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ABSTRACT

One of the main forces behind global health campaigns is quality improvement, and this is especially true in acute care settings like emergency departments, where making quick, life-saving judgments is of utmost importance. The majority of researchers in Ghana have focused mostly on secondary and tertiary hospitals in Ghana, paying less attention to primary healthcare settings, which are the main entrance points for the majority of emergency situations. The purpose of this study was to investigate how patients perceived receiving high-quality care in primary healthcare facilities in Ghana's emergency rooms. A sample of 160 patients was used to explore perception on quality care delivery at the Emergency Department (ED) of selected primary healthcare facilities in Ghana.The findings showed that patients thought doctors had adequate knowledge in their field based on their ability to assess, prescribe appropriate medications, and request diagnostic investigations that are pertinent to the working diagnosis, even though they thought the physical care and information flow at the ED was subpar. The study suggests using a digital compliant management system that enables patients to express their issues in real time, along with a high degree of responsiveness. Future studies may also investigate the perceptions of particular patient populations to discover requirements unique to them, thus enhancing the patient-centered approach to care, taking into account that this study examined the viewpoints of a variety of patient demographics.

KEY WORDS: Patient, Quality, Care delivery, Primary Healthcare, Emergency Department.

INTRODUCTION

Over the years, the quality movement in healthcare has undergone significant changes as a consequence of an increasing demand to not merely promote quality but it has also become mandatory to consistently improve quality (Graham, 1995). This has triggered several global efforts with the World Health Organization (WHO)leading the change to ensure quality in health care settings (World Health Organization, 2003). Quality can be defined as " the extent to which healthcare services provided to individuals and patient populations produce desired health outcomes"(WHO | Quality of Care, 2020). It has always been the objective to ensure access to high -quality health services to all populations irrespective of their location (World Bank Group, 2018) however the shift to supporting the drive for patient-centeredness in quality is burgeoning.Quality in terms of emergency care is

a priority area for improvement at the Emergency Department (ED) (Dewulf et al., 2017) in as much as ED plays a pivotal role in the health system, designed to provide expeditious, accessible and urgent care (Ieraci et al., 2000). In view of this, The World Health Assembly Resolution 60.22 recognized the need to strengthen emergency care systems (Anderson et al., 2012). This further suggests how imperative it is to hold quality at the ED in high regard. In the acute care setting, time is a limited resource, thus involving a patient in the plan of care may present as an additional responsibility (Leitch et al., 2013), however it is worth noting that measuring patient satisfactionand experiences remain pertinent in discussing issues of quality (Fakharian Somaye et al., 2017). The feedback on the care patients receive serves as useful data in designing health care that is tailored to meet their needs. This empowers them to become custodians of their health subsequently promoting a patient safety culture (*Patients Perceptions of Quality in Healthcare*. 2017). Moreover, positive patient experiences have been shown to improve treatment compliance (Kipnis et al.,2013) and this translates into better health outcomes (Balik et al, 2011) which eventually reduces unwarranted hospital visits (Bayliss et al., 2015). Nonetheless, evidence shows that there is a stark deficiency in quality in emergency care settings which more often than not leads to preventable deaths (Hogan et al., 2012) thus culminating in loss of trust in the healthcare system (Smith, 2017).

Quality in the emergency care setting encompasses acknowledging the perspectives and demands of patients in the care delivery process. Undoubtedly, failure to consider these would inadvertently result in death and other unwanted complications. Therefore, the exigencies of conforming to quality standards in the ED are critical considering the implications of compromising quality, warranting a need to further explore this area. Although there is an expanding interest in enhancing quality in the ED, research studies have largely focused on quantitative data in the form of Likert scale responses to patient surveys (Fontova-Almató et al., 2019; Gishu et al, 2019; Yarney&Atinga, 2017) which cannot create and capture a more patient-centered focus for this field of research. Conversely, other studies (Graham et al., 2019; Nastui et al, 2019; Swallmeh&Arisha, 2018) have suggested that a qualitative analysis of patient-reported outcomes will allow for the assessment of the broad range of patient experiences which could better outline areas for improvement in the ED experience from the patient perspective. However, it appears there is little to no evidence on studies in Ghana that have explored both approaches where the views of managers are incorporated to provide a more complete understanding of patients' view of quality in emergency care settings particularly at primary healthcare facilities which are initial entry points for most emergency cases. Quality patient care is paramount and it should be a matter of grave concern to all stakeholders in the health care system worldwide. Globally, ensuring quality in healthcare is a challenge, particularly in low and middle-income countries (Kruk et al., 2018). In Ghana, there are continuous efforts to support the quality improvement campaign. (Escribano-Ferrer et al., 2016). In this regard, the Ghana National Healthcare Quality strategy was also developed to ensure patient-centered care in an attempt to improve health outcomes (Ministry of Health,2017). This may have resulted from the quest for change across the healthcare

industry as a consequence of heightened concern for safety and consumer preference (Barnsteiner,2014). Soeters et al (2011: p. 1519) posit that, "person-centered care is not just one the dimension of healthcare quality, it is the doorway to all qualities". Although there has been a paradigm shift from paternalism to partnership in healthcare service delivery, this does not seem to feature well in acute care settings such as the Emergency Department (ED) especially among patients that require acute care (Leitch et al., 2013). This implies that emergency care is largely not responsive to the needs of patients thus compromising the quality of care. This phenomenon is not any different from what pertains currently in Ghana (Norman et al, 2012). This impact heavily on acutely ill patients since it determines their chances of survival for definitive management. Furthermore, in another study, it was confirmed that service quality was rated high in private hospitals and this was associated with increased customer satisfaction and the opposite was true for public hospitals (Anabila et al., 2019). Despite efforts to improve emergency care in Ghana through capacity building (Martel et al, 2014) and infrastructure development, evidence suggests that the majority of patients are dissatisfied with emergency care (Yarney& Atinga,2017; Norman et al., 2012). To a large extent, these studies have been limited to secondary and tertiary hospitals with little to no focus on the perspectives of patients on emergency care at primary care facilities where most emergency cases are managed before onward referral for definitive management (Yarney&Atinga, 2017; Norman et al., 2012). Thus, to this end, this study seeks to examine the perceptions of patients on healthcare quality emergency care at Emergency Department of selected private hospitals in Ghana.

METHODOLOGY

A sample of 160 patients was used to explore the perception of patients on quality care delivery at the emergency department of selectedprimary healthcare facilities in Ghana. The scale on perception of healthcare quality was a 4-point scale ranging from 1=**disagree**, 2= **neither agree or disagree**, 3=**agree** and 4=**strongly agree.**

Descriptive Statistics

In general, the respondents agreed that there is empathy from caregivers, good socio-cultural atmosphere, high medical/technical competence of care givers, and good physical/technical conditions. They however, neither agreed nor disagreed that there is access to information on care givers and treatment received.Comparatively, the dimension of health care quality the respondents agreed with the most was the fact that there was high medical/technical competence (Mean=3.38, SD=0.71); this is followed by good physical/technical conditions (Mean=3.36, SD=0.80), good socio-cultural atmosphere (mean=3.28, SD=0.88), empathy from caregivers (mean=3.06, SD=1.01), and access to information on caregivers and treatment (mean=2.06, SD=1.03) in descending order of healthcare quality received.

Overall Perception of Healthcare Quality

Access/availability of information on caregivers and treatment (Identity oriented dimension)

Among the six variables on the availability of information on caregivers and treatment, the statement the respondents agreed with the most was the fact that there is information on the results of examinations and treatment (mean=2.38), and the one they least agreed with was the fact there is information on responsible doctors and nurses (Mean=1.70).This goes to indicate that when it comes to patients' perception on information about those providing care, they have little access or information about care givers and treatment given them. This could affect their openness in dealing with care providers as patients may not be comfortable with someone, they do not have any information about most especially on their level of competency.

Empathy from caregivers (Identity Oriented dimension)

Among the four variables on empathy from caregivers, the statement the respondents agreed with the most was the fact that doctors understood their situation (mean=3.30), and the one they least agreed with was the fact doctors showed commitment (Mean=2.70).This goes to show that although doctors who attend to patients understood their predicament, the commitment to help resolve it was much to be desired.

Socio-cultural atmosphere

Among the three variables on socio-cultural atmosphere around the ward/facility, the statement the respondents agreed with the most was the fact that there isusually a pleasant atmosphere on the ward (mean=3.61), and the one they least agreed with was the fact care is determined by their own requests and needs (Mean=2.85).This goes further to suggest that, patients were not involved much in what type of care being metted out to them although the fact that their relatives were treated well (Mean= 3.39) coupled with the fact that high mean score for pleasant atmosphere on the ward may suggest that care givers interacted with the patients' relatives more other than the patients themselves largely because of their ill-health and incapacitation.

Medical and Technical Competence

Among the four variables on medical and technical competence of caregivers, the statement the respondents agreed with the most was the fact that there is effective pain relief (mean=3.71), and the one they least agreed with was there is examination and treatment within acceptable waiting time (Mean=3.00).This suggests that despite the pleasant atmosphere in the selected Ghanaian primary healthcare facilities, patients spend more hours before they were attended to. This is a precursor to the staff deficit in Ghanaian hospitals regardless of density of physicians, nurses and midwives haven increased over the years (Ministry of Health, 2017).

Physical/technical conditions

Among the three variables on

physical/technical conditions around the ward/facility, the statement the respondents agreed with the most was the fact that there is comfortable bed (mean=3.38), and the one they least agreed with was the fact that there is food and drinks they like (Mean=3.26).This be that usually most patients bring their own drinks and food unless it is strictly recommended by the hospital to patronize the food served during their stay at the hospital.

Table 1. Descriptive Results-Perception of healthcare quality

Items	Min	Max	Mean	S.D
1. Access/availability of information on caregivers and treatment				
Information on responsible doctors	1.00	4.00	1.74	1.22
Information on responsible nurses	1.00	4.00	1.74	1.20
Information on results of examinations and treatments	1.00	4.00	2.38	1.37
Information on self-care	1.00	4.00	2.14	1.35
Information on examinations and treatments	1.00	4.00	2.29	1.38
Participate in decisions applied to my care	1.00	4.00	2.06	1.29
Overall	**1.00**	**4.00**	**2.06**	**1.03**
2. Empathy from caregivers				
Nurses understood my situation	1.00	4.00	3.09	1.23
Doctors understood my situation	1.00	4.00	3.30	1.08
Doctors showed commitment	1.00	4.00	2.72	1.33
Information on effects and use of medicine	1.00	4.00	3.13	1.20
Overall	**1.00**	**4.00**	**3.06**	**1.01**
3. Socio-cultural atmosphere				
Relatives and friends treated well	1.00	4.00	3.39	1.00
Pleasant atmosphere on the ward	1.00	4.00	3.61	0.85
Care determined by own request and needs	1.00	4.00	2.85	1.35
Overall	**1.00**	**4.00**	**3.28**	**0.88**
4. Medical/technical competency				
Best possible medical care	1.00	4.00	3.51	0.90
Examinations and treatment within acceptable waiting time	1.00	4.00	3.00	1.29
Effective pain relief	1.00	4.00	3.72	0.69
Best possible physical care	1.00	4.00	3.31	1.06
Overall	**1.00**	**4.00**	**3.38**	**0.71**
5. Physical/technical conditions				

Comfortable bed	1.00	4.00	3.38	1.12
Access to necessary apparatus and equipment	1.00	4.00	3.31	1.01
Food and drink I like	1.00	4.00	3.26	1.16
Overall	**1.00**	**4.00**	**3.36**	**0.80**

Scale used: 1=Disagree, 4=Strongly Agree
Source: Field Data (2021)

Table2.CrosstabulationresultsforRespondents'ProfileandPerceptionofhealthcarequality

	OverallPerception/Effect			availability ofinformationoncar egivers andtreatment		Empathyfromcar egivers		Socio-culturalatmosphere		Medical/technicalco mpetency		Physical/technicalcon ditions	
Variable	Mean	Type of test	P	Mean	P	Mean	P	Mean	P	Mean	P	Mean	P
Gender													
Male	2.90	t-test	0.76	2.07	0.93	2.87	0.15	3.41	0.27	3.37	0.90	3.24	0.27
Female	2.93			2.06		3.13		3.23		3.38		3.41	
Age													
<20 years	2.74	Correlation	0.05*	1.86	0.64	3.42	0.41	3.11	0.00**	3.04	0.04*	2.83	0.01**
20 -29years	2.78			2.03		2.77		2.97		3.27		3.09	
30-39years	2.99			2.19		3.17		3.34		3.40		3.43	
40 -49years	2.67			1.69		2.94		3.02		3.23		3.35	
>50 years	3.16			2.27		3.20		3.73		3.63		3.60	
EducationalLevel													
None	3.19	Correlation	0.01**	2.21	0.60	3.00	0.91	3.52	0.00**	3.59	0.00**	3.52	0.24
Primary	2.97			2.05		2.95		3.43		3.64		3.38	
Secondary	2.98			2.03		3.32		3.38		3.53		3.38	
Tertiary	2.69			2.04		2.92		2.92		2.86		3.24	
Self-reportedphysical health condition atdischarge													

Verypoor	4.00	Correlation	0.40	4.00	0.75	4.00	0.21	4.00	0.34	4.00	0.01**	4.00	0.82
poor	2.78			2.17		2.91		2.63		2.66		3.48	
Fair	2.84			2.00		2.92		3.33		3.30		3.22	
Good	2.90			2.03		3.02		3.30		3.40		3.37	
Excellent	3.12			2.15		3.38		3.35		3.64		3.44	
Self-reportedpsychological wellbeingatdischarge													
verypoor	3.45	Correlation	0.90	3.11	0.48	3.67	0.23	3.67	0.87	3.83	0.13	4.00	0.54
Poor	2.73			1.85		2.75		2.79		2.91		3.41	
Fair	2.88			2.06		2.86		3.31		3.33		3.33	
Good	2.98			2.08		3.20		3.38		3.44		3.37	
Excellent	2.73			1.86		3.12		2.92		3.54		3.22	
Length ofstay													
<24hours	2.98	Correlation	0.404	2.04	0.838	3.18	0.186	3.37	0.678	3.50	0.01**	3.42	0.194
2 -5days	2.83			2.09		2.90		3.08		3.40		3.32	
6 -9days	2.97			2.07		3.04		3.33		3.10		3.47	
>10 days	2.72			2.10		2.72		3.33		3.19		2.71	
Mode of payment													
Cash	3.06	one-way ANOVA	0.02*	2.29	0.03*	3.17	0.28	3.29	0.40	3.44	0.61	3.45	0.09+
Private insurance	2.63			1.90		2.76		3.04		3.34		2.95	
NHIS	2.82			1.85		3.02		3.34		3.32		3.35	

**significant at p<0.01; *significant at p<0.05; +significant at p<0.10
Source: Field Data (2021)

ANALYSIS AND DISCUSSION OF RESULTS

Perceptions of patients regarding quality emergency care

The results of cross-tabulation for respondents' profile and perception of healthcare quality, as seen in Table 2, show a significant relationship between respondents who had no educational background and their view on medical/technical competency. Further, whereas those with no education, primary and secondary education had relatively high mean scores (3.59, 3.64, and 3.53) for the medical/technical competency levels of staff who attended to them, patients with tertiary education, however, thought otherwise to some extent. Again, on the same point, those who were older than 20 years indicated a favorable response (significant at p 0.05) to the technical/medical competence of the staff who attended to them. This disparity in viewpoint could be that the patients (20 years and above) compared to patients who were less than 20 years old may have had several opportunities to visit the hospital and thus be in a position to better assess the competency of the staff who regularly attended to them. Similarly, patients' views on the social-cultural atmosphere within primary healthcare facilities as per this study reported a significant relationship with the various levels of education, except for patients with a tertiary background, who had a lower mean score (2.92) compared to patients with no education or with primary and secondary education.

On self-reported physical health condition at discharge, there appeared to be a significant correlation between the nature of the health condition being poor and the technical/medical competence of the staff who attended to the patients. As a result of insufficient staffing levels, personal and infrastructure deficits, patients are discharged early to continue recuperating at home when they show little signs of recovery at the primary health care facility. The same applied to the availability of information on caregivers and treatment and the technical/medical competence of staff, although, in this instance (p value > 0.001) at 0.40 was realized, with a mean value of 4.0 for very poor availability of information on caregivers and treatment. Besides, there is a significant relation between the length of stay and technical or medical competency, which to some extent is acceptable, as with more competent medical staff, patients are less likely to spend more hours at the primary healthcare facility.

From the foregoing discussions, it does appear that generally, they perceived the care as good. This was evidenced by mean scores of patient's perceptions of quality of care (PR) on four of the quality dimensions ranging between 3.06 – 3.38 as seen in Table 1. These were medical technical competence dimension, socio-cultural, physical technical and empathy form care givers an aspect of the identity-oriented dimension. These findings are consistent with studies that suggested that general perception of care at the ED was good (Frojd et al., 2011; Muntlin 2006). This implies patients were confident that the doctors demonstrated adequate knowledge in their area of work based on their ability to assess, prescribe appropriate medications and request diagnostic investigations that are relevant to the working diagnosis. Basically, they were more convinced of the technical competence of the health care providers when

they realized an improvement from their earlier state of health. This may have accounted for the high scores given that patients generally are unable to appreciate the technicalities associated with healthcare (Bowling et al., 2012), especially those from lower educational background who make majority of the participants in this study. Patients prefer that care givers possess the needed expertise to that enables them to take decisions regarding their health (Regula et al.,2007). Most patients agreed that they received effective pain relief which is usually a challenge as most studies have portrayed (Muntlin et al.,2006; Sampson et al.,2020). This may have resulted from strict adherence to pain management protocol available and ensuring pain management is at the core of ED processes. Also, they perceived that the physical care was adequate. This implies that they received the necessary assistance if they struggled getting out of bed needed to use the washroom take a bath, or eat. Many studies have reported otherwise (Muntlin et al.,2006; Laal, 2013; Gishu 2019). This may be attributable to the adequacy of nurses. In relation to the identity-oriented dimension, the aspect rated high was the empathy from care givers. Most patients agreed that the doctors and nurses understood their situation. This may have been made possible through allowing patients to communicate their fears in an attempt to alley their anxieties. They also received information on results of examination and treatment. According to (Dibbelt et al., 2009), a good provider -patient relationship has a positive impact on outcomes. In respect of the sociocultural aspect of the care environment, patients agreed with the pleasantness of the facility. This implies that the staff was friendly towards patients, friends and family members. Also, they felt their privacy was respected. This finding was contradictory to that of (Mohanan et al., 2010). In terms of the physical technical dimension, they felt that the beds were comfortable and also availability of apparatus required to care for them. Muntlin and colleagues supported this outcome.

CONCLUSION

Patients' perception of quality care delivery was that doctors demonstrated adequate knowledge in their area of work based on their ability to assess, prescribe appropriate medications and request diagnostic investigations that are relevant to the working diagnosis although they perceived that the physical care and information flow at the ED was inadequate. It is worth noting that in a high-pressure work environment such as the ED patients prefer to be adequately informed about all aspects of their care and be involved in decision making at each point of the care pathway. This is particularly useful information for primary health care settings since they are the first point of entry for most emergency cases.

RECOMMENDATION

The researchers suggest regular routine customer care training for clinical staff with much emphasis on the patient centered approach to care. More so, the facility should design a digital compliant management system that allows patients to communicate their concerns anonymously in real time and this should be accompanied by a high level of response. There should also be regular clinical updates and not at the request of patients.Lastly, in consideration of the fact that the study explored the views of a variety of patient populations, future researchers may explore the perceptions of specific patient populations to unearth needs peculiar to them, thus further strengthening the patient centered approach to care in primary healthcare facilities in Ghana.

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REFERENCES

Anabila, P., Kumi, D. K., &Anome, J. (2019). Patients' perceptions of healthcare quality in Ghana. *International journal of health care quality assurance*.

Anderson, P. D., Suter, R. E., Mulligan, T., Bodiwala, G., Razzak, J. A., Mock, C., ... & International Federation for Emergency Medicine. (2012). World Health Assembly Resolution 60.22 and its importance as a health care policy tool for improving emergency care access and availability globally. *Annals of emergency medicine*, *60*(1), 35-44.

Asamani, J.A., Ismaila, H., Plange, A. et al. (2021). The cost of health workforce gaps and inequitable distribution in the Ghana Health Service: an analysis towards evidence-based health workforce planning and management. Hum Resour Health 19, 43. https://doi.org/10.1186/s12960-021-00590-3

Balik, B., Conway, J., Zipperer, L., & Watson, J. (2011). Achieving an exceptional patient and family experience of inpatient hospital care. *IHI Innovation Series white paper*.

Barnsteiner, J., Disch, J., & Walton, M. (2014). *Person and family centered care, 2014 AJN award recipient*. Sigma Theta Tau.

Bayliss, E. A., Ellis, J. L., Shoup, J. A., Zeng, C., McQuillan, D. B., & Steiner, J. F. (2015). Effect of continuity of care on hospital utilization for seniors with multiple medical conditions in an integrated health care system. *The Annals of Family Medicine*, *13*(2), 123-129.

Bowling, A., Rowe, G., Lambert, N., Waddington, M., Mahtani, K. R., Kenten, C., Howe, A., & Francis, S. A. (2012). The measurement of patients' expectations for health care: a review and psychometric testing of a measure of patients' expectations. *Health technology assessment (Winchester, England)*, *16*(30), i–509. https://doi.org/10.3310/hta16300

Bowling, A., Rowe, G., Lambert, N., Waddington, M., Mahtani, K. R., Kenten, C., ... & Francis, S. A. (2012). The measurement of patients' expectations for health care: a review and psychometric testing of a measure of patients' expectations. *Health technology assessment*, *16*(30).

DeWulf, A., Otchi, E. H., &Soghoian, S. (2017). Identifying priorities for quality improvement at an emergency Department in Ghana. *BMC emergency medicine*, *17*(1), 1-6.

Dibbelt, S., Schaidhammer, M., Fleischer, C., &Greitemann, B. (2009). Patient–doctor interaction in rehabilitation: The relationship between perceived interaction quality and long-term treatment results. *Patient education and counseling*, *76*(3), 328-335.

Fakharian Somaye, Jalili Mohamad, & Khanki Hamidreza. (2017, January 1).

Examination of the Perception and Experiences of the Patients in the Emergency Departments of Imam Khomeini and Shariati Hospitals Regarding the Quality of Care Provided by the Health Care System – Directory of Open Access Journals (DOAJ). Health in Emergencies and Disasters Quaterly. https://login.research4life.org/tacsgr1doaj_org/article/0996bd14946a4d5482089a8f2728ed3d

Fröjd, C., Swenne, C. L., Rubertsson, C., Gunningberg, L., &Wadensten, B. (2011). Patient information and participation still in need of improvement: evaluation of patients' perceptions of quality of care. *Journal of nursing management*, *19*(2), 226-236.

Gishu, T., Weldetsadik, A. Y., &Tekleab, A. M. (2019). Patients' perception of quality of nursing care; a tertiary center experience from Ethiopia. *BMC nursing*, *18*(1), 1-6.

Graham, B., Endacott, R., Smith, J. E., & Latour, J. M. (2019). 'They do not care how much you know until they know how much you care': a qualitative meta-synthesis of patient experience in the emergency department. *Emergency Medicine Journal*, *36*(6), 355-363.

Hogan, H., Healey, F., Neale, G., Thomson, R., Vincent, C., & Black, N. (2012). Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study.

Ieraci, S., Cunningham, P., & Talbot-Stern, J. (2000). Emergency medicine and" acute" general practice: comparing apples with 0ranges. *Australian Health Review*, *23*(2), 152-161.

Kipnis, A., Rhodes, K. V., Burchill, C. N., &Datner, E. (2013). The relationship between patients' perceptions of team effectiveness and their care experience in the emergency department. *The Journal of emergency medicine*, *45*(5), 731-738.

Kruk, M. E., Gage, A. D., Joseph, N. T., Danaei, G., García-Saisó, S., & Salomon, J. A. (2018). Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. *The Lancet*, *392*(10160), 2203-2212.

Laal, M. (2013). Inpatient's perspective on nursing care; affecting factors. *Procedia-Social and Behavioral Sciences*, *84*, 243-247.

Leitch, L., Long, J., Lyness, R., McDonald, C., Miller, E., Murdoch, P., ... & Ward, D. (2013). RCPE UK Consensus Conference on 'Acute Medicine: improving quality of care through effective patient flow–it's everyone's business!'. *JR Coll Physicians Edinb*, *43*, 316-7.

Martel, J., Oteng, R., Mould-Millman, N. K., Bell, S. A., Zakariah, A., Oduro, G., ... & Donkor, P. (2014). The development of sustainable emergency care in Ghana: physician, nursing and prehospital care training initiatives. *The Journal of emergency medicine*, *47*(4), 462

Ministry of Health. (2017). Ghana *National Healthcare Quality Strategy. https://www.moh.gov.gh/wpcontent/uploads/2017/06/National20Quality20Strategy20Ghana.pdf*

Mohanan, K., Kaur, S., Das, K., & Bhalla, A. (2010). Patient satisfaction regarding nursing care at Emergency Outpatient Department in a Tertiary care Hospital. *J Mental Health Hum Behav*, *15*(1), 54-8.

Muntlin, A., Gunningberg, L., &Carlsson,M (2006). *Patients' perceptions of quality of care at an emergency department and identification of areas for quality improvement., 15(8), 1045–1056.*

Natsui, S., Aaronson, E. L., Joseph, T. A., Goldsmith, A. J., Sonis, J. D., Raja, A. S., ... & Mort, E. (2019). Calling on the patient's perspective in emergency medicine: analysis of 1 year of a patient callback program. *Journal of patient experience*, *6*(4), 318-324.

Norman, I. D., Aikins, M., Binka, F. N., & Nyarko, K. M. (2012). Hospital all-risk emergency preparedness in Ghana. *Ghana medical journal*, *46*(1).

Regula, C. G., Miller, J. J., Mauger, D. T., & Marks, J. G. (2007). Quality of care from a patient's perspective. *Archives of dermatology*, *143*(12), 1589-1603.

Sampson, F. C., O'Cathain, A., & Goodacre, S. (2020). How can pain management in the emergency department be improved? Findings from multiple case study analysis of pain management in three UK emergency departments. *Emergency Medicine Journal*, *37*(2), 85-94.

Swallmeh, E., Byers, V., &Arisha, A. (2018). Informing quality in emergency care: understanding patient experiences. *International journal of health care quality assurance*.

WHO | Quality of care. (2020). *WHO*. http://www.who.int/maternal_child_adolescent/topics/quality-of-care/en/

World Bank Group. (2018). Delivering Quality health Services: a global imperative for universal health coverage. In *World Health Organization, World Bank Group, OECD*(Issue July). https://www.who.int/publications/i/item/9789241513906

World Health Organization. (2003). *The world health report 2003: shaping the future*. World Health Organization.

Yarney, L., &Atinga, R. A. (2017). Patients' perspectives of emergency care quality and priorities for care improvement. *International Journal of Health Governance*.