocate on their own behalf.

Thacker (2008) explored advocacy among nurses in end of life care and found communication to be a key support to nurses who advocate for patients. Vaartio and his colleagues (2006) commented that advocacy was more than providing good care. Rather, it included actions that enhanced patient safety and quality care. Hanks (2008), and O'Connor and Kelly (2005) also identified unmet needs of vulnerable patients and the work environment as factors that could influence the nurse's ability to advocate. These authors further warned that the advocacy roles of nurses were often accompanied by risks, and the implications of such risks include frustrations, feelings of anger and loss of job. Besides, Thacker (2008) asserted that the foundation of successful advocacy resides in the nurse-patient relationship. Thacker (2008) therefore referred to the concept of advocacy as providing safe care and improving quality of life for patients and their families. Patient advocacy has been described by Davis and Konishi (2007) as "whistle blowing", meaning the act of exposing institutions or practices deemed unethical or negligent.

The importance and the need for nurses to advocate for patients cannot be over emphasized. Vaartio et al. (2006) revealed that nurses are capable of empowering the weak and vulnerable patients, releasing them from discomforts, unnecessary treatment, as well as, protecting them from actions of incompetent healthcare professionals through advocacy. Graham (2012)

argued that even competent patients are also at risk of making wrong decisions due to insufficient information hence, nursing advocacy is very essential.

Many theorists in nursing tend to agree that patient advocacy by nurses is important and that all healthcare facilities must hold patient advocacy in high esteem (Gadow, 1980; Curtin, 1979; Peplau, 1992). Kohnke (1982).

Patients are usually vulnerable due to either lack of education, severity of their illness, or fear due to terminal conditions. Advocacy allows nurses to defend and promote patients' rights and interest in such situations (Negarandeh, 2006; Graham, 2012; Black 2011). Further benefits of patient advocacy included empowerment of patients, and positive health outcome (Bu & Jezewski (2007), preservation and protection of patient's rights and safety (Thacker, 2008), changing inappropriate rules, and enhancing the public image of the nursing profession (Negarandeh et al., 2008).

Abbaszadeh et al. (2013) contend that the nurse is always placed in an exceptional position to advocate for the patient because of the strong nurse-patient relationship that exists within healthcare facilities. Abbaszadeh et al. (2013) further confirmed that the nurses spend more working hours with patients which provide them the best opportunity to advocate for patients. Most patients prefer to ask nurses questions rather than asking other health professionals. According to Graham (2012), nurses have a long history of advocating for patients because of their concern about caring for the patient as a whole and not just their physical health condition. Nevertheless, critics are of the view that nurses should not be the ultimate patient advocate due to their conflicting loyalty to both the employer and the patient (Black, 2011).



According to Black (2011), nurses may choose not to advocate if the advocacy process become very complex and also due to fear of losing their jobs.

### **Description of How Nurses Carried Out their Role in Patient Advocacy**

Nurse's role of advocacy started at the time of Florence Nightingale when she and other nurses opposed the ethics of total obedience to the physician and employers rather than the patient. Yet, the role of the nurse as patient advocate was not widely embraced in Ghana until 1992 when the Patient Charter Act was introduced by the Ghana Health Service (GHS, 1992). Adoption of the Patient Charter made the public more aware of patients' rights and responsibilities. Nurses became both legally and ethically accountable to the patient. As part of the nurse's role in patient advocacy, the Patient Charter (GHS, 1992) obliged nurses' practicing in Ghana to protect patients' rights to safety, competent and quality care. To date, it seems little is known about how nurses experience and carry out the advocacy role in Ghanaian health care settings.

Unlike other professions, nurses are charged with additional responsibilities of empowering patients through education and moral ethical issues of healthcare, solving problems of conflicting interest and providing a balance between the patient's desire and that of healthcare providers (Graham, 2012). Specific actions that described nurses' advocacy role include: providing necessary information to help the patient and family to arrive at a decision that will enhance good health. It also involved supporting and defending patients' choices even when the nurse is not in agreement. Graham (2012) identified advising, sharing, protecting, teaching, listening, referring and consulting patients as additional roles to be undertaken by nurse advocates.

Vaartio et al. (2006) argued that each patient is unique with peculiar needs hence ensuring holistic care goes beyond just informing and educating patients. They therefore described the advocacy role of the nurse as an invincible work of caring. These roles included therapeutic nurse–patient relationship, the nurse’s presence and protecting patients with cognitive impairment and/or unconscious patients from danger. In addition, Vaartio et al. (2006) described the nurses’ role in patient advocacy as participating with the patient in determining the meaning of health, illness, suffering and dying. The authors further revealed that providing information and supporting patients in their decisions, pleading the cause of a patient and protecting them from unnecessary worries were all part of the advocacy role of the nurse (Vaartio et al., 2006).

Gadow (1980) and Curtin (1979) also supported the idea that without caring, advocating for patients is limited. The nurse acts as an informer for the patient’s decision–making process. Other nursing theorists have also described the nurse’s advocacy role. Peplau (1992) viewed the nurse’s advocacy role as ethical and philosophical foundation for the nursing profession. For example, Peplau (1992) revealed the nurse’s role to include assisting patients to identify their felt difficulties through interpersonal relationship. Peplau viewed the nurse as an advocate, surrogate, counselor and a teacher.

Cho (1997) described the advocacy role of the nurse as a behavioral process that is enacted at some risk to the nurse in order to assist the patient’s self–determination when the nurse recognizes that an ethical dilemma or conflict exists. Cho further identified specific role of the nurse as patient advocate as follows: first, protecting patients from risky and harmful situations

such as poor medical and nursing care quality. The second role is supporting patients' rights to live and peaceful death, as well as, the right to participate in all decision-making processes regarding medical care. Nurses need to offer support but must not make decisions for patients. Thirdly, speaking and acting on behalf of patients, monitoring and reassuring medical quality also constitute a key role of the nurse advocacy. An example of this role included protecting patients from medical incompetent, illegal and unethical practices. These protections can be accomplished by correcting prescription errors, medications administration errors, procedural errors, ensuring timely procedures and treatments or rejection of unreasonable medical procedures (Cho, 1997).

Furthermore, the role of the nurse advocate as indicated by Jezewski (1993) involves acting as a mediator by coordinating medical services between the health care team and the patient and family regarding the patient's problems. Jezewski (1993) noted that nurse advocates empower patients to acquire information needed to accept or refuse treatments and make informed decisions based on their beliefs and value systems. Benner (1984) revealed that empowering patients ranged from interpreting medical jargons to informing patients about alternatives and details necessary to make informed decisions that best suit their needs. Bu and Jezewski (2007) reported that the nurse's role of patient advocacy included championing social justice in the provision of healthcare. This role is concerned with nurses taking necessary steps to make changes to inequalities and inconsistencies in the provision of healthcare services. On the other hand, Thacker (2008) asserted that the advocacy role of the nurse is embedded in the entire nursing practice. Yet, a

clear definition of the nurse's role is difficult to find. Thacker therefore claimed that the act of caring by nurses in itself is a form of patient advocacy.

### **Implications of the Patient Advocacy Role on Safety and Quality Care**

Nurse's role of patient advocacy has a direct effect on the safety and quality of care patients received in health care settings (Blacks, 2011; Ropper, 2008). Ropper (2008) considered advocating for patients as a central driver for all aspects of quality improvements in healthcare facilities. The American Nurses Association (ANA) (2010) viewed patient advocacy role as a fundamental principle in nursing practice that assures delivery of safe and high quality patient care. Similarly, Blacks (2011) found that patient advocacy has a positive impact on the health of patients yet, when neglected it may result in negative implications and put the quality and safety of patient care at risk. For instance, nurses' failure to advocate for patients on issues such as medication errors, poor hand washing practices, and wrong treatments prescribed by doctors may lead to complications, prolonged hospital stay, acquisition of infections and possible death (Blacks, 2011).

Bu and Jezewski (2007) reported that when nurses carry out their advocacy role, it ensures patients' safety and quality care. These authors identified that advocating on behalf of patients lead to a change of some inappropriate rules and policies in healthcare facilities. These changes improved social justice, prevented harm to patients, and promoted patient safety and wellbeing as well as quality of health care delivery. According to Davis and Konishi (2007), a major implication of the advocacy role was that incompetent health workers and poor healthcare practices are identified for correction and improvement. Further positive implications identified by Davis

and Konishi (2007), included implementation of good rules and policies in healthcare facilities, prevention of injury and enhanced patient well-being.

In addition, Hanks (2010) noted that an effective patient advocacy promotes safety and improved patient outcome. An example is when a nurse recognizes prescription error and he or she is bold enough to draw the attention of the physician for a change. Such actions minimize possible medication errors, harm and complications, resulting in an improved quality care. The failure of the nurses to advocate for their patients will result in more injuries, health complications and less quality care (Hanks, 2010). The ultimate goal of the Patient Charter in Ghana was to increase patient safety and quality care through the advocacy role of the nurse (GHS, 1992). Studies by (Hanks 2010; Black 2011) have shown that there is a relationship between nurse's role of advocacy and the extent of safety and quality care a patient received in healthcare settings.

Black (2011) examined registered nurses' experiences with work attributes towards patient advocacy. Black in his study revealed that the advocacy role of the nurse is a safety and quality of patient care issue. He reported that due to fear of retaliation, most nurses could not advocate for patients. Hence, unsafe patient care conditions that lead to nosocomia infections such as hepatitis B and C often went unreported. Black (2011) suggested that the advocacy role of nurses in healthcare facilities should not be a matter of choice for nurses but rather a necessity. He further stated that health care authorities must provide necessary support and motivation that will enable nurses to advocate for patients. Black (2011) believed that failure of nurses to advocate may result in a significant deficiency in quality care and

safety of patients. Hence, he recommended a need for establishment of strong legislation to provide legal support for nurses who advocate for patients.

Patient advocacy has been described by Negarandeh et al. (2006) as assuring quality care of patients. Therefore, the nurse's ability to carry out the advocacy role seems to determine the extent of quality care patients received.

According to Negarandeh et al. (2006) patients who are vulnerable and powerless should be advocated for. Failure to advocate might diminish quality care and put patients' right, welfare, basic need and safety in danger. Similarly, Abbaszadeh et al. (2013) mentioned that patients might not receive adequate quality care if nurses are unable to advocate for them effectively. The authors affirmed that effective patient advocacy was the strongest determinants of patient's safety and quality in healthcare settings.

### **Barriers to Patient Advocacy in Health Care Facilities**

Nurse's role of patient advocacy has been widely accepted as a major means of enhancing patient safety and quality care. Yet nurses are often limited in the extent to which they are able to carry out the advocacy role. Negarandeh et al. (2006) explored barriers and factors influencing the patient advocacy role among Iranian nurses. Outcome from the study revealed that powerlessness, lack of knowledge in law and nursing code of ethics, lack of support and motivation for nurses, physician leading in hospitals, inadequate time for nurses, limited communication, loyalty to peers, risks and consequences are the main barriers in carrying out the advocacy role in healthcare settings

According to Negarandeh et al. (2006), the existing nurse patient relationship, recognizing patient's needs, the nurse's responsibility in the

health facility and the nurse's knowledge and skills can determine whether or not a nurse will advocate for a patient. The greatest obstacle to patient advocacy was found by Negarandeh et al. (2006) to be the healthcare institution itself. They argued that patient advocacy was basically in conflict with the culture of the hospital system. Negarandeh et al. (2006) admitted that most practicing nurses are knowledgeable and capable of advocating for patients, yet, they lacked sufficient power and the autonomy in the work environment to perform the advocacy role.

A study by Vaartio et al. (2006) identified barriers to the advocacy role as fear of being sued by patients and family in the event of a mistake in the advocacy process and lack of clear guidelines to assist nurses in their advocacy role. Black (2011) also confirmed fear of being labeled as trouble-makers by colleagues, accusation of insubordination by employers, workplace retaliation and fear of loss job as barriers to patient advocacy within the Southern Nevada context of nursing care. Abbaszadeh et al. (2013) however, reported that fear of losing job was not a barrier to advocacy among Iranian nurses. Rather, they identified inadequate educational programmes on patient advocacy for practicing nurses as a major hindrance to carrying out the patient advocacy role. According to Abbaszadeh et al. (2013) nurses with more working experience were more likely to advocate for patients than younger nurses who had less work experience. The challenges for advocacy are more complicated.

Thacker (2008) was of the opposing view that no significant differences existed between nurses' age, level of work experience and their views on patient advocacy. Thacker agreed that the workplace environment

can either positively or negatively influence the practice of advocacy among practicing nurses. Hanks (2010) however, identified that nurses' own characteristics can either enhance or serve as a barrier to the advocacy role of nurses. These characteristics included self-esteem, personal values about ethical treatment of patients and personal trait such as being empathetic, assertive and a sense of caring for the vulnerable. Currently in Ghana, no data has been found documenting the prevailing barriers to the patient advocacy role among nurses in healthcare facilities. Therefore, there is the need to explore the barriers to patient advocacy within the Ghanaian context.

Furthermore, cultural beliefs have been indicated by Davis and Konishi (2007) as a barrier to patient advocacy in the Japanese community. These authors confirmed that nurses who embraced the traditional role of nurses at bed side of patients were found not to value whistle blowing as a nurse's responsibility. In addition, Bu and Jezewski (2007) considered lack of nursing autonomy as the main obstacle to practicing patient advocacy. Considering the nursing profession as a whole, Bu and colleague (2007) argued that professional organizations of nurses often acted as self serving when lobbying politicians and policy makers. Hence, there lack adequate legislation that support nurses who in their quest for carrying out their advocacy role find themselves in the law court.

### **Empirical Review of Related Studies**

A qualitative study by Negarandeh, Oskouie, Ahmadi and Nikraves (2008) explored the meaning of patient advocacy from Iranian nurses' perspective. They used purposive sampling technique to select 24 nurses, working in different clinical settings in an Iranian university hospital. These



participants ranged from 23 to 50 years with 1 to 2 years of work experience. The meaning of patient advocacy and the nurse's role was grouped into five main categories. These categories included informing and educating, valuing and respecting, supporting, protecting, and promoting continuity of care for patients.

According to Negarandeh et al. (2008), the nurse's role of informing and educating included informing patients about medical problems, treatment options, available services for patients and family both within and outside the hospital and means of empowering patients and family. Valuing and respecting required the nurse to view the patient as an individual who must be valued. The patient's right to privacy, confidentiality, quality healthcare, and ensuring patient access to available hospital and community resources must also be respected. Concerning the nurse's role of supporting, Negarandeh et al. (2008) viewed it from the physical perspective; such as meeting patients' physical comfort and pain relief. There is also financial support role in which the nurse identifies and attends to the patient's needs immediately to decrease hospital stay and limit treatment cost. Providing emotional support means establishing therapeutic nurse-patient relationship and gaining trust. Protecting role of patient advocacy involved defending, interceding, reporting, protecting, securing and ensuring privacy. Patients in danger must be protected immediately to enhance safety (Negarandeh et al., 2008).

Promoting continuity of care was indicated as an advocacy role that comprised follow up and effective coordination of patient care. In order to ensure effective patient advocacy, these researchers suggested that nurses ought to have adequate knowledge with regards to patient's situations that

required advocates. They added that nurse's ability to effectively advocate does not come by chance. Nurses' personal values and perceptions about their professional roles determine how well if at all they will advocate for patients (Negarandeh et al., 2008). They indicated that nurses must possess good assessment skills to be able to identify what is in the patient's best interest and corresponding advocacy actions. In conclusion, Negarandeh et al. (2008) believed that patient advocacy was contextually complex and controversial component of nursing practice. Hence, examining this phenomenon in a different workplace within the Ghanaian culture may reveal different findings related to the nurse's role of advocacy and its effects on safety and quality care.

Abbaszadeh et al. (2013) conducted a study in Iran using questionnaire and a descriptive-analytical design to measuring nurses' attitudes towards patient advocacy. The study included a total number of 374 nurse participants by means of quota sampling technique. These participants were between the ages of 22 and 55 years with six month to ten years of work experience. Outcome from the descriptive analysis revealed positive attitude towards nursing advocacy amongst the participants. Further results from the study indicated that most nurses saw themselves as ethically obliged to act as patients' advocates when patient's safety were in danger. Abbaszadeh et al. (2013) found that the nurse and the patient could simultaneously advocate. The authors and indicated that being a good patient advocates was a sign of commitment to the nursing profession. Nurses viewed the advocacy role as preserving the patient's dignity and not necessarily protecting patients from a harmful situation (Abbaszadeh, et al., 2013). The researchers suggest that

nurses needed more advocacy education programmes and more support from their employers to carrying out the role. They finally recommended inclusion of patient advocacy in curriculum of nursing educational institutions. This study will examine whether or not the above study findings are similar to the prevailing situation within the Ghanaian context.

Boyle (2005) embarked on a qualitative descriptive phenomenological study aimed at defining patient advocacy and the nurse's role of patient advocacy in the perioperative setting. Boyle (2005) audio taped the interviews of 33 perioperative registered nurses from Eastern New York. These participants were selected through purposive sampling technique. All participants were asked to respond to three open-ended questions in an individual bases regarding perioperative nurse's definition of patient advocacy, their role of patient advocacy and how they experienced patient advocacy. Data from the study were obtained and analysed using a nine-step interpretive phenomenological approach (Boyle, 2005).

According to Boyle (2005), nurses described patient advocacy at the perioperative setting as: protecting patients from harm, making sure that patients are being cared for safely, informing patients about their rights, providing facts about health care and acting on behalf of patients including intervening and assisting patients to obtain the best outcome. Boyle further identified the advocacy role of the perioperative nurse to include: protection, communication, giving voice, doing, comfort and caring, mediating between the perioperative team and the patient as well as treating patients like family members. The author further revealed that protection, communication, giving voice and comfort and care were how the nurses experienced advocating for

patients. These findings overlapped with the nurse's description of patient advocacy (Boyle, 2005).

The small sample size was a limitation in the study. Hence, Boyle agreed that the study finding may not be generalized. However, Boyle (2005) believed that findings from the study could help the nursing profession to develop a common definition of patient advocacy and improve the role and personal experiences of practicing nurses who advocate for patients. Boyle (2005) stated that patient advocacy is very essential for patients who are unconscious or sedated and are unable to make decisions for themselves. Protecting patients from harm is the essence of advocacy role of nurses, and a critical point for patients whose family members are not available and whose only possible advocate is the nurse. This statement seems to support Peplau's (1992) description of the fundamental role of the nurse as an advocate and a surrogate. Boyle (2005) finally suggested that nurses should accept accountability for actions that safeguard the rights of patients to promote safety and quality care.

A study by O'Connor and Kelly (2005) with the purpose of investigating general nurse perceptions of being patient advocate in Ireland and how they carry out their advocacy role. An inductive qualitative approach was used for the study. The researchers made use of a purposive method to select a total number of 20 practicing nurses as participants. Data was collected through focus group interview. The interviews were taped and transcribed for analysis using Strauss and Corbins' approach to concept development.

O'Connor and Kelly (2005) grouped their findings under six key headings, namely: the causal conditions, context, intervening conditions, action/interaction strategies, consequences and the phenomenon itself. First was the casual conditions under which the nurse will advocate for patients. These conditions included vulnerability and obligation of duty of the nurse advocate and moral obligation of the nurse to advocate for patients. Secondly, the context under which the nurse advocated for patients varied and may be in response to specific needs of the patient. These interventions ranged from ensuring quality meals for patients to protecting patient's right, speaking on behalf of patients and acting as a mediator between the patient and the health care team.

Regarding intervening conditions, O'Connor and Kelly (2005) revealed that the nurse-patient relationship, nursing knowledge or expertise and nursing relationship with other healthcare team were significant factors that influenced how nurse advocacy was put into practice. Action or interaction strategies referred to the steps that were taken when advocating for patients. These actions were based on using expert knowledge and challenge to power institutions. According to O'Connor and Kelly (2005), consequences of advocacy could bring negative or positive outcome for both nurses and the patients. The participants indicated that outcome for patients were always positive both for the patient directly involved and for future patients as well. Positive outcome for nurses were identified as increased professional recognition and job satisfaction. However, negative consequences for nurses which also served as barriers to advocacy included risks of conflicts and

confrontations at the workplace often leading to feeling of anger and frustrations among nurses (O'Connor & Kelly, 2005).

The common meaning of patient advocacy presented by all study participants were stated as being supportive and the voice of patients. A key characteristic of advocacy was bridging the gap between the patient and others within the healthcare environment. Finally, the two levels of patient advocacy that emerged from the study were “clinical advocacy” meaning acting for patients in relation to their treatment, and the second level was “organizational advocacy” which involved acting on behalf of patients to effect changes within the organization (O'Connor & Kelly, 2005).

Bu and Jezewski (2007) synthesized advocacy literature in nursing from 1976 to 2006 to establish a theoretical basis for future studies on patient advocacy in nursing. The study's aim was to clarify and refine the concept of patient advocacy. The researchers conducted an extensive literature search using electronic version of CINAHL and MEDLINE for the year 1966 to 2006. The 220 articles were reviewed on nurses' advocacy role in the United States of America (USA), United Kingdom, Sweden, Australia, Canada, Ireland, New Zealand, Finland, Turkey and Japan. No article was found published in Ghana related to the advocacy role of the nurse in their study.

Based on the analysis, Bu and his colleagues described patient advocacy as a process consisting of specific series of actions for preserving, representing and safeguarding patient's right, best interest and values within the healthcare system (Bu & Jezewski, 2007). The authors discovered that each of the advocacy models reviewed focused on only one specific aspect of patient advocacy. They also pointed out that the nurse's role of patient

advocacy is context-based hence, nurses take different action to advocate for patients depending on the clinical setting in which they find themselves. Yet, the advocacy role of nurses in the Ghanaian healthcare setting has not been identified to date.

Bu and Jezewski (2007) viewed advocacy as multi-dimensional and suggested that nurses need to incorporate different types of advocacy models as a guide to ensure effective nursing advocacy in various context of patient care. The researchers further attested to the fact that safeguarding patient autonomy, acting on behalf of patients and championing social justice in the provision of healthcare were the key attributes of patient advocacy. Finally, Bu and Jezewski (2007) developed a mid-range theory from their study. This mid-range theory conceptualized patient advocacy in nursing as a relationship between the nurse's ability to recognize the need for advocacy, the act of advocacy and the possible positive and negative consequences associated with the advocacy process.

MacDonald (2007) also conducted a study on relational ethics and advocacy in nursing through an extensive literature review. The purpose of the study was to analyse themes from accounts of nurses' experiences with advocacy that may expand understanding of advocacy in nursing practice. The author claimed that despite the ethical obligation of nurses to advocate, a lack of clarity persists about the nurse's role and nature of advocacy in nursing practice. MacDonald (2007) therefore examined various qualitative studies conducted between the years 1993–2005. Important themes related to nursing experiences and applications of advocacy in literature were selected and were analyzed. The result of the study indicated that advocacy in nursing is

embedded in relational context. The interpersonal relationship between the nurse, the patient and other professionals in the healthcare environment plays a significant role in influencing the enactment of advocacy.

MacDonald (2007) concluded by suggesting the need for the inclusion of relational ethics, therapeutic relationship and workplace culture in nursing education to assist in empowering nurses enactment of advocacy in nursing practice. Skills of negotiation, mediation, and conflict resolution are collaborative techniques that must be included in the preparation of nurses as advocates (MacDonald, 2007). Findings from MacDonald's study supported the Peplau's interpersonal relations in nursing theory. Peplau believed that advocacy as a fundamental role of the nurse can only be enacted through good therapeutic interpersonal relationship (Nystrom, 2007).

A qualitative pilot study was undertaken by Hanks (2008) to explore three medical–surgical registered nurses' lived experience of nursing advocacy with their patients. The study participants were purposively selected from a large university medical center in southwest USA. The researcher used a maximum of 90 minutes semi–structured interview and completion of a one–page bio–demographic profile to collect her data from participants. The researcher answered two key questions: first, “how do registered nurses practicing in the medical–surgical specialty area describe their experiences with nursing advocacy for their patients?” Second, “what reflections on educational preparation for their professional roles do registered nurses identify as related to their practices of nursing advocacy with their patients?” Hanks (2008) indicated that a phenomenological inquiry method was best



suiting for describing the lived experiences of several individuals regarding a particular phenomenon.

The study data was analysed using transcendental phenomenology as outlined by Moustakas (Hanks, 2008), in which preconceptions are bracketed out before analysing results in a structural description of experiences (Hanks, 2008). Each audio-taped interview was transcribed by a trained transcriptionist and the content was well verified by the researcher for accuracy. Rigor was measured against credibility, dependability, and transferability as required by Lincoln and Guba's criteria of rigor determination (Hanks, 2008).

Result from the study indicated nurses' experienced advocacy as: speaking out and speaking for patients, as well as feeling compelled to act on unmet needs of patients. Regarding experiences with outcomes of advocacy, Hanks (2008) found that nurses experienced both fulfillment and frustrations as outcomes of their advocacy. It was revealed that nurses felt fulfilled and satisfied when advocacy for patients were successful and patients were changed in a positive manner by their advocacy actions. However, in the event where nurses' attempt to advocate for patients became unsuccessful, negative outcomes of frustrations occurred.

According to Hanks (2008) nursing advocacy was primarily learned on the job through role modeling and self-taught based on the nurse's family background and personal life experiences and exposures. Other nurses gained confidence in advocating through work and practice experience. Further findings from Hanks' study revealed that despite the negative consequences faced by nurse advocates, there is real patient benefit to nursing advocacy outcome each time nurses advocate for patients (Hanks, 2008). Hanks

concluded that inclusion of patient advocacy programmes in nursing educational institutions is important.

In 2010 Hanks explored medical–surgical nurses’ advocacy actions and the support these nurses received at the workplace for their advocacy actions (Hanks, 2010). Only nurses who have had one year work experience in the medical–surgical units in an acute care setting were allowed to participate in the study. The theoretical framework of Hanks study was drawn from three conceptual models, namely; Cho (1997), Ingram (1998) and Hanks (2005). Open ended questions were mailed to participants who narrated their responses and mailed them back to the researcher. A qualitative content analysis was used by Hanks (2010) to analyze the resulting narrative data.

Participants described key advocacy actions as educating patients and family and communication with other members in the healthcare team. Hanks further revealed that there was a poor support from the institutions with regards to nursing advocacy actions of the study participants. The above finding was described by Hanks (2010) as very troubling considering the importance of advocacy for patients. In conclusion, Hanks (2010) noted that the anonymous nature of the mailed survey encouraged participants to freely express their experiences. The responses were however, written narratives hence, it did not allow for clarification of responses as could be done in a qualitative interview process.

Thacker (2008) believed advocacy was the common thread of quality end–of–life nursing care. She indicated that nursing professionals are in key positions to support end–of–life decisions and to advocate for patients and families across all health care settings. Thacker (2008) therefore, embarked on

a comparative descriptive study to reveal acute care nurses' perceptions of advocacy behaviours in end-of-life nursing practice. A total number of 317 practicing nurses participated in responding to the study questionnaire. Benner's novice to expert process model provided theoretical framework for the study (Benner, 1984). The study data were gathered from participants using the ethics advocacy instrument (EAI) in three regional hospitals within urban areas of the mid-Atlantic region of the USA.

The researcher also conducted content analysis of self-reported data obtained from two open-ended questions. Thacker (2008) reported no significant differences in the perceptions of advocacy behaviours as measured by the advocacy perception scores (APS), the advocacy behaviour scores (ABS) or the combined scores among novice, experienced and expert nurses. No significant differences according to Thacker (2008) were found among hospital structure support received by novice, experienced and expert nurse participants. However, all participants identified key support to their advocacy practice as nurse managers and co-workers. Additional support were revealed as multi-disciplinary team, communication, relationship with patients, the family, nurses knowledge, beliefs and compassion.

The study participants further revealed that the most frequent barriers to patient advocacy at end-of-life patient care were the physician, the patient's family and fear. Other barriers were named as lack of communication, knowledge, time and hospital support. The limitation in the study was however attributed to the fact that the data collection instrument employed by Thacker was based on the changing nature of advocacy despite the EAI's reliability measurement below generally acceptable levels.

Vaartio et al. (2006) performed a qualitative study to explore what is involved in nursing advocacy and how is it experienced. These researchers were of the view that advocacy is an integral part of nursing. However, there is a scarcity of empirical evidence on nursing advocacy process. Hence, their study described the way that nursing advocacy is defined, the activities through which nursing advocacy is accomplished, and the way that nursing advocacy is experienced by patients and nurses. A total number of 22 patients experiencing procedural pain in somatic care and 21 nurses practicing within four medical and surgical wards in Finland were recruited through convenient sampling method. Data was collected using a maximum of 70 minutes interview of all participants and analysed using qualitative content analysis.

According to Vaartio et al. (2006) participants described advocacy as something that nurses do for their patients related to or beyond good care based on their personal and/or professional commitment to help. Advocacy also meant caring specifically for patients in relation to a particular need and/or continuous care based on patient observation and responsibility of the care process. Vaartio et al. (2006) found that the nursing advocacy role is not a single event, but a process of analyzing and clarifying patient's needs, counseling, responding and shielding by protecting patients from harm as well as whistle blowing activities in clinical nursing practice. The researchers categorized how nursing advocacy is experienced in relation to the right of a patient and the duty of a nurse. Right of a patient was experienced in the form of self-determination and respect of patients' rights and wishes as a manifestation of professional duty of the nurse. Vaartio et al. (2006) concluded by suggesting that the aim of nursing advocacy should be to

promote patient empowerment instead of patient autonomy to promote collaboration in the decision-making process during patient care.

Choi, Cheung and Pang (2014) were of the view that nurses' role as patient advocates in safeguarding patients' interests and well-being is constantly upheld. Yet, clear explanation of the processes of how and in what conditions the patient advocacy role is operationalized was lacking in nursing literature in some countries. Hence, Choi et al. (2014) conducted a study in Hong Kong to fill the evidence gap by examining nurses' advocacy role and practices in real clinical contexts. The purpose of their study was to explicate nurses' role and the underlying processes involved in advocating for safe practice in hospitals. The focus was on clarifying nurses' advocacy role and practices pertaining to patient safety. Through purposive sampling method, a total of 28 nurses comprising 2 enrolled nurses, 18 registered nurses (RNs), 2 advanced practice nurses, 2 nursing officers and 4 first-line nurse managers were selected to participate in the study.

Data were collected over one year from February 2010 to March 2011 through a field study approach that involved multiple methods of data collection. Participants were observed at each study site once in week for over three (3) hours each time adding up to total of 733 observation hours. Further data were collected through semi-structured interviews with all participants and analysed utilizing comparative analysis process. Choi et al. (2014) found that issues related to nurses role of advocacy and patient safety included risks, incidents, errors and near-misses in daily practice. Although forms of risks, incidents, errors and near-misses that occurred varied from one medical unit to another, the nurse's role of advocacy had no variation.

The implications of the nurse's role of advocacy on patient safety and quality care were identified under two main themes. These included as mitigating risk arising from sudden changes in patients' health conditions and correcting near-misses for co-workers to prevent harm. Choi and colleagues (2014) further explained that nurses were able to act proactively in preventing anticipated harm that might arise from patients' health conditions and the hospitalization process through their advocacy role. Nurses acted just like the patients' guardians due to patients' vulnerability during times of illness. Nurses therefore protected patients from being harmed and ensured that they received the necessary treatments to cure their illnesses (Choi et al., 2014). The second theme was identified as correcting near-misses for co-workers to prevent harm was related to filling the gap to correct near-misses. Thus, nurses played mediator role by identifying the gap and correcting their co-workers' omissions at work in daily practice to prevent patients from being harmed (Choi et al., 2014).

Choi et al. (2014) revealed being proactive, vigilance, modeling of expert nurses and team-based learning as the essential factors that facilitated the development of nurses' advocacy role and practices. Most participants embraced only the paternalistic feature of safeguarding patients against harm without empowering patients in decision-making (Choi et al., 2014). Limitation of the study was centered on the inclusion of participant observation during data collection. According to critiques, it is possible that the informants changed their behaviours in response to the researcher's presence in the study contexts.

However, Choi et al. (2014) believed the negative effect was minimized through the long period of participant observation and the use of a larger number of field observation activities to account for any observed differences. Choi and colleagues (2014) concluded that despite the above limitation, the study findings have generated more insights into nurses' role of advocacy and the underlying processes involved in advocating for patient safety and quality care in daily practice.

### **Related Theoretical Models of Patient Advocacy**

Several nursing theorists have developed models to guide the practice of advocacy by nursing professionals. Most of these theorists viewed advocacy as: (1) protecting patients' rights to self-determination (Kohnke, 1982), (2) acting as a surrogate and assisting patients to identify their felt difficulties through interpersonal relationship (Peplau, 1992), (3) assisting patients in their own actions and decisions related to healthcare, and (4) act as bridging links or mediating between groups or persons for the purpose of reducing cultural conflicts (Jezewski, 1993). These models are usually influenced by whether advocacy is an inherent component of nursing role as proposed by Peplau (1992) or a unique action of nurses. Below are some of the models of patient advocacy.

Curtin's model of human advocacy (1979) viewed the practice of advocacy as a philosophical role of the professional nurse. Curtin assumed that the nursing profession has moral purpose of promoting human welfare. This model is based on attributes common to both nurses and patients such as humanity, needs and rights. The focus is on human advocacy in which the nurse views the patient as a whole human being made up of body, spirit and

mind. The closeness of the nurse–patient relationship determines the extent of advocacy. Hence, the nurse–patient relationship is vital to carrying out the advocacy role. According to Curtin, the patient retains the right to make choices whilst the nurse’s role is mainly to support the patient in their choices. However, Curtin (1979) believed that in situations where the patient lacks the ability, the nurse should collaborate with the patient to preserve his/her humanity.

Similar to Curtin, Gadow’s also based her model of existential advocacy (1980) on a philosophical definition of nursing. She viewed advocacy as the ideal nature and purpose of the nurse–patient relationship (Graham, 2012) rather than a set of specific behaviour of the nurse. The model was developed on the assumption that self–determination is the most fundamental of human rights. Patients must be recognized as individual human beings with peculiar needs and not as objects (Gadow, 1980). He therefore described advocacy as assisting patients in their own actions and decisions related to healthcare. Gadow proposed that the nurse should only assist the patient to clarify what they want to do and not what the nurse feels, thinks or observes.

Gadow (1980) suggested five key steps to follow when advocating for patients. First, the nurse is to provide adequate information that will assist patients to make informed decisions. The second step is to allow patients to select aspects of information they would like to consider. Thirdly, the nurse should be present to clarify and also answer patients’ questions. The fourth step is for the nurse to recognize his or her own values, determine that of the patient and help the patient to clarify her values. Finally, the nurse must ensure



holistic care by attending to the patient as an individual during decision making process.

The nurse can only be effective in carrying out the advocacy role through an in-depth relationship with the patient (Gadow, 1980, Negarandeh et al., 2008). Curtin and Gadow's model of advocacy are very similar. They are both of the view that it is the patient and not the nurse who should decide what is in the best interest of the patient. The Gadow's model does not encourage nurses to make decisions for patients; hence it poses less risk to the nurse. However, Abbaszadeh et al. (2013) were of the view that both Curtin and Gadow's model cannot be applied to patients who are not able to communicate due to unconsciousness, sedation or severe illness.

On the contrary, Kohnke (1982) defined advocacy as an act of supporting persons to make the best possible decisions for themselves. Kohnke was opposed to advocacy as a philosophical basis for nursing. Her assumption was that, advocacy is a process by which the nurse acts as an advocate by informing patients on their rights and supporting their rights to freely make decisions as they wish. A major characteristic of Kohnke's model is the idea that the nurse is a free moral being that has the right to decide whether or not he or she wants to advocate for the patient. According to this model, the nurse should decide whether or not to disclose information. Kohnke does not view patient advocacy as a natural role of the nurse because appropriate skills and knowledge are needed to be able to advocate. Also, the nurse must be willing and prepared to face the risks and consequences that accompany the advocacy role.

The model of advocacy by Bramlett, Gueldner and Sowel (1990) was a consumer-centered advocacy model for nursing practice. Similar to Curtin (1979), the key component of this model is providing information and supporting patients in decision making related to health care. However, Bramlett et al. (1990) proposed that nurses can both act on behalf of patients and or assist them to make their own decisions. Bramlett explained that patients have the right to make their own decision, yet depending on the circumstances, some patients may lack full knowledge on certain conditions compared to the nurse. It is therefore acceptable for the nurse to take decision for patients who lack the power to do so for themselves.

The final model reviewed under this section is the cultural brokering model developed by Jezewski in 1993. This model defined advocacy as the act of bridging links and mediating between cultural groups or people for the purpose of reducing conflict or producing a change. Jezewski's model proposed three key steps for carrying out the advocacy role. The first step is the perception stage whereby the nurse assesses the need for advocacy. Second, is the implementation stage which requires the nurse to take all necessary actions to assist the patient based on his or her assessment findings at the first stage with regard to the patients needs. The last step is the evaluation or outcome stage. In conclusion, Jezewski (1993) revealed that mediation, negotiation and innovation are essential skills needed to enhance the process of resolving conflict, creating opportunities, and finding a common ground for agreement when advocating for patients from divers cultural backgrounds.

In conclusion, this section provides differences and similarities in advocacy models. Whilst some theorist viewed advocacy as a philosophical foundation of the nursing profession, others believed that advocating for patient by nurses was a matter of choice. None of the reviewed model has been adopted by the nursing profession to guide nurses in their advocacy role.

Hence, these models only provided a guide for nurses who engaged in the advocacy activities and cannot form the theoretical basis underpinning the practice of patient advocacy in the nursing profession. Therefore, the Peplau's theory of interpersonal relations in nursing discussed below remains the ideal theoretical framework for this study.

### **Theoretical Framework**

The study was guided by the inter-personal relations theory, introduced by Hildegard Peplau, in 1992. Peplau's interpersonal relations theory described a person as a developing organism trying to reduce anxiety caused by needs and that the purpose of nursing is to help individual to identify their felt needs. Nurses should therefore apply principles of human relations to problems that arise at all levels of experience (Nystrom, 2007). Peplau analysed the full development of the nurse as a person who is aware of how he or she functions in different situations, assuming maximum responsibility for meeting treatment goals of the patient. As part of the theory's interpersonal focus, Peplau explained that the purpose of nursing is to help others to identify their felt difficulties.

The theorist is of the view that nursing is therapeutic, since it is a healing art that assists an individual who is sick or in need of health care. Nursing is therefore a significant therapeutic interpersonal process because it

involves interaction between two or more individuals with a common goal. The attainment of the goal is achieved through the use of a series of steps following a series of pattern. The nurse and patient work together so that both of them become mature and knowledgeable in the process. Nursing functions cooperatively with other human process that makes health possible for individuals in communities (Papathanasiou et al., 2013).

Peplau (1992) placed emphasis on the roles of the nurse as a stranger: meaning she receives the client in the same way one meets a stranger in other life situations and provides an accepting climate that builds trust. She also viewed the nurse as a teacher and a resource person who imparts knowledge in reference to a need or interest and provides specific needed information that aids in the understanding of a problem or new situation. Further role of the nurse include: leader, technical expert, consultant, health teacher, tutor, socializing agent, safety agent, manager of environment, mediator, administrator and a surrogate who helps to clarify domains of dependence interdependence and independence and acts on clients' behalf as an advocate.

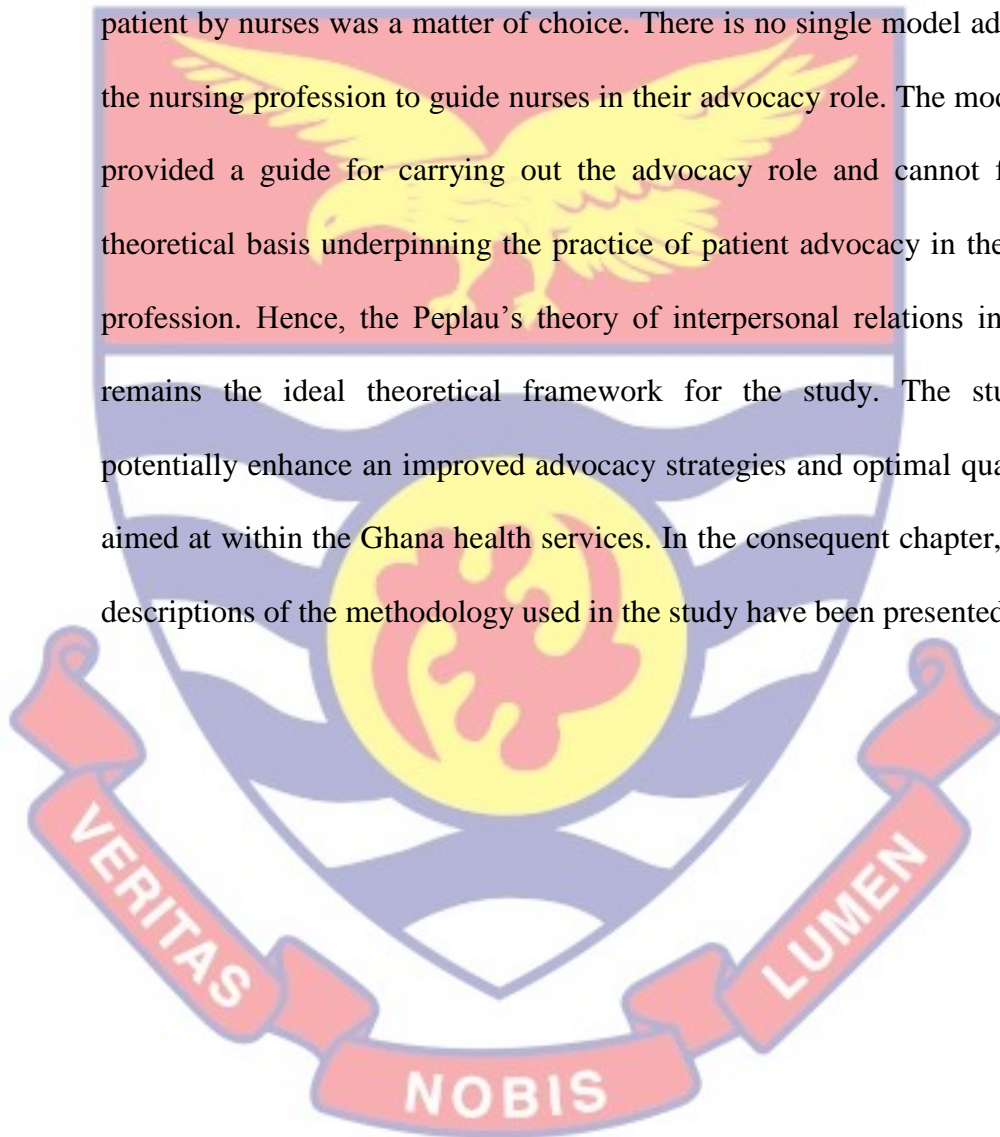
Peplau's theory described the structure of the nurse-patient relationship as one of building trust and helping persons to begin to identify problems (orientation phase), assisting patients to work on their problems, which may include providing physical care, health teaching, and counseling (working phase), and finally providing closure of their work together also called termination phase (McEwen & Wills, 2011). This interpersonal relations theory therefore promotes nursing advocacy by ensuring that nurses act on behalf of their patents to ensure safe and quality care through good interpersonal relationship.

The above theoretical framework therefore guided the choice of the study participants, the methodology, data collection process and analysis. First, the choice of nurses as study participants was based on the fact that Peplau's theory (1992) viewed the nurse as a leader, surrogate and an advocate who helps individuals to identify their felt needs. The nurse assumes maximum responsibility for meeting treatment goals of patients. According to Peplau's theory (1992), nursing is a therapeutic interpersonal process between two or more individuals with common goal. The closeness of the relation determines the level of goal attainment. Hence, the study methodology was developed to allow direct contact and therapeutic interaction between the researcher and the study participants. Through interpersonal relations, the researcher gained participants confidence and trust which enabled her to elicit rich information regarding participants' experiences of patient advocacy.

### **Chapter Summary**

The concept of patient advocacy, barriers, how advocacy is pursued and experienced by nurses as well as its implication for safety and quality care of patients are reviewed in this chapter. The differences and similarities in various advocacy models have also been examined. The exact meaning of patient advocacy differs in nursing literature. Yet, generally, patient advocacy is believed to be an embedded component of nursing practice. Nurses are expected by their professional code of ethics to advocate on behalf of patients in their daily practice across the globe. The evidence clearly suggests that nurses need to advocate for patients if safety and quality care are to be achieved.

In addition, the key differences and similarities in advocacy models have been examined. It is evident from the models above that advocacy as a phenomenon is a complex concept, involving multi-dimensional behaviour, roles and actions. Whilst some theorist viewed advocacy as a philosophical foundation of the nursing profession, others believed that advocating for patient by nurses was a matter of choice. There is no single model adopted by the nursing profession to guide nurses in their advocacy role. The models only provided a guide for carrying out the advocacy role and cannot form the theoretical basis underpinning the practice of patient advocacy in the nursing profession. Hence, the Peplau's theory of interpersonal relations in nursing remains the ideal theoretical framework for the study. The study will potentially enhance an improved advocacy strategies and optimal quality care aimed at within the Ghana health services. In the consequent chapter, detailed descriptions of the methodology used in the study have been presented.



## CHAPTER THREE

### RESEARCH METHODS

Research methodology focuses on the research designs and methods the researcher uses for a study. It also describes the strategies through which the goals of the research are achieved (Burns & Grove, 2011). The goal of this chapter is to provide an understanding of the methodology that was used, how and why it was used for this study. First, it provides a brief description of quantitative research, followed by the qualitative research, particularly the descriptive study design and why it is the best approach for this study. Finally, the remaining part of the chapter is organized into study setting, population and sample size, sampling procedure, data collection instrument and process, data analysis, ethical considerations and field experiences.

#### Research Design

Studies have shown that the two main approaches of research are the quantitative and the qualitative (Polit & Beck, 2010; Newman, 2011). The goal of the quantitative research approach according to Sarantacus (2005) and Newman (2011) is to discover laws that explains, predicts or controls individuals or groups of individuals, and also leads to numerical or quantitative information. Quantitative research, therefore, deals with objectivity and empirical data by avoiding use of personal beliefs and values as sometimes done in qualitative. Newman (2011) ascertained that it is best to use quantitative approach when much is known about a phenomena or concept to be studied than a particular context since its focus is on large sample size and quantity. Therefore, the researcher did not opt for the quantitative

approach because it is believed it would not help to achieve the study objectives.

A qualitative approach with descriptive study design was used since this allows the researcher to meet the set objectives. Qualitative approach was chosen because it is explorative. It enables researchers to gain an understanding of individuals' underlying reasons, opinions and motives, as well as, insight into the problem (Creswell, 2007). Unlike quantitative research, Creswell (2007) indicated that qualitative research collects subjective information related to human experiences, thoughts, feelings and intentions. This study described registered nurses' understanding of their advocacy role and their experiences in carrying it out. The study objectives required subjective information including personal experiences from participants. Hence, the qualitative approach was deemed the ideal method for this study (Creswell, 2007; Newman, 2011).

In addition, Polit and Beck (2010) revealed that descriptive study design is ideal for gaining more information about the characteristics of a phenomenon of interest as they naturally occur. Descriptive study ensures rich in-depth understanding of valuable knowledge of the individual nurse's experience of how it feels and what is it like to carry out the nurses role of patient advocacy.

### **Study Setting**

Burns and Grove (2011) noted that the study setting is the location where the study took place. This study was conducted at the Cape Coast Metropolitan Hospital. This setting was chosen because it is a large public hospital that currently served as the first point of care for the entire Cape Coast



metropolis population of over hundred and forty thousand individuals (Ghana Statistical Service, 2014). Besides, CCMH also receives referred patients also from the Poly clinics and minor health centers as well as the Cape Coast Teaching Hospital when the facility is overburdened. CCMH also has over fifty registered nurses with more than two hundred inpatient bed capacity.

Finally, CCMH was chosen because patients admitted to the facility would most likely need to be advocated for by their nurses to ensure safe and high quality care.

### **Study Population**

The study population included all nurses currently practicing at the male and female wards made up of surgical and medical patients, the children wards and maternity ward. It also included the theater, communicable disease unit, ophthalmological unit and psychiatric unit, as well as, outpatient department of the CCMH. These wards and units were chosen to enable the researcher to obtain adequate participants and the appropriate responses needed to achieve the research objectives (Creswell, 2007). In addition, these wards constituted the main inpatient beds with various health conditions that require nurses to advocate for their patients to ensure high quality care which is the facility's mission.

### **Sample Size**

In qualitative research the size of the sample depends on what is to be studied, purpose of the study, how findings will be used, and what resources including time available (Polit & Beck, 2010). Speziale and Carpenter (2007) suggested that two to ten participants or until saturation is appropriate for a qualitative enquiry. In this study, a total sample size of 25 was selected from

the study population. The sample size was determined after the 25<sup>th</sup> participant was interviewed and saturation was achieved. Saturation or redundancy is a situation in which no new information emerges or when boredom develops during interviews with participants (Creswell, 2007; Polit & Beck, 2010; Speziale & Carpenter, 2007).

### **Sampling Procedure**

Purposive sampling technique was used to enable the researcher to select the specific registered nurses who were eligible and willing to participate in the study. Purposive sampling was appropriate for this study because only practicing registered nurses (RN) who have had experiences relating to the phenomenon to be researched were recruited to respond to the issues that were raised to meet the set objectives (Burn & Grove, 2011; Polit & Beck, 2010; Creswell, 2007).

Following the approval of this study by the Institutional Review Board at the University of Cape Coast (Appendix A), the researcher was granted permission by the hospital authorities at the CCMH to conduct this study (Appendix B). One week before the commencement of the interview, the researcher was introduced to all the units in the hospital. This introduction gave the researcher an opportunity to familiarize herself with the hospital environment and to also establish rapport with the nurses so as to win their confidence and trust. Through the help of the ward managers, the researcher was able to gain access to the duty roster of potential participants and noted their work schedules. From that time onward, the researcher went round the various wards on daily bases, approached potential participants on duty and declared the intent of the study to them. Finally, arrangements of time and

place of interview were made with registered nurses who fell within the inclusion criteria and were willing to participate in the study.

### **Data Collection Instrument and Procedures**

Data for this qualitative study were collected from RNs through a semi-structured and tape recorded interview by the researcher. Sony Corp. ICD-AX412 Class B tape recorder was used for this study (Model Number: ICES-NMB-003). Study has shown that the use of semi-structured interviews affords the interviewer the flexibility in the way questions are asked to enable the participants to better understand the question for maximum participation (Polit & Beck, 2010). Similarly, Burns and Grove (2011) noted that semi-structured interviews ensured proper understanding, and also elicit appropriate responses. It is also the best way of ensuring collection of in-depth information from participants on their personal experiences (Creswell, 2007). Interview guide (Appendix E) was developed by the researcher to assist in collection of appropriate and in-depth information from the study participants (Polit & Beck, 2010). The interview guide was developed based on nursing literature. In addition, the researcher was guided by two expert supervisors and one doctoral nursing student during the development of the interview guide. Also, earlier pre-tests conducted by the researcher together with comments from other colleagues were very helpful in the development of the interview guide. Detailed description of the procedure for the data collection is presented below.

In this qualitative study as mentioned earlier, a semi-structured face-to-face in-depth interview procedure was used to collect data. The interviews conducted were audio-taped and transcribed verbatim by the researcher. The

interviews lasted between 30 to 45 minutes. However, two of the interviews took about 50 minutes while one interview went on for a little over 60 minutes. The prolonged interview was because the respondents had a lot more advocacy experiences to share with the researcher. On the contrary, the participants' demographic information collected during the interview was not audio recorded. This approach was necessary to maintain the participant's confidentiality.

All participants were also assigned pseudonyms at the start of the interview. The researcher conducted the interview alone with the participants in a location and at a time appropriate and convenient for the participants. Five of the interviews occurred at the offices of the participants within the hospital on a day shift. These participants were nurses in-charge of their wards. The remaining twenty interviews took place in special rooms arranged by the participants within the hospital.

Five participants were interviewed just before the start of their evening shift schedule. Three interviews were arranged during night shift while the remaining twelve were conducted at specified times convenient for participants within their day shifts. The researcher reminded them of the issues to be discussed and asked them to recall some of their experiences with patient advocacy. The researcher explained the study purpose to the participants and reassured them of confidentiality after which written consent forms (Appendix C) were signed by both the researcher and the participants before the interview began. Both the researcher and the participants retained copies of the informed consent forms.

The researcher's thoughts, ideas, and interpretations about what she observed during the interviews were written in her field notes. The field notes helped the researcher to make sense of the data and also added context and depth to the study findings during the data analysis (Creswell, 2007).

### **Pre-testing**

Research suggests that it is advisable to test a developed methodology on a smaller sample to amend possible errors before applying it to the actual sample (Burn & Grove, 2011). As a result, a pre-test was conducted at the University of Cape Coast Hospital using two registered nurses to ensure clarity of the interview guide. This hospital was chosen because it had similar characteristics like those of CCMH (Burn & Grove, 2011). Although Creswell (2007) noted that qualitative studies may not necessarily require pre-test due to its flexibility, yet the researcher found it very necessary in this study. The pre-test result helped the researcher to make good changes to the initial interview guide. For example, the initial interview guide had no probes, but after the pre-test, the researcher was able to add relevant probes that assisted in eliciting rich in-depth experiences of participants during the interview. The pre-test also served as an opportunity for the researcher to practice and improved on her own interviewing skills.

### **Data Processing and Analysis**

Data was collected through an in-depth semi-structured interview and analyzed inductively, utilizing a qualitative content analysis described by (Creswell, 2007; Polit & Beck, 2010; Miles & Huberman, 1994). The data analysis for this study occurred concurrently with the data collection. The analysis process included data reduction; data display, drawing conclusion and

verification (Miles & Huberman, 1994; Punch, 2005). Qualitative content analysis is described as a systematic and objective way of analyzing large amount of qualitative data. The analysis is carried out by means of labeling, coding, organizing and integrating narratives based on emerging themes and concepts. The aim is to get familiar with the content of the data, make sense of the raw data and to also enhance proper description, interpretation, and discussion of the phenomenon of interest (Creswell, 2007; Punch, 2005; Polit, & Beck, 2010).

Figure 1 below represents a summary of the method of data processing and analysis for this study. The steps outlined below were followed during the qualitative content analysis. First, the audio-taped responses of participants were transcribed verbatim manually by the researcher. The hand written transcripts were also typed into word document by the researcher. Accuracy of the transcribed data was checked by listening to each audio taped interview and reading through the transcripts simultaneously (Creswell, 2007; Miles & Huberman, 1994). Secondly, the researcher read through transcribed data several times to have a complete understanding of the content of the entire data, and to have a holistic view of the participant's experiences with the patient advocacy role.

Thirdly, significant statements in the transcribed data were identified and reduced into themes. A list of significant statements made by participants in relation to the advocacy experience was developed. This step was carried out by first printing out a hard copy of the transcribed data. The researcher carefully read through each participant's transcript, underlying significant statements, meaningful single words, whole sentences and key phrases as units

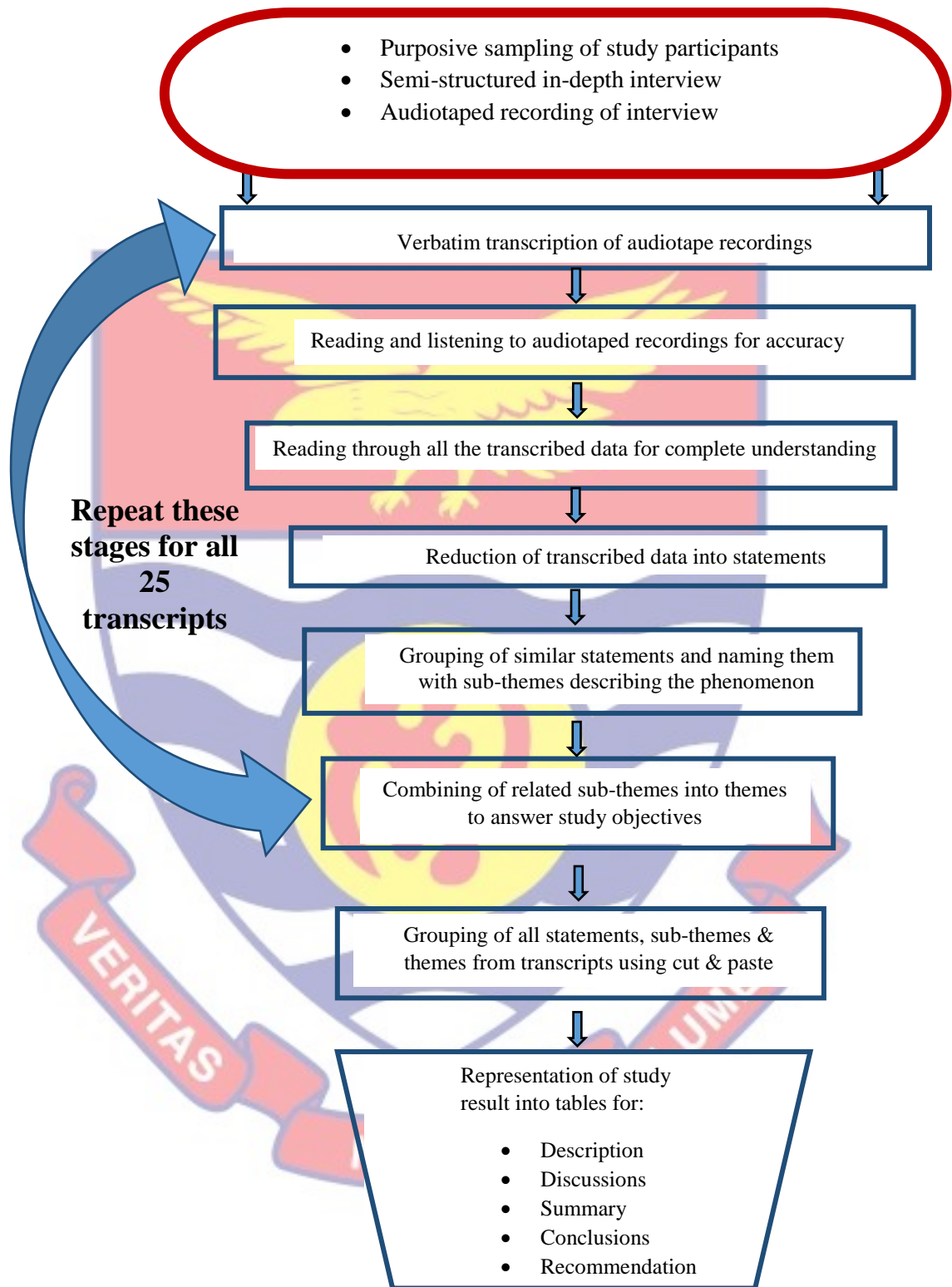


Figure 1: A summary of data process and content analysis

of analysis and reducing them to form sun-theme. The sun-theme and themes identified were written in the margin created beside the line of the transcripts where it was found (Appendix F). Each theme was viewed as equally important as others (Creswell, 2007; Polit & Beck, 2010).

The fourth step involved listing of all significant statements. The statements were all listed horizontally. Similar statements were further grouped into sub-themes describing the phenomenon. The fifth step dealt with further grouping of the sub-themes. All related sub-themes were combined into themes answering the research objectives (Miles & Huberman, 1994). The above steps were repeated for each of the transcripts. New statements, sub-themes and themes that emerged during the process were added to their respective files until the entire scripts were examined (Creswell, 2007; Polit, & Beck, 2010).

Various files were formulated for statements, sub-themes and themes. Using the methods of cut and paste, the researcher managed the process by cutting and pasting data from one transcript after the other using different colour fonts. The researcher read original transcripts and ensured that all necessary information had been categorized as expected. All statements, sub-themes and themes were further reviewed to ascertain their appropriateness (Creswell, 2007). Through the content analysis of the data, the researcher gained understanding of the study findings, developed themes and meanings, clustered data to ensure appropriate written description of the patient advocacy phenomenon. Data were displayed in tables made up of statements, sub-themes and themes for discussion and appropriate recommendations



(Creswell, 2007; Polit & Beck, 2010). Detailed study results have been provided in chapter four of this study.

### **Trustworthiness of the Study**

Trustworthiness in qualitative study is explained by Creswell (2007) as a means of ensuring the quality of a research. Several methods were used to improve trustworthiness in this study. First, to achieve credibility, detailed description of sampling method, data collection procedure and analysis were clearly documented. Participants in this study were purposefully selected to ensure that they could provide an in-depth information on their experiences with patient advocacy. Credibility was further assured through member check, peer review and prolonged engagement with study participants (Creswell, 2007). Two expert supervisors, one professor in nursing and one doctoral nursing student reviewed the researcher's method of data analysis, study findings and its interpretations separately. Discrepancies were discussed and necessary amendments were made to avoid researcher bias.

The member checks were done by verifying responses and interpretations with the participants at the end of each interview before drawing final conclusions from the data. The feedback obtained from the participants ensured correct and clear presentation of participants' experiences. Guba and Lincoln (1981), Polit and Beck (2010), and Creswell (2007) are of the view that study sample must be adequate in size and sufficiently varied to enhance confirmability and transferability. Adequacy of sample size in this study was enhanced by selecting 25 participants from diverse units across the hospital. Vast range of views and experiences were captured. Most themes were mentioned by more than one participant.

Theoretical saturation was attained as mention of themes became increasingly redundant (Creswell, 2007).

In addition, significant agreement of the themes and categories identified in this study and those of nursing literature indicate that the research findings have been confirmed by other researchers. Detailed descriptions of participants' characteristics, demographic data, and the study setting have been documented in the final report of this study. In ensuring authenticity, direct quotes from participants' narrations were provided to enable readers have a feel of the realities of participants' experiences.

### **Ethical Considerations**

The research study commenced after permission was granted by both Institutional Review Board (IRB) of the University of Cape Coast and the authorities at the CCMH. An introductory and permission letters were obtained from the School of Nursing and Midwifery at the University of Cape Coast. The letter was sent through the medical superintendent of CCMH to seek permission from the Deputy Director of Nursing Services (DDNS) and to the managers of all the wards in which the study were conducted. An informed consent was obtained from all participants before any information was collected. Participants were assured that their rights to privacy and confidentiality would be protected. Participant's identity and responses was kept anonymous. To maintain confidentiality, demographic data (Appendix D) that was obtained from participants were excluded from the audio taped portion of the interview. Each participant was assigned an identifying number, known only to the participant and the researcher at the start of the recording session. Participation was purely voluntary; therefore, participants

can withdraw at any time without penalty or consequence. Participants were informed that they will be engaged in 45 to 60 minutes of an interview with the researcher in a location and at a time appropriate for both. Participants may choose not to answer any particular question or questions.

Finally, the study data were managed appropriately to prevent breach of confidentiality. The raw data collected from participants was transcribed from the audio recorder and secured on a computer with a password, only the researcher had access to the password. Transcribed data were type written, printed and stored anonymously in a locker with a key accessible to only the researcher. After the completion of data analysis, the researcher backed up the data by storing the information on a pen drive and secured anonymously in a locker with a key. The information for the study will be stored for at least two years after the completion and publication of the study findings before it would be destroyed.

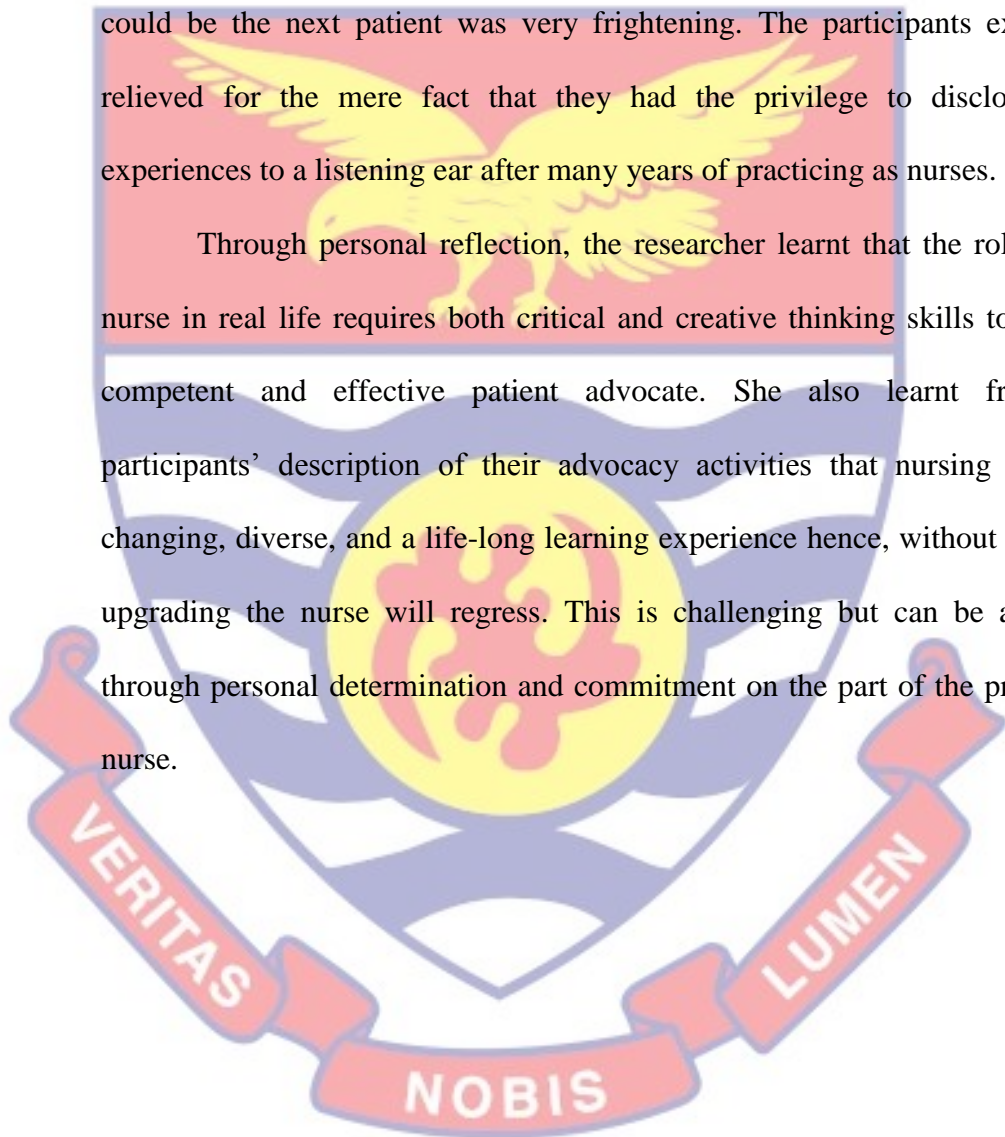
In summary, the methodology of this study, the sampling procedure, data collection and data analysis has been explained in detail including ethical considerations. The next chapter focused on discussion of the key findings from the data collected in accordance with identified themes.

### **Field Experiences**

The researcher's achievement of her goal in this study has been challenging but exciting, revealing and worthwhile experience. The study exposed the researcher to the realities of nurses carrying out their patient advocacy role. The researcher had a feel of what nurses go through in their everyday life as they advocate for patients at the CCMH. In fact, emotional reactions such as empathy for patients and greater admiration of the sacrificial

nature of the nursing profession were the researcher's feelings during the interview sections. The researcher's experiences of intense mixed emotions resulted from the interviews with nurses who disclosed instances of patient's death right in their sight after several attempts to advocate for those patients failed. The thought of the fact that anybody at all including the researcher could be the next patient was very frightening. The participants expressed relieved for the mere fact that they had the privilege to disclose their experiences to a listening ear after many years of practicing as nurses.

Through personal reflection, the researcher learnt that the role of the nurse in real life requires both critical and creative thinking skills to remain competent and effective patient advocate. She also learnt from the participants' description of their advocacy activities that nursing is ever-changing, diverse, and a life-long learning experience hence, without constant upgrading the nurse will regress. This is challenging but can be achieved through personal determination and commitment on the part of the practicing nurse.



## CHAPTER FOUR

### RESULTS AND DISCUSSION

This chapter provides a detailed description of the findings that emerged from the analysis of the responses of study participants' role as patient advocates. The specific objectives guiding this study were to: (1) explore the registered nurses' description of patient advocacy, (2) describe how registered nurses carry out their role as patient's advocate, (3) explore experiences of nurses in acting as patient's advocate in clinical practice and (4) explore barriers to the practice of patient advocacy among registered nurses. This section of the chapter provides description of the study participants followed by detailed analysis of the findings that emerged from this research based on the study objectives.

#### Study Results

##### Description of Study Participants

It is important to understand key characteristics of the nurses who participated in this study. Yet, for the purpose of confidentiality, the individual characteristics of the nurses are described in general rather than specific terms. First, the nurses who responded to the interview did so voluntarily and none of them was financially rewarded for participating in the study. Secondly, these nurses were full-time workers in the health facility where the study was conducted. Based on the hospital's policy, nurses are rotated each year across the various units within the hospital. Therefore, most of the participants have had the opportunity to practice and also advocate for patients in almost all the units within the hospital. The nurses agreed to participate because they felt it was an important and timely study that could enhance the safety and quality

care of patients in Ghanaian hospitals. A summary of participants' demographic data is presented in Table 1.

Table 1: *Participants' Demographic Characteristics*

<b>Age/years</b>	<b>Frequency</b>
20 – 30	16
31 – 40	6
41 – 50	1
51 and above	2
Total	25
<b>Sex</b>	<b>Frequency</b>
Male	3
Female	22
Total	25
<b>Years as Registered Nurse</b>	<b>Frequency</b>
1 – 5	15
6 – 10	6
11 – 15	2
21 and above	2
Total	25
<b>Years Worked at Facility</b>	<b>Frequency</b>
1 – 5	17
6 – 10	5
11 – 15	2
16 – 20	1
Total	25
<b>Nursing Education</b>	<b>Frequency</b>
Diploma	17
Degree	7
Certificate Midwife	1
Total	25

Table 1: *Continued*

<b>Current Rank</b>	<b>Frequency</b>
Staff Nurse	9
Senior Staff Nurse	6
Nursing Officer	4
Senior Nursing Officer	3
Principal Nursing Officer	1
Rotation Midwife	1
Staff Midwife	1
<b>Total</b>	<b>25</b>

**Source: Field data, Nsiah (2016)**

A total of twenty-five (25) registered nurses comprising three males and 22 females practicing within various units of CCMH participated in the study. The age of participants ranged from 20 and 51 and above. Similar to the ages, the participant's years of work experiences as registered nurses also varied from each other. Out of the twenty five participants, fifteen (15) nurses had worked between one and five years, six nurses ranged from 6 to 10, two had 11 to 15 work experience while the remaining two confirmed their years of work to 21 years and above. Beside their work experiences as registered nurses, the participants were not completely new in the health facility. Participants' work experiences in the facility ranged from one to 20 years. Nursing ranks of these participants ranged from staff nurse to principal nursing officer.

#### **Nurses' Descriptions of Patient Advocacy**

The first objective of this study was to explore the registered nurses' description of patient advocacy based on their experiences. In an attempt to address this objective, participants were asked to describe the concept of patient advocacy. Seven main themes defining patient advocacy were identified based on the participant's responses as indicated in Table 2.

Table 2: Nurses' Descriptions of Patient Advocacy

Statements	Sub-Themes	Themes
Acting as a mediator for the patient Carry out certain activities for the patient Sometimes you have to talk to the family Stand and defend for your patient Standing in for the patient Standing in on behalf of the patient To defend the patient We as nurses stand in the gap and do the needed thing Standing in for the patient need You stand in the place of the patient	Acting on behalf of patients	Protecting
As a nurse you speak up for your patients Being the mouth piece of the patient Communicating their needs Speak on their behalf Speaking up for patients Stand in and speak for her Talk for the patient Talk to the doctor about whatever the patient need To speak to the doctor for patients You talk on behalf of the patient	Speaking up for patients	Being patient's voice
Best care Care for the patient Care that we need to render Caring for their needs Giving quality health care Good care Maximum care Quality care Quality personal care The patient is in a better way taken care of	Ensuring Quality Care of patients	Provision of Quality Care
Help them with their care Helping in settling patient's bills Helping our patients to recover Helping patients to get well Helping the unconscious To help patients Helping them to get the necessary help	Helping patients when needed	Supporting



Table 2: *Continued*

Statements	Sub-Themes	Themes
The patient can come in and speak something that they think that is what will be better for the patient.	Self-determination	Self-determination
To educate the patient on their conditions To get the patient to understand	Educating patients	Educating
Interpersonal relationship between the nurse and the patient Our relationship with them and their relationship with us	Interpersonal Relationship	Interpersonal relationship
Administering their medications on time Being there for the patient We try to calm and tell them that we are here for them You being there for your patient	Being available	

**Source: Field data, Nsiah (2016)**

The participants describe patient advocacy as protecting the patients. This advocacy involved protecting patients from injury, acting on behalf of patients, representing and safeguarding patient's right. They believed that all patients are vulnerable and limited in knowledge regarding their health conditions compared to the nurse. Advocating for the patient, therefore means protecting the patient from injuries both present and anticipated, negative actions and inactions of relatives, colleague nurses, physicians and other health care professional that might not promote safety and quick recovery of the patient. Acting on behalf of patients involved defending, fighting for patients, and acting as a mediator as well as standing in to acquire needed resources for patient care. Below are direct statements of some participants:

...Sometimes when our clients come to the hospital sometimes they need somebody to stand in for them to help them with their care and speak sometimes on their behalf to the management or other people. So I think advocating as a nurse just means that I am standing in for the patient in time of need. So far as they come to the hospital, they are

coming in for some sort of help. So we are there to help them to get the necessary help and needs... (Mrs. C1)

Patient advocacy in my view is the nurse being there for the patient or the nurse insisting on the rights of the patient. The nurse being able to insist on the rights of the patient to make sure that the patient is in a better way taken care of... (Mrs. C 2)

...to help them know their rights and maybe in case there is any human right abuse against them (patients), you fight against that to you help them. (Mr. P1)

A second theme that emerged was being patients' voice which was a major component of the participants' descriptions of patient advocacy. All the research participants described advocating for the patient as being patient's voice. This included speaking up, speaking for, and speaking on behalf of the patient. The participants revealed that patients are mostly vulnerable. The patients either do not know what they need to enhance their healing process or they are unable to present their needs and request to both doctors and the health authorities due to fear. The following were statements of some participants:

...maybe the patient is feeling shy to talk to the doctor. So you stand in and talk to the doctor about whatever the patient need or want. Because as you are with them you gain their trust so they can tell you everything but they can't tell the doctor... (Mrs. O 3)

Ok, to me it is basically being the mouth piece of the patient in terms of you communicating their needs and concerns let's say to the public or if necessary to the government, organizations or to institutions responsible. (Mr. P3)

Patient advocacy is about how as a nurse you speak up for your patients to ensure that they get the best. Sometimes, the patients may come to us but they don't know much about what is happening to them. So having the technical knowledge, there are a times you have to speak up for the patients when it comes to taking critical decisions... (Mrs. T1)

The participants stated that the goal of the patient advocacy was to achieve quality care of patient which was the third theme. Participants described patient advocacy as providing quality patient care. Some participants expressed these sentiments:

As nurses we always advocate for the patient as part of giving quality health care...it means going out of your way to help patients get or achieve the best care they are supposed to have. (Mrs. O 2)

...Caring for their needs, administering their medications on time, feeding them and helping the unconscious patients in order for them to be discharge early... (Mrs. M 3)

...It's how we the nurses stand in for our clients and patients. If they need our care, like the things we need to work for them and the care that we need to render the patient and then how we can get our material and the tools that we use to give them maximum care. (Mrs. O 5)

...What I understand is that you take good care of them... (Mrs. O 6)

Supporting the patients was another major theme used by the participants to describe patient advocacy. This theme covered the areas of giving physical, emotional and financial support for patients. It also meant nurses were available to help whenever needed by their patients. The participants made the following comments:

“Patient advocacy is basically about you being there for your patient, when your patient expresses any need...” (Mrs. F2)

...Helping our patients to recover from their illness... (Mrs. M 3)

Well, I will say that being a patient advocate means putting yourself in the patient's shoes, standing in for the patient in anything that the patient does not understand... (Mrs. M 4)

So if for instance you have a patient and you have a medial practitioner who normally shouts on patients, as a nurse since you have studied your patients and you know how patients mean to you, you can stand and defend your patient. (Mrs. T2)

Even though only two nurses mentioned self-determination in their description of patient advocacy, the researcher saw it as a very important point to be noted. These nurses believed that it was not only the nurse who could advocate for patients. Instead, the patients could also advocate for themselves. The patient has the right to be assertive, speak and defend themselves when necessary. Two participants expressed that:

...Sometimes the patient can come in and speak something that they think that is what will be better for the patient... (Mrs. CH1)

...it means empowering the patient to speak out... (Mrs. F 2)

The interpersonal relationship as described by all participants dealt with establishing rapport with the patient and family member. It also involved getting to know the patients, their needs, respecting and valuing them as well as involving them in the entire care. Two participants viewed patient advocacy and the entire process involved as interpersonal relationship. They believed without it, there will not be patient advocacy. For instance, two nurses made the following statements:

...Patient advocacy, I think is an interpersonal relationship between the nurse and the patient, how cordial it is between them... (Mrs. O 1)

“Is how we treat patients, our relationship with them and their relationship with us, whiles it include relationship, everything is included. (Mrs. OP 1)

Valuing and respecting under the interpersonal relationship theme were very important point raised when respondents were describing patient advocacy. The nurses viewed patients as human beings who unfortunately were ill. Thus, advocating for them meant respecting them, recognizing their

individualities and giving them dignify care without any intimidation. For example one participant in defining patient advocacy noted that:

As much as possible, when they come to the ward, we try to calm them and tell them that we are here for them. So they should feel free and ask whatever they need so that we can also give them the quality of care that is needed. So that at the end, they will have a quick recovery and they will go home. (Mrs. E 1)

Some participants described educating as a patient advocacy. To those participants, education meant enlightening the patients on their health conditions and getting the patient to understand all that will be involved in their care process. Understanding the care process enhances cooperation and speedy recovery. For example, a participant mentioned that:

...advocating for the patient is when you try to educate the patient on their conditions when you want to get the patient to understand. In our case for instance when you want to admit, then getting her to understand the reasons for the admission, the complications and getting the family on board to help in the health care delivery. (Mrs. O 7)

### **How Nurses Carried Out Their Patient Advocacy Role**

Analysis of the participant's responses to the question of how nurses carried out their patient advocacy role or activities that went into the advocacy process is presented in Table 3. Responses obtained from participants produced 24 sub-themes out of which eight themes were derived.

According to the participants, the number of hours spent mediating for the patients on the ward helped them to appreciate patients' situation. The mediating activities involved standing in between relatives, physicians and health team, and even in some cases, the payment of patient's hospital bills. The nurses in advocating for their patient acted as intermediary between the patient and the doctor. They also liaised with the hospital management and members in the health care team, as well as, other health care givers outside

Table 3: *How Nurses Carried out their Patient Advocacy Role*

Statements	Sub-themes	Themes
<p>An intermediary between the patient and the doctor</p> <p>I told the doctor and she was taken care off</p> <p>Liaise with the kitchen and then other departments</p> <p>Mediate between them and other health care givers</p> <p>We discuss with family members to support</p> <p>stand in for the patient so that the family can pay</p> <p>We try to talk to the husband to understand.</p> <p>You can suggest that this person need scan or x-ray</p> <p>You stand in for them and explain</p>	<p>Mediating on behalf of patients</p>	<p>Mediating</p>
<p>Help them in terms of management of their bills</p> <p>We advocate on their behalf to solicit for funds to help them settle the bills</p> <p>We mediate and intercede for them sometimes to have a spacing time to pay their bills</p>	<p>Mediating in hospital bill payment</p>	
<p>As nurses, we step in for them the patient's interest is upheld</p> <p>Protecting them</p> <p>Stand in for the patient</p> <p>We fight for the welfare of the patient</p> <p>We stand in when their husband are around</p> <p>When patient is to be discharged, there are times you have to come in as a nurse</p> <p>Fight for the equipment or the items in order to better care for the patient</p>	<p>Defending</p>	<p>Protecting</p>
<p>Identifying emergency cases and seeing to it that they jump the cue</p> <p>Insisting on having emergency drugs</p> <p>Making sure that all that you need to work with is available</p> <p>Proactive</p> <p>With your little experience you can tell that this patient needs ABC</p>	<p>Acting proactively</p>	

Table 3: *Continued*

Statements	Sub-themes	Themes
Talk to the doctor about it so that the patient is not given a wrong dose or wrong medication. They write medications or some things but then you realize that there are mistakes You may have a prescription and may be due to oversight the dosage might be wrong	Correcting near misses to prevent harm	Protecting
Tell them this and this is why we want to do this thing We tell them it is in the interest of the patient to be referred You have to tell them why you are doing that for them. You inform the patient	Informing patients	Counseling
Let the doctor know so that the patient can stay longer Some patients can't talk; we have to tell the doctor their problems	Informing others in the team	
We speak for them to the doctors and let them know what is really happening to the patients You report to your ward in charge to take it to the appropriate place	Informing others in the team	
Collaborate with social welfare and relevant institutions Collaborate with them It also involved collaboration Sometimes you need another person to talk to them before they agree. The nurse in consultation with her authorities can contact the leaders in the community and discuss possible solutions	Collaboration	Promoting continuity of patient care
Ability to communicate very well is the key Communication is the number one key communicate well We continue to talk to them You also talk to the patient You write the complaints of the patient	Communicating	

Table 3: *Continued*

Statements	Sub-themes	Themes
Prompt referral Refer them to the social welfare	Referring	Promoting continuity of patient care
I encourage them to start something that will bring income empower them You encourage them to speak out their problems	Empowering	Teaching
Explain and communicate well to the clients. Explain to the client why they have to join a long cue Explain to them about their diagnosis If they lack knowledge about anything you have to explain to them We explain certain things to them We help the people to understand what goes on You have to explain to the patient	Explaining	
We educate them and advise them We educate them on the need to enroll in the health insurance scheme A nurse you can stand in and educate them	Educating	
You become the patient's mother and everything	Acting as surrogate	Caring
Help in some situations. Helping our patients to recover from their illness Helping the unconscious	Helping patients	
Sometimes we even pay for the bill for them We put our heads together, collect money to pay and discharge them	Supporting	



Table 3: *Continued*

Statements	Sub-themes	Themes	
Address them with their names as soon as they come	Respecting and valuing	Caring	
Make sure that our patients are mostly welcome			
Make them relax			
Making them feel at home			
Meet them with a smile			
Reduce all anxiety			
Welcome them			
You greet them			
Assessing			Assisting and caring for the patients
Bed bath			
Feeding them			
Tepid sponging			
Administering their medications on time			
Caring for their needs			
Holistic care of the patient			
We also do both spiritual and physical care			

**Source: Field data, Nsiah (2016)**

the health facility. In addition, nurses mediated between patients and employers regarding their need for a change in the job descriptions due to change in patients' health conditions. These activities occurred throughout patients' hospitalization as the need arose. The responses of participants regarding their mediating activities for patients included:

...Sometimes they may find it difficult to find something from a department. And being a nurse, most of the clients are very comfortable with us. So we have to mediate between them and other health care givers, the doctor, the lab, they will go there and wouldn't know what to do so we have to mediate as well... (Mrs. E 1)

...The other time we were supposed to check patient's sugar level, but that time patient's family were arguing that it was not necessary. So we have to stand in for the patient so that the family can pay for the cost of the test for the patient. (Mrs. F 1)

...Due to our experiences on the ward, at times you may have a new doctor and because of the nature of the conditions, we can talk to the doctor and suggest that if you can do this lab or request for this investigations, it will help. Because this profession is a team work, you

may have a doctor who is new to the profession and you may have to advocate for the patient... (Mrs. M 2)

...Sometimes too when a patient is to be discharged, there are times you have to come in as a nurse. Because sometimes the appearance of the patient might look good to the doctor but you might have observed some changes over the night, and you need to let the doctor know so that the patient can stay longer. This is just a few of them. (Mrs. T 1)

The participants mentioned that most patients who went on admission found it difficult to pay their bills during discharge. The nurses therefore advocated by negotiating with appropriate authorities for the patients to pay their bills in instalments. Participants stated that in most cases they had to act as sureties for patients. In the event that patients refused to fulfil their promises, those nurses were made to pay. Some participants stated the following:

...in cases of their bills and stuff we stand in for them. Moving in through the social welfare, we mediate and intercede for them sometimes to have a spacing time to pay their bills... (Mrs. C 1)

Some patients when they are being discharged especially those who are non-insured; sometimes they find it difficult in settling their bills. So as nurses, we step in for them and then we see the management on how best we will be able to help them in terms of management of their bills...So at times, we advocate on their behalf by solicit for funds to help them settle the bills...(Mrs. M 2)

...Sometimes they don't even have money to buy the drugs... we even pay for the bill for them. Sometimes a patient is discharged and she can be here for over a week due to the bills and they tend to out scorn. Then you the nurse on duty will be held responsible. So we put our heads together, collect money to pay and discharge them. (Mrs. M 4)

The participants noted that the four main advocacy activities they carried out under protection included defending, protecting the patients, correcting near-misses to prevent harm and acting proactively either to prevent anticipated injury, complications or death. It also included making prior request for necessary supplies or equipment that will enhance healing

and speedy recovery of patients. The nurses stood in for the patient, making sure that the patient's interest was upheld. They also fought for the welfare of the patients and in some cases discussed with the doctor for possible amendments when they anticipate or realized that there are mistakes, wrong dose or medication.

... Identifying emergency cases and seeing to it that they jump the cue. Insisting on having emergency drugs set aside for such things. You must be proactive... (Mrs. O 2)

... You try to make sure that the patient's interest is upheld in the case of dealing with doctors and dealing with authorities as well. For instance there are times you will really want to take care of patient but then you don't have the equipment you want. You need to go to the authorities to fight for the equipment or the items in order to better care for the patient, making sure that the patient's interest is your number one priority... In the case of doctors there are times they write medications or some things but then you realize that there are mistakes or oversight. So you want to further research into the medication or the dosages and then talk to the doctor about it so that the patient is not given a wrong dose or wrong medication. (Mrs. C2)

According to the participants, patients were vulnerable and did not always have adequate information about their health conditions. Patients were assisted through counseling by providing them with relevant details of their health conditions and informing them about the reasons behind their treatment options. Participants also assisted patients to make informed decisions regarding their care as evident in some participants' statements:

..It's not only about medication or vital, but also spiritual and counseling are all involved... (Mrs. O 5)

...may be the patient has some misconceptions, she has been told something in the house, so we try to counsel them and tell them this and this is why we want to do this thing...(Mrs. O 7)

...Sometimes too you have to explain to patients about their surgery. Sometimes you have clients coming in but their relatives are against their surgery. They have their own superstitious beliefs, but you have to explain to the patient and help her to take a decision... (Mrs. T 1)

Promoting continuity of patient care consisted of collaboration, communication, and consultation among relevant parties involved in the caring process. The parties were team members, hospital authorities, physicians, ward in-charges, and other inter-disciplinary team members. A cross-section of participants stated that:

...You have to collaborate with them and other staff also because you alone cannot do it...You need each other to help yourselves. (Mrs. M 3)

...our drugs too that we don't have, we mostly consult administration for help, example, emergency drugs and other things, and then we have some individuals who also come to pray with the patients...(Mrs. O 5)

We advocate for prompt referral and coming to the hospital early when they see complications. With prompt referral you have to liaise with the hospital, the patient, sometimes the relatives, making them come around and the physicians... (Mrs. O 7)

...We also collaborate with social welfare and relevant institutions... (Mr. P 3)

Teaching is a major activity nurses embarked on during patient advocacy. The theme comprised explaining, empowering and educating the patients to enable them to make informed decisions that would enhanced the healing process. Nurses explained to family members, and other members of the health team when necessary to get their support in the advocacy process.

...The client's relatives if they come we make sure that we explain certain things to them. Sometimes when they come because of the insurance they think they don't have to buy anything for the patient. But we make sure that they understand that the insurance does not cover all the drugs. Especially with our patients sometime we stand in when their husband are around making them know that their health is important to us... (Mrs. O 4)

...We also explain to them about their diagnoses and let them know more about it. If they lack knowledge about anything you have to explain to them... (Mrs. OP 1)

The issue of caring was the sixth theme of patient advocacy activities identified from the participants responses. This aspect of caring was described as acting as surrogate, supporting and assisting the patients in all areas of their needs, as well as, the nurses' normal duties of managing the patient on the ward. Specific actions undertaken by nurses during the caring activities involved: assessing, bed bath, feeding, administering medications on time, caring for daily needs and providing holistic care of the patient especially spiritual and emotional care. The participants noted the following:

...bed bath, feeding, checking of vital signs, tepid sponging, giving suppository and helping them any means to get well... (Mrs. F1)

I want to start on simple bed lined. You can see the patient trying to assess and express their right that the bed lined should be changed. But because of Africa economy is like once the bed is laid it cannot be changed. But putting myself in the shoes of the patient, I will normally stand in for them, and permit me to say I ask my junior nurses to give them new linen and I can see smiles on their faces. When it comes to the unconscious patients they can hardly tell you what they need. But by the grace of God and with your little experience you can tell that this patient needs ABC. Even when you are doing it for them you can see them reacting and responding, though unconscious you see the eye balls telling everything... (Mrs. F 2)

...While the patient is on our care, the holistic care of the patient depends on us. So any sector of the hospital that patient need help we can stand in. Even on the food they eat we can stand in and advocate for them... (Mrs. M 1)

Supporting aspect of the caring theme consisted of providing financial, psychological, physical and spiritual support. It also included helping patients in every possible way and acting as surrogate for patients whose relatives had either neglected them or were not available to offer the needed support at the right time. The nurses therefore acted like the patient's mother, helping them to recover from their illnesses. In some instances, the nurses paid for their hospital bills after discharge. For instance, some participants stated that:

Some relatives too when they bring the patient, they will not come here again. That way you become the patient's mother and everything. (Mrs. F 1)

Sometimes in the morning when they are hungry you the nurse you buy food for them using your own money. Somebody will come here who is bed ridden without pampers; you have to buy it for the patient. If you don't the patient will get soaked and your ward will smell so you have to buy it. (Mrs. M 3)

...Sometimes you need another person to talk to them before they will understand and agree with you. We do our best to support them. At times we discuss with family members to support the clients and help them to rest. (Mrs. O 4)

Mostly our patients, the health issue itself is not about maybe the mere illness. They may need some psychological support, which is the health personnel, so we support them. At times, you will hear some people say this condition (sickness) is not hospital matter, so it may be spiritual. And somebody can say "Auntie Nurse pray for me". So at times we also do both spiritual and physical. (Mrs. O 5)

Respecting and valuing included aspects of caring related to being respectful to patients and family members, reassuring the patients and getting to know the patients, their peculiar needs and wishes. Patients usually come to the hospital as strangers, full of anxieties, with specific needs sometimes known to them only. Therefore, in order to perform proper assessment, identify patient's needs for the appropriate diagnosis and treatments, nurses had to advocate for the patients. Such activities involved making the patients feel at home, reduced anxiety through reassurance and probing to find out more about what was really happening to them. The participants noted that:

...I normally make sure that our patients are mostly welcome by making them feel at home, addressing them with their names. As soon as they come I meet them with a smile. Even if they have needs that don't suit our jobs, you still need to try and make them relax by making them feel that you are here to help them. By this, they are able to communicate better for us to understand and be able to help them... (Mrs. E 1)

... You greet them, smile to them and welcome them. That way even if the patient is in pain it will reduce, it will reduce all anxiety. (Mrs. O 6)

### Barriers to the Practice of Patient Advocacy

The third objective in this study was to explore barriers to the practice of patient advocacy among registered nurses. In the quest to achieve this objective, participants were asked to tell the researcher about the challenges or barriers they encountered when they advocated for patients. Analysis of data yielded 14 themes. These themes involved the health institution and work environment, the patients, legal support, anticipated negative outcome of advocacy, and fear of loss of job. In addition, limited communication, patient's family members, limited interpersonal relationship, lack of support for nurses, the nurses, the advocacy process, financial difficulties, inadequate knowledge and religious beliefs formed the remaining themes as presented in Table 4.

Table 4: *Barriers to the Practice of Patient Advocacy*

Statements	Sub-Themes	Themes
The environment	The health care institution itself	The health institution and work environment
The place we nurse the patient doesn't suit for that advocacy		
Authorities who don't really understand Rules and regulations given by the facility	The institution	
The codes of conduct of the facility		
The facility itself		
The institution	The institutional authorities serve as a barrier	
The institutional authorities serve as a barrier		
The policies of supervisors don't favour advocacy		

Table 4: *Continued*

Statements	Sub-Themes	Themes
<p>Colleagues discourage you</p> <p>Colleagues see you as a threat or they feel you want to get them to do more work</p> <p>Some colleagues will not do it and they will not allow you to do it</p> <p>They are not ready to change</p> <p>They will not make the place conducive for you to stay</p>	Lack of support from colleagues	The health institution and work environment
<p>You really need to spend time to speak to this patient before they understand</p> <p>It is time consuming</p> <p>It takes too long to get a simple thing</p> <p>We don't have the full time</p>	Limited time	
<p>You call a doctor and he says no, I will not come</p> <p>Patients will come and you call the doctor and he says no, continue to monitor</p> <p>The doctors are not cooperative at all</p> <p>The doctors will not agree with you</p> <p>When you suggest to them, some take it, but others will not take it</p> <p>You talk and talk but the physician will say what I have written is OK</p>	Physicians	The health institution and work environment
<p>At times you try your best but the hospital is not having those things you need to give out</p> <p>Logistics, we don't get them</p> <p>The facility does not have resources</p> <p>The labs are not working</p> <p>The things that you need, you will not find them</p> <p>There is no bag to collect the blood</p> <p>This hospital lacks many things</p> <p>Transportation means</p> <p>Treatments are also not available in pharmacy</p> <p>We don't have important drug</p> <p>We don't have the material to work with</p> <p>You don't have suctioning machine or NG tube</p>	Inadequate medical equipment and supplies	



Table 4: Continued

Statements	Sub-Themes	Themes
<p>If you need emergency drugs, the NHIS is not paying The NHIS It's a big problem</p>	The NHIS	
<p>Other persons refuse Superiors The facility does not have a social worker The nature and attitude of the person you want to contact for the advocacy The personnel that are also in charge The personnel to act on the problem The personnel to intervene when is beyond the nurse's capacity The staff are reluctant to help We don't have specialist here</p>	Lack of personnel to intervene when needed	
<p>The ward in-charge Your superiors Most dwells on our in-charges</p>	Ward in charges	The health institution and work environment
<p>The patients themselves A lot of illiteracy among our patients Our patients also don't understand Patient doesn't want you to intervene Patient's preconceptions before coming Patients has certain ideologies Some patients are not cooperative They don't see the nurse as a friend to establish that relationship the patient says I don't want it You want to advocate but the patient is not willing Because of patients' rights, at times you can't force the patient</p>	The Patients	The Patients
<p>Because of the legal backing, you can't defend yourself Even though you know what to do but because of the legalities you just can't help Lack of legal support Sometimes the legalities The patient right thing</p>	Legal support and patient's right	Legal support

Table 4: *Continued*

Statements	Sub-Themes	Themes
<p>The result not seems to be coming and it becomes frustrated for the nurse                      The outcome is also another challenge.                      The end result                      Should that thing fail?                      Fear of being in trouble                      You might think that if something negative occurs, or the outcome might be bad                      The consequences might be devastating</p>	Possible outcome of advocacy	Anticipated negative outcome of advocacy
<p>I have reported it to my in-charge and she has not said anything about it, I will not stand inn again another time                      I would not talk about it again                      If I have advocated for someone and sail through and things did not go well for me the next time I will not do it again.                      The next day, you won't do anything again because nothing good will come out of it                      The patient become disappointed                      The response you get from reporting the issues</p>	Previous experience	Anticipated negative outcome of advocacy
<p>The result not seems to be coming and it becomes frustrated for the nurse                      The outcome is also another challenge.                      The end result                      Should that thing fail?                      Fear of being in trouble                      You might think that if something negative occurs, or the outcome might be bad                      The consequences might be devastating</p>	Possible outcome of advocacy	
<p>The risks                      The risk of travelling are all involved</p>	Associated risks	
Prayer camps	Religious activities	Religious beliefs

Table 4: *Continued*

Statements	Sub-Themes	Themes
Awkward relationship between you and there other staff Human relationship They don't see eye to eye with you Challenges like communication and interpersonal relationship, we must do well to prevent	The existing nurse patient relationship	Limited interpersonal relationship
It's a challenge trying to communicate everything so that nothing goes wrong Poor Communication skills The communication There are people who really don't know how to communicate. You can get the other person angered by the way you bring out your point The problem is with effective communication	Communication	Limited communication
Families are not supportive Family just come and dump patient in the hospital and the nurse has to do everything Relatives may not understand Relatives too are not appreciative The husband The relative don't understand You expect the family, father and mother to even pick calls when you call, but they will not The relative are not appreciative	Patient's family and relatives	Patient's family members
If I try to prescribe and something goes wrong and they call I will not get support If something goes wrong, who will support me? Should anything happen who will stand behind you? We don't have clear guidelines as to how nurses are backed You become helpless	Lack of support for nurses	Lack of support

Table 4: *Continued*

Statements	Sub-Themes	Themes
As nurses are not assertive enough Background of the person whom you are dealing with You should be assertive to always pull things through It is quiet subjective Commitment	Nurses' personal characteristics	The nurses
At the beginning it is very difficult Extra work Is sometimes tiresome The bureaucracies The channels you need to pass through To do one thing right is not easy You have to you move from here, go here, do this When I first tried to advocate for a patient, I got fed up and I said why don't I stop? It is just difficult pushing it It's not easy but we need to do our best It is difficult	Complexity of the advocacy process	The advocacy process
Lack of financial support Poverty The economic status of the patient The guys who took the patient have to use their own money The patient does not have the money They need to spend a lot of money for that thing but they don't have You advocate for the patient but there is no money for the patient to go They can't purchase this for this or that. In the long run, your hands are tied	Patient's financial status	Financial difficulties
Education Knowledge is very important Lack of education on health issues Lack of knowledge You must have all your facts and explain things Knowledge You become helpless	Knowledge	Inadequate knowledge

Source: Field data, Nsiah (2016)

The first theme identified under barriers was the health institution and work environment. This theme covered eight main areas such as: the health care institution itself, colleagues, limited time, inadequate medical equipment and supplies physicians, lack of personnel to intervene when needed, the national health insurance scheme (NHIS), and Labeling at work. Below were

direct speeches of participants:

...We face a lot of challenges when sometimes you try to help or speak for a patient. They (colleagues) think you have turned to the other side instead of their side but may be they are doing something which is not good. So you speaking for the patient may bring awkward relationship between you and the other staff. When you come to the facility itself, I will say they don't give you the chance to advocate for the patients in terms of the rules and regulations given by the facility. (Mrs. OP 1)

...It is the doctors that don't support us at times. Sometimes patients will come and you call the doctor and he says no, continue to monitor, but you know something bad will happen if they don't come and do something. At times a very serious problem which is beyond your control, you call a doctor and he says no I will not come I don't suture those things... This hospital lacks many things. Even a bag for patients to donate blood there is none available... at times you need an ambulance at night to take a patient to another facility and there is none. (Mrs. T 2)

In fact, the number one problem here is the NHIS. It's a big problem. Everything that you request from above, the response is: "we don't have it in the hospital". So if you need fuel, there is no fuel, it means you cannot cater for the patient where there is light off. If you need emergency drugs, the NHIS is not paying. So we don't have it at the pharmacy. So you have to send the patient to town to get it. So what about if it's 10pm, 12am, or at night, what happens? The patient will die. So at times you try your best but the hospital is not having those things you need to give out. (Mrs. O 5)

...Some of your colleagues say is the patient your relatives that you are eager to help? But the person doesn't have to be your relative before you can help...Some colleagues discourage you. At times to some of the doctors are not cooperative at all because they think that they are ahead of us, so at times when you suggest to them, some take it, but others will not take it and refuse your offer. (Mrs. M 2)

... In the small unit where I am, if am going to be tagged and when I come to work I am not comfortable, then I wouldn't. Because you are coming to work and they will not make the place conducive for you to

stay. Because if a client comes and I want to help the client, some colleagues will not do it and they will not allow you to do it. (Mrs. C 1)

Participants stated that the patients themselves in most cases served as a barrier to patients' advocacy. Hindrances related to patients included: language problems, high illiteracy level, and inadequate knowledge about their health conditions. It also involved the patient's wishes, preference, superstitions and ideologies. Most patients did not cooperate with the nurses if what they wanted to do was contrary to their ideas.

...Sometimes, the patients themselves; at times you want to advocate but the patient is not willing so you cannot go ahead. Because at the end of the day, when we get to the next level, the patient will say I am not interested. So you are forced to let the situation remain as it is... (Mrs. T 1)

We have a lot of illiteracy among our patients, so sometimes they don't understand what is going on. So when you try to tell them their attitude pushes you away... (Mrs. OP1)

First of all I think some of the patients have certain perceptions and ideologies before they come to the hospital. So it doesn't matter how you educate them when they come they still stick to what they know from the house, they are not ready to change... (Mrs. O 2)

Legal support in this case was related to patients' wishes, rights and the associated legal backing, as opposed to the lack of legal support for nurses should they go contrary to patient's wish and advocate. Majority of the participants mentioned that sometime patients made decisions that would not promote their healing process but because of the legalities involved they just could not helped. Some of the participants cited the following examples:

Sometimes patient will come to our ward, you give patient medication, patient will tell you, I will not take it. The patient has their right, you will still explain to the patient but if he still says no, you cannot force the person. So I think legally sometimes it binds us from doing certain things for them, because if maybe I do certain things and then the outcome can have let's say a repercussion on me then I think I need to stop it. (Mrs. P 1)

Hmm, because of patients' rights, at times you can't force the patient. You don't have to do anything against the patient's wish. So if a patient says this is what I want you can't say I would not do it for you. At times this is what the patient wants but you know that this is not good for the patient. But you have to allow the patient... Sometimes you would want to do it by force but because of the legal backing, you can't defend yourself... (Mrs. O 4)

Anticipated negative outcome of advocacy dealt with possible outcome of advocacy process, previous experience of nurses when they advocated for patients and the associated risks involved. The nurses revealed that delayed result in previous attempts to advocate coupled with the fear of being in trouble should the process fail constituted formidable barriers to advocacy. In addition, the perceived repercussions in reporting the issues deterred nurses from engaging in further advocacy for patients. Participants gave the following examples:

We know that when you advocate for the patient you expect a positive feedback. And here is the case you advocate and advocate and the result not seem to be coming and it becomes frustrated for the nurse. When the advocacy is not successful the patient become disappointed to the extent that some of them lose the trust they have in you the nurse advocating for them... There are several cases where you attempt to advocate, but whatever you write, your superior comes and cancels it. So the next day, you wouldn't want to do anything again because nothing good will come out of it... (Mrs. P 3)

Sometimes you want to stand in for the patient and some of the patients are not trustworthy. For example, may be the billing issue, you go and stand in for them but they will not bring the money so you have to pay. In that way I will not stand in again another time. (Mrs. M 3)

Fear of loss of job was another challenge nurses faced in the advocacy role. Some participants stated how they were threatened with transfer from the hospital, if they continued to speak out for patients as noted below:

...Hmmm, at times, you can lose your job... (Mr. OP 2)

...It is possible to lose your job. (Mrs. M 4)

...Because I do it once and am told if I don't take care I am going to be transferred, then I will not do it again. In fact when I come to work and do my duties, if I leave the work that is all, nothing about work again.

Because if you transfer me to a place where my family is not there, I will not ... (Mrs. C 1)

Limited communication and interpersonal relationship which constituted gaps in communication were identified as barriers to patient advocacy. Lack of openness in relation to interpersonal relationships between the nurses, patients and the health care team was a hindrance to advocacy as evident in the following quotes from participants:

...At times the patient may not see the nurse as a friend. They already have their preconceptions or determined mind before coming to the hospital. So they don't see the nurse as a friend to establish that relationship with you for you to be able to get to know their need to be able to help them. (Mrs. C 2)

...The other thing is human relationship. Sometimes, you want to communicate to a person, but the person has built so much a defense and you cannot even go ahead and communicate to the person. Sometimes the nature and attitude of the person you want to contact for the advocacy. It can be a doctor, a superior, a colleague or a paramedic...Another challenge is about communication skills. There are people who really don't know how to communicate. You might be saying a good thing but you can get the other person angered by the way you bring out your point (Mrs. T 1)

On the part of the problems posed by the patients' family members, some participants had this to say:

Sometimes families are not supportive. Families that you expect that they will show much love and care are not supportive. There have been cases whereby families just come and dump patient in the hospital and the nurse has to do everything like the parents. You expect the family, father and mother to even pick calls when you call, but they will not. (Mrs. P 3)

...Language barrier; so you might have all your facts and explain things, but the relatives may not understand the language (I mean they may not agree with your point). Another challenge is Lack of education on health issues, especially concerning women. Also, superstitions, because they have a lot of ideas before they come so if you want to change everything at once you normally face a challenge. (Mrs. O 7)



The participants disclosed that lack of support for nurses from other health care teams impeded their quest to advocate for patients. Participants stated that nurses who tried to advocate for patients got themselves into trouble without any support from the nursing authorities. Concerns were raised regarding lack of clear guidelines in support of nurses who faulted in their bid to advocate for patients.

If you are advocating definitely you will need the help of a physician, a nutritionist, or maybe a physiotherapist, the lab people might have to come in. and if they are not ready or maybe they don't see eye to eye with you, they can't get your concept. And it will kind of make your job more difficult. Because when you get to one level and the other person refuses to take it up, there is a gap and advocacy becomes difficult. (Mrs. C 1)

Sometimes a patient come at midnight and there is no doctor but in my job description I am not supposed to prescribe, am just supposed to give first aid so I will only do my part. Even though you know what to do but because of the legalities you just can't help. If I try to prescribe and something goes wrong and they call I will not get support... (Mrs. OP 1)

...should the advocacy fail the fear of being in trouble make you think twice. (Mr. P 2)

The nurses' theme is in relation to the nurses' own personal characteristics such as lack of commitment, unassertiveness, personal beliefs and values about the advocacy role as evident in the following quotes from participants:

...sometimes we as nurses are not assertive enough... (Mrs. M 4)

Sometimes the staff ourselves are bit a reluctant to help the patients but myself when I see certain things I can't stay... (Mrs. O 2)

Sometimes is very sympathetic, empathetic, you feel for them, and yet in such cases some nurses don't care about whatever happens to the patient... (Mrs. C 1)

The advocacy process was said to be too complex, hence some nurses got frustrated and gave up their advocacy role.

...Is sometimes tiresome, the bureaucracies, the channels you need to pass through, to do one thing right is not easy, you have to you move from here, go here, do this...(Mrs. O 7)

Oh, the challenges are many, you have to you know move from here, go here, do this, the bureaucracies, the channels you need to pass through and sometimes, the resources you need to do so is a challenge...(Mrs. P 1)

Responses from participants indicated that majority of patients admittedly faced financial difficulties. Hence, patients lacked financial resources required to assist nurses accomplish the advocacy process where necessary. Some participants made the following comments:

I also think poverty. Because let's say if is referral, at the end of the day you advocate for the patient but there is no money for the patient to go. (Mrs. O 7)

...At times too, may be we don't have the drugs and the patient does not have the money. We have a case here, we want to refer the case. We gave her the drugs we have here in the emergency kit. She is supposed to replace it and she doesn't have the money...(Mrs. O 5)

The economic status of the patient for example; sometimes you advocate and it gets to a level where they need to spend a lot of money for that thing but they don't have...You stand in for the patients to make part payment, but they go and don't come back. And you the nurse who stood in for them will have to pay. You call and they will not respond... (Mrs. M 4)

The aspect of inadequate knowledge related to both nurses and patients. Some nurses are said not to be confident and assertive enough to defend the patient due to lack of knowledge about the patient's problem or how to go about the entire advocacy process. In addition, some patients exercised their rights wrongly by refusing to agree with the nurse's decision due to limited knowledge.

When I first tried to advocate for a patient, I got fed up and I said why don't I stop, then I realized that this is someone's life we are talking about. So whether the person at the superior end likes it or not, you

have to find a way around it. So I think is about lack of knowledge. Something might be harmful but I might not know that that thing is causing harm, you might not be able to advocate for the person. (Mrs. T 1)

...Knowledge and education can be a hindrance. ...So knowledge is very important. It has really helped some of us in advocating for the patients... (Mrs. M 2)

Finally, the participants mentioned individual patient's religious and cultural beliefs as another key barrier to patient advocacy. Some patients preferred going to prayer camps rather than accepting referral to a different facility. Some opted to pray instead of taking their medications.

The husband is also saying that the conditions that we want to refer he is not ready to take the woman to the place. Rather he wants to take the woman to a prayer camp... We tried to explain to the man but he is still saying the same thing. The BP was very high. We gave her a drug and needed her to sleep but she told me she will not sleep and that she is praying with a pastor. At times too we have those things. Even though prayer is very good, we have to combine it with the medical care... We admitted her but she went to the house with the husband and was not there and because the man was not available to accept her admission she was staying at home till it became complicated then she came and right now the husband is not willing that she goes to where she has been referred to. (Mrs. O 5)

### **Experiences with why Nurses Decided to Advocate for Patients**

Reflecting on the numerous barriers and challenges nurse encountered in carrying out the advocacy role, the researcher wanted to find out why the nurses still decided to advocate for patients on a daily bases. The results of the analysis revealed six main themes that informed the nurses' decision to advocate for the patients. The themes are patient's vulnerability, patient safety and quality care, religion and spirituality of nurses, nurse's personal values and knowledge, feelings of moral obligation, and professional responsibility and duty of the nurse.

The nurses mentioned patients' vulnerability due to their health conditions compelled them to advocate on behalf of patients. The patients also

lacked adequate information and understanding about their own diagnosis. Nurses, therefore found it necessary to act on behalf of the patients to ensure best care as indicated below:

There are times that considering our nursing care, you need to advocate for the patient. You realize that the patient is helpless; the patient can't forge ahead again (vulnerability). So the nurse will have to step in and give a helping hand, pull the patient out, and somehow you are able to reduce the stress from the patient. (Mrs. M 1)

Hmm, because of the conditions, I saw that it was an emergency, it was confirmed that it was an intestinal obstruction and we didn't have a surgeon here. The only thing that could be done was for her to be referred and we asked the doctor and he did it and money was the issue so we had to intervene. (Mrs. M 2)

Regarding patient safety and quality care, the nurses indicated that prevention of harm to the patients and the willingness to achieve the best possible health outcome were their motivation in pursuing their advocacy activities. Some participants made the following statements:

...You also think if you ignore the patient and he loses his or her life, after that what happens? So the little that you can have you just use to support the person so that you save the person's life. So if you help and the next day you meet the person, you are OK, you are happy. The person is also happy. (Mrs. O 7)

...Because a delivering woman with strong contractions like that if nothing is done she can rapture and we will lose the mother and the baby as well...(Mrs. O 6)

...From the situation she was bleeding so if you sit and wait till the relatives come, it will not be a good story. So why wouldn't I help... (Mrs. OP 1)

Is because you want to save life, provide comfort for the patient, prevent emergency running here and there... (Mrs. T 3)

With regards to religion and spirituality, the nurses revealed that their personal beliefs in God compelled them to help the patients. Some quotes from participants were:

...Above all we are all Christians and I ask myself why is it that I got up today and there is nothing wrong with me? Then I think I have to give back my best like health promotion so that the rest can come back and join us in the work force...I mean when one is sick, spirituality, medications, family members, giving her services and the patient herself, all this things come into play to bring about the healing. Sometimes what we do will not help but it will take the person's spirituality and their faith to have healing. It is a topic in chronic illness to let the person hold on to their faith to help them. So you see that moved me, one thing is we are also spiritual. (Mrs. F 2)

...I think even the Bible speak of it, and so I think basically it's our responsibility and the Bible also encourages us to do so. (Mr. P 1)

...We were also brought up as Christians, our religion teaches us to be nice to others. (Mr. P 2)

Nurses' personal values included empathy, sympathy, compassion, and inner desire to help the patients to recovery quickly as soon as possible.

Since we are dealing with human relations, sometimes you can't just look as your fellow human being to suffer, and as nurses our key role is to be empathetic. If you are a nurse and you don't have empathy for a client then you are not a nurse. So far as empathy is one of our key roles as nurses, I think that moved me to advocate for patients. (Mrs. C 1)

...Personally I have interest in caring for children most of the time... (Mrs. CH 1)

...That one I can tell is my inner being. I feel like helping them sometimes even if you don't do your conscience will not allow you... (Mrs. F 1)

In addition, due to nursing knowledge acquired, they felt morally and ethically obliged to intervene on behalf of patients even when the patients did not know that they needed that kind of help.

...Quiet long services and after some practice, you pick experiences from your bosses and you are able to make a projection. And you know if you don't do this or that within this time, they say things happen... (Mrs. F1)

...Sometimes I think that the patient doesn't have the information I have in terms of knowledge. You have to step in to help the person whom you are helping. (Mrs. T 1)

Well, one, it is my area and I know when patients come from theatre, there are some observations that need to be done for the patient (knowledge). And while there I realized that that thing was not being done. How can a patient finish hernia surgery and remain in bed snoring after 24 hours in the hospital? (Mrs. T 2)

The good interpersonal relationship established with the patient also moved the nurses to advocate for patients as evidenced in the statements below:

I had established a good rapport and explained things to the patient and encouraged him that it is a simple procedure. I had interpersonal relationship with the patient and promised him that it shall be well. That made me concentrated on it, because I had earlier promised that it will be well. I was also expecting a good outcome from the procedure... (Mrs. T 2)

Finally, most of the participants viewed patient's advocacy as a professional responsibility and duty of the nurse. Hence, they had no excuse than to advocate for their patients when necessary. The following examples were given by participants:

The nursing profession as a whole moved me to advocate... (Mrs. C 1)

For me I know that when you want to give a complete care, then when the patient is with you, whether you are at the ward or at OPD, wherever you are, you want the best for the patient. And as nurses we talk about mental, physical, spiritual or holistic care. So with that you will be able to try to get the best for the patient. That is when you want to help, you will be able to advocate for the patient. As nurses, I see it as our role that is what we have said we are doing and if we are doing it well, that's how it's supposed to be. (Mrs. E 1)

...I see it as a duty. That is why I leave my home and come to work. You are seeing danger that is why you step in to act... (Mrs. O 2)

...I think, as it is said, they say nursing is a call. And even if you don't have the call, I think when you come into it, you need to do what is required of you. And we all know advocacy is our responsibility as nurses and when you look at the human rights charter too... (Mr. P 1)

As a nurse it forms part of my core responsibility to advocate. What moved me apart from my responsibility is the human nature. (Mr. P 3)

### Experiences of Nurses in Acting as Patients’ Advocate in Clinical Practice

The fourth objective in this study was to explore experiences of nurses in acting as patient’s advocate in clinical practice. The participants were asked to describe experiences they had where they felt they were successfully in advocating for a patient. Analyses of participants’ advocacy experiences have been indicated in Table 5.

Table 5: *Patient Advocacy as Experienced by Nurses in Clinical Practice*

Sub-Themes	Themes
Valuing and respecting patient’s their wishes and rights Having right to self-determination	Right of a patient
Monitoring and observing	Professional
Responsibility of a nurse Professional task of a nurse	Responsibility and Duty of a nurse
Speaking out and speaking for patients Identifying and correcting near-misses to prevent harm	Protection of patients
Acting proactively to ensure patient safety and quality care Mitigating risk arising from sudden changes in patients’ health conditions	Caring
Compelled to act on patient’s unmet needs	Feeling morally compelled to act on patient’s unmet needs
Educating and mediating Mediating in hospital bill payment	Educating and mediating
Providing financial support for patients and family	Supporting
Physician’s refusal and delay in attending to patients Pleading for and lack of support from patient’s family members	Pleading on behalf of patients and lack of physician’s and family members’ support
Consulting and collaborating	Ensuring continuity of care

Source: Field data, Nsiah (2016)

Eight themes emerged from the participants' advocacy experiences; right of a patient, professional responsibility and duty of a nurse, caring, protection of patients, feeling morally compelled to act on patient's unmet needs, educating and mediating, supporting and ensuring continuity of care. The rights of patients involved valuing and respecting patients, their wishes and rights as well as acknowledging the patients' right to self-determination.

The example below was given by a participant:

...An example is NHIS registration; we had a client who according to the mental health act belongs to the disable group, so they are not supposed to pay. We sent the patient to their office and the director did not even know that such clients were not supposed to pay. So we have to stand in to the extent of producing a copy of the mental health act. So he agreed and we registered the client. Another example was with the principal health directory social welfare. We had a patient who was mentally not stable, who had given birth to seven years old baby. This patient was lying in the market so feeding the baby was a problem. We knew it was the assembly's responsibility and also the municipal to take the baby to the foster home. So we took the child to their office for them to do their responsibilities. So we were able to send the child to a foster home and the mother to a psychiatry hospital for a good care. (Mr. P 3)

The professional responsibility and duty of a nurse relates to monitoring and observing the patients. This category also included performing specific procedures for the patient as depicted in the following statements given by participants:

...A patient was brought from the theatre and he was to be monitored. The patient did the hernia in the theatre and I was there. And the following day in the male ward he was still lying in bed. So for me to see him in bed after 24 hours, I was not feeling comfortable. The man was sleeping a lot. So I made him to walk around the bed. I told him not to go far but stay close. So later he was discharged and then he came the following morning and he came to the ward and said hello to us and we were all happy... We were sitting closed and heard a voice like snoring. So the nurse got up and attended to a CVA patient we realized the neck had become stiff and the snoring was getting louder so I went there, felt the pulse and it was there. We check the withal. I check the mouth and found that the tongue had fallen back blocking the air way. ...We asked someone to call the anesthetic and she



quickly came and asked give me this drug and that drug and managed to get the air way opened, later she decided that they should return the patient to the theatre and started monitoring him. So even though we were there doing the exams we came back to ask how patient is doing, he is responding but he is on ventilator. The following day by the grace of God we saw the patient laughing and smiling in bed. I always say if we had not got those hands, we would have lost that patient. If it was only left to be in that ward only, how many people will have known that the tongue was fallen back? (Mrs. T 2)

Protection of patients was experienced in the form of recognizing and correcting near-misses to prevent harm, acting proactively to ensure patient safety and quality care and mitigating risks arising from sudden changes in patients' health conditions.

I remember this particular patient, she was coming to us for eye care, and when she came, I saw that she wasn't feeling well, and I said I think the eye conditions would not be a danger to her health so we need to find out. So we took her and helped her to check her blood sugar level. And it was very high. So that patient was referred to the general practitioner and got admitted that day. And the sugar was so high that she was on admission and on a sliding scale for more than even two weeks. Then after that the patient was very grateful for us taking that step to help her get the best care she needed at that time. So being proactive was a key in this act. (Mrs. E 1)

I remember one time we had a patient with threatened abortion and this lady had come in one admission on several occasions. And I was getting a bit worried because this was about her fourth admission. So I just took a chair and sat with her and found out few things from her. So I told her that I am worried about the way she has been coming frequently for the same condition. And I think there is something more than what we think so I would like to find out few things from her. So I started by asking if she knew her blood group and she said yes. And I found if she had her husband's blood group and she said yes. So when I probed, I realized that her problem was rhesus incompatibility. Because she had had the first child, but she had lost the subsequent pregnancies and this was the fourth one. So I just went to the in-charge and explained that this is what I found today and I think there is something more than the threatened abortion, we need to draw the doctor's attention. So the next day we communicated to the doctor and she was not discharged this time till around six months. Then later she came to deliver and had her baby. So I think the advocacy role really worked and it's because the information which was not given was now discovered. (Mrs. T 1)

In addition, the nurses' patient advocacy experiences included feeling morally compelled to act on patients' unmet needs as revealed by participants below:

There was one patient when she came her hemoglobin was very low. She was 36 week so she had about 4week to deliver. She was like I have no money to buy the needed medication. And I asked her if she had money to buy fruits, some particular vegetables and leaves for some local juice. I told her that every morning she should make a mixture of those vegetables and drink it with milk and also take her breakfast and in the afternoon she should take the "Bisab" (a local drink). I asked her not to buy the drink from the market so I taught her how to prepare it at home. After two weeks when she came back to the hospital her hemoglobin had increased and she was doing well. So although she could not buy the medications, she was very well. (Mrs. O 3)

About two month ago, a patient came here with severe injury. It was somebody, not her parent who brought her here. We were not having the instruments needed to do suturing, so we padded it and sent her to the CCTH. There was no relative around so I have to become the family and take her to the CCTH. It was like great. Two days after the relatives came and said she was doing well. I was happy. (Mrs. OP 1)

Majority of participants talked about their experiences of patient advocacy as educating patients and family members as well as mediating in their hospital bill payment.

It was about the patient bill. The patient was discharged but the bill was very expensive. So we have to go and talk to our administrator for the bill to be split. The patient signed undertaking and paid part of the bill. If I had not stepped in the patient will have stayed on the ward very long. Sometimes they out-scorn. For me the bill issue is very important to me because it concerns money and you know now a day's there is no money in the system. (Mrs. M 3)

"I was then working in the maternity ward and then a woman came, she was gravida 6, para 5 and they were all alive. And the woman was like "Auntie Nurse, I don't want to go home without a baby girl". I said why and she said "my husband says he has five boys so if I don't get a girl I should not even come to the house; I should stay at the hospital". So I told my in-charge, then we called the man, he came, and when he came it was very true, of what he is saying. So we had to go through series of lectures for him to understand that it's not the women's duty to determine the sex of the child, and when they gave birth too, amazingly it was a boy. (Mrs. M 4)

Supporting as an experience included the aspects of providing financial support for patients and family. The nurses carried out patient advocacy by spending their own pocket money to meet the patient's needs as cited by participants:

We had this patient who was referred to the Regional hospital. In fact, the parent had problem with money, but it was an emergency case. It was an intestinal obstruction which needed immediate surgery. And the parent weren't having the money. So I had to go round, beg for money to give to the mother to help the situation. It was last year around March. (Mrs. M 2)

...At times too in terms of monetary, we just arrange and talk to other staff and collect money for the patient. Sometimes the patient is discharged and she can't pay the bills, and transportation back to the house too we can arrange that. And then blood donation too at times we also talk to other people who can help. Like we have people in town who can help, but with that when the person comes, we pay money. But if we get the blood to save the person's life then we have done something. (Mrs. O 5)

...Sometimes too from our own pockets. I think last time a patient came, she said she doesn't have anything. We have to contribute and gave her some money so that she can go and sell pure water so that she can earn a living... (Mr. P 2)

Pleading on behalf of patients and lack of physicians and family members' support was another way in which the nurses experienced patient advocacy. Participants gave examples of instances of such experiences as:

There was one doctor here when you call him to review a patient he will not come. He will say call a ward doctor and the patient will be suffering and you call the ward doctor too, he will not come on time. So it's a challenge to us. You feel bad but you will do what you can do. Okay, I quiet remember few years ago there was a patient here who needed to have C -section. So we took the patient to the theater and the doctor who was supposed to do the operation for one or two reasons said he will not do it. That time the patient has already been anaesthetized already lying on the theater bed. So I took the phone and called the hospital superintendent and told him about the situation. He assured me that he is going to call someone, so he called a different doctor who came and did the operation. We got the baby and the mother too. So I think I did my best. (Mrs. O 1)

...There was once a patient here, that patient had died, the relatives never came to visit the patient at all. So the nurses we contributed for the patients for all the care and evening food. But when the patient died the relatives were here. Even they wanted to fight with us. (Mrs. F 2)

Ensuring continuity of care was the final theme extracted from the participant's descriptions of their experiences. This aspect relates to consulting and collaborating with appropriate individuals and authorities to acquire needed assistance to promote quality care of patients.

Just this morning we had a case; we had a seven years old girl whom we were treating for TB but is as if the child was still coughing so we went with the child to the doctor for her to be reviewed again. We put the child on a treatment and is finished still child isn't too well so we had to go back to the doctor. We went there; spoke with the doctor, the doctor examined the child. Now it came out that the child now has a different condition, and we are now moving into a different facility, and now we are still talking with the facility pleading with them. Now we are interacting with the relatives also making sure that the child is fed well. This morning they were supposed to pay a bill to transport the child to the new facility but they don't have money. And since we want the child to get well, we had to help to facilitate some of the things that this little girl needs to help her come out of her ill health. Now they are saying the child is on oxygen as we are speaking now. When we took the x-ray, I think the one side of her lungs is all gone. So we are still pleading with the pediatricians there to help this little girl. So as for the advocacy we are still doing it. (Mrs. C 1)

#### **Nurses' Experiences with Unsuccessful Patient Advocacy**

After hearing the positive experiences of patient advocacy, participants were then asked to describe circumstances in which they could not advocate for patients due to a challenge or barriers. Participants narrated several instances where they became unsuccessful in their quest to advocate for patients. The reasons attributed to these unsuccessful attempts were quite similar to those deducted from the barriers to patient's advocacy indicated earlier in this study. Some of the experiences disclosed by participants included:

For example some people will be here with a problem and we say Auntie we need to take you to theatre because of ectopic gestation. The Patient will say “I’m not going”. We had a woman here, she had gone through CS once. After our assessment, we found that this woman cannot deliver per vagina. So we called the woman and explained things to the woman. She said “I’m not going”. This woman is highly educated she knows her right. Afternoon people tried to talk to her, she said “No, I can deliver. The doctor came around and discussed with the patient, she refused. The doctor also can’t force the woman. So we all were monitoring her. Around 2 to 3pm, she said OK, this time let’s go. We prepared her and we went to do it. Unfortunately for her the uterus was ruptured. So within that time we lost the baby also... But glory to God the mother was alive. But we knowing what we discussed with her we were sad, but at least we did our best. So if not for fear of legal issues, we would have gone ahead to do it. (Mrs. O)

...There are also times when x-ray and scanning machines are not working. The patient is in pain and you need a scan or something to better know what is really causing the pain but since the machines are not available the patient is not able to take the scan. And then you the nurse you just look helpless, wishing that you could do something or the machines could be repaired but there is nothing you can do. You just have to go and report to the authorities and they will say today, tomorrow while patient suffer or go to a different facility. (Mrs. C 2)

When I was doing my service we had an asphyxiated baby and we needed to resuscitate but I wasn’t that skilled to intervene so I referred them to the CCTH but on transit the baby died. We were understaff at the time, and we also had an obstetric emergency at the same time. So by the time we got to this woman, it was a little late... (Mrs. O 2)

### **Nurses’ Experiences with Outcomes of Patient Advocacy**

Nurses' experiences with outcomes of patient advocacy were grouped into positive and negative outcomes out of which seven themes were derived. A summary of nurses' experiences with outcomes of patient advocacy are presented in Table 6.

Table 6: *Nurses' Experiences with Outcomes of Patient Advocacy*

Sub-Themes	Themes
<b>Positive outcomes:</b>	
Inner satisfaction Motivation	Satisfaction and fulfillment
Quick recovery and discharge Quality care achieved Improved patient's health outcome Positive patient health outcome Patient's needs are met Enhanced patient's wellbeing	Patient's condition is positively changed
Patient's safety and life is protected Positive effect on the nation Increased Positive image of facility Increased Positive image of nursing the profession	Positive effect on the nation, health facility and the nursing profession
<b>Negative outcomes:</b>	
Death of patients	Death
Less quality care Negative patient outcome	Lack of quality patient care
Health complications	Increased health complications
Negative effect on the nation Negative image of health facility Loss of confidence in the facility and health system Financial loss to the health facility Decreased attendance to the health facility	Negative effects on the nation, health facility and the nursing profession

**Source:** Field data, Nsiah (2016)

**Positive Outcomes:**

Results from the analysis of nurses' experiences with positive outcomes of patient advocacy as presented in Table 6 revealed three themes. These themes involved satisfaction and fulfillments, patients' condition is positively changed, positive effect on the nation, health facility and the nursing profession. The positive outcomes occurred when the patient advocacy succeeds. The outcomes in such instances covered not only patients but also

nurses, the health institution and the nation as a whole. The direct quotes from some of the participants are presented below.

...In the end the patient was treated, they had the best care and they were in good health. There is that job satisfaction, and when the patients go, they talk about it, and they inform others. I always say that it's our jobs that sell us. When you are done with one patient and he is satisfied, they will even announce for the hospital or the institution. (Mrs. E 1)

...God will bless you. You also get the work done. The patient is also OK... (Mrs. OP 1)

Generally, it had always been positive. Because you use evidence base, you have the facts; you have the data of what you are doing. It is just difficult pushing it but it has always been positive. It saves lives; because all the referrals that were able to take place you have a discharge and quick recovery. (Mrs. F 2)

...I felt satisfied, at least I have been able to at least make one of my patients laugh and that is what we are here for. We are not only here to care for their illness, but at least making them feel at home and that they are in good hands around us. We are also happy when we see our patients happy. (Mrs. E 1)

...It also reduced the burden on the patient psychologically, because being discharged and still on the ward can be very demeaning. If things go through you become fulfilled. For the facility the outcome only improved their finances. (Mrs. M 2)

The patient was fine, responding to treatment and quick recovery. Because imagine her being there without suturing and the needed interventions. She could have gotten worse. But me hearing that she is recovering made me happy. The family was happy that I took that challenge. It does have outcomes on the facility and on the nursing profession. Because mostly patients have this perception that nurses are wicked, they don't know how to talk. But me showing this act of love I have changed some perceptions about nurses. It is a source of motivation for myself too; all my colleagues who heard it said eh, you did well, so I was happy. (Mrs. OP-1)

...At least I can be proud that I have helped saved a life. Because that baby would have been lost...So for the patient, I know there has been an improved outcome. And then the facility as a whole, the patient will always feel good to come back to the facility because she will have developed the confidence that if I go there I will get somebody who will help me. (Mrs. T-1)

### Negative Outcomes:

The analysis further showed that in the event where the advocacy actions became unsuccessful it resulted in negative outcomes. These negative outcomes were grouped into four themes. The themes included death, lack of quality patient care, increased health complications, and negative effects on the nation, the health facility and the nursing profession. Excerpts from participants in support of these outcomes included:

You feel a bit crippled but there is nothing much you can do. It also has negative consequences. It leads to a rise in mortality. Because you know that when a patient is moved to right or left he can survive but this patient is being kept here. There is nothing much you can do than to just keep quiet and just watch on the patient and do your best for them. (Mrs. M 1)

Sometimes patient go and not come back, they go and sell our name very bad outside...it also diminishes the image of the facility. People wouldn't trust the facility anymore. (Mrs. M 4)

...we lost the mother! It was very sad issue... (Mrs. O)

...At the end of the day there is morbidity, mortality or delay referral. When such things happen I see it as a failure on the part of the facility and the nurse, because we have failed to render quality service. At the end of the day we are not able to help the patient that is how I feel. We have failed the patient. (Mrs. T-3)

...On the patient, sometimes they feel like, was it worth coming to the hospital. Especially if it is a delivery issue and she feels she could have been helped at home. Sometimes too may be the consequences might be devastating. In terms of quality of life, the patient might not get back to the original state of life again she was in before coming to the facility. They also turn to lose confidence in the facility... (Mrs. T-1)

### Nurses' Emotional Experiences with Patient Advocacy

Analysis of nurses' emotional experiences with patient advocacy resulted in two main themes known as negative and positive emotions. Aspects of positive emotions covered happiness, feeling great, feeling good, joy and satisfaction. The negative emotions were described by the nurses as



bad feeling, frustrations, depressing, painful and feelings of failure. Participants stated having heart-break, being worried, unhappiness, and feelings of helplessness and powerlessness were hindrances in their path to patient advocacy. Participants made a number of disclosures to substantiate their positive and negative emotions.

**Positive Emotions:**

...Sometimes I am happy, at least I have achieved something for the day, and I have made somebody smile... Hmm, hmm, emotionally it does affect, because when you are able to help your patients there is these inner satisfaction and joy... (Mr. O 3)

...Oh, joy, in fact when you help someone like that even you the nurse you become happy that even God has helped you to also help someone like that. They are grateful when you advocate for them. This patient died, but we also nurse unto a peaceful death. (Mr. P 3)

...Later the mother came here to thank all of us. I don't even know how to express it. Because the girl needed help and I had to help, even at that time, if I had money myself I would have given it out. But I was not having enough that is why I had to go round and solicit for the funds. I felt worried initially, but later when they came back and everything was okay, I just thanked God that at least I was able to do something for her. (Mrs. M 2)

...The family also felt happy especially the woman. She was very thankful. Because we saw that when we were explaining she was also naïve about the issue and was blaming herself rather but after the education, she said "Auntie Nurse, God bless you all". They felt good without blaming themselves. (Mrs. M 4)

**Negative Emotions:**

...the patient will be suffering and you call the ward doctor too, he will not come on time. So it's a challenge to us. You feel bad but you will do what you can do. (Mrs. F 1)

As a nurse you will be helpless and sometimes you are forced to go along with what they are insisting you do. Sometimes you go ahead and do what is right. If everything goes on well then everything becomes quiet, but if it goes the other way they will make you feel worse. They will say you didn't do according to my instructions and now see this and this and you end up feeling helpless. Because you know what will help the client but your hands are tied and you can't do much. (Mrs. CH 1)

...very bad; this morning one has happened, I have a patient who should go to the next level and they are still keeping him, you are not happy. The final authority should have communicated and explain things to us why it cannot be done. But that portion is missed, like you don't know why he is not doing it. So you feel so bad. (Mrs. F 2)

Hmm, I feel helpless, I will not talk about it again, I will leave it for them... (Mrs. F 3)

...You not being able to help the patient also make you feel bad. At times it will bring your spirit down... (Mrs. C 2)

...Oh, you know, under such circumstance when you want to see that things are done right and it does not go that way, you feel bad, as human as you are you will not be happy, so we really felt frustrated. (Mr. P 2)

Sometimes they have to go to another facility and the transportation alone is a lot. I really feel for the patients. Sometimes the patient go there for the bottle, come back here for the sample and take it back for the test. You can see the emotional trauma the patients go through. If we call for them to bring their scan machine here too, the cost is high. (Mrs. O7)

### **Nurses' Psychological Experiences with Patient Advocacy**

The nurses affirmed that they went through various psychological experiences as they carried out their patient advocacy role. These experiences ranged from continuous thinking and pondering over the patient's problems even after working hours. Some nurses were left with psychological pain especially after observing their patients die in situations where a remedy could have been provided. Besides, some participants wondered why these experiences persisted after several years. The experiences which occurred frequently after nurses strived to advocate for patients without positive result were enumerated as follows:

...To date (over four years) I feel bad. Sometimes you will be thinking about the client... (Mrs. O 2)

...Because you understand the condition and you know that when this woman goes to the house something else can happen. So when she

even goes to the house you will still be thinking about it, so unless you have the contact and then you can check on the person. (Mrs. O 6)

...So at times you would be thinking about it even at home, saying this woman could have survived... (Mrs. M 3)

...So imaging myself, if I fall sick and my family rejects me this way, how will I feel. So at times you find it difficult to even accept that a human being can go through even this experience. (Mrs. P 3)

...depending on the outcome, I feel sad, especially where it involves life. May be we lose a life or there are complications or bad consequences to the patient. You are going home and at the back of your mind, you keep thinking I could have done something. I conceive that you have failed. In those instances, it's a bit depressing. (Mrs. M 1)

### **Nurses' Physical Experiences with Patient Advocacy**

Participants in this study revealed that their involvement in patient advocacy role affected them physically. In some cases, participants went through experiences of anger by way of exchanging unpleasant word, loss of appetite, and loss of two-week working hours due to sickness. The following statements were expressed by some nurses:

...it affected me physically because that was her (the patient) first child... (Mrs. O 3)

Sometimes I get angry because I am of the notion that we all chose to do something. For example, if the problem is with pharmacy, you chose to do pharmacy and I chose to do nursing. But we are all looking for common good of the patient so I don't see why because you are in a certain area and you take an entrenched position which will not help the patient. (Mrs. T 1)

...When we lose a patient, sometimes, some even cry, some even don't eat, we fell reluctant leaving the place, because our joy is we rendering you service and you getting healed. (Mrs. T 2)

... It is very tiresome... (Mrs. F 2)

### **Nurses' Professional Experiences with Patient Advocacy**

Furthermore, nurses' professional experiences varied depending on the outcome of the advocacy process. Nurses who succeeded felt happy working

as nurses, their confidence level increased, got job satisfaction which lead to increased work output. However, lack of success in advocating for patients resulted in negative professional experiences. According to the nurses, the negative experiences made their work very difficult and resulted in patients' dissatisfaction of efforts made by participants towards patients' advocacy.

...but when you are not able, your mood changes and you get a bit of heart break, wishing that you could change things but you can't. Your moral is affected, even the zeal to even work get a bit dull. You don't really feel the excitement or the real power to help the patients. (Mrs. C 2)

...You the nurse also feel happy and job satisfaction... (Mrs. OP 1)

...It will increase work output... (Mrs. T 1)

...I went off for two weeks... (Mrs. O 3)

...I felt good, I felt like what I wanted to do as part of my work was done. (Mrs. M 1)

You become helpless, it make the work very difficult. Sometimes I feel like leaving this institution to a different place. Because sometimes you really need the client to undergo certain investigations and you are not able to achieve it. (Mrs. O 5)

### **What Made Nurses Successful in Advocating for Their Patients**

The nurses mentioned seven main themes that rendered their efforts effective towards patient advocacy. These themes included the health institution, patients and relatives, team work, the nurses' competence, the nurse's personal characteristics and religious beliefs.

The health institution was in relation to the support received from the institutional authorities, the nursing in-charges of the various wards and the available resources within the health facility at the time of the advocacy. The team work aspects also involved success that occurred due to collaboration

with other healthcare team and colleagues. Participants cited the following examples:

...The hospital itself at times supports us... (Mrs. F2)

At times too I think some of the nurses we also want the patient to be alive, so we always work hand in hand so that we can get through. So it's the unity between us and also in the end, you will all be happy. I will say is the collaboration between us and the social welfare department. If they had not collaborated well with us we wouldn't have reached anywhere. So I will say it is the collaboration between us and the social welfare department that made us successful. (Mr. P2)

...“It's the teamwork and the personnel that are available. The ICU nurse, the anesthetics, all played a role, even the student nurses all played a role. It was only me or the nurses on the ward alone, the patient could have been dead.” (Mrs. T 2)

Considering the aspect of patients and relatives, the nurses affirmed that without the support and cooperation of the patients and their families they couldn't have been successful. They stated that the patients agreed with them and were willing to accept their suggestions. Some patients offered necessary help needed for assisting other patients.

Some of our clients also support us. This dawn for instance, a client came; she was seven months pregnant and delivered at the OPD. They gave her hospital bed sheet to wrap the baby. But the woman herself doesn't have anything. So we have to go in to ask somebody (other patients) to give us clothes to keep the baby warm. Their relatives also helped us. (Mrs. O 5)

The nurse's professional competence level was acknowledged as key to the success of patient advocacy. This theme covered areas such as good interpersonal relationship and communication skills, the nurse's professional knowledge and skills, as well as, the ability to assess and recognize the patients' needs.

...I made sure that they understood the importance of doing this family planning. I told her that the doctor is here and what we are saying is that if she gets pregnant again she might die. Spending time to explain

the negative and positive aspect of the decision really helped. (Mrs. O 4)

I think is about the communication skills and also the fact, the evidence that you have to prove your point. In this case when you know that foetal heart rate is down with meconium, and of course, patient's consent. Because you can have all the evidence but if the willingness of the client is not there you will not be successful. (Mrs. O 7)

First thing I think it was about interpersonal relationship with my superiors and one thing was about, commitment to work. You see, when people know you are committed to a course, they are willing to listen to you. Because they know you will not come up with just anything. And it was about this interpersonal relationship. (Mrs. T 1)

...Apart from God, my knowledge in health... (Mrs. T 3)

The nurses' personal characteristics such as respect for the patients' choices and decisions, feeling empathetic, sympathy and their personal commitment to work assisted the nurses to successfully undertake their advocacy activities. These statements supported the nurses' assertions:

Hmm, having the courage and not sitting back. Most of my colleagues didn't want to go. You know you have to involve your money and other stuff so they didn't want to go. There was the willingness to sacrifice... (Mrs. OP 1)

...It took time and a lot of talking to the family. I was willing to spend much time to discuss with the mother. It was a difficult task. (Mrs. T 3)

...I know that it was my commitment that made my in-charge to listen and find out what is it I'm bringing up... (Mrs. T 1)

Some of the nurses mentioned their religious beliefs as the sources of their success in advocating for patients. Some attributed their success to supernatural assistance as expressed in the following statements:

Hmm, at times it's just by the grace of God, because you will be in need of something and this one you know there is nowhere that the help is coming from...(Mrs. O5)

I know it was God who helped me, not only my knowledge... (Mrs. O 6)

### **Communication and Interpersonal Relationship in Patient Advocacy**

Participants' perspectives regarding the correlation between the role of good communication and interpersonal relationship, and patient advocacy are indicated. The participants agreed that good communication and interpersonal relationship laid the foundation for effective patient advocacy. These experiences formed a major support base and means of obtaining support from authorities during advocacy. Participants mentioned that without those attributes success in patient advocacy would be very difficult and probably impossible. The following were the direct comments from participants' responses:

Yes, it's an important role. Like patient-nurse relationship. Before you can advocate for the patient, you need to establish rapport, know your patient and go into details. Sometimes patients come to the hospital, they are not sick, but they just need someone to talk to them and advise them. Especially those with hypertensive case, sometimes they come and you see that is a newly diagnosed and you ask if they have a history and they will tell you NO. Then when you try to establish rapport and communicate with them, they will now tell you their problems. Communication and interpersonal relationship play a very important role. Sometimes, you give them medications and you realized that they are not working for them. But an advice or talking with them rather calm them down and the BP will drop and they are discharged. For a relationship to be stronger there should be bond and the bond is communication. (Mrs. M 4)

...as the nurse you should have good interpersonal relationship with your client. There are things the patient will tell you but will not tell others. But that will depend on the relationship created. I need to be able to trust you before I can be able to trust in your absence. You must have very good communicative skills because we can say the same thing in two different ways. And they will mean two different things. The response might also mean two different things. You know sometimes there are issues that are very dicey and difficult, but the way you communicate it will minimize the negative effects that was expected initially. (Mrs. T 1)

Yes, I will say it played a major role, because you cannot force them. Even though it is their responsibility (nursing leaders) it depends on how you start the interpersonal relationship with them. For example if you go and start shouting on them that don't you know this or that they will not mind you. But if you are calm and talk to them like you are collaborating with them and not imposing anything on them that will work perfectly well. (Mr. P3)

...without communication and better relationship and cordiality among the health team, nothing can be achieved. Our work is such that you can't work for the 24 hours. Somebody may have to come and take over from you and you need to take over from somebody and if there is no proper communication, you end up killing the patient that you were trained to take care of. Because I have served medication to the patient and because of lack of proper communication I couldn't hand over, so you also come and serve the same medication and these drugs, for example, if it's to be taken daily and you serve it two times, you may end up harming the patient. And you know communication goes beyond the verbal one. They include at times charting that I have served this drug so I don't serve, is very important. (Mr. P 2)

#### **Experiences with the Benefits of Patient Advocacy**

The benefits of patient advocacy emerged from the participants' description of their experiences. Patient advocacy was said not only to benefit patients, but also the nurses and the health institution. According to participants' experiences, patients advocacy helped to save lives, maintain good health, and decrease the nurse's work load. Besides, patient advocacy contributed immensely to ensuring quality care of patients, quickly recovery and minimized burden on the health care system. The statements were made by some of the participants:

...If we are not able to do that the patient might lose interest in our quality health care service and look outside for alternative treatment. And our new millennium goal of rendering good health care service will remain unmet. If we are able to advocate it will lead to good health. (Mrs. M 4)

I will say, hmm, without it good health care that we are wishing to render to our patients we cannot achieve that optimum care. Because if we don't add advocacy to our care so that what needs to be done to be



done, at the end of the day what we are doing will be a cos. 90... (Mr. P 3)

It is a very good thing, very, very important and needs to be done. If we do it will end up saving lives and prevent future occurrences. We maintain the health of a whole family. One individual may come but at the end of the day, you maintain a whole family and spread it to the community. (Mrs. T 3)

### **Qualities and Skills Nurses Need to Ensure Successful Patient Advocacy**

Another issue that emerged from participant's experiences was important qualities and skills nurses need to ensure successful patient advocacy. Eleven sub themes were identified from which five themes were derived. In addition, the ability to communicate well was linked to the nurses' interpersonal communication skills. Being knowledgeable, having good interpersonal relationship skills coupled with nurse's personal characteristics and moral values were regarded a very important qualities and skill needed for effective advocacy. The aspect of nurse's personal characteristics and moral values involved the nurse's inner sense of caring and empathy.

Participants revealed that the nurse advocate should be assertive, zealous, persistence in their demand and at the same time being patient. The nurse must be respectful and be able to establish rapport with both patients and family, as well as colleagues and other members in the health team.

Participants expressed that:

I think that the nurse will need good communication skills. They will need to communicate well with the patient. The nurse will need to have good interpersonal relationship before they can talk to them. The nurse will also need good interpersonal relationship with the authorities so that you can go to them and talk to them. Because if you are not in good relationship with them you can't really go to them and tell them issues you have at your unit which you need help. But if you have good interpersonal relationship you can better go to them and better bring out your views (Mrs. C 2)

As a nurse apart from some of the qualities that we say a nurse must have, other skills include intelligence, empathetic, you should be open to people, people should be able to approach you with their problems. You should also try to get them to tell you what they need. Try to establish rapport with them so that they can tell you what they need. You will be able to go out there and speak on their behalf. You should be able to present your case very well before patients, colleagues and authorities. You should be very firm in decision making. You should be assertive. (Mrs. M 4)

You must be knowledgeable so that you will be able to talk the fact. You need to know what you are talking about. You must also have good communication skills. Sometimes you have the fact but the ability to tell the patient and bring it down to relative's understanding is important. You should have respect for your patients. (Mrs. O 7)

...For example when you are trying to advocate you should be a person who have patience, because the result don't just come like that. At times you have to push and push and push, so you have to have the zeal. You have to be somebody who has that persistence, because that is the virtue you need when you are trying to advocate on someone's behalf. Either than that if you are a person who will go once and leave everything it will not go well with our advocacy. (Mrs. P 1)

#### **Lack of Clear Guideline for the Patient Advocacy Process for Nurses**

Analysis of participant's responses revealed that there was no guideline for nurses who advocate for patients in the health facility. Each nurse took up the challenge in his or her own way to help when situation emerged. Some nurses talked to colleagues and doctors for help. The nurses complained that there was no protocol for advocacy in their respective wards. Neither was there any policy that favoured or empowered them to take certain decisions on behalf of patients. For instance, some participants said:

For the medications and other issues that demands advocacy there are no clear guidelines. Except that sometimes we have to talk to colleagues and doctors so that we can raise personal funds to help them. Also there are times that the medical director sees that we need to help this kind of patient due to the condition or how bad things are with the patient. Each nurse takes things on her own and does what he or she thinks she can to help the situation. (Mrs. C 2)

I have never seen a protocol on nursing advocacy, if there is a protocol all over it will come to stay so well. It will not be like why are you so

like this or that. People will not ask, this advocacy thing is it like human being or what? Sometimes you even forget that the person is doing advocacy because there are no protocols on our wards. I see it as a proactive nursing. (Mrs. F 2)

### **Experiences with Colleague Nurses who Commit Acts of Negligence**

Reporting practices of nurses when their colleague nurses commits acts of negligence also emerged from the study. Participants were asked whether they report colleague nurses who commit acts of negligence. Only two participants stated that they periodically report such acts to those in-charge or authorities, especially when culprit was unwilling to change after repeated warnings. Other participants mentioned that reporting colleague nurses (whistle-blowing) was not a common practice among the nurses. The reasons given by participants for not reporting were related to culture, fear of becoming a victim one day, fear of retaliation and avoiding of being accused by colleagues at the workplace.

It's not common here, but what I see is if you do something bad against a patient, then your colleagues will call you and talk to you, correct you. It will be reported to the in-charge or authorities when you have been repeating the same thing and you don't want to change. Maybe it's done in other countries. Because at times you do something but it's not intentional...I don't think the reporting we are doing it here, it's only once a while... (Mrs. O 5)

...I don't normally do that. If even is a mistake of that colleague nurse we don't normally speak out. I think it is due to fear of retaliation because nobody wants to be pointed. (Mrs. OP 1)

### **Discussion**

This study was designed to explore ways in which registered nurses described patient advocacy, and specific activities involved in carrying out the patient advocacy role. Additionally, the barriers nurses encounter when advocating for patients, and experiences of nurses in acting as patients' advocate in clinical practice at the CCMH were also explored. This section of

the chapter interprets the study results by comparing with existing research, the theoretical framework of this study and the reviewed literature. The discussion is organized according to the set objectives and other issues that emerged during the data analysis.

### **Description of Study Participants**

The nurses who participated in this study did so voluntarily without any financial reward. Secondly, they were all fulltime workers in the health facility where the study was conducted. Based on the hospital's policy, the participants have had the opportunity to practice and also advocate for patients in almost all the units within the hospital. The study participants willingly shared their experiences mainly because they felt it was a very important study that could lead to an enhanced safety and quality care of patients in Ghanaian hospitals. This background of the study participants suggested that the nurses would most likely disclose true experiences that reflect realities on the ground.

In addition, the study participants viewed themselves as their patients' advocates. This finding supports the Peplau's interpersonal relations in nursing theory (1992), which viewed advocacy as a major role of the nurse. However, the participants shared different views as to whether or not the advocacy role was a professional obligation. Majority of the nurses described advocacy as an important component in their daily practice as professional nurses. This finding affirmed Curtin's model of human advocacy (1979), which viewed the practice of advocacy as a philosophical role of the professional nurse. On the contrary, few of the nurses also believed that patient advocacy was a separate and a sacrificial role of the nurse and not an obligation. This assertion meant that they would only advocate if they wished and deemed it necessary. One

cannot condemn these few nurses because this finding has been supported by some nursing theorist. For instance, Kohnke (1982) was opposed to advocacy as a philosophical basis for nursing. Kohnke's advocacy model in (1982) proposed that the nurse is a free moral being with the ability to decide whether or not to advocate for a patient. This controversy surrounding the various advocacy models further support the reason for the choice of the Peplau's theory (1992) as the ideal theoretical framework for this study. It is evident from the findings that these advocacy models only provided a guide for carrying out the advocacy role and do not form the theoretical basis underpinning the practice of patient advocacy in the nursing profession.

#### **Participants' Demographic Characteristics**

The study results revealed that most participants were females with three males. This ratio means the study participants were dominated by females. In addition, judging from the age categories of the 25 nurses, the highest number of participants (16) who responded to the interviews were between 20 and 30 years. Moreover, 15 of the nurses had between 1 and 5 years work experience, six of the nurses had worked between six and 10 years, while two confirmed their years of work to be 21 years and above. The study participants were made up of 17 diploma and seven university degree holders in nursing

The nursing ranks of these participants ranged from staff nurse to principal nursing officer making it clear that the study participants were neither novice within the nursing profession nor within the health facility where they worked as nurses. The participants had rich experiences with patient advocacy throughout their years of work at the CCMH.

## Registered Nurses' Description of Patient Advocacy

The participants' descriptions of patient advocacy were similar to those already mentioned in nursing literature. Several nursing theorists have described the diverse activities and actions taken by nurses on behalf of patients as being their patients advocates (Kohnke, 1982; Curtin, 1979; Gadow, 1980).

The study participants believed that patients were vulnerable and limited in knowledge regarding their health conditions and the best treatment options. Advocating for the patient therefore meant protecting the patient from injuries both present and anticipated, negative actions and inactions of relatives, colleague nurses, physicians and other health care professional that might not promote safety and quick recovery of the patient. This finding implies that the nurses' role of patient advocacy is crucial to minimizing injury, enhancing safety and optimal care for patients and their family members. A similarly study by Boyle (2005) revealed nurses' description of patient advocacy as protecting patients from harm and making sure that patients are being cared for safely.

In addition, this study data revealed patient advocacy as being the patients' voice. This result seems consistent with Abbaszadehl et al. (2013) definition of patient advocacy as an action taken to attain goals on behalf of patients. The study participants affirmed that the essence of advocating was to ensure quality care. Hence, patient advocacy is simply providing quality care for patients. This finding provided evidence to support Vaartio and co-workers (2006) and Thacker (2008) who ascertained that advocating for patients involved the nurse undertaking many actions that enhanced patient safety and

quality care. Further description of patient advocacy by the study participants included supporting, valuing and respecting the patient as well as self-determination. This interpretation implies that advocating for the patients goes beyond caring for the physical needs of that person. Patients should be valued and respected as individuals with specific needs, giving them dignified care without any form of intimidation.

Moreover, the participants believed that patients must be allowed to participate in the decision making process by speaking up and advocating for themselves if they had the ability to do so. These assertions reflect the views of Kohnke (1982) and Negarandeh et al. (2008) who described advocacy as an act of supporting persons to freely make decisions regarding their health as they wished. The participants also described the entire patient advocacy process as interpersonal relationship which involved establishing rapport with patients and family, getting to know the patients and their needs, and involving them in the caring process. The view expressed here is in line with Gadow's model of existential advocacy (1980) which viewed advocacy as the ideal nature and purpose of the nurse-patient relationship.

The result revealed that educating the patients as a form of advocacy meant enlightening the patients on their health conditions and getting them to understand their care process to enhance cooperation and speedy recovery. This result supports Peplau's interpersonal relations theory (1992) which served as the theoretical framework for this study. Peplau viewed the nurse as a teacher and a resource person who imparts knowledge in reference to a need or interest and provides specific needed information that aids in the understanding of a problem or new situation. Similarly, Thacker (2008)

explored advocacy among nurses in end of life care and concluded that the foundation of successful advocacy resides in the nurse patient relationship.

Finally, the participants' description of patient advocacy was in agreement with the existing nursing theory (Peplau, 1992), nursing advocacy model (Kohnke, 1982) and existing nursing literature (Negarandeh et al., 2008). It was expected that better understanding of the patient advocacy concept should of necessity translate into its practice within the clinical setting. Thus, nurses in this study were asked to share their experiences regarding specific activities they performed when advocating for patients. The next section presents discussion on the findings.

#### **How Registered Nurses Carried Out Their Role as Patients' Advocate**

Analysis of the participants' responses to the question as to how nurses carried out their patient advocacy role or activities has been presented in Table 3. The results produced six themes and these included; mediating, counseling, protecting, caring, teaching and promoting continuity of patient care. The results obtained from this study seemed to support Jezewski's (1993) and Peplau's (1992) propositions that mediation, negotiation and innovation are essential skills needed to ensure that patients' needs are met during the advocacy process. Jezewski and Peplau viewed nurse as an advocate, surrogate, counselor and a teacher. The nurse's duty involves acting as a mediator by coordinating medical services between the health care team, and the patient and family regarding the patient's problems.

The finding further supports Cho's (1997) model which described the advocacy role of the nurse as protecting patients from risky and harmful situations. The caring activities of the nurse also agreed with Gadow (1980)



and Curtin (1979) who supported the fact that without caring, advocating for patients cannot occur. On the contrary, Gadow and Curtin also held the view that self-determination was the most fundamental human right. Hence, the patient retains the right to make their own choices while the nurse only supports their decisions. Yet, this study finding suggests that some patients do not even know what their conditions require to enhance speedy recovery. The patient's lack of knowledge informed the nurses' mediation, protection and counselling and other advocacy activities. It is therefore necessary for health authorities to ensure that patient advocacy and its associated activities are operationalised with clear protocols to guide nurses. The clarity of such protocols will equally assist patients who require advocacy.

The study participants revealed that most patients who went on admission found it difficult to pay their bills during discharge from the hospital. The nurses therefore advocated by consulting appropriate authorities, and interceding on behalf of the patients for them to defray their bill by instalments. Participants stated that in most cases they had to act as sureties for patients. In the event when patients refused to fulfil their promises, those nurses were made to pay the bills. This finding is in agreement with Negarandeh et al. (2008) who explored patients' advocacy from Iranian nurses' perspective. Despite the similarities in these findings the type of financial support and the intensity of the advocacy activity in this current study varied from that of Negarandeh and others. The financial needs of the patients in Iran were not related to payment of hospital bills rather it was based on other needs of the patients. In addition, what the Iranian nurses did was to contact the appropriate authorities such as social welfare to assist the patients.

The afore-mentioned finding seems to suggest that there was probably good health insurance system that took care of major health care cost and bills for hospitalization in Iran. This revelation is contrary to the experiences faced by the study participants in Ghana in their provision of financial support to patients by paying hospital bills and acting as sureties. Hence, the issue with financial difficulties as avenue for advocacy might be a regional problem and only related to specific hospitals. In a nutshell, financial support might pose a challenge to the average Ghanaian patient who is faced with inadequate National Health Insurance coverage and poor Social Welfare Services.

Furthermore, four main advocacy activities carried out under protection were identified. They included defending, protecting the patients, correcting near-misses to prevent harm and acting proactively. Acting proactively meant either preventing anticipated injury, complications and death or making request for necessary supplies or equipment to enhance healing and speedy recovery. These findings were consistent with Cho (1997) who regarded protecting the patient as the essence of nursing advocacy. The nurses in this study rated acting proactively as a top priority. This revelation is similar to the observations of Choi et al. (2014). Choi et al. (2014) noted that nurses who were able to act proactively prevented anticipated harm likely to originate from patients' health conditions, the hospitalization process and incompetent actions of other health care workers. The implications of these findings suggest that patient advocacy is vital in ensuring patient safety and quality care. In addition, it is necessary for nursing educational institutions and health authorities to equip nurses with requisite knowledge and skills to promote the advocacy role of the nurses.

Further analysis of the data revealed that nurses advocated for patients through counseling activities by informing the patient about decisions which directly impact their health and reasons for such decisions. This finding agrees with Bramlett et al (1990) model of advocacy. The key component of Bramlett et al model was providing information and supporting patients in decision making related to health care. This result has implication on patients' safety and quality care. Patients might make wrong decisions or reject good decisions that might contribute to effective treatments. The health facility' management will have to establish good counselling and support services with professional expertise to assist patients and families to make informed decision independent of nurses.

Besides, teaching is said to be a major activity nurses embarked on during patient advocacy. Nurses explained issues, empowered and educated patients, family members and other members in the health team when necessary to get their support in the advocacy process. The participants believed that patients usually come to the hospital as strangers, full of anxieties with specific needs known to them only. Therefore, respecting and valuing related to nurses being respectful to patients and family members, reassuring patients and getting to know the patient's peculiar needs and wishes. This finding supports the Peplau's interpersonal relations in theory (1992). Peplau described the role of the nurse as an advocate who assists patients to work on their problem through physical care, health teaching and counselling.

It emerged from the study that promotion of continuity of patient care included informing others in the health team. Collaboration, communication,

referrals and consultation among authorities, physicians, ward in-charges, colleagues and individuals involved in the caring process promoted continuation of care and speedy recovery. This study finding is consistent with studies carried out by Negarandeh et al. (2008) and Hanks (2010) who described advocacy action as promoting continuity of care, educating patients and family, as well as, communicating with other members in the health care team. This finding suggests promoting continuity of patient care as key means to achieving successful advocacy. This result is probably due to the fact that even though nurses could advocate for patients as individuals, in most cases it required a team work.

To this end, patients' needs vary and may require the inputs of different specialties to provide quality care for the patients. Work schedule for the ward nurses do change because of differences in their shift system. Hence, it is important that nursing managers institute policies that will require nurses to do proper handing over of patients to colleagues and other appropriate authorities to promote continuation of care. In addition, how nurses in this study carried out their advocacy role supported the views of Bu & Jezewski (2007).

Most of the participants' definitions of patient advocacy overlapped with their advocacy activities within the health facility. For example, a study by Boyle (2005) also indicated that nurses advocated for their patients in the form of protecting, communicating, giving voice, doing, comforting caring, mediating and treating patients like family members. Boyle (2005) further revealed that protecting, communicating, giving voice, comforting and caring overlapped with the nurse's description of patient advocacy. This finding

suggests that skills acquisition and knowledge level are very crucial in nursing practice irrespective of the context. Nurses would most likely practice within the limits of their professional knowledge. The implication of this finding calls on individual nurses to ensure their own professional development through constant practice, learning, research, workshops and in-service training. This study further probed into the challenges and hindrances nurses faced in their quest to advocate for patients. Findings related to these challenges have been discussed under the barriers to the practice of patient advocacy.

### **Barriers to the Practice of Patient Advocacy**

The third objective of this study centered on exploring barriers to the practice of patient advocacy among registered nurses. Fourteen themes were identified. Similar results were found in other nursing literature (Negarandeh et al., 2006; 2008; Hanks, 2010; Kohnke, 1982; Thacker, 2008). Barriers related to health institution and work environment covered eight main areas. The areas identified included: colleagues, limited time, inadequate medical equipment and supplies physicians, lack of personnel to intervene when needed, the national health insurance scheme. The participants revealed that lack of support for nurses in previous attempts to advocate, coupled with the response received from management for reporting those issues deterred nurses from engaging in further advocacy for patients.

Similarly, Negarandeh et al. (2006) noted lack of support and motivation for nurses, as well as, powerlessness among Iranian nurses as hindrances to patient advocacy. Besides, the patient advocacy process was said to be complex, hence, some nurses got frustrated and give up. This result supports Negarandeh et al. (2008) who argued that patient advocacy was

contextually complex and controversial component of nursing practice. Kohnke (1980) also identified the health institution and work environment as a major barrier to the practice of patient advocacy. Kohnke noted that patient advocacy actions can contradict the accepted norms of the health systems.

In addition, the study finding supports Black's (2011) report that fear of being labelled at work, workplace retaliation and fear of loss of job were major obstacles to patient advocacy within the health institution in Southern Nevada. However, fear of loss of job identified in this study contradicts the findings of Abbaszadeh et al. (2013) in Iran. Abbaszadeh and others rather reported inadequate educational programmes for practicing nurses as key barrier to patient advocacy. This study is however in agreement with a similar study conducted by Negarandeh et al. (2006) in the Iran although within a different facility. This finding therefore implies that barriers to patient advocacy in one health facility may differ from another even within the same country. These variations could be attributed to peculiar protocols, procedures, policies, the rules and regulations, the culture and or acceptable practices with individual health facilities.

The problem of lack of legal support identified in the study agreed with the findings of Vaartio et al. (2006) who identified lack of legal support and clear guidelines for the nurses as a challenge in patient advocacy. The participants stated that a number of patients took wrong decisions which adversely affected their healing process but they looked on helplessly due to legal reasons. This finding provides evidence to support Bu and co-workers (2007) that there is lack of adequate legislation that support nurses who in their quest for carrying out their advocacy role find themselves in the law

court. The lack of support can be due to failure of professional organizations of nurses to lobby politicians and policy makers.

Participants acknowledged that limited communication among the health care team and poor nurse-patient relationship hindered advocacy for the patients. Yet, as MacDonald (2007) and Peplau (1992) made clear, the nurses' role of patient advocacy can only be carried out effectively through therapeutic communication and interpersonal relationship. This result reveals a gap in nursing theory and practice. It is therefore necessary for hospital ward in-charges to ensure proper flow of information and interpersonal relationship among nurses and other health care workers in the facility. This move will enhance effective advocacy, job satisfaction and quality care of patients.

The nurses' personal characteristics such as lack of commitment, unassertiveness, personal beliefs and values were obstacles to their practice of patient advocacy. This affirmed the finding of Hank's (2010) that nurses' characteristics could either enhance or serve as a barrier in carrying out their role as patient's advocates. This finding suggests that advocacy is subjective. Hence, irrespective of patients' conditions and peculiar needs, advocating for patients will depend largely on the attendant nurse. This finding has implications for nursing care and patient safety. Nursing leaders should discharge their supervisory role effectively within health facilities.

Additional barriers identified by participants included the patient's family and inadequate knowledge on the part of both practicing nurses and the patients. Participants noted some nurses were not assertive enough to defend patients due to lack of knowledge about patient's problems or how to go about the entire advocacy process. Some patients were also noted for exercising their

rights wrongly by refusing to agree to the nurses' decision due to limited knowledge. This is consistent with Thacker (2008) who affirmed patients' family and lack of knowledge as obstacles to patient advocacy in the health facility.

According to the participants, there were several instances in which they advocated for physicians to either transfer patients to another facility or prescribe drugs they believed will help the patients. Yet, due to financial constraints, patients and families were unable to pay for the transportation to the new facility and also unable buy the needed drugs.

Religious and cultural beliefs also served as a barrier to patient advocacy. Some patients and families preferred going to prayer camps rather than accepting a referral to a different facility. Some patients opted to pray rather than taking their medications. Participants added that some patients refused treatment, giving excuses that it was against their religious and cultural practices. Other patients rejected treatment on the basis that their husbands had travel and until they are come back and grant permission they could not consent to such treatments.

The finding suggests that the socioeconomic status and cultural beliefs of patients and families greatly determines the success of the patient advocacy role of practicing nurses within the Ghanaian context. It also behooves on the government to put structures in place to assist the very poor especially during hospitalization. These findings also have implications for nursing practice. It implies that strong interpersonal dialogue between patients, their families and religious leaders are very crucial to effective advocacy and patient safety and quality care.



### **Patient Advocacy as Experienced by Nurses in Clinical Practice**

The fourth objective in this study was to explore experiences of nurses in acting as patients' advocate in clinical practice. The participants explained that the right of a patient was experienced through valuing and respecting patients, their wishes and rights and acknowledging the patient's right to self-determination. Nurses undertook their advocacy role as part of professional responsibilities. These responsibilities involved performing specific procedures for the patient within the health facility including monitoring and observing the patients. Protection of patients was experienced in the form of identifying and correcting near-misses to prevent harm, acting proactively to ensure patient safety and quality care and mitigating risk arising from sudden changes in patients' health conditions.

The finding of how nurses experienced patient advocacy is congruent with previous studies in Finland in which nurses reported the right of a patient and the duty of a nurse as to how they experienced patient advocacy (Vaartio et al. 2006). A study by Hanks (2008) indicated nurses' experiences with advocacy as: speaking out and speaking for patients, and feeling compelled to act on unmet needs of patients. This finding suggest that some nurses advocated for patients due to the emotional and moral distress coupled with the frustrations they experienced as a result of patients circumstances and not because of their professional responsibility or nursing duty in the health facility.

### **Nurses' Experiences with Unsuccessful Patient Advocacy**

All participants attributed their lack of success in advocacy experience partly to insufficient medical equipment and supplies, patient's rights and

wishes, and hospital policies that supported physician autonomy. A study by Negarandeh et al. (2006) admitted that most practicing nurses are knowledgeable and capable of advocating for patients, yet, they lacked sufficient power and the autonomy in the work environment to perform the advocacy role. Similarly, Bu and Jezewski (2007) considered lack of nursing autonomy as the main obstacle to practicing patient advocacy. This finding is very crucial to nursing practice since without teamwork or agreements between nurses and physicians; patient advocacy will most likely remain impossibility irrespective of its importance. Outcomes of successful and unsuccessful experiences of patient advocacy are discussed below.

#### **Nurses' Experiences with Outcomes of Patient Advocacy**

The study participants described outcomes of their patient's advocacy experiences as both positive and negative depending whether or not the patient advocacy process became successful. The positive outcomes of advocacy involved satisfaction and fulfillments for nurses, patients' conditions are positively changed, positive effect on the nation, health facility and the nursing profession. However, when the advocacy actions became unsuccessful it resulted in negative outcomes such as; death, lack of quality patient care, increased health complications, negative effects on the nation, the health facility and the nursing profession.

The afore-mentioned assertion is consistent with a study by Hank's (2008). Hank noted that nurses felt fulfilled and satisfied when advocacy for patients were successful and patients were changed in a positive manner by their advocacy actions. However, in the event where the patient advocacy was unsuccessful, negative outcomes of frustrations occur. Similar finding have

also been reported by several studies (Hanks 2010; Black 2011; Abbaszadeh et al., 2013). The result implies that nurses' role of advocacy can determine the extent of safety and quality care a patient receives in healthcare settings. O'Connor and Kelly (2005) have also indicated that consequences of advocacy could have negative or positive outcomes for both nurses and patients. They added that when nurses succeeded in the advocacy process, the outcomes for patients were always positive not only for the patient directly involved but also for future patients as well. This finding revealed the necessity of promoting patient advocacy in all hospital environments.

#### **Nurses' Emotional Experiences with Patient Advocacy**

Negative and positive emotions were identified from the analysis of nurses' emotional experiences with patient advocacy. O'Connor and Kelly (2005) arrived at similar finding above. However, the finding does not seem to conform to Vaartio et al. (2006) whose study participants in Finland did not express any feelings of limited professional autonomy, helplessness and powerlessness. This contrast is probably due to laid down policies, available support from nursing managements and good nurse physician relationship that existed within the health facility in Finland. Unlike the nurses in Finland, these study participants reported lack of support and disagreement with physicians as a barrier to patient advocacy.

Furthermore, the emotional experiences of patients and their families were extracted from the nurse's description of their personal emotional experiences. According to participants, whenever they were able to meet the patients' needs through advocacy, they expressed feelings of happiness, good and grateful. Patients and their family were always thankful and very

appreciative. On the contrary, negative emotions were expressed and observed when efforts to advocate failed. Patients and families went through emotional trauma, some even cried, refused to eat, very dull, withdrawing and refused any other treatments on the ward. This finding seems to provide evidence to support O'Connor and Kelly's (2005) earlier study that consequences of advocacy could be negative or positive outcome for both nurses and patients. This suggests that when the advocacy activities of nurses are unsuccessful the emotional consequences may be severe for the patient than even the nurse.

### **Nurses' Psychological, Physical and Professional Experiences with Patient Advocacy**

The nurses reported various psychological experiences as they carried out their patient advocacy role. Some participants found it difficult to accept why negative emotions persisted after several years. The experiences occurred most often especially after nurses strived to advocate for patients without positive result. In addition, some nurses confirmed experiences of being angry and finding it difficult to eat. Others participants also reported falling sick to the extent of staying out of work for two weeks. This finding is very significant to the nursing profession since it means nurses' role of patient advocacy is associated with psychological problems. Individual nurses should make it a duty to seek for psychological counselling whenever they are faced with such challenges to avert possible health complication.

Regarding the nurses' professional experiences with patient advocacy, the study result indicated that it varied depending on whether or not the advocacy process went successful. In cases where they succeeded the nurses felt happy working as nurses, their confidence level increased, they got job

satisfaction which lead to increased work output. However, lack of success in advocating for patients resulted in negative professional experiences. According to the nurses, it made the work very difficult, the zeal to even work went a bit dull. The patients gave negative comments about the nurses because they probably did not have detailed information about the efforts nurses may have made to advocate for them without success. This finding supports O'Connor and Kelly's (2005) report that positive outcome for nurses were identified as increased professional recognition and job satisfaction. Besides the identified barriers above, nurses' actions when their colleagues committed acts of negligence has also been discussed in the following section.

#### **Experiences with Colleague Nurses Who Commit Acts of Negligence**

Participants' experiences with colleague nurses who committed acts of negligence also emerged from the study. Most of the participants admitted that reporting colleagues at the work place (whistle blowing) was not a common practice among the nurses in the study area. Only two participants stated that they reported once in a while to the in-charge or authorities, especially when the particular nurse involved has been repeating the same thing and was not willing to change after several corrections. The reasons given by participants for not reporting was related to culture, fear of becoming a victim one day, fear of retaliation and prevention of being accused by colleagues at the workplace.

Similarly, cultural beliefs have been indicated by Davis and Konishi, (2007) as a barrier to whistle blowing in the Japanese health care setting. Black (2011) also found that due to fear of retaliation, most nurses do not advocate for patients. Hence, possible unsafe patient care conditions that lead

to hospital acquired infections such as hepatitis B and C often went unreported. This finding is very worrying because it suggests a compromise in patient safety and quality care within the hospital setting. Yet, in the absence of effective legislations and policies that support and protect nurses who engage in whistle blowing in the hospital setting, this problem will most likely remain unabated.

### **Experiences with What Made Nurses Successful In Patient Advocacy**

The nurses in this study discussed the main themes that enabled them to effectively advocate for their patients. These themes include the health institution; comprising the institutional authorities, the nursing in charges of the various wards and the available resources within the health facility at the time of the advocacy. Patients and relatives, collaboration with other healthcare team and colleagues were further means of success. There was also the nurse's competence such as nursing knowledge, good interpersonal relationship, recognizing patient's needs and good communication skills as well as nurse's personal characteristics and their religious beliefs.

A study by Thacker (2008) revealed a similar finding in which all participants identified key support to the success of their advocacy practice as nurse managers, co-workers, multi-disciplinary team, communication, relationship with patients, the family, nurse's knowledge, beliefs and compassion. Similarly, Negarandeh et al. (2006) found that the existing nurse patient relationship, recognizing patient's needs, the nurse's responsibility in the health facility, as well as nurse knowledge and skills can determine whether or not a nurse will advocate for a patient and succeed.

Most of the nurses in this study mentioned their religious beliefs as the sources of motivation in advocating for patients. Some attributed their victory in advocating to the help of God, adding that God commands all humans to do good to people. The nurses believed it was by prayers and the grace of God and not only their knowledge that helped them to succeed in the advocacy process. It was not surprising then that Thacker (2008) and Negarndeh et al. (2006) made mention of the nurse's beliefs and knowledge as facilitating and influencing factors in the success of advocacy. This study found no evidence in the literature reviewed attributing the nurse's success in patient advocacy to their obedience to God's command, prayers and grace. This finding suggests that these practicing nurses within the Ghanaian context mostly depend on God and hold their faith in God in very high esteem. This is probably due to the barriers of lack of support for the nurses, inadequate health personnel, lack of medical equipment and hospital supplies, and the physician autonomy identified by participants. Therefore, the nurses seem to rather depend mostly on God for help instead of the health institution and the employer for the success of their advocacy role.

### **Experiences with Communication and Interpersonal Relationship in Patient Advocacy**

The nurses viewed good communication and interpersonal relationship as the foundation of effective patient advocacy. Participants viewed good communication and interpersonal relationship as major means of obtaining support from authorities during the advocacy process. Participants mentioned that without it success in patient advocacy will likely be a mirage. The nurses further noted that communication with their patients helped them to

understand their problems. In addition, the nurses admitted that their work schedule required constant taking and handling over patients' care to colleagues. Hence, there is the need for proper communication and therapeutic relationship to enhance continuity of the advocacy activities.

The finding is supported in the nursing literature where for example, Curtin (1979) in her model of human advocacy proposed that the closeness of the nurse-patient relationship determines the extent of patient advocacy. The finding also supports Peplau's theory (1992). Peplau believed that the nurses' role as a leader, teacher, resource person, surrogate and advocate can only be accomplished through good interpersonal relations. Commenting on communication, Thacker (2008) found that it was a key support to nurses who advocated for patients in end of life care. In addition, MacDonald (2007) attributed the success of patient advocacy to the existing interpersonal relationship between the nurse, the patient and other professionals in the healthcare environment.

Similarly, effective nurse-patient relationship has been described by Vaartio et al. (2006) as an antecedent of patient advocacy, whereas Negarndeh et al. (2006) viewed it as a facilitator to patient advocacy. It means strengthening therapeutic communication and interpersonal relations within health facilities and nursing educational curriculum should be a priority in the nation due to the numerous advantages of patient advocacy.

### **Important Qualities and Skills Nurses Needed to Ensure Successful Patient Advocacy**

According to the participants, the nurse advocate must be proactive, assertiveness, zealous, persistence in their demand and at the same time very



patient. They believed the nurse must be respectful and possess the ability to establish rapport with patients and family, as well as, colleagues and other members in the health team. This observation made by the participants is congruent with the findings of MacDonald (2007), Choi and co-workers (2014), Thacker (2008), Hanks (2010) and Abbaszadeh et al. (2013). This suggests that nurses in different countries require similar skills and qualities needed by practicing nurses within the Ghanaian health care environment to effectively advocate for patients.

Kohnke (1982) believed that nurses ability to advocate for patients in not automatic, because requisite skills and knowledge are essential for advocacy. This finding has serious implications on the nursing profession, patient safety and quality care, and the entire nation. There is a need for collaborative efforts on the part of nursing educational institutions, nursing organizations and hospital managements to assure that nurses are well equipped with the required skills for patient advocacy.

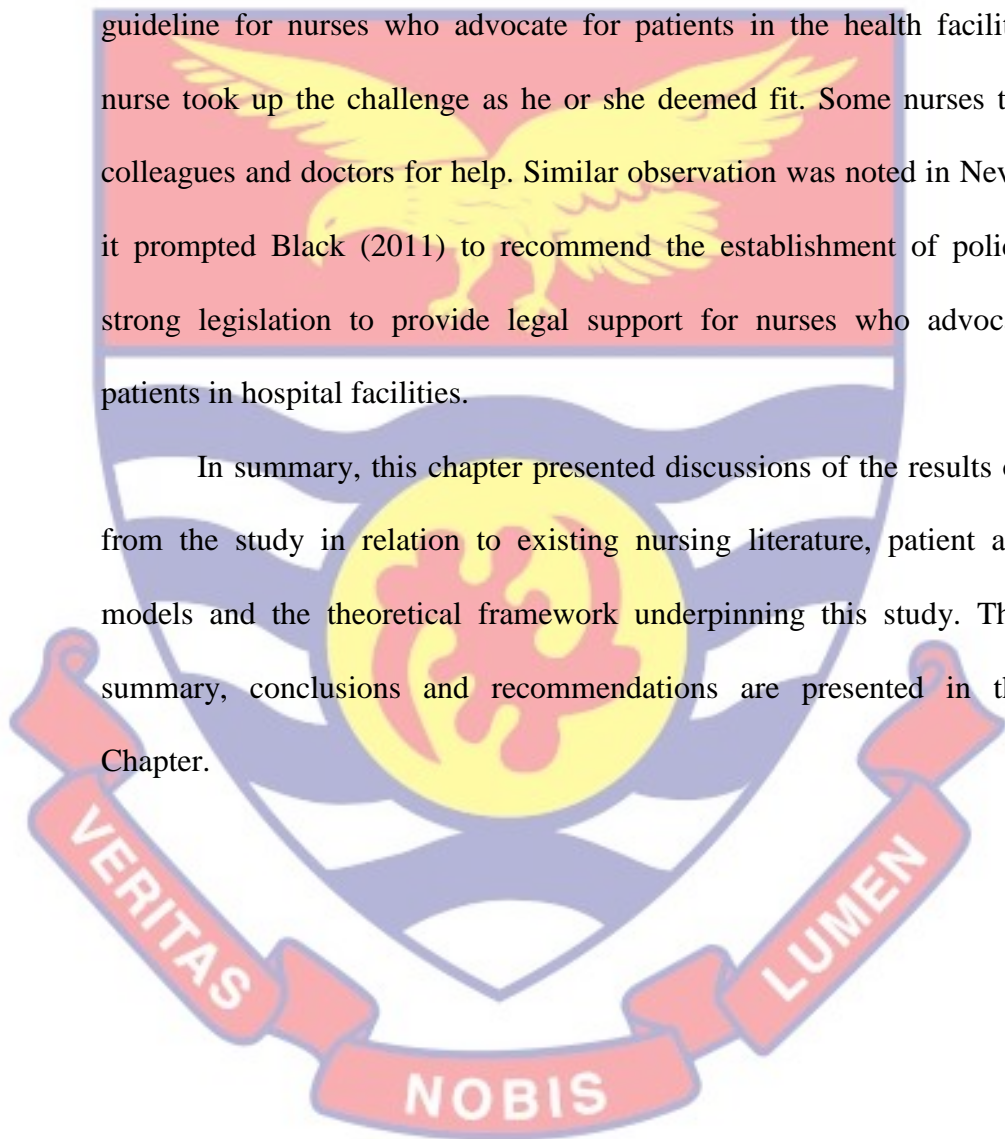
### **Nurses' Experiences with the Benefits of Patient Advocacy**

Based on the participants' experiences, patient advocacy saved lives, helped to maintain good health, decreased the nurse's work load, ensured caring and quality care of patients, quickly recovery and minimized burdens on the health care system. The finding affirmed the numerous benefits of patient advocacy identified by studies in nursing literature. Hanks (2008) and Blacks (2011) indicated that outcome for patients were always positive both for the patient directly involved and for future patients as well. In addition, Hanks (2010) noted that patient advocacy improved patient outcome, safety and quality care. Further advantages included implementation of good rules

and policies in healthcare facilities, prevention of injury and enhanced patient well-being (Davis & Konishi, 2007; Bu & Jezewskii, 2007; Negarandeh et al., 2008) and preservation and protection of patient's rights and safety (Thacker, 2008).

Despite the benefits, participants' responses indicated that there was no guideline for nurses who advocate for patients in the health facility. Each nurse took up the challenge as he or she deemed fit. Some nurses talked to colleagues and doctors for help. Similar observation was noted in Nevada and it prompted Black (2011) to recommend the establishment of policies and strong legislation to provide legal support for nurses who advocated for patients in hospital facilities.

In summary, this chapter presented discussions of the results obtained from the study in relation to existing nursing literature, patient advocacy models and the theoretical framework underpinning this study. The study summary, conclusions and recommendations are presented in the final Chapter.



## CHAPTER FIVE

### SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

#### Summary

The study explored and provided an in-depth description of experiences of registered nurses in carrying out patient advocacy within the Cape Coast Metropolitan Hospital in Ghana. The specific objectives guiding the study are to: (1) explore the registered nurses description of patient advocacy, (2) describe how registered nurses carried out their role as patients advocates, (3) explore barriers to the practice of patient advocacy among registered nurses, and (4) experiences of nurses in acting as patients advocates in clinical practice. A qualitative approach with descriptive study design was used to meet the set objectives, guided by Peplau's theory (1992). Purposive sampling technique was used to select the participants in this study. Through a semi-structured interview, data were collected from 25 participants, transcribed verbatim, and analysed using a qualitative content analysis. The study results and discussions were organized based on the four main objectives of the study, followed by discussion of issues that emerged during data analysis. The key findings of the study have been summarized below based on the study objectives and emerging issues from participant's experiences.

#### Key Findings of the Study

##### Registered Nurses Description of Patient Advocacy

- The nurses at CCMH described patient advocacy as protecting patients, being patients' voice, provision of quality care, supporting, valuing and

respecting of patients, self-determination, and interpersonal relationship as well as educating patients.

### **How Registered Nurses Carry out Their Role as Patients' Advocates**

- The nurses advocated for patients by embarking on the following activities: mediating on behalf of patients, counselling the patients, protecting, supporting, caring, respecting and valuing, and teaching and promoting continuity of patient care.
- The nurses' definitions of patient advocacy were found to be consistent with the way they pursued their advocacy activities within the health facility.

### **Barriers to the Practice of Patient Advocacy among Registered Nurses**

- The main barriers to patient advocacy identified at the CCMH were: the health institution and work environment, the patients, lack of legal support, anticipated negative outcome of advocacy, fear of loss of job, limited communication, patient's family members, limited interpersonal relationship, the nurses themselves, the complexity of the advocacy process, financial difficulties, inadequate knowledge and religious beliefs, as well as anticipated negative outcome of advocacy.

### **Experiences of Nurses in Acting as Patients' Advocate in Clinical Practice**

- Outcomes of successful patient advocacy included satisfaction and fulfillments for nurses, patient's conditions are positively changed, positive effect on the health facility, the nursing profession and the nation.
- Outcomes of unsuccessful patient advocacy included death, lack of quality patient care, increased health complications, negative effects on the health facility, the nursing profession and the nation.

- The nurse's positive experiences with patient advocacy consisted of happiness, feeling great and joy, increased confident level, work output and job satisfaction.
- The nurses described their negative experiences with patient advocacy as frustrations, depressing, painful, feelings of failure, being worried, feelings of helplessness and powerlessness, inability to forgive self, psychological pain, anger, difficult to eat, falling sick, decreased zeal for work, negative comment about nurses and the nursing profession.
- The nurses admitted that reporting colleagues at the workplace in the event of negligence was not a common practice among the nurses at the CCMH due fear of retaliation and lack of support should the case end up in the law court.
- The study revealed that important qualities and skills nurses needed to ensure successful patient advocacy included: good communication skills, being knowledgeable, having inner sense of caring and empathy as well as being proactive and assertive
- The sources of success in patient advocacy reported by the nurses included superiors at the CCMH, patients and relatives, team work, nurse's competence, good interpersonal relationship, nurse's personal religious beliefs

### **Conclusions**

The following conclusions were made based on the study findings. The nurses had adequate understanding of patient advocacy and were willing to advocate for patients. Participants' description of patient advocacy was mostly in agreement with nursing theory, nursing advocacy models and existing

nursing literature. Yet, practically, advocating for patients within the clinical setting was difficult owing to several existing barriers including but not limited to the health institution, physicians, limited communication and interpersonal relationships in the health facility. There is therefore a gap in nursing theory and practice at the CCMH.

Considering physicians' autonomy in the health facility, the study concluded that without some form of teamwork, collaboration and agreements between nurses and physician, patient advocacy will most likely remain impossibility irrespective of its importance. The ability to advocate for patients does not come automatically; nurses must possess certain qualities and skills in order to be effective in pursuing their patient advocacy role. Nurses who lacked specific qualities and skills will most likely not advocate for the patients. The nurses experienced emotional, physical, psychological and professional problems as well moral distress in pursuing their advocacy activities for the patients. Therapeutic communication and good inter-personal relationship is effective in promoting patient advocacy in clinical practice.

Finally, this study contributed to the understanding of patient advocacy as experienced by nurses within the CCMH. Following the study findings and conclusions, recommendations for an improvement in patient advocacy and quality care are presented below.

### **Recommendations**

#### **Education and Training:**

- The Ghana health service and nursing educational authorities should ensure that curriculum design for nursing education takes into account the

qualities, knowledge and skills required in the training of nurses for effective patient advocacy.

- The hospital managements should ensure that nurses are well equipped with the requisite skills for patient advocacy through regular organization of workshops, in-service training and seminar on patient advocacy for the nurses.

- Nursing educational authorities should include therapeutic communications and interpersonal relations in nursing as a course in the curriculum both at the diploma and university degree levels.

#### **Policy and Planning:**

- The authorities at CCMH should establish a counselling centre within its premises to house accredited religious ministers and professional psychologists to provide the needed assistance to meet the needs of both patients and nurses.
- CCMH authorities and stakeholders should motivate nursing staff through establishment of patient advocacy team, creation of awareness and provision of the basic equipment needed to provide quality patient care.

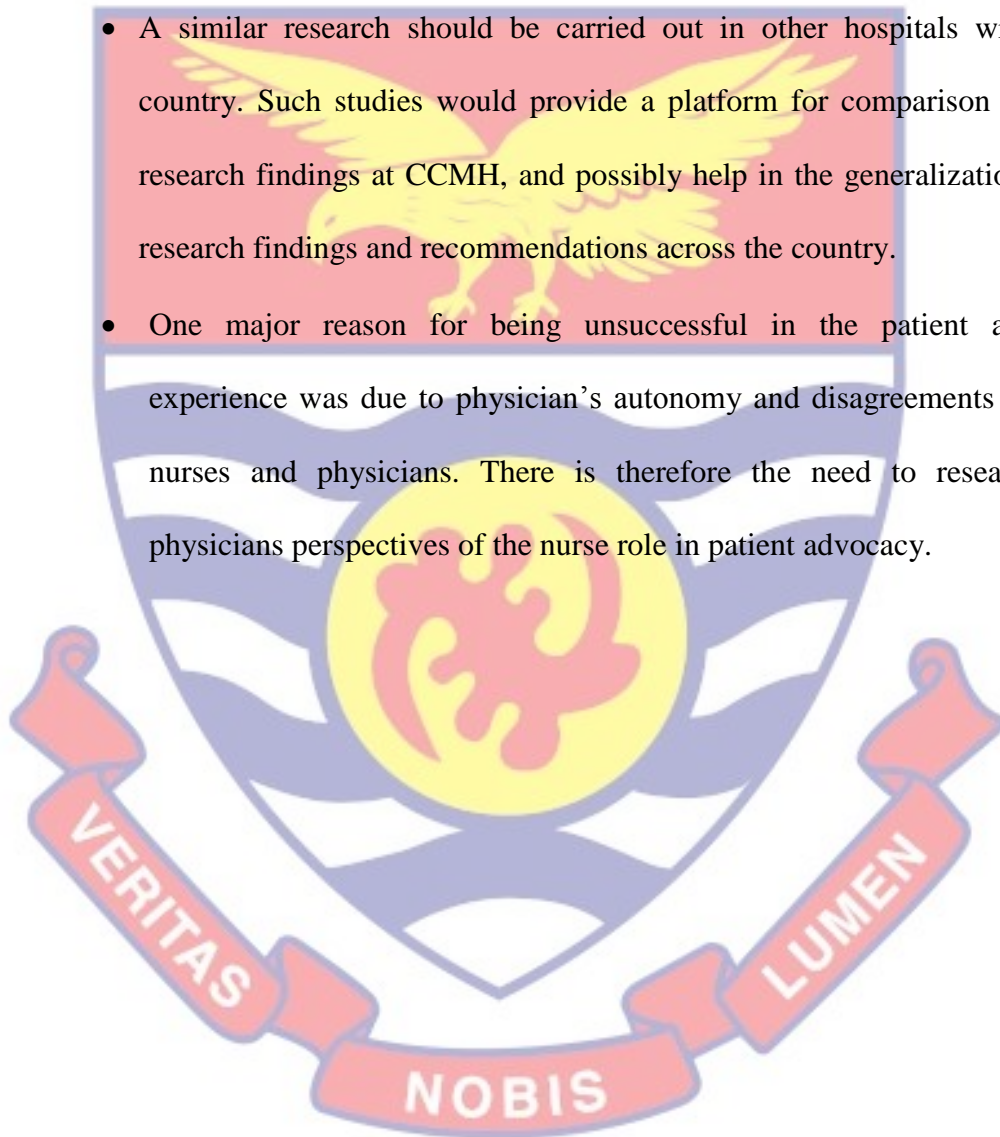
#### **Clinical Nursing Practice:**

- This study found that nurse's competence and knowledge are essential to effective patient advocacy. Nurses should therefore make time to care for themselves holistically and ensure their own professional development through constant practice, learning, research, and participation in workshops and in-service training that will enhance their competence level in their patient advocacy role.

- The study revealed that nurse's role of patient advocacy is associated with physical, psychological and professional problem. Individual nurses should make it a duty to seek for psychological counselling whenever they are faced with such challenges to avert possible health complication.

**Suggestions for Further Research:**

- A similar research should be carried out in other hospitals within the country. Such studies would provide a platform for comparison with the research findings at CCMH, and possibly help in the generalization of the research findings and recommendations across the country.
- One major reason for being unsuccessful in the patient advocacy experience was due to physician's autonomy and disagreements between nurses and physicians. There is therefore the need to research into physicians perspectives of the nurse role in patient advocacy.





## REFERENCES

- Abbaszadeh1, A., Borhani, F. & Motamed-Jahromi, M. (2013). Nurses' attitudes towards nursing advocacy in the southeast part of Iran. *Journal of Applied Environmental and Biological Sciences*, 3(9), 88–93
- Abekah-Nkrumah, G. (2010). Assessing the implementation of Ghana's Patient Charter. *Emerald Group Publishing Limited*, 110(3), 169-185
- Almidei, N. (2010). *So you want to make a difference: Advocacy is the key.* (16<sup>th</sup> ed.) Washington DC: OMB Watch.
- American Nurses Association. (2010). *Code of ethics for nurses with interpretive statements.* Silver Spring: ANA
- American Nurses Association, (2006). *National database of nursing quality indicators (NDNQI).* Retrieved March 20, 2007, from <http://www.nursingquality.org>
- Attree, M. (2007). Factors influencing nurses' decisions to raise concerns about care quality. *Journal of Nursing Management*, 15(4), 392–402.
- Boyle, H. J. (2005). Patient advocacy in the perioperative setting. *AORN Journal*, 82(2), 250– 262.
- Bu, X., & Jezewski, M., A. (2007). Developing a mid-range theory of patient advocacy through concept analysis. *Journal of Advanced Nursing*, 57(1), 101-110.
- Benner, P. (1984). *From novice to expert.* Menlo Park, CA: Addison-Wesley.
- Black, L., M. (2011). Tragedy into policy: A quantitative study of nurses' attitudes towards patient advocacy activities. *American Journal of Nursing*, 111(6), 26–35.

Bramlett, M., Gueldner, S., & Sowel, R. (1990). Consumer centric advocacy; Its connection to nursing frameworks. *Nursing Science Quarterly*, 1(3),156-161.

Burns, N., & Grove, S., K. (2011). *Understanding nursing research: Building evidence based practiced* (6<sup>th</sup> ed.). Philadelphia, Elsevier Health Sciences.

Choi, S., P-P., Cheung, K., & Pang, S., M-C. (2014). A field study of the role of nurses in advocating for safe practice in hospitals. *Journal of Advanced Nursing*, 70(7), 1584–1593.

Cho, K. (1997). *Concept development of client advocacy using the hybrid model*. Handout at Scientific Session, Sigma Theta Tau International's 34th Biennial Convention.

Curtin, L. (1979). The nurse as advocate: A philosophical foundation for nursing. *Advances in Nursing Science*, 7(3), 1–10.

Creswell, J.,W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.), Thousand Oaks, CA: Sage

Davis, A. J., & Konishi, E. (2007). Whistleblowing in Japan. *Nursing Ethics*, 14(2), 194–202

Gadow, S. (1980). Existential advocacy: Philosophical foundation of nursing. In S. F. Spicker & S. Gadow (Eds.), *Nursing images and ideals: Opening dialogue with the humanities* (pp. 79–101). New York, NY: Springer Publishing Co.

Ghana Health Services (1992). *The patent's charter*. Accra. GHS.

Ghana News Agency (GNA). (2015). *Cape Coast Metropolitan Hospital in a bad condition*. Retrieved February 1, 2016 from:

<https://www.newsghana.com.gh/cape-coast-metro-hospital-bad-condition/#respond>

Ghana Statistical Service (2014). 2010 *Population and Housing Census, District Analytical Report*. Accra: Cape Coast Municipality.

Graham, K., (2012). Patient advocacy in nursing practice: A systematic literature review. *TUAS BA THESIS*, 54(4), 5-39.

Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches*. San Francisco, CA: Jossey-Bass.

Hanks, R. (2008). The lived experience of nursing advocacy. *Nursing Ethics*, 15(4), 468–477.

Hanks, R. G. (2010). The medical–surgical nurse perspective of advocate role. *Nursing Forum*, 45(2), 97–107.

Hanks, R. G. (2005). Sphere of nursing advocacy model. *Nursing Forum*, 40(3), 75–78.

Ingram, R. (1998). *The nurse as the patient's advocate*. Unpublished Master's Thesis, University of Portsmouth, Portsmouth.

Jezewski, M. A. (1993). Culture brokering as a model for advocacy. *Nursing & Health Care*, 14, 78-85.

Kohnke, M. F. (1982). *Advocacy, risk and reality*. St. Louis: The C. V. Mosby Co.

MacDonald, H. (2007). Relational ethics and advocacy in nursing: Literature review. *Journal of Advanced Nursing*, 57(2), 119–126.

McEwen, M., & Wills, E., M. (2011). *Theoretical basis for nursing*, (3<sup>rd</sup> ed.). New York, Lippincott Williams & Wilkins.

Miles, M. B., & Huberman (1994). *Qualitative data analysis: An expanded source book*, (2nd ed.). Newberg Park, CA: Sage.

Nursing & Midwifery Council of Ghana (2006). *Code of Professional Conduct: Standards for Conduct, Performance and Ethics*. Accra: Nursing & Midwifery Council of Ghana

Negarandeh, R., Oskouie, F., Ahmadi, F., Nikravesh, M., Hallberg, I., R. (2006). Patient advocacy: Barriers and facilitators. *BMC Nursing*, 35, 358-371.

Negarandeh, R., Oskouie, F., Ahmadi, F., & Nikravesh, M. (2008). The meaning of patient advocacy for Iranian nurses. *Nursing Ethics*, 15(4), 457–467.

Neuman, W. L., (2011). *Social research methods: Qualitative and quantitative approaches*, (7<sup>th</sup> ed.). Boston: Pearson (Allyn & Bacon).

Norman I. D., Aikins M., Binka F., N., & Nyarko K., M. (2012). Hospital All-Risk Emergency Preparedness in Ghana. *Ghana Medical Journal*, 46(1), 34–42

Nystrom, M. (2007). A patient-oriented perspective in existential issues: A theoretical argument for applying Peplau's interpersonal relation model in healthcare science and practice. *Scandinavian Journal of Caring Sciences*, 21(2), 282–288.

O'Connor, T. O., & Kelly, B. (2005). Bridging the gap: A study of general nurses' perceptions of patient advocacy in Ireland. *Nursing Ethics*, 12(5), 453–467.

Papathanasiou<sup>1</sup>, I., Sklavou, M., & Kourkouta, L. (2013). Holistic nursing care: Theories and perspectives. *American Journal of Nursing Science*, 2(1), 1–5.

Peplau, H., E. (1992). The art and science of nursing: Similarities, differences, and relations. *Nursing Science Quarterly*, 1, 8–15.

Polit, F., D. & Beck, T. (2010). *Essentials of nursing research: Appraising evidence for nursing practice* (7<sup>th</sup> ed.). Wolyres: Kluwer Health/Lippincott Williams and Wilkins.

Punch, K., F. (2005). *Introduction to social research: Qualitative and quantitative approach*. (2nd ed.). London: Sage Publications.

Roper, W., L. (2008). Foreward. In J. L. Earp, E. A. French, & M., B. Gilkey, *Patient advocacy for healthcare quality: Strategies for achieving patient-centered care*. Sudbury, MA: Jones & Bartlett.

Sarantakos, S. (2005). *Social research*. (3<sup>rd</sup> ed.). New York: Palgrave Macmillan.

Speziale, H., J., S., & Carpenter, D., R. (2007). *Qualitative research in nursing: Advancing the humanistic imperative* (4th ed.). Philadelphia: Lippincott Williams & Wilkins.

Thacker, K., S. (2008). Nurses' advocacy behaviors in end-of-life nursing care. *Nursing Ethics*, 15(2), 174–185.

Vaartio, H., & Leino–Kilpi, H. (2004). Nursing advocacy: A review of the empirical research 1990–2003. *International Journal of Nursing Studies*, 1(42), 705–714.

Vaartio, H., Leino–Kilpi, H., Salanterä, S., & Suominen, T. (2006). Nursing advocacy: How is it defined by patients and nurses, what does it

involve and how is it experienced? *Scandinavian Journal of Caring Sciences*, 1(20), 282–292.




## APPENDICES

### APPENDIX A

#### Ethical Clearance from IRB-UCC

UNIVERSITY OF CAPE COAST  
INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 03321-33172/3 / 0207355653/ 0244207814 C/O Directorate of Research, Innovation and Consultancy  
E-MAIL: [irb@ucc.edu.gh](mailto:irb@ucc.edu.gh)  
OUR REF: UCC/IRB/3/48  
YOUR REF:



1<sup>ST</sup> MARCH, 2016

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Mrs. Comfort Nsiah  
School of Nursing and Midwifery  
University of Cape Coast

Dear Mrs. Nsiah,

**ETHICAL CLEARANCE –ID NO: (UCCIRB/ CHAS/2015/40)**

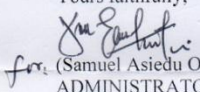
The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for implementation of your research protocol titled: **“Registered Nurse’s Role In Patient Advocacy and Implications on Patient Safety and Quality Care.”**

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

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

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

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


Yours faithfully,  
  
for: (Samuel Asiedu Owusu)  
ADMINISTRATOR

cc: The Chairman, UCCIRB


**ADMINISTRATOR  
INSTITUTIONAL REVIEW BOARD  
UNIVERSITY OF CAPE COAST  
Date: 11-03-16**


APPENDIX B

INTRODUCTORY AND PERMISSION LETTER

 **UNIVERSITY OF CAPE COAST**  
COLLEGE OF HEALTH AND ALLIED SCIENCES  
SCHOOL OF NURSING AND MIDWIFERY  
**DEAN'S OFFICE**

Telephone: 233-3321-33342/33372  
Telegrams & Cables: University, Cape Coast  
Email: [nursing@ucc.edu.gh](mailto:nursing@ucc.edu.gh)  
SN/77/Vol. 2/  
Our Ref:  
Your Ref:

 **UNIVERSITY POST OFFICE**  
CAPE COAST, GHANA.  
25<sup>th</sup> February, 2016



The Medical Superintendent  
Cape Coast Metro Hospital,  
Cape Coast  
Central Region

Dear Sir/Madam,

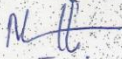
**LETTER OF INTRODUCTION: MRS. COMFORT NSIAH**

The above named person is a level 850 student of the School of Nursing and Midwifery, University of Cape Coast with ID number BS/MNS/14/0016.

Mrs. Nsiah is in her final year, pursuing a Second Degree in Nursing. She is conducting a research on the topic: "Experiences of Registered Nurses in carrying out their role as patients advocates."

We would be very grateful if you could offer her the necessary assistance and support.

Thank you.

Yours faithfully,  
  
Dr. Samuel Victor Nuvor  
VICE-DEAN

*③ PHS A  
check to see if she had satisfied*

*④ Adm. Mgr. will  
Please attention  
DDNS for action  
Approval granted 3/3/16  
PHSA 4/3/2016*

*① Med Dept  
Full please  
PHSA  
5/3/16*

*Seen for DDNS  
4/03/16*



## APPENDIX C

### INFORM CONSENT FORM

#### UNIVERSITY OF CAPE COAST

#### INSTITUTIONAL REVIEW BOARD

### INFORMED CONSENT FORM (INFORMATION FOR PARTICIPANTS)

**Study Title: Experiences of Registered Nurses in Carrying out their Role**

**as Patients' Advocates**

**Principal Investigator:** Mrs. Comfort Nsiah

**Address:** c/o University of Cape Coast, School of Nursing and Midwifery,  
Cape Coast, Ghana

#### **General information about the research**

I am a Master of Nursing (MN) Student at the University of Cape Coast. I am currently undertaking the above research in partial fulfillment of the requirements for the award of Master of Nursing Degree. The purpose of this research is to explore experiences of nurses regarding their role in helping patients to get the best possible care. Participants will engage in an interview alone with the researcher in a location appropriate for both. The interview will be tape recorded and will take about 45-60 minutes of your time. Issues to be discussed during the interview will include: the way nurses help patients to get the best possible care, the role nurses play in speaking up for patients and things that prevent nurses from speaking or acting on behalf of their patients. There is no direct benefit to participants however, it is expected that outcome from the study will contribute to the body of nursing knowledge. It will also help to identify and improve on challenges related to nurses' role of acting on behalf of their patients and contribute to the efforts aimed at maintaining the quality of patients care and safety within the Ghana health care system.

#### **Invitation and Procedure**

We invite you to take part in this research project to enable us to find some of the answers to the set objectives. If you accept, you will be required to participate in an interview with the researcher herself.

#### **Why are we doing this project?**

We want to find out your views and experiences in carrying out your role as patients' advocate. This project will be written up by the researcher for a

research degree (MN). In the future, we hope the research will lead to people knowing more about this complex phenomenon of patient advocacy and the implications it has on patient's safety and quality care within the Ghana health care system.

**Why have I been chosen?**

You have been asked to take part in this interview because we feel that your experiences as a registered nurse will contribute much to achieving the objectives for the study.

**Do I have to take part?**

You can choose whether you want to say **yes** or **no**. You do not have to give reasons. You may withdraw at any time without giving any reason for withdrawal.

**What will happen to me if I take part?**

We will ask you about your views and experiences regarding the concept of patient advocacy, nurses' role in patient advocacy, how nurses carry out their patient advocacy role and barriers to the practice of patient advocacy. There are no foreseeable risks or injury to participants. However, if you do not wish to answer any question posed during the interview or the focus group discussions you may say so and the interviewer or moderator will move on to the next question. The interview will be tape recorded and will take about 45-60 minutes of your time.

**Will my taking part be confidential?**

Yes. Anything you tell us will be used without using your name. All information provided will be kept confidential to the best of our ability, and no names will appear on the transcribed interviews, discussions, and the research report.

**Who has checked or reviewed this study?**

This research has been reviewed and approved by the Institutional Review Board of University of Cape Coast (IRB-UCC).

**For further information contact:**

If you have any questions or concerns, kindly ask the researcher in person or by phone at 0572173255. For further questions regarding your right as a participant you can contact the Administrator at (IRB-UCC) office between

the hours of 8:00 a.m. and 4:30 p.m. through the phones lines 0332133172 and 0244207814 or email address: [irb@ucc.edu.gh](mailto:irb@ucc.edu.gh).

**Thank you for agreeing to take part in the study.**





**APPENDIX D: Participants' Demographic Information Sheet**

Participants ID Code: \_\_\_\_\_

**1. Age range:**

- 20-30years
- 31-40 years
- 41-50 years
- 51 and above

**2. Sex:**

- Male
- Female

**3. How long have you worked as a registered nurse?**

- 1-5years
- 6-10 years
- 11-15 years
- 16-20 years
- 21 and above

**4. How long have you worked in this facility as a registered nurse?**

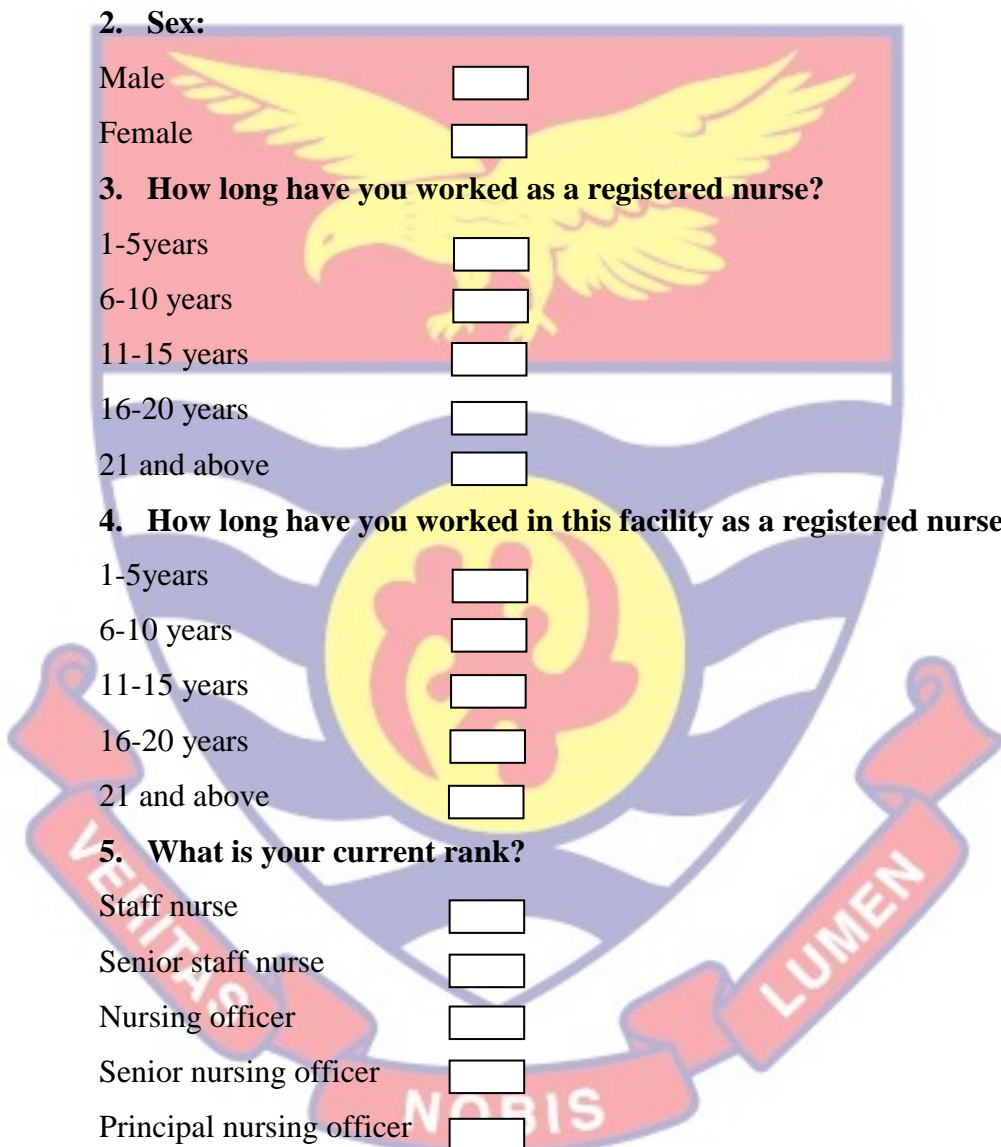
- 1-5years
- 6-10 years
- 11-15 years
- 16-20 years
- 21 and above

**5. What is your current rank?**

- Staff nurse
- Senior staff nurse
- Nursing officer
- Senior nursing officer
- Principal nursing officer
- Other:

**6. What is your current level of nursing education?**

- Diploma
- Degree
- Masters and above



## APPENDIX E

### INTERVIEW GUIDE

#### PARTICIPANTS' INTERVIEW GUIDE

Each participant will be asked to respond in their own words to the interview questions and probes below:

##### 1. Knowledge of nurses regarding the concept of patient advocacy

- Tell me about how you would you describe the concept of patient advocacy.

**Probes:**

- what does it mean to you?
- How you would you describe it?
- Tell me more about your views on patient advocacy

##### 2. How registered nurses carry out their role as patient's advocate

- Tell me about the things you do when you advocate for patients.

**Probes:**

- What do you actually do?
- How did you do it?
- Tell me about the processes you go through
- Do you involve others when advocating for the patients?
- Who were those involved?
- Tell me more

##### 3. Experiences of nurses in acting as patient's advocates in clinical practice

- Describe experiences you had in which you felt a patient was successfully advocated for.

**Probes:**

- What happened?
- Why did you decide to advocate?
- What were some of the things you did?
- What made you successful?
- What were the outcomes of these experiences?

**Probes:**

- Personal; (physical, emotional, social and professional)
- Patient and family; (physical, emotional and social)
- The health facility;
- The nursing profession

#### 4. Barriers to the practice of patient advocacy among nurses in CCMH

- Tell me about the challenges or barriers you encounter when you advocate for patients.

**Probes:**

- The health care facility:
- Patients and family:
- Personal
- Legal issues

- Describe circumstances in which nurses could not advocate for a patient due to some challenges or barriers.

**Probes:**

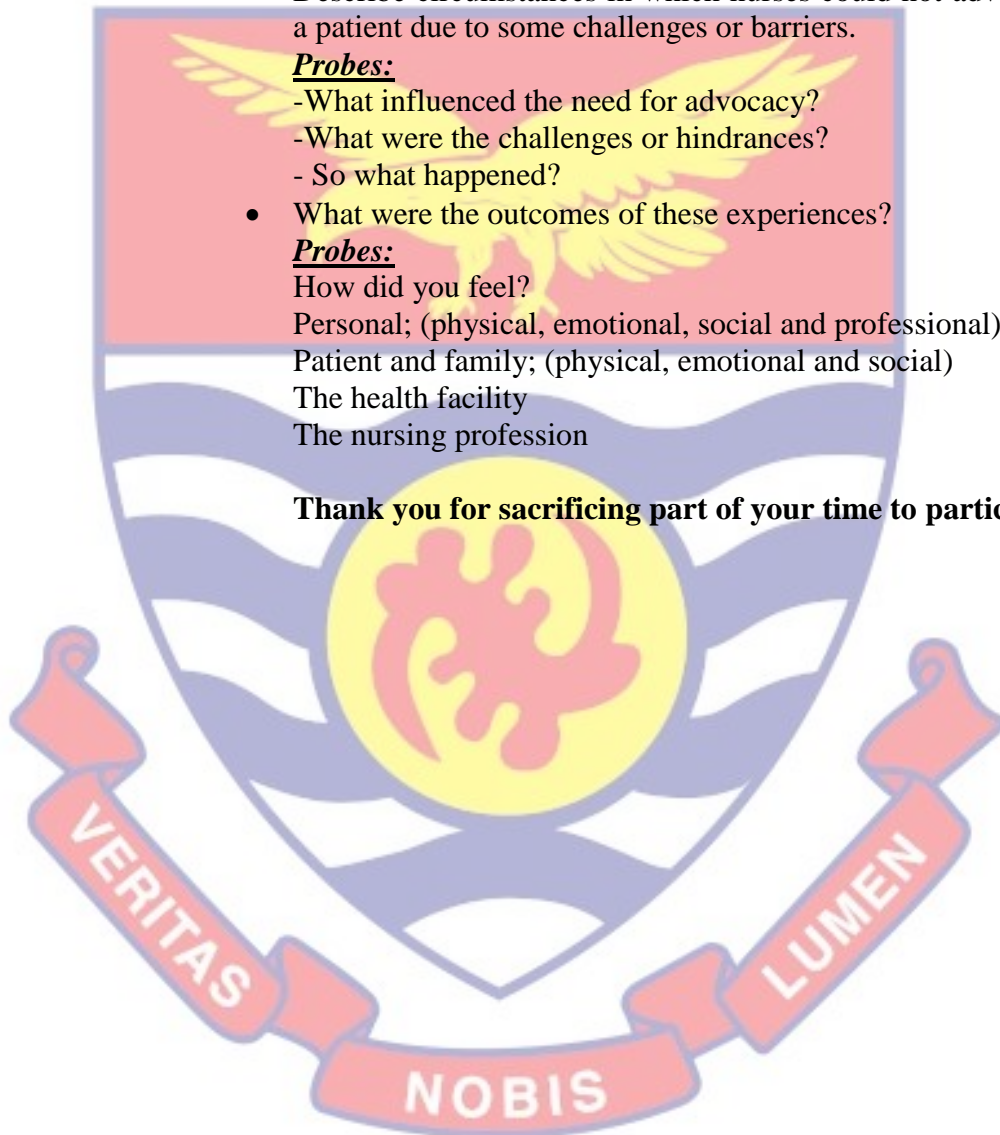
- What influenced the need for advocacy?
- What were the challenges or hindrances?
- So what happened?

- What were the outcomes of these experiences?

**Probes:**

- How did you feel?
- Personal; (physical, emotional, social and professional)
- Patient and family; (physical, emotional and social)
- The health facility
- The nursing profession

**Thank you for sacrificing part of your time to participate**



## APPENDIX F

### EXCERPT FROM ANALYSIS OF THE TRANSCRIBED DATA

MRS. M-2

Q. Tell me about how you would describe the concept of patient advocacy

*provision of quality care*  
Response: As nurses we always advocate for the patient as part of giving quality health care. Then many a time, you see that a patient may need something, or when they come to the hospital, they are afraid, they have this perception that nurses are bad, and at times it's true, because some of the experiences some of them had with some nurses. As much as possible, when they come to the ward, we try to calm and tell them that we are here for them. So they should feel free and ask whatever they need so that we can also give them the quality of care that is needed. So that at the end, they will have a quick recovery and they will go home.  
*- Valuing  
- Respecting  
- Interpersonal relationship* *Quality care*  
*promoting quick recovery & discharge*

Q. Tell me about the things you do when you advocate for patients.

*- Financial support  
- medical help*  
Response: Some patients when they are being discharged especially those who are non-insured, sometimes they find it difficult in settling their bills. So as nurses, we step in for them and then we see the management and see how best we will be able to help them in terms of management of their bills. If you don't step in and do anything about it, they will remain in the ward for several days and weeks. So at times, we advocate on their behalf to solicit for funds to help them settle the bills, at times too their medications. Due to our experiences on the ward, at times you may have a new doctor and because of the nature of the conditions, we can talk to the doctor and suggest that if you can do this lab or request for this investigations, it will help. Because this profession is a team work, you may have a doctor who is new to the profession and you may have to advocate for the patient. At times those who take the advice of the nurses it really helps them. Except that those who are arrogant and think that nurses don't know anything. But this work, based on experience you may learn everything but because of your experience on the ward, you are able to help in some situations. *acting on behalf of pts.*  
*speaking up for them.*  
*medical help*  
*helping pts*

Q. Describe experiences you had in which you felt a patient was successfully advocated for.

*feeling compelled to act on pts unmet needs*  
Response Yes, he was at female ward and we had this patient who was referred to the Regional hospital. In fact, the parent had problem with money, but it was an emergency case. It was an intestinal obstruction which needed immediate surgery. And the parent weren't having the money. So I had to go round, beg for money to give to the mother to help the situation, she smiled. It was last year around March.

Probe: What were the outcomes of these experiences?

Response: She had a successful surgery. And later the mother came here to thank all of us.  
*positive patient outcome*  
*pts family are appreciative*