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Views, expectations and level of satisfaction of parents/guardians regarding paediatric emergency and critical care provided by nurses in the Bamenda health district

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Abstract

Introduction: Emergency care is defined by the World Health Organization (WHO) as care for the acutely ill and injured delivered by frontline providers who manage medical, surgical, and obstetric emergencies, relying on early recognition and resuscitation. Paediatric critical care on the other hand consists of identification of children at risk of dying or having adverse outcomes, and in need of intensive monitoring and provision of appropriate interventions.

Aim: The main aim of this study was to assess the views, expectations and level of satisfaction of parents/guardians regarding paediatric emergency and critical care provided by nurses in the Bamenda health district.

Materials and methods: This study employed a descriptive cross-sectional and analytical design using a mixed method of both descriptive quantitative/qualitative data. Interview and observational guides were used to collect data. The study population included parents of children aged 1 month to below 18 years old admitted in the paediatric intensive care units and/or specialised paediatric wards. Purposive and convenience sampling techniques were used to select the study sites and the sample size of 88 parents. Data was made of categorical and numerical variables, analysed using frequencies, proportions and Multiple Response Analysis to aggregate responses.

Results: Majority of the parents 56(63.64%) felt that the child would die because treatment was delayed. Concerning the views of parents on the time nursing care should commence, 56 (63.64%) of the respondents correctly said nursing care to commence immediately on arrival in the hospital. Again, 69 (78.41%) of the 88 respondents expected that the child will get well, 47 (53.41%) preferred nurses to take care of their children reason being that nurses are always

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with the child at all times as stated by 15 (17.04%). Also, 68(77.287%) were satisfied with nursing care and, a relative majority 27(30.68%) said they were satisfied because they did not wait for long. There was no significant relationship between nurses' attributes and parental satisfaction except for good reception; x^2 = 4.036 and P= 0.045 and giving of complete and detailed information about the child's progress; x^2 =10.571, P= 0.001. Only 3 out of the 30 (10.0%) parents observed were very satisfied with care while 27(90.0%) were either just satisfied or not satisfied with care given.

Keywords:

Views, expectations, satisfaction, Parents, Paediatric, Emergency, critical Care, nurses

INTRODUCTION

Emergency care is defined by the World Health Organization (WHO) as care for the acutely ill and injured delivered by frontline providers who manage medical, surgical, and obstetric emergencies, relying on early recognition and resuscitation. (1, 2**)** An emergency is when it is believed a severe injury or illness is threatening a child's health or may cause permanent harm. In these cases, a child needs emergency medical treatment right away. (3) In an emergency, a child may manifest strange or more withdrawn and less alert behaviour, unconsciousness or no response when talked to, rhythmic jerking (a seizure), increasing effort or difficulty with breathing, skin or lips that look blue, purple, neck stiffness with fever, increasing or severe persistent pain, a cut that is large, deep, or to the head, chest, or abdomen, bleeding that does not stop after applying pressure for 5 minutes, a burn that is large or involves the hands, feet, groin, chest, or face and any loss of consciousness, ongoing or worsening confusion, headache, or vomiting after a head injury. (3)

The emergency department is the heart of the hospital and the arrangement of affairs in this unit can save many lives, since the patients referred to this unit are in critical physical conditions and it is important to consider their conditions as quickly as possible and with the highest quality of care. The first experience of the patients is often referred to the emergency department and since they need specific and urgent treatment and care, it is important to understand the patients' problem to satisfy them. (4)

On the other hand, the care of critically ill patients has become increasingly complex as severity of illness continues to increase; the amount of clinical information available at the bedside is growing, and also the quantity of evidence supporting or refuting specific therapies and interventions for this population is escalating. (5) Paediatric critical care consists of identification of children at risk of dying or having adverse outcomes, and in need of intensive monitoring and provision of appropriate interventions. Such services usually require specifically trained and highly skilled staff. (6)

A parent is someone responsible for child rearing, which is the process of promoting and supporting the physical, emotional, social, financial, and intellectual development of a child from infancy to adulthood (Davies, 2000). (7) The parents of these critically ill children have the right to be present, participate and co-decide medical care issues (8) concerning the child. Caregivers are the gatekeepers to their child's pain management and they have unique expertise regarding their child's temperament, behaviour, and pain response. (9) As documented in some reports, parents have indicated that they are treated as outsiders; a feeling that can heighten their sense of helplessness and powerlessness. (10) Mothers frequently had negative

perceptions of their communication with nurses. (11) Some mothers reported that their stress was related to the incomplete and inconsistent information they received from the nurses concerning their premature infants' care. (10)

Despite its important and increasing role, however, the development of emergency care delivery system has largely been overlooked and neglected in low-and middle-income countries (LMIC) in Africa. (12) A modified approach or model for paediatric emergency and critical care would be a timely intervention to help reduce this gap in the care of critically ill children especially if the expectations and participation of parents are considered.

This research work was carried out to identify the views of parents on what they expect regarding the emergency/critical care of children and what level of satisfaction they have with the outcomes of care at the Bamenda health district.

Hypothesis

Parents' satisfaction is not associated the with outcomes of paediatric emergency/critical care.

Specific objectives:

- To analyse the views of parents/guardians about paediatric emergency and critical care provided by nurses at the Bamenda health district.
- To verify the expectations of parents/guardians about paediatric emergency/critical care provided by nurses at the Bamenda health district.
- To determine the level of satisfaction of parents regarding paediatric emergency and critical care.

MATERIALS AND METHODS

Study design

This study was employed a descriptive cross-sectional and analytical design using a mixed method of both quantitative/qualitative data (triangulation) because data collected included both numerical and non-numerical data from verbal/behavioural responses and observation of parents.

In this design, interview guides were used to collect data from parents on their views, expectations, and level of satisfaction concerning paediatric emergency and critical care. The criteria used for observation/interview were rated as very satisfied, satisfied or dissatisfied with care given.

Study area

The study was conducted at the Bamenda health district specifically the paediatric ward, emergency and intensive care units of the selected Hospitals which included the State hospital; Regional hospital Bamenda, the Baptist, Presbyterian, and Catholic Hospitals in Bamenda.

Study population

This included parents of children aged 1 month to below 18 years old who were received in the emergency departments or admitted in the paediatric intensive care units and/or specialised paediatric wards.

Sampling technique

Purposive sampling was equally used to select the hospitals in the selected health areas. This was in order to have a representation of all the carder of healthcare services; State owned and faith-based hospitals. The ICUs, EDs and paediatric wards of all the hospitals were purposively selected because these are units where critically ill children are admitted and/or taken care of.

Convenience and purposive sampling techniques were equally used to select the parents in the above units based on their availability at the time of data collection. All the parents who had critically ill children were studied. We had a sample size was 88 parents.

Data collection instrument

An interview guide was used comprising of five sections as follows:

A- Socio-demographic of patients and parents; B- Perceptions of critical illness; C- satisfaction with care; D- Dissatisfaction with care; E-Expectations of parents/guardians concerning emergency and critical care. An observation guide to determine their satisfaction or dissatisfaction with care was also used.

Validation of data collection instruments

Pretesting was conducted after the final design of the interview guides in a state-owned, faith based private hospitals in Kumbo Bui Division, of the Northwest Region of Cameroon. The feedback from the pre-testing was used to identify and correct any flaws in the interview guides and some questions were modified, some deleted and some added before the commencement of the study.

Data collection procedure

All the parents of the critically ill children in the selected hospitals were studied. Interview guides were self-administered to parents and an observation guide was equally used to collect data from these participants during care. A baseline measurement was gotten from both Hospitals through observation of parents during admissions, care of children admitted in the wards and the discharge process /follow-up using the observation guide.

Data analysis

Data was keyed in using the statistical software SPSS version 21.0 (IBM Inc., 2012). Consistency, data range and validation checks were also performed in SPSS version 21.0 to identify invalid codes. Data was made essentially of categorical and numerical variables and was analysed using frequencies, proportions and Multiple Response Analysis to aggregate responses within conceptual components. Chi-Square test of equality of proportion was used to compare proportions for significant difference as well as to measure the association between the study indicators and background information; relationship of parental satisfaction and outcomes of care was also assessed using logistic regression to describe odd ratio and adjusted odd ratio using univariate and multivariate analysis. Data was presented using frequency table and charts. All statistics were presented at the 95% Confidence Level (CL), Alpha =0.05.

Ethical considerations

Ethical clearance was obtained from the Institutional Review Board of the Faculty of Health Sciences at the University of Bamenda. After this, administrative approval was obtained from the regional delegate of Public Health for the North West Region, and directors of the different hospitals that were selected for the study. These hospitals either gave a verbal or written authorisation for the study to be carried out. The CBC health services requested for an application for ethical review which was submitted and an ethical clearance was issued giving approval for the study to be conducted in their facilities.

An informed consent was sought before participation. Participants were given background information on the purpose of the research and how it will be done and how it will benefit them. These participants were allowed to decide whether or not to take part in the study. They were also made to understand that they are free to ask questions and also to withdraw at any point in the course of the study without any explanation or punishment. After full understanding of the purpose of the study and giving of their consent, they were then interviewed.

Assent forms were used for children above ten years to obtain their approval to be used for the study.

Codes were used most often in place of participant's names and data collected was stored safely in a secret file where only the principal investigator had access to in order to enhance confidentiality.

Results

Demographic characteristics of patients

The results from the study revealed that 48 (54.55%) were males while 40 (45.45%) were females. The mean age of the critically ill children was 1.61, and the standard deviation was 0.90. This shows that majority of the children were one year plus but not up to 2 years old.

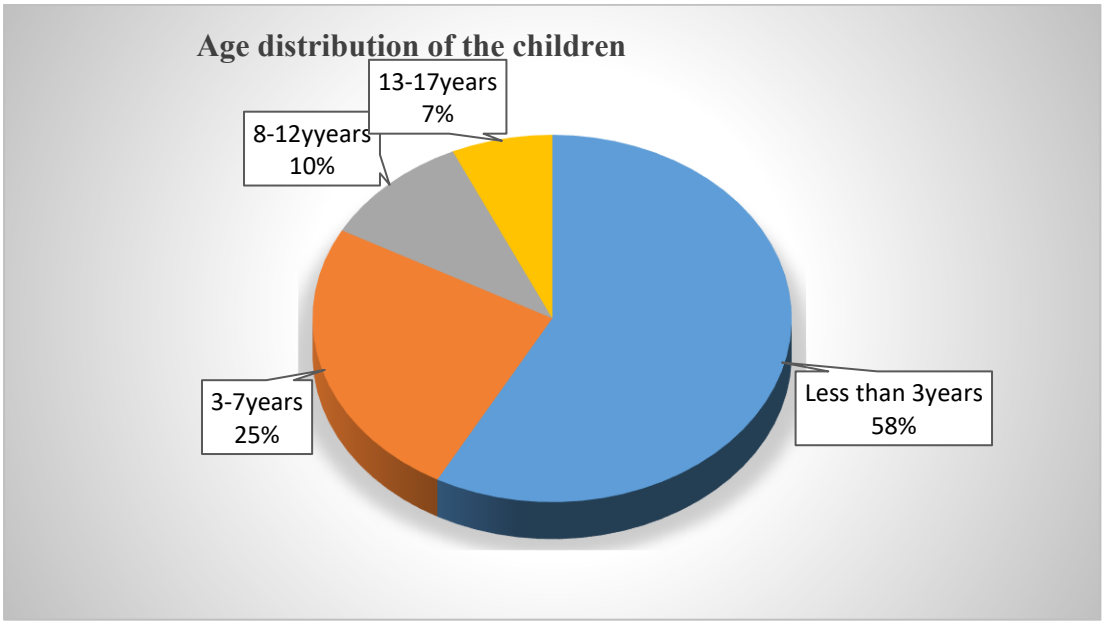


Figure 1: Age distribution of the critically ill children

From the figure 1 above, more than half (57.95%) of the children were less than 3years.

Demographic characteristics of parents

Data on demographic characteristics of parents showed that Females were majority and most of them were those at Secondary level 42 (47.73%). With regards to marital status, a majority of 69(78.41%) were married while 20% were single mothers. (Table 1)

Table 1: Demographic Characteristics of Parents

Variable	Frequency (N = 88)	Percentage (%)
Gender of Parents/Guardians		
Male	6	6.82
Female	82	93.18
Total	88	100.00
Parents'/Guardians' Level of Education		
Primary	23	26.13
Secondary	42	47.73
Tertiary	22	25.00
Total	88	100.00
Marital Status of Parents/Guardians		
Married	69	78.41
Single	18	20.45
Widowed	1	1.14
Total	88	100.00

Relationship of caregivers/significant others to patients

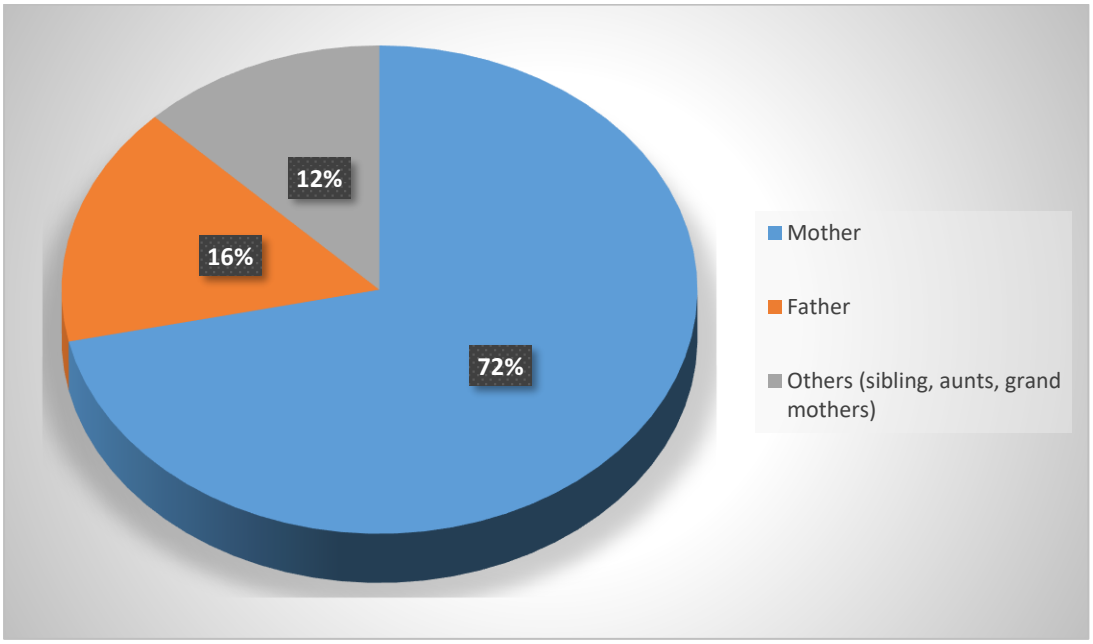


Figure 2: Relationship of caregiver (significant others) to patients

Data on figure 2 concerning Relationship of parent/guardians to patients revealed that Mothers

were 63 (78.41%), while Fathers were just 7.95% of the 88 respondents.

Results on reasons why child was considered critical, revealed that 14 (15.91%) said child was not breathing well, 16 (18.18%) said child had severe pains, 12 (13.64%) said child was crying nonstop, 10 (11.36%) said child was either unable to cry or talk or eat anything.
On the other hand, 4 (4.55%) said reason for considering the child to be critically ill was because the child was unable to respond to calls, 1 (3.41%) said it was because the child was bleeding severely from open wounds and the same proportion of respondents said it was because the child was passing stool and urine on the body. Results showed that 79 (89.77%) have rushed a child to hospital while only 9 (10.23%) had not.

Views, of parents/guardians on critical illness
From table 2 below, 26(29.55%) acknowledged presence of chronic illness in the child, 60 (68.18%) said there was no chronic illness in the child while 2 (2.27%) said they did not know. Data on where the child was admitted from, showed that half of the patients were admitted from the home while a significant proportion (38.6%) were admitted from the ED. Only 14 (15.91%) of the parents/guardians have always had critical illness, 33 (37.50%) said they have never had critical illness, 28 (31.82%) said it was just this episode.

Table 2: Views of parents on whether Patient had a chronic condition, place admitted from and number of previous admissions.

Variable	**Frequency (N = 88)**	**Percentage (%)**
Child Had a Chronic Condition		
Yes	26	29.55
No	60	68.18
Don't know	2	2.27
Total	88	100.00
Views of Parents on Place Patient Was Admitted into the Ward/ICU From (N = 88)		
Emergency department (ED)	34	38.63
Home	44	50.00
Operating room	9	10.23
Others	1	1.14
Total	88	100.00
Views of Parents on Number of Previous Admissions (N = 88)		
None	59	67.05
1	17	19.32
2	2	2.27

3	9	10.23
More than 3	1	1.14
Total	88	100.00

Table 3 below shows that majority of the parents 56(63.64%) felt that the child would die because treatment was delayed.

Table 3: Views of parents on reasons why they felt the child would die

Variable	Frequency (N = 88)	Percentage (%)
Because the child was not breathing well	12	13.64
Because the child could not talk	13	14.77
Because nurses delayed in assessing the child	2	2.27
Because treatment was delayed upon arrival in the hospital	56	63.64
Because the healthcare workers were looking sad and could not answer me	1	1.14
Because the child had severe pains	4	4.55

Table 4 below shows that a significant number of respondents, 15 (17.05%) felt sad while a relative majority of the respondents 29 (32.95%) felt they should be the ones sick and as many as 25 (28.41%) felt sorry for the child who was critically ill. Also, 58 out of the 88 respondents (65.91%) said these feelings were because of the pain the child was experiencing, while 21 (23.86%) said it was because the child could not talk.

Table 4: Feelings of parents when a child is critically ill and reasons for these feelings

Variable	**Frequency (N = 88)**	**Percentage (%)**
Frustrated	8	9.09
Helpless	2	2.27
Hopeless	3	3.41
Demoralized	4	4.55
Disappointed	2	2.27
Sad	15	17.05
I feel I should be the one sick	29	32.95
Sorry for my child	25	28.41
Total	**88**	**100.00**
Reasons for the Above Feelings		
Because of the pain my child is experiencing	58	65.91
Because the child cannot talk	21	23.86
Because the child cannot eat	9	10.23
Because the child passes stool on the body	3	3.41
Because the child cries nonstop	10	11.36
Because the child calls me for help	7	7.95
The child not responding to treatment	5	5.68
The condition of the child getting worse	12	13.64
Child cannot walk	2	2.27
Total	**88**	**100.00**

Expectations of parents regarding nursing care

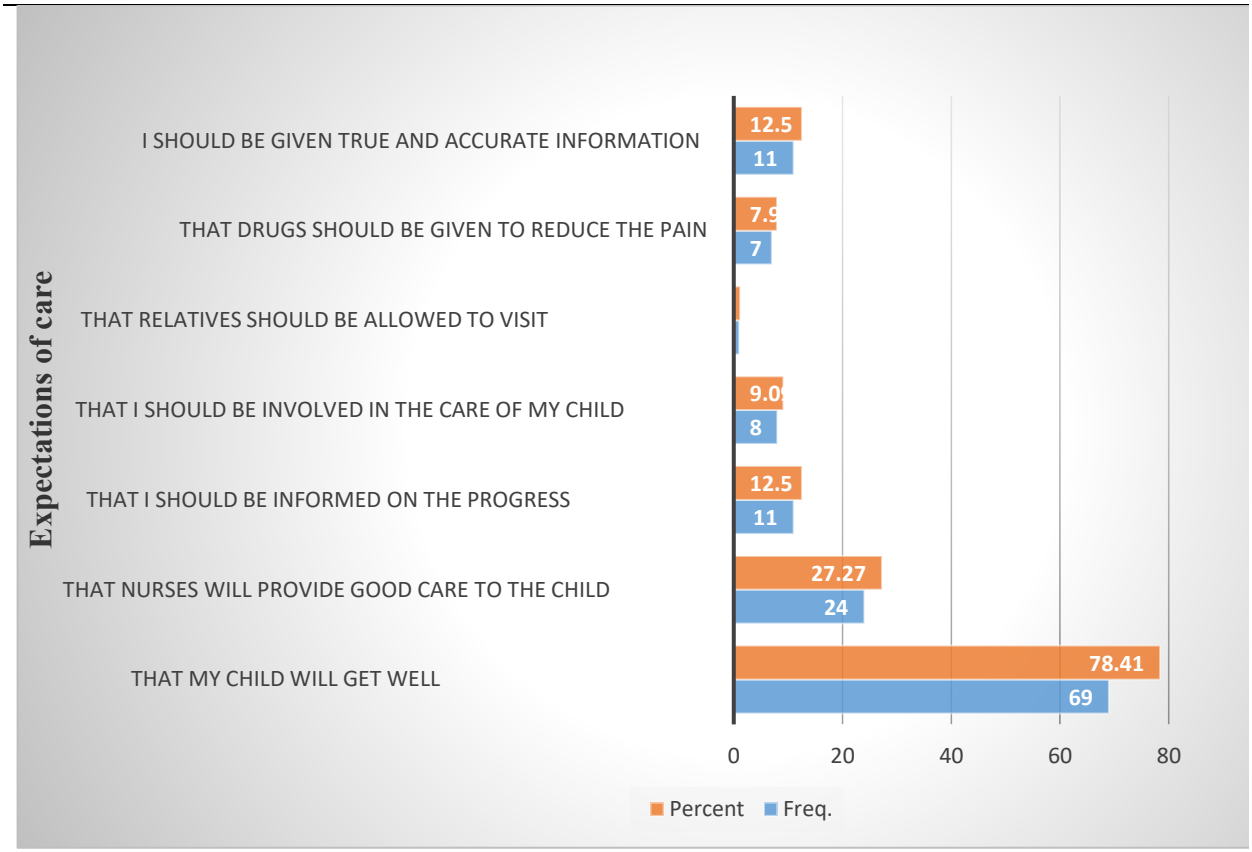


Figure 3: Expectations of parents regarding nursing care

According figure 3 above, majority 69 (78.41%) of the 88 respondents expected that the child will get well while 24 (27.27%) of the respondents expected that nurses will provide good care to the child.

Table 5 below shows that 44 (50.00%) said they expect to be received with love, 43 (48.86%) of the respondents said they expect that the child should be assessed immediately. Majority of the participants expected their children to be admitted in the paediatric ward meanwhile only 17 (19.32%) correctly stated that they expected their children to be admitted in the emergency unit. Concerning the time nursing care should commence, 56 (63.64%) of the respondents correctly said they expect nursing care to commence immediately on arrival in the hospital, while 12 (13.64%) said it should commence when the laboratory and other tests are out.

Table 5: Expectations from nurses on arriving in the hospital; expected place of admission and time to commence nursing care

Variable	**Frequency (N = 88)**	**Percentage (%)**
Expectations from Nurses on Arrival at the Hospital		
To be received with love	44	50.00
That the child should be assessed immediately	43	48.86

Nurses should put the child on the bed before beginning treatment	17	19.32
That nurses should tell me what is wrong with my child	20	22.73
Expected Place for the Child to Be Admitted		
Paediatric ward	68	77.27
Emergency department	17	19.32
ICU	3	3.41
Expected Time for Nursing Care to Commence		
Immediately on arrival at the hospital	56	63.64
When the laboratory and other tests are out	12	13.64
When the child's diagnosis is known	5	5.68

Results on table 6 shows that 54 (61.36%) of the 88 respondents said the reason why they expected immediate treatment was to save the child's life. 30 (34.09%) of the respondents said timely intervention increases the chances of survival. More than 10% of the respondents expected immediate treatment on arrival because delay can cause loss of life or complications and also that putting the child on the bed before treatment can promote rest and correct treatment is given when lab results are out.

Table 6: Reasons for the expectations of parents

Reasons	**Frequency**	**Percentage (%)**
Because immediate treatment would save the child's life	54	61.36
Timely intervention increases chances of survival	30	34.09
Delay can cause loss of life or complications	11	12.50
Putting the child on the bed before treatment can promote rest	9	10.23
Correct treatment is given when lab results are out	13	14.77
It will reduce cost of treating other diseases that are not there	5	5.68

When the doctor sees the child, he will give the nurses directives	8	9.09

From table 7 below, 47 (53.41%) preferred nurses to take care of tier children while 39 (44.32%) preferred doctors. Out of the 47 respondents who preferred the nurses to care of their critically ill children, 15 (17.04%) preferred nurses because they are always with the child at all times, 11 (12.50%) because they give drugs and other treatment to the child yet, 10 (11.36%) preferred nurses because they are readily available when needed. On the other hand, 17 (19.32%) of the parents preferred doctors to take care of the critically ill children because They write the drugs and other treatment for the child they write the drugs and other treatment for the child but 7 (7.95%) preferred doctors because they give all the necessary information concerning the child and also because they do most of the things for the child.

Participants said they preferred above health personnel because they will understand them better, 30.68% of the participants said because the nurses are always with the child. 11 (12.50%) of the participants preferred doctors because they give drugs and other treatment to the child, meanwhile more than 20.00% of the 88 participants preferred either nurses or doctors because they are readily available when needed and also because they give all the necessary information concerning the treatment and progress of the child.

Table 7: Parents' views on preferred health care provider for the critically ill child

Reasons for Preferring the Healthcare Provider	Nurses: Frequency	Nurses: Percent (%)	Doctors: Frequency	Doctors: Percent (%)	Pharmacists: Frequency	Pharmacists: Percent (%)	Laboratory Scientists: Frequency	Laboratory Scientists: Percent (%)
They will understand me better	4	4.55	1	1.14	–	–	–	–
They are always with the child at all times	15	17.04	1	1.14	–	–	–	–
They always listen and talk to us	5	5.68	–	–	–	–	–	–
They give drugs and other treatment to the child	11	12.50	–	–	–	–	–	–
They are readily available when needed	10	11.36	1	1.14	–	–	–	–

They are polite	1	1.14	2	2.27	1	1.14	–	–
They do most of the things for the child	7	7.95	–	–	–	–	–	–
They show concern for the relatives	1	1.14	3	3.40	–	–	–	–
They give all the necessary information	–	–	7	7.95	–	–	1	1.14
They write the drugs and other treatment for the child	–	–	17	19.32	–	–	–	–
Total	**47**	**53.41**	**39**	**44.31**	**1**	**1.14**	**1**	**1.14**

Satisfaction of parents/guardians with nursing care

From table 8 below on satisfaction with care, 68(77.287%) were satisfied. With regards to the reason of their satisfaction, a relative majority 27(30.68%) said they were satisfied because they did not wait for long.

Table 8: Parent Satisfaction with care and reasons for the satisfaction

Variable	**Frequency (N = 88)**	**Percentage (%)**
Satisfied with care	68	77.27
Not satisfied with care	20	22.73
Total	**88**	**100.00**

B. Reasons for Being Satisfied

Reasons	**Frequency**	**Percentage (%)**
The child's pain was treated	33	37.50
The nurses welcomed me when I arrived	20	22.73
I did not wait for long to be attended to	27	30.68
The nurses received and treated me well	23	26.14

Nurses gave me all the relevant information	18	20.45
Nurses answered all my questions	16	18.18
Nurses did all they could to calm my fear	15	17.05
Nurses showed concern for my child	21	23.86
The nurses in the ward kept each other informed	3	3.41
Nurses asked my opinion when making decisions	17	19.32
Nurses frequently checked on my child	19	21.59
Nurses/other care providers responded to my worries	9	10.23
Nurse informed you when you would be discharged	11	12.50

From the table below, there was no significant relationship between nurses' attributes and parental satisfaction except for good reception; $x^2 = 4.036$ and P= 0.045 and giving of complete and detailed information about the child's progress by nurses; $x^2 = 10.571$, P= 0.001. Both show a proportionate relationship between parental satisfaction and good reception as well as giving of complete information about the child. These results are not surprising because there are few parents who were not satisfied with care and a small sample size could partly explain these results. This is further supported by the fact that those not satisfied and sometimes satisfied combined still had cells with zero respondents.

Table 9: Relationship (association) between Attributes of nurses and parents' satisfaction

Attributes of Nurses	**Response**	**Satisfied (N = 68)**	**Not/Sometimes Satisfied (N = 20)**	**χ^2-value**	**P-value**
Pain management	Yes	27	6	0.636	0.425
	No	41	14		
Friendly attitude of nurses (nurses showing love and concern)	Yes	18	3	1.207	0.272
	No	50	17		
Short waiting time	Yes	20	7	0.223	0.637
	No	48	13		

Good reception by nursing staff	Yes	21	2	4.036	**0.045**
	No	47	18		
Complete and detailed information about patient	Yes	18	0	10.571	**0.001**
	No	50	20		
Giving psychological support	Yes	13	2	1.002	0.317
	No	55	18		

Dissatisfaction of parents/guardians with nursing care

From the results obtained, 38 (43.18%) were dissatisfied with care and the reasons are given below.

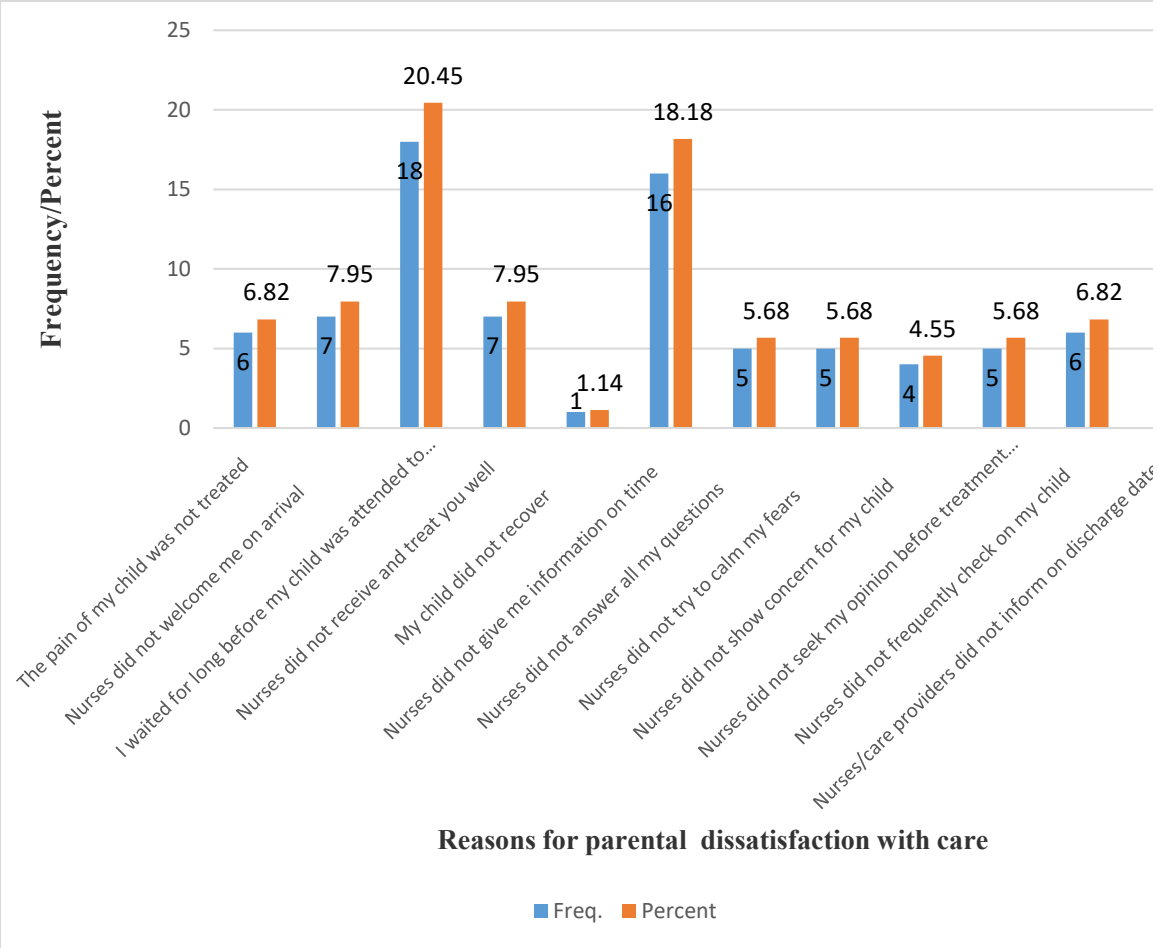


Figure 4: Reasons for parental dissatisfaction with care

Out of the 38 (43.18%) of the parents who were dissatisfied with care, according to 18 (20.45%) of the participants, they waited for long before child was attended to while 16 (18.18%) of the participants said nurses did not give them information on time. Results also show that majority

of the respondents were not happy during admission into the ED. The majority of respondents were not satisfied with the nursing care they received in the government hospitals. (figure 4)

Expectations of parents during hospitalisation and reasons for their expectations on the nursing care rendered

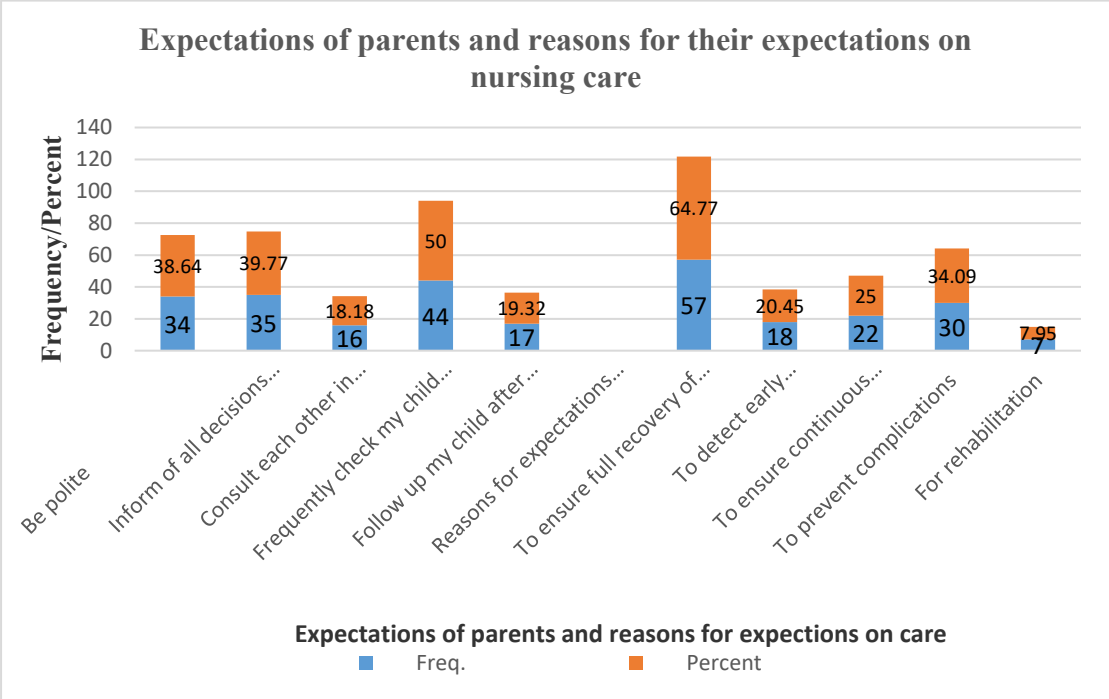


Figure 5: Expectations of parents and reasons for their expectations on the nursing care rendered

Figure 5 above shows that less than 40% of the participants wanted nurses to be polite and to inform them of every decision about their children whereas 44 (50.00%) expected nurses to frequently check their children.

From the figure above, 57 (64.77%) of the respondents said the reason for their expectations was to ensure full recovery of the child, more than 20% said frequent checks should be done to detect early deterioration in the condition of the child, and also to ensure continuous treatment of the children. A significant number of the respondents 30 (34.09%) said their expectation is to prevent complications.

Observation/interview of parents on their level of satisfaction with care

From the data obtained, only 3 out of the 30 (10.0%) parents observed were very satisfied with care given to their critically ill children while 27(90.0%) were either just satisfied or not satisfied with care given.

Table 10 below shows that only 2 out of the 30 (6.70%) parents observed were very satisfied with the way nurses showed concern for the child whereas 14 (46.7% were either just satisfied or not satisfied with the way nurses showed concern for them. Again, majority of the nurses 16(53.3%) were not satisfied with the way nurses gave them information about the treatment of the children as can be seen in the table below. Half of the respondents observed were simply satisfied with the way their questions were answered while as many as 13(43.3%) of the study

participants were not satisfied.

Majority 25(83.3%) of the parents were satisfied with their involvement with care, 19(63.3% of the respondents were satisfied regarding answers nurses gave concerning the care and treatment of their children. 10(33.3% were not satisfied in this aspect. According to the data obtained, 18(60%) of the parents were not satisfied with the time information was given to them about changes in the condition of their children (table 10).

Half of the respondents were satisfied with the fact that nurses frequently checked or assessed their children. For pain assessment and management, table above shows that half of the respondents were satisfied but a good number of them 13(43.3%) were not satisfied. 18(72.00%) of the participants were satisfied with the nurses concerning assessing readiness for discharge.

In the aspect of giving psychological support, majority 19(63.3%) of the participants were not satisfied at all with this aspect of care by nurses.

Also, 6(20%) were not satisfied with information given on continuation of continuing treatment at home. As concern reminder for follow up dates 14 parents were observed, and 8 (57.14%) were satisfied, half of the respondents were satisfied with the improvement of their children while 13(43.3% were not.

Table 10: Level of satisfaction of parents on nursing care rendered based on interview results (N=30)

Variable Category	Very Satisfied: Frequency	Very Satisfied : Percent (%)	Satisfied: Frequency	Satisfied : Percent (%)	Not Satisfied: Frequency	Not Satisfied : Percent (%)
Nurses showed concern and interest for the child	2	6.67	14	46.67	14	46.67
Nurses gave all information about the child's treatment	2	6.67	12	40.00	16	53.33
Nurses answered their questions in a way they could understand	2	6.67	15	50.00	13	43.33
Involvement in decision-making and care of the child	2	6.67	25	83.33	3	10.00
Nurses answered all their questions regarding care and treatment of the child	1	3.33	19	63.33	10	33.33
Timely and regular information about changes/improvement	1	3.33	11	36.67	18	60.00

s in the condition of the child						
Frequent assessment of the child	3	10.0	23	76.67	4	13.33
Assessment and adequate pain management	2	6.67	15	50.0	13	43.33
Assesses readiness for discharge and prepares parents (N = 25)	1	4.00	18	72.00	6	24.00
Giving psychological support	1	3.33	10	33.33	19	63.37
Child's condition improved	2	6.67	15	50.0	13	43.33
Clear and complete information on continuation of treatment at home (N = 14)	1	7.14	7	50.00	6	42.6

Discussion

General characteristics of patients, parents/guardians

The findings from parents in this study revealed that 51(57.95%) of the children were less than 3years. This is similar to the findings of (6) which shows that the burden of critically ill children is very high in the setting, constituting about a third of paediatric medical emergencies seen in the UCH, majority of whom were under-5 but contradicts a study unit, in Paediatric/Neonatal Intensive Care Unit (PNICU) in Johannesburg, South Africa which showed that 59% of admissions were neonates, 27% had primary surgical conditions and 14% were for primary medical conditions as stated by (14).

The mean age of the critically ill children in this current study is 1.61±0.9. This finding differs from the findings of (6), who reported the that mean age of critically ill children of a study was 4.4±4.2 which was comparable to his own study with mean age of 4.9±4.4 (6). This could be due to the fact that these studies were conducted at different settings and using different sets of study subjects as he indicated the use of post-operative patients in the surgical wards which this study did not include.

With regards to gender of the critically ill children, more than half, 48 (54.55%) were males while 40 (45.45%) were females. These results affirm the notion that male children are more prone to infections and disease than females.

Half of the admissions of these critically ill children were from the emergency department. This is contrary to the findings of (14) who reported that majority of admissions in the study were surgical patients.

A relative majority 29 (32.95%) felt they should be the ones sick and 25 (28.41%) felt sorry for the child and others were either frustrated or felt hopeless. The reasons for these feelings according to 58 (65.91%) were because of the pain the child is experiencing and 21 (23.86%) said because the child could not talk, while 12 (13.64%) said because the condition of the child was getting worse. These findings support the findings in a related study reported by the American college of critical care medicine, society of critical care medicine 1999 (15) where the overall parental satisfaction was best predicted by how well physicians and nurses work together, followed by wait time and pain management. Issues concerning the timeliness of care, perceived quality of medical care, and communication and staff showing courtesy and respect through compassion and caring words and behaviors and paying attention to nonmedical needs are other potential satisfiers with emergency care as purported by the American college of critical care medicine, society of critical care medicine. (15) Our findings indicated that these parents had a lot of psychological needs that should have been taken care of by nurses and other health care team members. According Joe B. (7), parents expect their children will receive acceptable good standard medical care and have the best treatment available in attempt to cure them and provide them a healthy future. Clear explanation to patients and relatives with open reporting and investigation of incidents and humility in discussions are usually all that most people require. (7)

Parents' satisfaction was not associated with the strategies/outcomes of paediatric critical/emergency care as there was no significant relationship between nurses' attributes and parent satisfaction except for good reception; $x^2 = 4.036$ and P= 0.45 and, giving of complete and detailed information about the child's progress by nurses with $x^2 = 10.571$, P= 0.001 showing a significant relationship. Both show a proportionate relationship between parent satisfaction and good reception as well as giving of complete information about the child.

According to (16) adequate communication promotes relationship building between the relatives and healthcare providers. These results were in accordance with previous studies, which suggested that a dedicated family liaison nurse could provide all warranted care and profound emotional support for the relatives during and after ICU admission. (16)

With regards to satisfaction with care, 68 (77.27%) said they were satisfied, while 38 (43.18%) said they were not. Reasons for satisfaction were as follows: The child's pain was treated-33 (37.50%) of the participants; the nurses welcomed me when I arrived 20 (22.73%), I did not wait for long to be attended to 27 (30.68), the nurses received and treated me well 23 (26.14%), of the respondents nurses gave me all the relevant from 15 (17.05%) of the parents and many more reasons as can be seen in the results presented. These findings compliment the findings reported by (22) who said patient satisfaction and overall, ED throughput are strongly related to timeliness of care. This low levels of parental satisfaction further emphasizes the importance of timely interventions and pain management and showing love and concern for the patients and parents.

Thirty parents were observed during reception, restitution admission and care in the wards and overall results indicated that very few parents were very satisfied with care while more than half were either satisfied or not satisfied with care. Many were not satisfied with the management and monitoring of the critically ill children as one parent could be seen lamenting and regretting why he brought the child to that health facility. The parent said "since morning this child has not been checked and the child is not breathing well; I bought the drugs they asked me to buy but nobody has come to give the drugs or show me how to give the drugs to

the child. It is better I take my child to another hospital" The parent finally asked for discharge and took the child to another hospital.

Another incident was observed where a parent was very angry with the nurses that the child was very sick; with kidney failure and severe respiratory distress and massive edema. She said "they are confusing me; some nurse's say I should give the child water and some say I should not. So I am confused." The lady at the end of the day asked for discharge and took the child for prayers as she said it was above the hospital to treat. Some parents were not happy because of delays in initiating treatment as a parent was observed restless and confused with a child on her laps having hyperpyrexia and difficulty breathing but was told to follow the line. In some instances, parents were not happy with the expensive medical bills. This notwithstanding many parents expressed satisfaction that their children got well, and that the nurses and doctors were caring. These findings are in line with reports from various authors on the satisfaction and dissatisfaction of parents as seen in the report of the American college of critical care medicine, society of critical care medicine (15) which showed that overall parental satisfaction was best predicted by how well physicians and nurses work together and issues concerning timeliness of care, perceived quality of medical care, and communication were raised repeatedly by parents in response to open ended questions. Several studies indicate that the impact of the interaction, information exchange, and relationship between nurses and parents of infants in the NICU can achieve a more authentic partnership and more positive parental experiences (23). These findings call for urgent review of nursing strategies in the paediatric critical care to include both care of children and their parents as the impact of illness is felt more by parents who are often alert and sees the children suffer from these illnesses.

Conclusions

Views and expectations of parents/guardians on the care of critically ill children from this study indicates the need for parents to be well informed about care, be allowed to participate in the care and also the need for timely interventions. Regarding satisfaction, 68 (77.27%) of the parents were satisfied with care as more than half of them indicated and confirmed during interview /observation. This finding may be due to the fact that most parents are not knowledgeable enough on the expectations of care from the nurses as well as their rights as parents as one of them said there was no need for nurses to inform her or seek her opinion since they know more than her. That notwithstanding many nurses offered acceptable care standards to an extent but not the best so there is need for more training and improvement on the part of nurses in order to give quality and satisfactory care to critically ill children and their parents.

Recommendations

From the findings of this study, it is therefore recommended that:

To the nurses

- Nurses should ensure regular and continuous monitoring of the critically ill children through the care process
- Nurses should listen to parents and show love respect and concern for the patients and
- Parents should be encouraged by nurses to be involved in the care of their children

Parents

- Parents should open up in case of care disparities and inefficiencies
- Parents should express their feelings and emotions appropriately
- Parents should help the healthcare personnel to identify any deterioration in the conditions of the children for timely interventions

Limitations

1. The nursing care plan use by nurses was not studied
2. Not all the hospital in the Bamenda health district were studied due to the socioeconomic crisis that made some areas risky and difficult to access
3. There were a lot of financial constraints that did not permit the coverage of any health facilities largely because the study was not funded
4. The study was a cross-sectional study and so prevalence of critical illness could not be assessed.

Conflict of interest: The authors declare here that there was no conflict of interest in this study.

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