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Obstacles to the Quality and Continuity of Nursing Care for Patients Admitted to the Medical and Surgical Wards of Ebolowa Regional Hospital, Southern Cameroon

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Abstract

Introduction: The quality and continuity of care are major concerns for healthcare facilities in many countries. The nursing service, positioned as the hub of care and the interface between the patients and the medical-administrative system, plays a pivotal role. This study aimed to identify the obstacles to the quality and continuity of nursing care for patients admitted to the medical and surgical wards of Ebolowa Regional Hospital (ERH) in Southern Cameroon. **Methods:** This was a qualitative study conducted at HRE, involving 10 healthcare workers (5 from medicine and 5 from surgery) and 10 hospitalized patients from July 3 to 30, 2024. The study participants were selected on a reasoned basis. Data were collected during individual interviews using a structured, pre-determined interview guide. M. Grawitz's content analysis method guided each stage of data processing. Jean Watson's "Caring" theory served as the theoretical framework for linking the empirical data to the concepts of person-centered care. **Results:** Twenty participants were included. Content analysis revealed obstacles in several domains. Human and relational: poor caregiver-patient relationships; unpleasant caregiver-caregiver relationships; lack of motivation among caregivers; and high workloads. Access to care: difficulty accessing care and insufficient human resources. Organisational: poor organisation of care; insufficient supervision; irregular continuing education; limited information, education, and communication for behavioral change ses-

sions; and poor documentation within the structure. Material and economic: low monthly income and insufficient material resources. **Conclusion:** The quality and continuity of nursing care remain critical for patient safety and healthcare system effectiveness. However, various obstacles faced by patients and healthcare professionals compromise these goals. Integrating relational, organisational, and clinical strategies could contribute to overcoming these barriers, fostering more humane, effective, and sustainable care.

Keywords

Barriers to Care, Quality of Care, Continuity of Patient Care, Nursing Care, Health Workers

1. Introduction

Quality of care refers to the extent to which health services for individuals and populations increase the likelihood of achieving desired health outcomes and are consistent with available evidence-based professional knowledge [1]. Continuity of care, on the other hand, is an ideal situation in which healthcare is provided to individuals in a coordinated and uninterrupted manner, even though the healthcare system is complex and involves different professionals in different care settings [2]. These two concepts are based on criteria relating to relational, organisational, and clinical dimensions. They are closely interconnected, as the lack of continuity significantly undermines the quality of care [3]. All hospital staff, regardless of their role, are responsible for achieving this ideal. Poor quality care leads to a significant waste of resources and harms the health of populations by destroying human capital and reducing productivity [4].

Every year, an estimated 5.7 to 8.4 million people die in low and middle-income countries due to poor-quality healthcare. This accounts for up to 15% of all deaths recorded in these countries. Among deaths from treatable conditions, approximately 60% are attributed to poor-quality care, while the rest are due to patients not seeking care from the health system [1]. Data collected in 2024 in 39 African countries show that a large majority of citizens express dissatisfaction with the quality of health services. The main difficulties cited concern the lack of medicines and equipment, insufficient medical staff, outdated infrastructure, and long waiting times for access to care [5]. In Cameroon, the information available on the quality and continuity of care remains limited; however, some data show limited access to healthcare services. For example, in Bafia, in the central region of Cameroon, there are only seven doctors for nine health facilities, or a ratio of 0.99 doctors per 10,000 inhabitants, with 121 hospital beds. This situation reflects an insufficient supply of care, which prevents patients from benefiting from quality medical services [6].

In Cameroon, the authorities have developed Sectoral Health Strategies (2001-

2015, 2016-2027) aimed primarily at improving people's access to basic healthcare and high-quality essential generic medicines. These strategies also include adapting health legislation to ensure equitable care, regardless of social origin, income, religion, ethnicity, or political affiliation. In addition, other policies have been implemented or are underway, such as the 2016-2020 Health Development Plan, the construction of health infrastructure, and the expansion of training for health personnel in the public and private sectors [6].

Despite the initiatives implemented to improve the quality and continuity of nursing care, obstacles remain, and progress is limited, particularly in certain regions such as the South region. In this context, it seems appropriate to analyze the factors hindering the quality and continuity of nursing care for patients in the medical and surgical wards of the Ebolowa Regional Hospital (HRE).

2. Materials and Methods

2.1. Type of Study

This was a qualitative study focusing on healthcare staff and patients hospitalized in the medical and surgical wards of the ERH to identify barriers to the quality and continuity of nursing care for patients.

2.2. Study Site and Population

This study was conducted in the medical and surgical wards of the ERH from July 3 to 30, 2024. The source population comprised all individuals attending the ERH. The target population consisted of healthcare staff and patients admitted to the medical and surgical wards of the ERH.

2.3. Selection Criteria

Inclusion Criteria:

This study included healthcare staff and patients admitted to the medical and surgical wards of the ERH.

Exclusion Criteria:

This study excluded healthcare staff and patients admitted to wards other than the medical and surgical ward of the ERH, who didn't consent to participate.

2.4. Sampling

The sampling method used was non-exhaustive and purposive, in order to target the participants most relevant to the study. The process was conducted in several distinct stages for both healthcare staff and patients.

❖ **Eligible Healthcare Professionals**

On the one hand, eligible participants included healthcare workers (doctors, nurses, and nursing assistants) working in the medical and surgical departments of the Ebolowa Regional Hospital who met the predefined inclusion criteria. Second, patients who had been hospitalized for at least three days were able to express themselves clearly and met the predefined criteria.

❖ **Selection of Participants**

The selection of healthcare providers was conducted by the investigator based on the inclusion criteria. For patients, identification was carried out in collaboration with department staff, targeting individuals who had been hospitalized for at least three days and were able to express themselves clearly, in accordance with the predefined criteria.

❖ **Recruitment of Participants**

Twelve healthcare providers were approached individually by the researcher and agreed to participate in the study. In addition, of the 20 patients approached, two did not give their consent. Participants were subsequently informed of the study's objective and assured of the confidentiality and anonymity of their responses. Those who freely consented were interviewed outside of care hours, in a private space located within the hospital premises.

❖ **Sample Size**

A total of 30 individuals were approached for the study. Data saturation was assessed separately for the two categories of participants (healthcare staff and patients). It was considered to have been reached when the interviews no longer yielded new or relevant information regarding the research themes. Specifically, among the 12 healthcare staff interviewed, saturation was observed with the 10th informant, *i.e.*, 10 healthcare staff members (5 in medicine and 5 in surgery). Regarding the 18 patients interviewed, saturation was observed with the 10th informant, *i.e.*, 10 patients. Beyond this point, the responses collected became repetitive and confirmed the elements already identified.

Recruitment was therefore halted at 20 participants, in accordance with the saturation principle, in order to avoid redundant data collection and to focus the analysis on rich and relevant data. The 10 other individuals who were initially approached were not included in the analysis, as their responses did not provide any new information.

2.5. Data Collection Tools and Techniques

Data were collected using interview guides developed based on the study's subthemes.

Operational Procedure for Interviews

❖ **Initial Contact:** After contacting the head physicians and staff of the medical and surgical departments at HRE, the purpose and methodology of the research were clearly explained to the participants, their informed consent was obtained, and they were assured that the information collected would remain confidential.

❖ **Preliminaries:** Interviews began with greetings and the scheduling of an appointment that accommodated the informants' schedules.

❖ **Conduct of Interviews:** Interviews were conducted individually, face-to-face, in a quiet and private setting. They lasted between 30 and 40 minutes. A tape recorder and a notepad were used to record and document the participants'

statements.

- **Languages Used:** The interviews were conducted primarily in French, but some patients were interviewed in the local language (Bulu), with immediate translation by the interviewer. The transcripts were then standardized in French prior to analysis.
- **Topics Covered:** The interview guides covered the following subtopics:
  - Human and interpersonal barriers.
  - Barriers related to access to care.
  - Organisational barriers.
  - Material and economic barriers.

Based on these subtopics, we formulated brief questions while allowing the interviewees to express themselves freely. However, we always tried to rephrase the questions to ensure better understanding. Depending on the responses, the order of the questions was not always followed. At the end of the recording, we thanked the participants and said goodbye.

2.6. Data Analysis

The collected data were transcribed in full to faithfully preserve the informants' words and expressions in the order in which they were spoken. Notes recorded in the field journal were used to provide additional context for certain statements. Grawitz's content analysis method, which allows for defining categories, quantifying elements, conducting a thematic analysis, and studying discourse [7], was used to guide each stage of data processing:

- **Identification of Units of Meaning:** The transcripts were reviewed several times to identify meaningful sentences or segments related to the quality and continuity of nursing care.
- **Coding:** Each unit of meaning was coded (e.g., caregiver-patient relationship, workload, lack of supplies). Codes were assigned to each informant anonymously (Nurse 1, Nurse 2... for nurses; Patient 1, Patient 2... for patients).
- **Grouping into Categories:** Similar or related codes were grouped into thematic categories (e.g., relational, organisational, material/economic).
- **Theme Development:** The categories were then organised into broader themes corresponding to the dimensions of the identified barriers (human and relational, access to care, organisational, material, and economic).
- **Discourse Analysis:** Beyond the content, the manner in which participants expressed their difficulties (tone, emphasis, repetition) was taken into account to strengthen the interpretation.

This approach made it possible to identify the key information relevant to the research objective: to examine the barriers to the quality and continuity of nursing care. Data formatting and processing were performed using Microsoft Word 2013.

Finally, the interpretation of the themes was informed by Jean Watson's theory of caring, which served as a theoretical framework for linking the empirical data

to the concepts of person-centered care (respect, dignity, empathy, a relationship of trust, the care environment, and the humanization of practices).

3. Ethical Considerations

Our study received authorization to collect data from the HRE administration. Prior to data collection, the purpose of the study was clearly explained to participants, and their informed consent was obtained using an information sheet. Data collection was anonymous to ensure the confidentiality of the responses. Participation in the survey was voluntary, and participants had the option to withdraw at any time.

4. Study Results

4.1. Sociodemographic Characteristics

A total of 20 key informants were interviewed, including 10 patients and 10 health personnel, equally distributed between the medical and surgical wards of the ERH. The sex distribution showed a predominance of females, with 65% (13) women compared to 35% (7) men. Men were the majority among patients (60%, *i.e.*, 6 out of 10), while women largely dominated among health personnel (90%, *i.e.*, 9 out of 10). The mean age of participants was 35 years, with a minimum of 24 years observed among patients compared to 26 years among nurses, and a maximum of 50 years among patients compared to 45 years among nurses. Regarding marital status, most participants were single (60%, *i.e.*, 12), followed by married (35%, *i.e.*, 7), while cohabitation represented a minority (5%, *i.e.*, 1). Educational level varied considerably between groups. Among patients, 20% (2) had primary education, 30% (3) secondary, and 50% (5) higher education, reflecting a diversity of educational profiles. In contrast, all health personnel (100%, *i.e.*, 10) had attained higher education, which reflects their professional training. Finally, among the health personnel interviewed, professional experience ranged from 2 to 17 years, with a median duration of 9 years (Table 1).

Table 1. Demographic data of informants.

Sex	Patients		Health Personnel		Total
Marital Status	**Number**	**%**	**Number**	**%**	**N (%)**
Single	8	80%	4	40%	12 (60%)
Cohabiting	0	0%	1	10%	1 (5%)
Married	2	20%	5	50%	7 (35%)
Sex					
F	4	40%	9	90%	13 (65%)
M	6	60%	1	10%	7 (35%)
Educational Level					
Primary	2	20%	0	0%	2 (10%)
Secondary	3	30%	0	0%	3 (15%)
Higher	5	50%	10	100%	15 (75%)

4.2. Information on Obstacles to Quality and Continuity of Care Related to Staff

4.2.1. Organisation and Working System in the Medical and Surgical Wards at ERH

The interviews showed that there are three teams in the medical and surgical ward at HRE. Each team is made up of two people, as one nurse pointed out: "There are three teams in the department, with two staff members in each team" (Nurse 2).

The work system in the wards consists of alternating between three days on duty, three days on call, and three days off. "Three days on duty, three days on call, three days off" (Nurse 2). Overall, this work system seems unsatisfactory for staff due to the workload and lack of personnel, as several nurses point out. "Not satisfied, because it doesn't suit us given the workload" (Nurse 2); "Not satisfied, it's not easy with the lack of staff" (Nurse 3); "Not satisfied, the workload and understaffing sometimes weigh heavily on us" (Nurse 4); "Not satisfied, because it's exhausting given the number of staff" (Nurse 5); "Not satisfied because there are far too few staff" (Nurse 6); "Not satisfied because with so few staff, we quickly become exhausted" (Nurse 10).

4.2.2. Availability of Work Equipment in the Medical and Surgical Wards at ERH

According to participants, work equipment is insufficient and constitutes a real obstacle to providing adequate care in the medical and surgical wards at HRE. This is demonstrated by the testimonies of several participants, such as: "No, insufficient equipment is really a real problem here" (Nurse 3); "No, we don't have the equipment to carry out our care, no surgical kit in the ward to apply dressings, faulty blood pressure monitor, no Poupinel to sterilise forceps" (Nurse 4); "No, we lack equipment for taking vital signs and even extractors" (Nurse 5); "No, there is no blood pressure monitor or glucometer, and of the 12 hospital rooms, only 5 are functional; the rest have waterproofing problems" (Nurse 6); "Not at all, the equipment is so inadequate" (Nurse 8). Other testimonies acknowledge that this lack of equipment affects quality, makes it difficult to provide care, and exhausts healthcare staff in the medical and surgical wards at HRE. "The lack of equipment makes it difficult to provide proper care" (Nurse 4).

All informants expressed dissatisfaction with the work system, mainly due to the workload and the lack of staff and equipment. "Not satisfied, because it doesn't suit us given the workload" (Nurse 2); "Not satisfied, it's not easy with the lack of staff" (Nurse 3); "Not satisfied, the workload and understaffing sometimes weigh heavily on us" (Nurse 4); "Not satisfied, because it's exhausting given the number of staff" (Nurse 5); "More or less satisfied, just the lack of equipment is a problem" (Nurse 6); "We don't have any equipment, not satisfied because with few staff we get exhausted quickly" (Nurse 10).

4.2.3. Continuing Education for Staff in Medical and Surgical Wards at ERH

Healthcare workers' perceptions of continuing education at the ERHhighlight an

urgent need to improve the organisation, frequency, and accessibility of continuing education at the ERH to ensure that skills are kept up to date, care is safe, and staff can develop professionally. Staff reported a glaring lack of continuing education. Several respondents reported that they have received virtually no training since starting work. Some mention having had only two continuing education sessions, which is considered insufficient (Nurse 1: "Only twice"). Others clearly express that continuing education is nonexistent or very rare in the institution, with a negative impact on their practice: "No continuing education, we are not retrained, and it is very dangerous" (Nurse 2). Several staff members indicate that they have never received training since their arrival, or even doubt that training exists in the hospital: "No continuing education, no seminars, nothing" (Nurse 7), "I haven't received any training yet, in any case, I even wonder if it exists here" (Nurse 8).

4.2.4. Collaboration and Relationships between Staff in the Medical and Surgical Wards at ERH

Collaboration between staff in the medical and surgical wards at ERH appears to be mixed, as several participants attest: overall, it is marked by tensions, "jealousy", "disagreements", and disputes that undermine good relations. "It's there, it's not so good, too much jealousy and complexes" (Nurse 5); "We don't get along very well, there are too many disagreements between us" (Nurse 10).

However, some testimonies temper this observation by referring to a correct professional relationship despite a few occasional disagreements. The need to work together in front of patients encourages staff to maintain a relative peace, even if the actual quality of the collaboration remains fragile and could be improved. "Things aren't always great between us; we just try to keep the peace because we have to be in front of the patients at the same time" (Nurse 3); "It's true that there are minor disagreements at times, but otherwise the professional relationship is good" (Nurse 9). One participant also describes the relationship as primarily professional: "Professional relationship between carers" (Nurse 4).

4.2.5. Satisfaction with Premiums for Medical and Surgical Services at ERH

Most healthcare workers expressed recurring dissatisfaction with the reduction or insufficiency of bonuses, which they perceive as a lack of financial recognition that affects their morale and motivation. Only a few adopt a more resigned attitude, accepting the situation without complaining. Several testimonies express strong dissatisfaction and frustration with the reduction or lack of bonuses, which impacts their motivation and feelings at work: "Not at all satisfied, the quotas have been almost halved" (Nurse 2); "This has always been a problem for us healthcare workers and we don't understand why it doesn't change. How can you work without bonuses? We are tired of demanding" (Nurse 5); "We are tired of demanding this because we are not well rewarded" (Nurse 10). One informant said she was less demanding, accepting what she received without complaining: "Yes, I don't complain, I take what I'm given" (Nurse 7).

4.3. Information on Obstacles to Quality and Continuity of Patient Care in Medical and Surgical Wards at ERH

4.3.1. Staff Behavior and Type of Relationship with Patients in Medical and Surgical Wards at ERH

The relationship between healthcare staff and patients appears to be generally conflictual and marked by communication difficulties, a tone that is often perceived as aggressive, and a lack of empathy. These complicated exchanges impact the quality of the therapeutic relationship and often generate a climate of mistrust and discomfort between caregivers and patients, as several patients have testified. "They are very rude, they talk to me like I'm a child, so we don't have a very good relationship: they also ask me to pay for my medication every time and I don't have any money; we really don't get along" (Pat 3); "The staff talk about me as if I were nothing, and that bothers me a lot. The relationship is not good at all because the tone is sometimes very aggressive, and I am not well understood" (Pat 4) and "Not really, we have a serious communication problem, as for the relationship, um... Ah, that's it! There's a bit of aggression on their part, and I don't like it at all" (Pat 9).

4.3.2. Reception of Patients in Medical and Surgical Wards at ERH

The reception of patients in wards appears to vary overall, with some positive experiences but most testimonials expressing a cold, distant, or even dehumanizing feeling. The perception of a reception conditioned by prior payment for care, or a lack of human attention, has a negative impact on the patient experience. "It wasn't a very warm welcome because in order to treat me, they first had to demand money for first aid" (Pat 2); "Fine, but after that it wasn't so great" (Pat 3); "The welcome was cold, no one smiled at me or asked me how I was" (Pat 5) and, "Um... I felt like I was a burden, not a patient who needed help" (Pat 8). Nevertheless, some patients reported feeling welcome, with prompt care or a polite attitude despite some difficulties: "I was made to feel welcome; when I arrived, they started treating me straight away" (Pat 1), and another said, "Fine, even though I couldn't find my way there easily" (Pat 6).

4.3.3. Delay in Seeking Treatment by Patients in Medical and Surgical Wards at ERH

The testimonies reveal two main situations: patients either seek treatment immediately or late, depending on the situation. A minority of patients seek treatment immediately after an accident, for example: "Immediately after my accident" (Pat 1 and Pat 6). The majority, however, wait or seek treatment late, often when their condition is already critical. This tendency to seek treatment late is accompanied by a certain initial minimization or misunderstanding of the severity of the condition. "When it was already really serious, I thought the medication I was taking would do the trick" (Pat 3); "When things weren't going well, I thought it would pass as usual" (Pat 8); "I arrived when it was still in the early stages, *i.e.*, I was already feeling the symptoms" (Pat 9) and, "When it was already hurting, we often stubbornly put up with it at first" (Pat 10).

4.3.4. Patients' Perceptions of the Organisation of Care in the Medical and Surgical Wards at ERH

Patients have mixed feelings about the organisation of care. Some acknowledge that schedules are generally respected and that the organisation is adequate. "Care schedules are respected because I see that I receive care in the morning, at noon, and in the evening, and the organisation is good" (Pat 2) and "Care schedules are respected, but there are several details to review in terms of organisation" (Pat 4). A majority highlighted significant shortcomings such as frequent delays, a lack of proactivity on the part of staff, and the need for patients to request or seek care. Patients say: "The organisation is terrible. You must go and find them, call them for treatment, even though we know I don't always have the medication. When I receive it, I receive it, and when it's available, I call them, even though they're supposed to be monitoring us at all times" (Pat 3); "No, very poor organisation, like this morning, I was supposed to receive care at 6 a.m. but so far I haven't received anything, and as for the organisation, I would say it's good but there are a lot of shortcomings" (Pat 5) and, "Yes, the nurses are always late, so the organisation is not good at all, too many shortcomings, sometimes she doesn't even know your products, she comes to ask at the time of care" (Pat 6). These shortcomings affect the quality of care and generate dissatisfaction.

4.3.5. Patient Compliance with Prescriptions and Other Medical Instructions

Patients highlighted a key issue of lack of financial resources, which directly impacts their ability to manage and comply with prescriptions. This shortfall creates a major difficulty in ensuring proper medication adherence, as some patients pointed out. "We don't have the means, because Ekombité pays for the prescriptions" (Pat 5); "When there's no money, how can we manage the prescriptions?" (Pat 8) and "It's the lack of money, my brother, that's all. Otherwise, we all want to be healthy, but we don't respect what we rely on" (Pat 10). Despite this, some emphasize their willingness to comply with prescriptions, and a commitment to health remains a priority even in a context of financial constraints. Overall, this reveals a dilemma between limited resources and the need to maintain care. "It's just a lack of means, otherwise I love my health, and I wouldn't be stubborn" (Pat 2) and "I particularly respect them" (Pat 4).

5. Discussions

The healthcare team can be understood as a group of professionals whose main mission is to provide care, based on a predefined organisation of work, roles, and resources. Healthcare is defined as a group of professionals whose explicit objective is to provide care, and who operate according to a pre-established division of labor, roles, and resources [8]. Our informants complain about understaffing in the department, which increases the workload. This could be explained by the fact that the ERH has low nursing staff coverage, with three teams in the medical and surgical wards, each with two people. One would expect there to be a considerable

number of staff, as this is a third-category health facility (HF) in the Cameroonian health system. Given that these units receive many patients, the staff would therefore be unable to provide better services. This is demonstrated in the comments of nurses such as Nurse 3, "we get exhausted quickly", and Nurse 10, "there are not enough staff". However, it is well known that having sufficient staff guarantees continuity of care, as confirmed in the literature. Hospitals with sufficient nursing staff have lower patient mortality rates and higher job satisfaction among nurses [9].

Continuing education in nursing corresponds to a long-term commitment by professionals to lifelong learning. It aims to enable them to acquire new knowledge and improve their skills through educational activities that meet the requirements of their practice and their individual needs [10]. Our study showed that at the ERHin the medical and surgical wards, continuing education is either absent or irregular, as stated by the nurses: "no continuing education, we are not retrained..." (Nurse 2) and "no continuing education, no seminars, nothing" (Nurse 7) and "I haven't received any training yet, in any case, I even wonder if it exists here" (Nurse 8). However, continuing education is crucial in the nursing profession to avoid routine practices. Nurses' participation in continuing education activities promotes the development of their professional skills and results in better quality care for patients and their families [11].

Interpersonal relationships refer to individuals' ability to connect with others, interact, and collaborate. They enable people to develop their own networks or integrate into existing ones [12]. According to the informants in our study, several factors negatively influence their relationships, such as: "Things aren't often good between us [...]" (Nurse 3); "It's not so good, too much jealousy and complexes" (Nurse 5), and "We don't get along very well, too many differences between us" (Nurse 10). These statements highlight the existence of poor relations or disagreements between colleagues in the medical and surgical wards of the HRE, tense relations that are said to be due to jealousy, complexes, disagreements, and factors that could not only tarnish the image of the healthcare facility but also undermine the quality of services. The working environment can highlight the fact that the ability of healthcare professionals to collaborate effectively is essential to ensuring quality of care. These professionals share common goals and representations, which they achieve through harmonious collective functioning [12]. Within the team, it is therefore necessary to collaborate, coordinate, cooperate, integrate, connect, explain, and share.

Our study showed that ERH medical and surgical staff were dissatisfied with the bonuses available to them, as Nurse 2 explains: "This has always been a problem for us healthcare workers, and we don't understand why it doesn't change. How can you work without bonuses? We're tired of demanding them." "We are tired of demanding this because we are not well rewarded" (Nurse 10). Professional motivation can be understood as all the factors that encourage an employee to be fully committed to performing their duties and achieving the objectives set

by their managers. It is generally based on individual, psychological, economic, and social factors, as well as factors related to the working environment [13]. Service bonuses are additional payments made to nurses to reward their work and commitment in specific situations. Irregularity, absence, or insignificance could promote psychological instability, leading to poor care practices such as HRE. Service bonuses would therefore be an important factor in motivating care staff. This could improve their job satisfaction and, in turn, the quality of care. Remuneration is presented as one of the most decisive factors influencing a company's overall performance, due to its direct impact on employee motivation [13]. It is essential that healthcare and medico-social organisations have the resources, appropriate means, and sufficient time to support the motivation of professionals. Indeed, the requirements relating to the quality and safety of care demand a high level of staff involvement [14].

Our study showed that the workload is very high according to the informants because it significantly impacts continuity of care, as stated by Nurse 2: "It doesn't suit us, given the workload." Other testimonials, such as those from Nurse 4 and Nurse 5 respectively, state: "The work exhausts us, given the number of staff" and "the workload and understaffing sometimes weigh heavily on us." Workload can be defined as all the physical and psychological demands to which an employee is exposed in the performance of their professional duties [15]. The informants also highlighted understaffing as a factor linked to the workload at the HRE. An adequate number of healthcare professionals is an essential factor in reducing the workload and ensuring the quality and continuity of care. To achieve these objectives, hospitals and healthcare organisations must implement strategies to attract and retain nurses, particularly by improving working conditions, continuing education, and professional development [16]. When nurses have a high workload, their ability to monitor patients is impaired, and the risk of adverse events increases. The risk of death among patients increases with increased exposure to work schedules with high patient turnover [9].

The results of our study show that in the medical and surgical wards of the HRE, the equipment is inadequate, defective, outdated and insufficient to provide proper care; the comments of (Nurse 4) illustrate this perfectly: "No, we don't have the equipment we need to provide proper care, there's no surgical kit in the ward for dressing wounds, the blood pressure monitor is faulty, and there's no autoclave for sterilising forceps"; Nurse 6: "No, because there is no blood pressure monitor or glucometer, and of the 12 hospital rooms, only 5 are functional; the rest have waterproofing problems." Nurse 8 states: "The lack of equipment is what is really lacking". Material resources correspond to all the physical assets available to a company that it uses to carry out its essential activities, while developing a value proposition tailored to the expectations of its target customer base [17]. The availability of adequate material resources is a determining factor in ensuring the quality of nursing care. In this context, the quality of care also depends on the availability of human and financial resources, compliance with professional and insti-

tutional standards, and the existence of structures equipped with appropriate equipment and technologies [18].

The comments gathered reveal stormy relations between patients and healthcare providers in medicine and surgery at the HRE, as illustrated by Pat 3: "The staff talks about me as if I weren't there, and that really bothers me. The relationship isn't good at all because the tone is sometimes very aggressive, and I don't feel understood". Others added, "They are very rude, they talk to me like a child, so we don't have a very good relationship [...]. We really don't get along" (Pat 4); "Not really, we have a serious communication problem" (Pat 9). The relationship between the caregiver and the patient is the essential basis for comprehensive, quality care [19]. A relationship based on trust and kindness between the caregiver and the patient is an essential element in ensuring quality care [20]. Our study reveals that the relationship between nurses and patients at ERHs is impaired, marked by tensions, conflicts, and a lack of friendliness. This situation is also found in other wards of the same healthcare facility, where it is frequently the cause of violent incidents [21].

Our survey revealed that several informants complained about poor reception, as in the case of Pat 2: "It wasn't a very warm welcome because in order to treat me, they first had to demand money for first aid"; Pat 5: "The reception was cold; no one smiled at me or asked me how I was"; and Pat 8: "Hmm, I felt like I was a burden, not a patient who needed help". Welcoming a patient to the hospital is an essential step that directly influences the quality of their care. It is therefore essential that healthcare professionals devote the necessary time to this welcome, considering it as an integral part of care, to involve the person being cared for as a true partner in the care process [22]. Thus, the welcome given to patients admitted to the medical or surgical wards of the ERHappears to be insufficient and marked by a certain degree of dehumanization. This situation risks creating a climate of mistrust and insecurity, compromising the quality of care provided. However, welcoming patients is a professional act in its own right, which must be thought out, learned, and continuously developed with a view to improving the quality of care [23].

Access to healthcare is defined as the ability of an individual to benefit from healthcare services tailored to their needs [24]. In our study, some patients are aware of their delay in diagnosis and treatment, as in the case of (Pat 3): "It was when it was already really serious, I thought the medication I was taking would do the trick"; Pat 8: "When things weren't going well, I thought it would pass as usual"; Pat 10 said: "When I was already sick, we often acted stubborn at first". These findings highlight that patients are unable to access care in a timely manner, which can compromise the effectiveness of certain treatments and, in the most serious cases, lead to death. This situation runs counter to the Sustainable Development Goals, particularly the target on universal health coverage, which aims to ensure that everyone can receive the care they need, when and where they need it, without financial hardship [25].

Our study also showed that lack of financial resources is an obstacle to compliance with medical prescriptions, as Pat 5 explains: "We don't have the means, because Ekombité pays for the prescriptions"; Pat 8 says, "When there's no money, how can we manage the prescriptions?" and Pat 10 adds: "It's the lack of money, my brother, that's all. Otherwise, we would all seek to improve our health, but we don't comply because we don't know what to rely on". This information clearly shows the non-compliance of hospitalized patients, even though following medical prescriptions contributes to rapid recovery, the prevention of complications, and the restoration of health. These results help explain the fragile economic situation of the populations who attend the HRE. Indeed, lack of therapeutic compliance not only increases the cost of medical care, but also contributes to the deterioration of patients' quality of life [26].

The organisation of care is based on the optimal use of available resources in order to ensure that it is provided under the best possible conditions, in accordance with quality standards. It promotes coordination between the various healthcare stakeholders, facilitating the performance of tasks with minimum constraints and maximum efficiency, thanks to appropriate organisational tools. Its ultimate goal is to ensure continuity and quality of care [27]. In our study, informants lamented the poor organisation of care in the medical and surgical wards of the HRE, as Pat 3 said: "The organisation is not good at all. You have to go and find them, call them for care, even though we know that I don't always have the medication. When I receive it, I receive it, and when it's available, I call them, even though they're supposed to be monitoring us at all times". Pat 5: "No, very poor organisation, like this morning, I was supposed to receive care at 6 a.m., but so far I haven't received anything, and as for the organisation..." And Pat 6 adds: "Yes, the nurses are always late, so the organisation is not good at all. There are too many shortcomings. Sometimes she doesn't even know what your products are. She only asks when it's time for your treatment." These statements indicate that the organisation of care remains inadequate, contrary to the definition that associates it with the coordination of nursing activities aimed at ensuring the continuity and quality of services provided to patients [28].

This study has certain limitations. First, its single-site design limits the generalizability of the results to other hospital settings. Second, social desirability may have influenced participants' responses, as some may have toned down their criticism due to the hospital setting. Finally, the patient recruitment process, conducted in collaboration with department staff, may have introduced selection bias: the patients selected were those deemed capable of expressing themselves clearly and who had been hospitalized for at least three days, which potentially excludes other profiles (more vulnerable patients, shorter hospital stays). This selection may have limited the diversity of the perspectives gathered.

6. Conclusion

The quality and continuity of nursing care remain crucial issues for patient safety

and the efficiency of the healthcare system. Our study showed that the organisation of medical and surgical services at ERH is characterised by a team-based structure but faces an unsatisfactory working system, mainly due to excessive workloads and persistent understaffing. This shortage of staff is compounded by a severe lack of medical equipment, which directly impairs the quality of care and exhausts staff. Continuing education for staff is virtually nonexistent, exacerbating difficulties in patient care and safety. On a relational level, collaboration between caregivers is fragile and fraught with tension, while the relationship with patients suffers from communication problems and a reception that is often perceived as cold or even dehumanizing. Finally, the reduction or lack of bonuses further demotivates the healthcare teams. On the patient side, perceptions of healthcare organisation are mixed, with a majority reporting delays and a lack of proactivity on the part of staff, exacerbated by financial difficulties that limit compliance with medical prescriptions. To respond effectively to these challenges, it is essential to increase staffing levels and ensure the availability of medical equipment while establishing a regular continuing education program for staff. It is also important to foster a harmonious working environment and improve communication with patients, emphasising a more humane and respectful approach. Furthermore, it is crucial to review the bonus policy to reward staff and support their motivation. Finally, rigorous monitoring of the organisation of care, combined with financial and social support for patients, will help to improve access to and continuity of care.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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