

Perceptions of Heads' Nursing Department (HND) on Knowledge, Attitudes, and Practices (KAP) in Nursing Care and Its Influence on the Quality of Care in Senegalese Hospitals: A Qualitative Study in 2025

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Abstract

Introduction: The nursing process (NP) is a methodological approach for formulating clinical nursing reasoning that ensures continuity, quality, and traceability of care. The management and clinical supervision of clinical quality within a hospital are mainly carried out by the heads of nursing department (HND). However, the NP for healthcare continues to be adopted unevenly in Senegalese healthcare facilities. **Objective:** To examine the perceptions, attitudes, and practices of HND toward NP, as well as organizational barriers and opportunities for improvement in hospitals in northern Senegal. **Methods:** Exploratory qualitative study conducted among HND in eight regional hospitals. A semi-structured interview guide was used to conduct the study and purposive sampling was using. Inductive thematic analysis, inspired by Braun & Clarke, was used to identify the main emerging themes. **Results:** Six major themes emerged: (1) contrasting levels of knowledge of the NP; (2) generally favorable but sometimes vague attitudes; (3) partial and irregular implementation, often dependent on human resources; (4) numerous structural barriers related to lack of training, supervision, tools, and staff; (5) recommendations focused on continuing education, institutional strengthening, tools, and supervision; (6) a positive perception of the impact of NP on quality of care and clinical outcomes. **Conclusion:** The adoption of NP by HND is influenced by a combination of knowledge, clinical leadership, and organizational context.

Training, resource strengthening, and structuring practices appear to be key elements for sustainable implementation.

Keywords

Nursing Approach, Nursing Department Heads, Nursing Leadership, Nursing Practices, Senegal

1. Introduction

The nursing process (NP) is a structured clinical reasoning framework for planning, executing, and evaluating personalized care while ensuring the continuity and traceability of interventions [1]. The NP supports clinical decision-making, allows interventions to be tailored to the patient's profile, and ensures the evaluative continuity of care [1].

Based on five steps (assessment, diagnosis, planning, implementation, and re-evaluation), the NAP is a disciplinary, methodological, and professional pillar [2].

Beyond its educational and clinical scope, NP is a tool for the continuous improvement of the quality and safety of care, supporting interprofessional coordination and strengthening the scientific dimension of the nursing profession [3]-[6].

From an educational perspective, NP is taught as a repetitive sequence of steps that are activated cyclically throughout the care of the patient [7]. The approach is aimed at both students and nurses to support traceable and communicable care [7]. Implementing NP requires taking the time necessary to identify nursing care issues.

In Senegal, although NP is included in initial training, its use remains insufficiently systematic in daily practice. Several studies report a discrepancy between declarative knowledge, positive attitudes, and actual implementation, which is often hampered by organizational constraints [8] [9].

Heads of nursing department (HND) occupy a strategic position within hospitals. They provide clinical supervision through continuing education, local supervision, work organization, team coordination, and the management of care standards. Their understanding and adoption of NP is a key lever for its sustainable implementation.

The study by Seck *et al.* revealed that 22.3% of nurses had a good understanding of the nursing care process and that 77.7% had gaps in their knowledge. Although 95% of participants expressed a very positive attitude toward its importance, only 23.3% practiced it regularly in their departments, mainly due to ongoing organizational restrictions [9].

The main questions were: What are the perceptions of nursing department heads regarding knowledge, attitudes, and practices related to the nursing care process, and how does this influence the quality of care in hospitals in Senegal?

This study aimed to explore in depth the perceptions, attitudes, practices, obstacles, and recommendations of heads of nursing department regarding NP in hospitals in northern Senegal in 2025.

2. Methodology

2.1. Study Setting

This qualitative study was conducted in eight hospitals in Senegal. These sites were in both rural and urban areas. Together, these establishments serve a population of approximately 3,165,639 inhabitants [10].

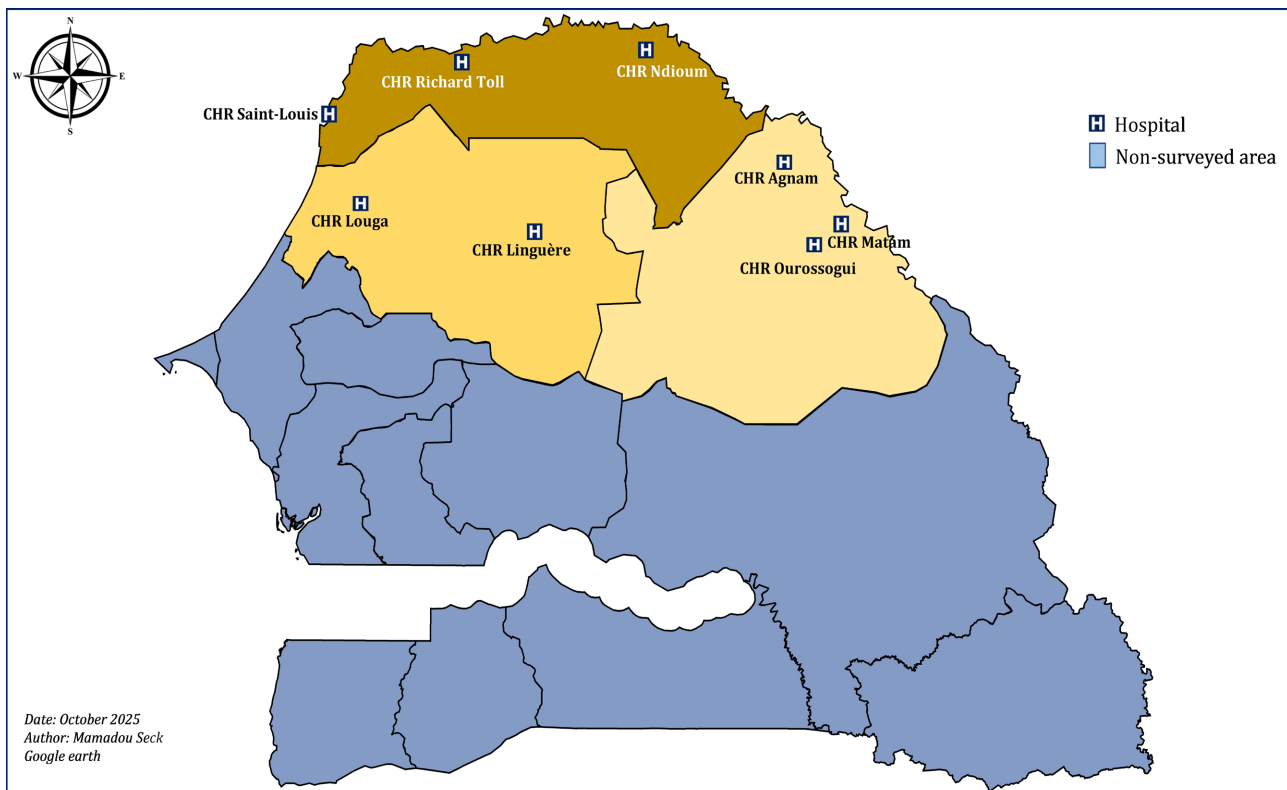


Figure 1. Map showing the distribution of public hospitals in the northern region.

The Lieutenant-Colonel Mamadou Diouf Regional Hospital (Saint-Louis) is the region's main hospital, located at the crossroads of health flows between the river valley and the coast. It provides general care and specialized referrals. It has a capacity of more than 240 beds and covers all medical and surgical specialties [11]. The Amadou Sakhir Mbaye Regional Hospital Center in Louga serves a vast agropastoral area, acting as a referral center for the districts of Koki, Sakal, and Keur Momar Sarr. The health directory lists 138 beds, supported by medical and surgical services and maternity and pediatric activities. The Magatte Lo de Linguère Level 1 public health facility is in the heart of Ferlo, a sparsely populated area with widely dispersed settlements. The facility serves as a primary hospital and stabilization center prior to transfer. It has a capacity of 52 beds. The Richard-Toll EPS

1 supports an industrial and sugar-producing area. It has a bed capacity of 71. It is in the Saint Louis region, 108 km from the city of Saint Louis. The Ndioum Hospital was historically built to structure healthcare provision in the Podor department and treats obstetric and medical patients. It has a capacity of 112 beds. The Ourossogui Regional Hospital Center (CHR), at the crossroads of the routes to Fouta and the Mauritanian border, provides medical, surgical, and maternity care, serving as a hub for the Matam region. It has a capacity of 118 beds. The Matam hospital completes the referral system in an area with significant healthcare accessibility constraints and has a capacity of 66 beds. Finally, in Agnams, the Abdoul Cissé Kane hospital (level 1), inaugurated in 2021, improves local access for neighboring communities. The facility was commissioned with 71 beds, a maternity ward, an operating theater, and a hemodialysis center, constituting a critical resource for the treatment of emergencies and pathologies in the northeast of the country [12]. **Figure 1** shows the distribution map of public hospital facilities in the northern zone.

2.2. Type and Period of the Study

This is an exploratory qualitative descriptive study, conducted through semi-structured interviews with healthcare supervisors, with inductive thematic analysis. It was carried out between July 15, 2025, and August 31 of the same year.

2.3. Selection Criteria

Included were HND who had been in post for at least one year; who had direct responsibility for coordinating nursing practices; and who volunteered to participate.

HND who had been in post for less than one year, who did not supervise the implementation of nursing care, and who did not agree to participate in the study were not included.

2.4. Sampling

Purposive sampling was used to obtain a diversity of contexts and perspectives among healthcare supervisors. Recruitment ceased when thematic saturation was reached.

2.5. Data Collection Procedure

A semi-structured interview guide was developed and tested. The interview guide was developed based on the study objectives and a review of the literature on the nursing process, in accordance with the methodological recommendations of Kallio *et al.* [13]. Structured in four sections (profile, knowledge, attitudes, practices), it included open-ended questions and follow-up questions. Its content validity was reviewed by three experts, and two pilot interviews were conducted to adjust the language and duration in accordance with the approaches of Turner [14] and Castillo-Montoya [15]. It was divided into four sections: 1) socio-professional profile; 2) knowledge of the NP; 3) perceptions of its usefulness and limitations;

4) practices and implementation methods, explored in depth through open-ended questions and follow-up questions. The individual interviews, lasting approximately 45 to 60 minutes, were conducted face-to-face or by videoconference, under conditions ensuring confidentiality. After informing the study candidate and obtaining their written consent, we conducted and recorded the interviews. Data collection was carried out until explicit thematic saturation was achieved. Thematic saturation occurs when data collection no longer yields new information, reflecting the redundancy and completeness of the qualitative data [16] [17]. In our study, this was achieved after iterative analysis of the interviews, when the participants' responses no longer revealed any emerging categories. This observation guided the decision to stop the collection, ensuring the depth and credibility of the analysis [18].

2.6. Data Processing

The audio recordings were transcribed verbatim and anonymized. Field notes were integrated, and the corpus was then imported into analysis software (NVIVO version 15). The analysis followed an inductive thematic approach inspired by Braun and Clarke [19] [20], comprising the stages of familiarization with the data, initial line-by-line coding, construction and revision of themes, and then definition, naming, and narration.

2.7. Ethical Considerations

This study was approved by the Senegalese National Health Research Ethics Committee (CNERS) in note no. 00000150/MSAS/CNERS/SP dated June 13, 2025. Participants were informed of the purpose of this study and informed consent was obtained. The study was anonymous, and only members of the research team had access to the information collected.

3. Results

Table 1 below presents a thematic summary of the results from the interviews. It highlights six main themes: knowledge, attitudes, practices, barriers, suggestions, and recommendations related to NP and the influence of the approach on the quality of care. Each dimension is broken down into sub-themes, illustrated by representative verbatim quotes. This organization allows us to visualize the contrasts observed between in-depth knowledge and persistent gaps, between a favorable attitude and misunderstandings, as well as the main obstacles (lack of training, staff shortages, work overload) and the levers proposed by the participants.

Interviews with heads of nursing department (HND) revealed heterogeneity in the concept of the nursing process (NP) within the departments for which they are responsible. Some HND have a systematic five-step approach (collection, analysis, planning, implementation, and evaluation) necessary to ensure effective care, while others have incomplete knowledge, which could also be the result of insufficient training for their workers. This discrepancy indicates major training issues

associated with the adoption of the NP. The lack of prior and ongoing training seems to be the challenge that prevents their teams from successfully applying NP, as one HND points out: “*We can't say that there is real application; there is a lack of training and involvement.*” (Discussion 2, HND).

Table 1. Summary of KAP survey results from nursing department heads.

Main theme	Sub-themes	Illustrative quotes (verbatim)
Knowledge of the NP	Limited knowledge	“ <i>For the moment... I don't remember anything about the care process.</i> ” (Discussion 1, HND)
	Partial knowledge	“ <i>The approach is the role of the nurse; we focus on the person rather than the illness.</i> ” (Discussion 2, HND)
	In-depth knowledge	“ <i>The approach is a five-step process: data collection, analysis, planning, implementation, and evaluation.</i> ” (Discussion 6, HND)
Attitudes toward the NP	Favorable Attitude	“ <i>It's very important because it allows us to accurately assess what the agent has done.</i> ” (Discussion 1, HND)
	No resistance	“ <i>No resistance to implementation, but the process is not really being applied.</i> ” (Discussion 1, HND & Discussion 4, HND)
	Lack of understanding/ non-application	“ <i>We can't say that it's actually being applied; there's a lack of training and involvement.</i> ” (Discussion 2, HND)
NP practices (application)	Limited or random application	“ <i>The approach is implemented randomly, often depending on people's profiles.</i> ” (Discussion 7, HND)
	Contextualized application	“ <i>Here, we don't follow the approach because there is no training.</i> ” (Discussion 2, HND)
	Partial and unstructured application	“ <i>Some apply the care map, but not rigorously or consciously.</i> ” (Discussion 2, HND)
	Positive impact in certain departments	“ <i>In the maternity ward, we have improved privacy by installing screens based on the approach.</i> ” (Discussion 5, HND)
Barriers to implementation	Lack of training	“ <i>The lack of training is the main obstacle.</i> ” (Discussions 1, 2, 3, 5, 7, HND)
	Insufficient qualified staff	“ <i>There is often only one qualified nurse, with the rest of the staff being underqualified.</i> ” (Discussion 7, HND)
	Lack of equipment and tools	“ <i>The lack of equipment and the working environment impact implementation.</i> ” (Discussion 5, HND & Discussion 7, HND)
	Lack of supervision and monitoring	“ <i>Training, practical guidance, close monitoring, and continuous evaluation are needed.</i> ” (Discussion 7, HND)
	Organization and management	“ <i>Collegial management of services makes it difficult to implement the approach.</i> ” (Discussion 7, HND)
Suggestions and recommendations	Initial and continuing training	“ <i>Train everyone, integrate the approach into the curriculum, and provide regular refresher training.</i> ” (Discussions 1, 2, 3, 5, 7, HND)
	Supervision and support	“ <i>Provide follow-up and formative supervision on site after training.</i> ” (Discussion 2, HND)
	Provision of tools	“ <i>Make materials, protocols, and data collection tools available.</i> ” (Discussions 4, 5, HND)
	Strengthening resources	“ <i>Increase the number of qualified staff and improve equipment and the environment.</i> ” (Discussion 7, HND)
Impact of the approach on the quality of care	Quality improvement	“ <i>The approach improves quality, compliance with protocols, and patient-centered care.</i> ” (Discussions 1, 4, 6, HND)
	Impact on outcomes	“ <i>We have seen an improvement in recovery rates and care since certain protocols were implemented.</i> ” (Discussion 6, HND)

In most cases, NP in departments is not systematic in practice or is non-existent. Certain departments, such as maternity and neonatology, demonstrate the benefits of partial but limited use of NP when they have responded to individual patient needs through modifications to improve the quality of care provided: *“In maternity wards, we have improved privacy by installing screens based on the approach.”* (Discussion 5, HND).

Regarding attitudes, HND agree that the NP is vital: *“It’s very important, it allows us to assess exactly what the agent has done.”* (Discussion 1, HND), especially regarding the care itself, and that changes or improvements to the work did not encounter any major resistance from the team: *“No resistance to implementation, but the approach is not really being applied.”* (Discussion 1, HND & Discussion 4, HND).

This is less a question of principle than an organizational failure of people and resources: These identified barriers also include shortages of trained staff, the unavailability of easily accessible tools and protocols, and a lack of follow-up and formative supervision: *“The lack of training is the main barrier.”* (Discussions 1, 2, 3, 5, 7, HND); *“There is often only one qualified nurse, the rest of the staff are underqualified.”*; *“The lack of equipment and the working environment impact implementation.”* (Discussion 5, HND & Discussion 7, HND) (Discussion 7, HND); *“Collegial management of services makes it difficult to apply the approach.”* (Discussion 7, HND); These shortcomings make it difficult to disseminate and maintain practices that comply with the model.

4. Discussion

4.1. Knowledge of NP

One of the key findings of this study is the wide variability in knowledge of the NP among the HND interviewed. Some expressed very limited or no knowledge: *“At the moment... I don’t remember anything about the care approach”* (Discussion 1, HND). This finding highlights a fundamental problem with training or skills maintenance. Several supervisors mentioned gaps in training, particularly for unqualified staff or nursing assistants who have not completed a full course on NP. This situation is echoed in previous studies conducted in sub-Saharan African countries, where practical training in NP is uneven or insufficiently in-depth, with a direct impact on the quality of care provided (Seck *et al.*, 2025) [8] [9].

At another level, some HND demonstrate partial knowledge, reduced to a general understanding: *“The approach is the role of the nurse, we are interested in the person rather than the disease”* (Discussion 2, HND). This quote highlights a view of PN that is perceived more as a person-centered philosophy. Although this interpretation is relevant, it remains limited in terms of fully meeting the methodological requirements of clinical practice. Indeed, NP is a dynamic and structured process comprising five key stages: data collection (initial assessment), analysis, planning, implementation, and evaluation, as another participant points out: *“The approach is a five-step process: data collection, analysis, planning, imple-*

mentation, and evaluation” (Discussion 6, HND). This distinction highlights that initial training does not always succeed in conveying this comprehensive approach in a coherent and complete manner, which disrupts professional practice and limits implementation.

The specialized literature confirms these observations, notably with Therrien and Dumas (2001), who emphasize that mastery of the care process requires progressive and structured training, supported by critical reflection and practical experimentation, enabling integrated clinical reasoning [3]. Inadequate initial training or discontinuity in continuing education undermine this mastery, as documented in several studies (Seck M *et al.*, 2025; Munyaneza, 2004) [4] [8]. It therefore seems imperative to establish a pedagogical continuum ranging from early teaching in the first year to regular in-service training, including nursing assistants, so that no link in the chain of care is left out of the process.

Beyond training, these observations also reveal a difficulty in translating theory into practice. Indeed, knowledge is not enough if it is not accompanied by conscious and valued professional integration. This disparity in knowledge directly affects the quality of care provided, given that the NP is designed to ensure structured care, adapted to the individual needs of patients and guaranteeing continuity and traceability of care [1].

4.2. Attitudes toward the NP: A Positive Outlook to be Consolidated through Practice

The attitude of heads’ nursing department (HND) and caregivers towards the NP is generally favorable, which is an important driving force for any improvement. One participant stated: “*It’s very important, it allows us to assess exactly what the staff member has done*” (Discussion 1, HND), highlighting the recognition of the role of the approach as a tool for evaluating and ensuring the safety of care. This favorable assessment is largely in line with the findings in the literature (Seck *et al.*, 2025; Bär *et al.*, 2024), which show that professionals, even when they have limited knowledge, remain committed to the care process because of its clear benefits for monitoring and continuity of care [8] [21]. However, this favorable perception is paradoxically tempered by complex practical realities. Some participants explicitly note the absence of resistance to the approach without, however, observing its effective application: “*No resistance to implementation, but the approach is not really being applied*” (Discussions 1 and 4, HND). This dissociation between attitude and action calls for a more detailed analysis.

Another participant summarized the situation as follows: “*We can’t say that it’s actually being applied, there’s a lack of training and involvement*” (Discussion 2, HND). This statement highlights two major obstacles to translating attitude into practice: on the one hand, insufficient continuing education, and on the other, weak institutional commitment to support, motivation, and planning.

Saraswata IW and Hariyati RT (2021) emphasize that a favorable attitude does not guarantee the effective use of NP. They explain that without the right conditions (protocols, specific time slots, guidance, and supervision), even a positive

attitude can remain a pipe dream [22]. This places the issue in an organizational and clinical leadership perspective, where it is no longer just a question of individual know-how but of creating an environment that values and supports this approach. In particular, the role of department supervisors in co-constructing a professional culture focused on quality and rigor becomes essential [23].

4.3. NP Practices: Contrasting Levels of Adoption in the Face of Realities on the Ground

The state of practices reflects the ambivalence observed between theoretical formulation and daily practice. Many report limited, random, and unsystematic application: “*The approach is implemented randomly, often depending on people’s profiles*” (Discussion 7, HND). This finding is corroborated by other surveys conducted by Seck *et al.* (2025) in Senegal and in similar contexts, where NP is considered a requirement but rarely applied in all its dimensions [8] [9].

The practices observed are often partial and unstructured: “*Some apply the care map, but not rigorously or consciously*” (Discussion 2, HND). This phenomenon can be interpreted as “*utilitarian*” or superficial use, linked to simple administrative formality rather than a real methodological intention.

This variability in adoption is frequently attributed to a lack of in-depth training: “*Here, we don’t do it because there’s no training*” (Discussion 2, HND). This comment highlights the crucial role of training, not only in the acquisition of knowledge, but also in the ability to link practice to concepts. Without ongoing training, there is a high risk of confining the NP to a set of mechanical actions without reflective integration.

However, positive feedback has also been reported in certain departments, particularly maternity wards: “*In the maternity ward, we have improved privacy by installing screens based on the approach*” (Discussion 5, HND). This improvement highlights that, when the approach is applied with a minimum of rigor, it has tangible effects on the quality of care, patient dignity, and respect for their rights. This is an example of contextualized adaptation that shows that the NP is not a rigid framework but a flexible tool that can be adjusted to the local institutional and cultural context.

At the same time, the literature indicates that the gains in quality, efficiency, safety, and patient satisfaction associated with a properly implemented NP are significant. Hoggui (2015) and Lara Monod (2013) point out that the approach promotes early identification of problems, the adoption of appropriate interventions, and traceability, enabling continuity and evaluation of care [1] [2]. However, these benefits can only be realized with collective accountability and mobilization of teams.

4.4. Barriers to Implementing NP: Human, Organizational, and Material Factors

Considering expectations, recurring obstacles are clear. Lack of training is the most frequently cited obstacle: “*The lack of training is the main obstacle*” (Dis-

cussions 1, 2, 3, 5, 7, HND). This training deficit affects the quality of adoption and disrupts practices. This problem is accentuated in Senegalese hospitals, where many staff members are technicians or nursing assistants who are not trained in NP [8].

The shortage of qualified personnel is a major obstacle: “*There is often only one qualified nurse, the rest of the staff is underqualified*” (Discussion 7, HND). This situation leads to overwork and an inability to follow all stages of the ISD in a stressful environment, compromising the quality of care (Seck *et al.*, 2025) [9].

The lack of equipment and tools also slows down implementation: “*The lack of equipment and the working environment impact implementation*” (Discussions 5 and 7, HND). The absence of standardized forms, protocols, or support materials leads to disorganized and untraceable practices, consistent with what several authors have noted in developing contexts [5].

The lack of supervision and regular monitoring exacerbates this situation: “*Training, practical guidance, close monitoring, and continuous evaluation are needed*” (Discussion 7, HND). Clinical leadership is essential for promoting the sustainable adoption of nursing process. Several studies have emphasized the decisive role of nursing managers in structuring and driving the implementation of clinical processes through regular reviews, promoting best practices, and mentoring new staff [21].

Finally, the very organization of services, sometimes characterized by collegial management or a lack of clarity in the distribution of roles, constitutes a constraint: “*Collegial management of services makes it difficult to implement the approach*” (Discussion 7, HND). This observation highlights the need for a clear, hierarchical management structure capable of establishing rigorous clinical policies and consistent oversight.

4.5. Impact of the NP on the Quality of Care

The participants perceived a tangible positive effect of the nursing process on the overall quality of care: “*The approach improves quality, compliance with protocols, and patient-centered care*” (Discussions 1, 4, and 6, HND). They emphasize that the approach allows for more accurate assessment, better targeted planning, and effective monitoring, thereby contributing to improved clinical outcomes and greater patient satisfaction. Some report a measurable improvement in health indicators: “*We have seen an improvement in recovery rates and care since the implementation of certain protocols*” (Discussion 6, HND). This positive association is widely supported by the literature, notably with studies by Hoggui M. (2015), Lara Monod TB. (2013), and Hagos F *et al.* (2014), which show that nursing process contributes to reducing errors, strengthening interprofessional coordination, and supporting comprehensive care centered on patient needs [1] [2] [23].

4.6. Outlook and Limitations

The study highlights the importance of developing an integrated model combin-

ing knowledge, continuing education, clinical leadership, and favorable organizational conditions. This model must be adapted to the Senegalese context and replicable in other developing countries facing the same challenges. However, this research has certain limitations, particularly related to the lack of direct observation of practices, which could complement the self-reported data. A future multi-site study, combining audio and observations, would refine understanding and better calibrate improvement actions.

This study, conducted among heads nursing department (HND) in Senegalese hospitals, highlights varying levels of knowledge of the nursing process, generally favorable but sometimes ambiguous attitudes, partial and irregular application, and several structural obstacles hindering its implementation. These results largely converge with national and international literature, while highlighting the pivotal role of HND in the operationalization of professional nursing standards.

4.7. Recommendations: Levers for Effective Integration of the Approach

The proposals made by supervisors converge by towards several strategic directions, in line with international best practices.

The need for enhanced training from the first year onwards and throughout the professional career is fundamental: “*Train everyone, integrate the approach into the curriculum, and provide regular refresher training*” (Discussions 1, 2, 3, 5, 7, HND). This iterative approach promotes gradual appropriation, skills reinforcement, and adaptation to changing contexts. The explicit inclusion of nursing assistants in these training programs is crucial to promoting effective teamwork [9].

Training can only be successful if it is accompanied by effective field monitoring: “*Conduct follow-up and formative supervision on site after training*” (Discussion 2, HND). Nursing leadership must therefore be equipped and recognized to carry out these coaching, supervision, and formative assessment activities, which increase the quality of care and the motivation of teams [21] [24].

The provision of standardized tools, whether paper or digital (evaluation forms, protocols, planning grids), helps to structure the process and, in, increase its visibility: “*Make materials, protocols, and data collection tools available*” (Discussions 4, 5, HND). The ergonomics and simplicity of these tools are essential factors in ensuring their effective use on a daily basis [5] [24].

The shortage of qualified personnel requires careful consideration of recruitment strategies, task distribution, and the adjustment of available resources: “*Increase the number of qualified personnel and improve equipment and the environment*” (Discussion 7). Adjusting ratios and schedules, guaranteeing protected time for the process, and clarifying responsibilities are essential conditions for establishing a sustainable and structured practice.

5. Conclusion

The nursing process is a strategic lever for improving the quality, safety, and con-

tinuity of care in Senegalese hospitals. HND have a relatively positive and strategic vision of the approach, but its effective adoption is hampered by gaps in training, organizational and material constraints, and shortcomings in clinical leadership. To overcome these obstacles, it is essential to act on several fronts: strengthening initial and continuing education, establishing rigorous supervision and support, providing standardized tools, and improving working conditions. The key role of nursing department heads in clinical management must be promoted and supported to transform the care process into a systematic, validated, traceable practice that benefits both professionals and beneficiaries. Only such a comprehensive commitment will enable the expected benefits of NP to be realized in Senegalese hospitals and similar settings.

Conflicts of Interest

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

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