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Filipino Nurses' Experiences in Conducting Health Education in the Emergency Room

Al-Sharif A. Sali[1], Rica Rose May A. Rubio[2]

Western Mindanao State University, College of Nursing, Zamboanga City, Philippines[1,2]

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Correspondence author:
Dr. Rica Rose May A. Rubio
Address: Western Mindanao State University College of Nursing, Normal Road, Baliwasan, 7000 Zamboanga City, Philippines
E-mail: rubio.rrm@gmail.com

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Abstract

Background: Nurses face more challenges in delivering health education in contexts where the milieus are not well defined, such as the emergency room (ER). **Objective:** This study aimed to explore the experiences of ER nurses in conducting health education inside the ER and identify the most common barriers therein. **Method:** A phenomenology approach was utilized involving Ten ER nurses purposely chosen for the interview. Braun and Clarke's framework was used in data analysis. **Results:** The participants' experiences were expressed and represented in the following themes and subthemes: The theme: Experiences in Conducting Health Education in the ER consists of three subthemes: (1) Routine Work in the ER, (2) Length, Frequency, and Manner in Conducting Health Education, and (3) Feelings Derived from Conducting Health Education. The theme: Barriers to Health Education in the Emergency Room comprised the six subthemes: (1) Lack of Time, (2) Language Barrier, (3) Patient's Psychosocial State, (4) Patient's Cultural Beliefs, (5) Nurse's Lack of Knowledge, and (6) Lack of Infographic Materials. **Recommendation:** Based on the findings, the conduct of health education in the ER can be done. Knowing the barriers can assist ER nurses and the hospital administration in producing the best solutions to solve them, thereby improving the quality of nursing care in the emergency room.

Keywords: emergency room nurses, health education, infographics, phenomenology, Philippines, thematic analysis.

INTRODUCTION

According to the World Health Organization (1), health education is an important strategy for health promotion that is essential for improving people's health and encouraging health investments. However, this has not received the necessary attention. The lack of interest stems from various causes, including a lack of awareness among health professionals and the difficulties that health educators face in translating efficiency into good results for their practice. There were numerous examples of health education success stories in schools (2), workplaces (3), and communities (4,5). However, delivering health education in contexts where the milieus are not well defined, such as the emergency room, becomes more challenging (1).

With an increasing number of disease spectra and other health problems, as well as the constraints of crowding and unpredictable workload, conducting health education in the ER is seen as the right place (6) to improve patient satisfaction and compliance with doctor's recommendations, preventing complications and early readmission (7). A lack of health education can lead to a high number of repeat hospital visits, both expensive and unsafe to the patients' health and convenience (8). As a result, delivering health education is an essential element of preventing these problems while effectively providing the high level of care nurses provide.

Health education is a common role within the practice of nursing. Different authors and experts have defined it in various ways (9, 10, 11). But this study refers to any instructional activity done by the emergency room (ER) nurses aimed at providing the patients admitted to the ER. their families or significant others information regarding their health condition, among others. The procedures, referrals, prevention of complications, and discharge instructions.

Little is known regarding the success of providing health education in the emergency room. A review by Wei and Camargo (12) synthesized the research on patient education in the emergency department (ED) and identified studies related to patients with asthma, MI, mental conditions, trauma, and injury. Because studies focused on education done exclusively in the ED are limited. They included studies with interventions that continued after discharge from the emergency department, those conducted in the coronary care unit, and those in acute care wards. The study's authors concluded that educational interventions in these settings, including the emergency department, have improved patient outcomes. While there are some parallels between the emergency room and other acute care settings, several vital differences may impact essential factors related to educational effectiveness, such as the time needed for teaching and the patients' anxiety. Ongoing counseling and education are ideal, but getting patients to attend education sessions can be difficult.

Effective health education in the ER poses many challenges for nurses. Thus factors that pose barriers should be investigated. Because there is not enough literature to provide a clear image of the health education process in the emergency room locally and internationally, knowing these aspects can assist ER nurses and hospital administration come up with the best answers on how to solve them.

OBJECTIVE

The study sought to examine emergency room nurses' experiences in conducting health education and identify the factors that serve as barriers therein.

METHODS

Design

The study utilized a phenomenological design focusing on the emergency room (ER) nurses' experiences conducting health education in the ER using a researcher-made questionnaire.

As explained by Teherani et al. (13), the approach to phenomenology seeks to describe the essence of a phenomenon by exploring it from the perspective of those who have experienced it. This research design applies to a study focused on a group of people, in this case, the emergency room nurses, whom the researchers need to understand more comprehensively and profoundly (14).

Sample size and sampling technique

The study participants were the nurses assigned to the ER (Table 1). Purposive

sampling was utilized. Ten ER nurses were selected following the inclusion criteria of at least two years of working experience in the ER department and were willing to participate.

Table 1. Summary Profile of the Participants

Participant No.	Age	Gender	Years of Working Experience in the ER
1	37	Female	10
2	55	Female	5
3	27	Male	4
4	25	Female	3
5	33	Female	8
6	31	Male	5
7	31	Female	7
8	26	Female	4
9	23	Female	2
10	23	Female	2

There were only two male nurses among the participants. The participants ranged from 23 to 55, and the average age was 31.1. They had an average work experience of five years. One of those ten presented herself as the ward supervisor, and the rest were the ER ward staff nurses. The supervisor also fulfills her ER nurse duties, especially when the ward is understaffed. The researchers were able to conduct the interviews on two shifts.

The instrument for data collection

A researcher-made questionnaire was used to gather data. Two nurse experts with more than 15 years of experience in the field validated the questionnaire. Their comments and suggestions were incorporated into the questionnaire, resulting in eight open-ended guide questions.

The validation resulted in a questionnaire with two parts. Part 1 of the questionnaire pertains to the demographic profile of the participants, including age, gender, and several years in the emergency room. Part 2 of the questionnaire comprises eight guide questions. Five guide questions intend to elicit the participants' experiences in giving health education in the emergency room. At the same time, three questions intend to produce the factors that the ER nurses perceived as barriers to conducting health education in the ER.

Data collection process

After the hospital granted permission to conduct the study, informed consent was distributed to all participants with complete information regarding the research study, design, and purpose. The interview schedule was planned relevant to the convenience and availability of the participants to avoid disruption from the flow of their job and personal time routine. The researcher then conducted the interviews on the 16th and 17th days of January 2020.

Data analysis

The data collected were analyzed using Braun and Clarke framework (15) in thematic analysis (Table 2).

Table 2. Braun & Clarke's Framework for Thematic Analysis

Steps	Task
1	Familiarization of Data
2	Development of the Initial Codes
3	Identification of themes
4	Re-examination of Themes
5	Definition of the Final Themes
6	Creation of the Write-up

Familiarization of Data. Braun and Clarke (2006) recommend that researchers thoroughly read the entire data set at least once before beginning coding, as ideas and identification of possible patterns may be shaped as researchers become familiar with all aspects of their data. In this study, the researchers needed to do several readings of the data transcript to be familiar with its content while making notes about the ideas for coding. The original transcript was in mixed Tagalog and English and was translated to English for better understanding and presentation purposes. The participants' responses were systematically arranged in a tabular form following the interview guide questions.

Development of the Initial Codes. Braun and Clarke (2006) recommend systematically working with the whole data set, providing full attention to each item in the data, identifying exciting aspects in the items, and labeling or coding them, as they may become the basis of themes representing the data set. The researchers identified essential text sections, usually phrases in the text, and labeled

or coded them as they relate to a theme or the objective in the study. These labels or codes were arranged and grouped into themes to represent the phenomenon of interest.

Identification of Themes. A theme must capture something important concerning or directly relevant to the research objectives or questions and is not dependent on quantifiable measures (Braun & Clarke, 2006). In this study, the researcher formed two main themes that had direct relevance to the research questions and created subthemes for each central theme.

Re-examination of Themes. The validity of each formulated theme is examined to see whether the themes correctly represent the meanings in the data set (Braun & Clarke, 2006). In this study, the re-examination of the theme was done by members of Technical Panel assigned to review this study. They examined the validity of each formulated theme to see whether the themes correctly represent the meanings that appear in the data set as a whole. Two technical panel members have found the need to rename two subthemes. These are "Limited staff," which was renamed to "Limited-time," and "Patient's culture," renamed to "Patient's cultural values. Likewise, upon reviewing the themes and the transcripts, the researchers renamed the subtheme "Experiences in the conduct of health education" to "Length, frequency, and the manner in conducting health education."

Definition of the Final Themes. The analysis for each identified theme must be detailed, relating to the story it tells, clearly defining and describing what the themes are all about (Braun & Clarke, 2006). The researchers described the coverage and content of each theme and ordered the themes in a way that answered the research objectives. Also, the subthemes were described and organized to represent the main themes. The researchers revisited the themes to ensure that the participants' powerful words were used in the themes.

Creation of the Write-up. In writing the report, excerpts from the raw data need to be placed within the analysis to show the intricate story of the data, going beyond its description and convincing the reader of the validity and value of the analysis (Braun & Clarke, 2006). In the write-up of the report, researchers included shorter and longer quotes from participants in the presentation of the results. All quotations were accompanied by a label (i.e., P1) to demonstrate that all participants were represented across the results. The short quotations help illustrate the prevalence of the themes, while the more extended quotes provide readers with the taste of the original narratives. To add richness to the data, the writing of the results was augmented, supported, and sometimes contrasted with the data from literature reviews and related studies used to inform this study.

Ethical consideration

Before data collection, ethics clearance for implementation was obtained from the Western Mindanao State University College of Nursing Ethics Review Committee (2019-002-CN-GS-SBR). The agency concerned also received a letter granting permission to conduct the study.

The purpose of the study was explained to the participant, and they were made aware that they could withdraw from the study without penalty. They were assured of their rights to confidentiality. Hence, each participant was assigned a code to avoid using their name. The codes were P1 until P10, with "P" meaning "Participant ."The researcher secured the consent from the participants before the actual data gathering.

RESULTS

The presentation of the main themes culled out from the analysis of the interviews is guided by the research objectives.

Central Theme 1: ***Experiences in Conducting Health Education in the ER.*** This theme consists of three subthemes as follows:

Routine Work in the ER. The participants' usual everyday routines in the ER can be seen in the following interview transcripts:

> "*When there are patients for admission, I routinely assess the patient's background, health, and family history to determine the admitting diagnosis of the patient, which is the role of the resident on duty. Other things that I usually do is to carry out doctor's order*" (P1)

> "M*y everyday routine in the ER includes triaging, assisting the ROD in some procedures, assessing patients' condition and prioritizing*

them, do emergent, urgent, and initial care, then admit the patient for hospital care" (P2)

"*I assist doctors in managing emergencies. Process admission, check e-cart, taking vital signs, provide health education*" (P3)

"*I participate in code blue, patient assessment, starting IV lines, carrying out doctors' orders, first aid, and wound dressing*" (P6)

"*When I arrive in the Emergency Room, I always check the E-Cart*" (P7)

"*For my every duty in the Emergency Room, upon entering the unit, I always check the E-CART. After checking, I listen to the outgoing nurse for endorsement. And lastly, I ready myself for the 8–12-hour shift*" (P8)

"*Code blue, attending to critical care like stab wounds or gunshot wounds and OB cases such as OB delivery*" (P9)

"*The most usual thing I do is whenever the patient comes in, I take her vital signs and immediately provide the necessary nursing care. I check and conduct a quick assessment on the patient based on the chief complaint*" (P10)

Length, Frequency, and Manner in Conducting Health Education. The interview transcripts for this subtheme are:

"*When needed, a few minutes will do since it is always busy in the ER. I sometimes use true-to-life situations as an example*" (P1)

"*From time to time. The best time to educate patient is while you are doing your assessment. Usually, it lasts for 1-3 minutes while I am assessing the patient*" (P2)

"*Always. The topic depends on the situations and the care, and I won't stop until they understand the instructions*" (P3).

"*I give health education as many times as I could depending on the patients' needs. At least five minutes will do*" (P4)

"*Occasionally, it depends on the situation. I explained what's important. If the area is too busy, I do it usually within 5 minutes*" (P5)

"*Yes, as much as possible but only for about 5 minutes before transporting patients to their respective wards. I stress the most important aspects of their treatment*" (P6)

"*I give health education as often as possible to all the patients while simultaneously doing the nursing procedures. It is not long enough, however, since we are short of staff*" (P7)

"*I do health teaching if the patient can't understand the explanation of the doctor. I do it precise and concise so that the significant others and patient can briefly understand what I am trying to say*" (P8)

"*Yes, as much as possible, I give a short but clear health education which ranges from 5-10 mins*" (P9)

"*Sometimes yes and sometimes no. I do it whenever or while I perform the nursing intervention. Five minutes would be long enough*" (P10)

Feelings Derived from Conducting Health Education. The interview transcripts related to this are:

"*Giving health education to my patients makes me feel good, especially when it is beneficial for them, and they will thank you in return*" (P1)

"*I would find the experience fulfilling and enjoyable despite the limited time available. The patient and their significant others are very eager and receptive to education. They are showing their utmost gratitude after* that" (P2)

"*My experience in giving health education is okay for as long as the patient is cooperative*" (P7)

"*Rewarding and fulfilling. I have dreamt of becoming an ER nurse, and I am having the time of my life*" (P9)

"*I usually do health education whenever I see that there is a need to do so. But there are times when we are only a few inside the emergency room, I have a hard time doing health education*" (P10)

Main Theme 2: ***Barriers to Health Education in the Emergency Room*** are those identified by the participants that give them difficulty in conducting health education. It comprises six subthemes as follows:

Lack of Time. This subtheme was mentioned as a barrier for nurses in conducting health education in the emergency room by two participants:

"*Time and lack of enough staff*" (P5)

"…*and the lack of time*" (P6)

Language Barrier. This subtheme refers to the different dialects of the participants, which posed as a communication barrier in giving health education in the emergency room:

"*Yes, when there is a barrier like establishing coherent communication with the patient. Even though I know a little, I would still shy away from trying*

to use their dominant dialects in conversing with them. I only use Tagalog, generally" (P1)

"*I sometimes encounter difficulty in giving Health Education because the language that I use is not familiar to the patients that I am dealing with*" (P7)

"*At some point yes, maybe because of the language barrier. There are terms in their dialect that are hard to understand*" (P8)

"*Yes, when the patient uses other dialects which are unfamiliar to me*" (P10)

Patient's Psychosocial State. This subtheme refers to the involvement of mental and social or behavioral aspects of the patients that can pose as barriers to health education in the emergency room:

"*First is the language barrier and second is anxiety. When the patient is anxious, they tend to have difficulty understanding what I say*" (P4).

"*…. being uncooperative, and the lack of drive and willingness to learn*" (P7)

Patient's Cultural Beliefs. This subtheme pertained to the rituals or other traditions of the patients that a participant expressed as a barrier to health education in the emergency room:

"*It's culture. They have their own beliefs and tradition that they refuse to open to new techno-social and medical advancement*" (P9)

Nurse's Lack of Knowledge. A participant mentioned this subtheme as one factor that can pose difficulty in conducting health education in the ER.

"*It depends on the occasion and if whether the nurse is knowledgeable enough on a certain health topic*" (P3)

Lack of Infographic Materials. A participant mentioned this subtheme as another factor that can pose difficulty in conducting health education in the ER:

"*…and lack of infographic materials"* (P10)

DISCUSSION

The first main theme, "*Experiences in Conducting Health Education in the ER*," included the participants' responses to questions regarding their work routines, the conduct of health education, and their feelings derived from conducting health education in the emergency room (ER).

The subtheme "*Routine work in the ER*" pertains to the activities done by the participants in the emergency room. Their routine activities are similar and are the expected activities in the ER. Only Participant 2 expressed that her everyday routine in the ER includes Triaging, among others. She further explained that Triaging demands a lot of nursing skills, nursing judgment, can be time-consuming, and should utilize all five senses. Nurses in the ER prioritize their patients according to the TRIAGE assessment, which means sorting patients into priority groups according to their needs and available resources (16). Triaging is recognized as the primary role of triage nurses, which is distinctive to the emergency department and linked with desirable outcomes (17).

Aside from triaging, the participants routinely assess the "*patient's background, health, and family history*" (P1) to determine and deliver the initial and timely care to their patients. Evaluating the patient is vital to ensure that no medical risks predispose the patient to any emergency during the actual procedure. Subsequently, Participant 2 and Participant 3 "*assist*" the resident doctors in some methods. While other participants (P1, P6) "*carry out doctor's orders*" routinely.

Participants' responses such as "*always check the e-cart*" (P3, P7, & P8) ensure the ward of the complete emergency equipment, medical supplies, expired drugs, or medication is being checked correctly. They do this routine to prepare for all types of emergencies or the sudden influx of patients coming in.

ER is an area to be equipped with staff providing treatment for all types of life-threatening diagnoses which require prompt medical care. It was understandable that two participants (P6 & P9) mentioned "*code blue*" as part of their routine work. It is the term used by most hospitals when there's an urgent medical emergency and indicates that a patient is

requiring resuscitation or in need of immediate medical attention.

The subtheme "*Length, Frequency, and Manner in Conducting Health Education*" includes the participants' responses regarding how long, how often, and how they conduct health education in the ER.

Most participants gave a straight "*Yes*" when asked if they provide health education inside the ER. As part of their responsibilities as health educators inside the ward, most give health education in a short or sometimes more extended period or on a case-to-case basis. Participants 1, 2, and 5 emphasized from time to time because of some cases that need urgent care like cerebrovascular accidents in which they somehow could no longer provide health teaching to the patient but to the significant others only.

It would take them an average of five minutes to do health education by highlighting the most critical information and simultaneously do it while giving care. As a solution to the barrier of lack of time for health-promoting activities, Casey (18) suggests the concept of "opportunistic health promotion" (p.1043), or informal teaching during the provision of care. Providing health education to the patient should focus on the most significant "must know" information. As much as possible, the least amount of data should be done to avoid confusing the patient. The most critical and vital information should be stated first or last, making the key points clear. All too often, the ER nurse can give the patient health education to the best they can that is restricted to essential forms, salient information and prescriptions, and any other incomplete health promotion (19).

In a study by Kelley and Abraham (20) on nurses' role identity regarding health promotion. The participants believe that part and parcel of their roles and responsibilities are giving health-promoting advice to their patients; however, very few provide health promotion and education regularly. The nurse participants argued that it is more challenging when it conflicts with other work responsibilities.

The subtheme "*Feelings Derived from Conducting Health Education*" pertains to the feelings that nurses experienced in giving health education to patients in the ER. Acknowledgment from the patients or their significant others is an external motivation that allows nurses to feel a sense of recognition for their work. Nurses feel contentment when jobs are accomplished according to time and standards. Each task being accomplished reflects on the nurse's ability to deliver quality care, as seen during health teaching and keeping the patient always informed, despite the heavy workload or even low nurse-to-patient ratio.

On the other hand, Participant 10 seemed not to agree with the other Participants as she had a "*hard time*" doing it because it makes the ER less efficient in dealing with other critical matters. This feeling is echoed in the sentiments of two veteran ER nurses who participated in a study by Devinney (19). The nurse participant with 20 years of experience in the ER in Devinney's study expressed that it is very time-consuming to do health education in that area because of the many patients and the fast-paced environment of the ED. At the same time, the other participant with 11 years of experience in the ED does not believe that most patients in the ED want education. After attempting to teach, she usually walks away feeling like she has wasted her precious little time.

A study by Cross (21) on the attitudes of emergency nurses toward health promotion in their work area found that health education is not a welcomed activity in the emergency department, as evidenced by statements of rejection (that ED is a stressful environment) by some participants in the study.

The second main theme, "*Barriers to Health Education in the Emergency Room*," included the participants' responses regarding the factors that interfere with health education in the emergency room.

The subtheme "*Lack of time*" was reported by two participants (P5 and P6) mentioned as a barrier for nurses in conducting health education in the emergency room. This is similar to the result of the thesis done by Devinney (19) regarding patient education in the emergency room. The participants of the thesis considered the time the most significant barrier to patient education in the said department. Another study has shown that

92.8% of the Canadian emergency department nurses (n=223) perceived the lack of time as the primary barrier (moderately or very influential) to patient health education in the emergency room (22).

The Emergency Room is an area specializing in emergency treatment providing acute care for individuals. Due to the unplanned nature of patients' cases, nurses cannot provide ample time to conduct health teachings to the patient. Most nurses dwell immediately on other priority cases, providing initial treatment for illnesses and injuries, some of which may be life-threatening and require immediate attention. Thus, there is a cease of information sharing to patients attended because of the limited time.

Ideally, ER nurses are experts in prioritizing nursing care and quick nursing intervention for the patient. However, one of the most common problems inside the ER is the lack of patient teaching because of the smaller number of staff nurses. This has been proven in this study whereby all the participants said "*Yes*" when asked if they agree that the lack of enough staff hinders nurses from providing health education to the patients in the ER.

The nurse-patient ratio should be equivalent so that health care provision is implemented along with health education. However, in this case, the researchers elaborated on the lack of staff for the ER of the said hospital. This lack of staff resulted in a "*lack of time*" when dealing with a patient for health teaching. Being able to extend and deliver knowledge and keeping patients well informed of their situation, intervention, and management despite the increasing demand of workload due to low nurse-to-patient ratio and too much paperwork to accomplish is difficult. It requires a high level of patience and nobility to do it to every patient in the ER daily. Such patience and nobility are evident in this phrase made by one participant, "*…I make it an effort to let them understand the importance of…*" (P10).

The subtheme "*Language Barrier*" is reported by the participants as one factor that interferes with giving health education in the ER. This usually occurs between health professionals and patients who do not have the same native language (23). The diversified languages between the ER nurses and the patients formed an impassable barrier to health education. They added further setbacks that could dampen nurses' enthusiasm for providing health education in the ER. Participant 1 expressed this sentiment, "*Even though I know a little, I would still shy away from trying to use their dominant dialects in conversing with them* ."Such concerns by Participants 1 and 7 are legitimate as several studies show language or communication barriers can lead to misunderstanding between health professionals and patients. In return, this misunderstanding can lead to unsatisfied working relationships between health professionals and patients, patient safety, and the quality of healthcare delivery (24).

Moreover, a study showed that thirty percent had difficulty understanding medical instructions among patients who received treatment from nurses who did not speak the local language. Thirty percent had a problem with the reliability of the information, and fifty percent believed that the language barrier contributed to errors (25). Another study found that forty-nine percent had difficulty comprehending a medical situation among patients who did not speak the local language. 34.7% had inadequate knowledge of medication use, 41.8% had trouble comprehending the label of medicine, and 15.8% had an adverse reaction to drugs due to a problem in comprehending the instructions given by the health providers (26). Furthermore, patients who were not proficient in the local dialect experienced unwanted health incidents that resulted in 49.1% of patients with detectable physical harm, 46.8% with moderate temporary damage, and 52.4% of the patients who experienced a miscommunication with medical providers (27). Not all patients have the same learning ability, and it could be due to language differences, among others. It is believed that good communication is an essential component in the dissemination of health education (28).

The subtheme "*Patient's Psychosocial State*" involves the mental and behavioral aspects of the patients at the time when they were in the ER, which can pose as barriers to health education. When patients are transported from the ER to the operating room in cases of emergencies, anxiety builds up with thoughts of wondering about the outcome of the procedure. Nurses should explain to the

patients and their significant others why such a procedure should be done. The nurse has to reduce anxiety by keeping the patients informed. However, there's a possibility that the more patients are informed, especially for considerably unknown procedures, the more the patients will question its manner, whether it's painful or not, and even its cost, which may result in increased anxiety.

Patients who are "*uncooperative*" and those with a "*lack of drive and willingness to learn*" are behaviors that may indicate a lack of interest on the part of the patient. This is the result of the thesis done by Devinney (19), wherein the Lack of Patient Interest was among the three most significant barriers to patient education in the emergency department. Similarly, Wingard (29) explains the need to capitalize on an individual's learning readiness. There will be times when patient education cannot occur simply due to a lack of enthusiasm or interest. An example is a patient who visited the ER for a superficial laceration may be unreceptive to discussing their eating or smoking habits with the nurse while being sutured by the physician.

The subtheme "*Patient's Cultural Beliefs*" pertained to the rituals or other traditions of the patients that the participants expressed as a barrier to health education in the emergency room. The hospital where the participants work is in a city known for its diversity in culture, with indigenous groups such as the Yakan, Badjao, Tausug, Chavacano, and Bisaya. Most of the locals in this city prefer to maintain its cultural beliefs and local traditions. For instance, some of its locals, like the Yakans and Badjaos, believed that "*tawal*" would help them heal faster.

"*Tawal*" or incantation is a practice often recited in Arabic or Malay to bring about the desired change in a physical or mental condition to heal a sickness or avert a storm (30). It is performed by a "*Magtatawal*" or "*Mangungubat*" (folk curers) who are sought in times of illness. They are considered traditional medical specialists who obtain their powers through dreams or by the instruction of older curers. They use herbs and prayers in their healing activities (31), which has led to some members of the indigenous group relying heavily on them rather than obtaining skilled medical help from a health professional.

In today's health systems, culture and health are vital to delivering quality care to patients because it influences health beliefs and behaviors and how health professionals respond to their patients in all facets of maintenance (32), (33). Madeleine Leininger, the founder of transcultural nursing, had predicted that congruent cultural practice provides meaningful, satisfying, and beneficial patient care (34). Her transcultural nursing theory embodies the basis of much of the application of cultural competence in healthcare (35). She suggests that nurses must maintain a broad, objective, and open attitude when caring for patients with different cultures; that nurses should avoid seeing all patients are alike (33).

The subtheme "*Nurse's Lack of Knowledge*" was mentioned by a participant in this study. Participant 3 expressed that for him, "*whether the nurse is knowledgeable enough on a certain health topic*" can pose difficulty in conducting health education in the ER. This is similar to a study was done by Livne et al. (36) regarding barriers to patient education wherein insufficient professional knowledge and nurse skills were predicted as among the obstacles to difficulty communicating with patients. This barrier could be due to nurses not having an extended contact period with the patients they encounter (22), especially when patients are for immediate surgery or referral to other hospitals. Insufficient knowledge here could also mean a lack of skills or health teaching strategies to use in the ER and may challenge the competency of the ER nurse.

The emergency department is a fast-paced, ever-changing environment that nurses must adapt. It requires them to have a higher-than-normal ability to think critically, clinical skills, prioritization skills, and communication skills (37). The complex and diverse patient care needs pose a significant challenge to the competence of ER nurses, and they should be aware of its impact on patient care outcomes (38). The patient's safety may be compromised if a nurse cannot provide such competence in the emergency room (37). ER nurses should be competent to differentiate patient status, do independent nursing interventions, be able to anticipate orders from the doctors, and

prioritize necessary care based on what is happening in the emergency room.

The subtheme "*Lack of Infographic Materials*" was mentioned by Participant 10 as one of the factors that serve as barriers for nurses in conducting health education in the emergency room. Patients admitted to the ER are frequently anxious, and nurses and physicians must explain their medical condition clearly to reassure them. The American Heart Association developed an example of an infographic in the clinical setting to facilitate patient education at appropriate levels for health literacy (39).

Infographics are intended to explain complicated but vital information on healthcare into simple graphics that can be quickly, clearly, and easily understood; nonessential or distracting images should be removed from the design (40, 41, 42). It would be best to consider the language of the residents where the ER is located when making an infographic material.

CONCLUSION

Based on the experiences of the ER nurses in this study, the conduct of health education in the emergency room can be done. For it to be genuinely beneficial for the patients and significant others, ER nurses must be mindful of their knowledge capability and that of their patients, and some external factors, specifically, lack of time, ER staff, and the need for infographic materials. It is recommended that ER nurses should understand the infographic fundamentals and be taught how to develop them for use in health education. In addition, ER nurses must consider their patients' backgrounds, such as ethnicity, cultural values, behavior, and mental state. Knowing these factors can assist ER nurses and hospital administration in coming up with the best solutions to solve them and can add to the body of knowledge of health education and nursing care in the emergency room.

Other factors could pose as barriers to health education in the ER, which can be explored further with a new set of samples and in another study setting.

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