

**FACTORS THAT INFLUENCE COMMUNICATION BETWEEN REGISTERED
NURSES AND PATIENTS AT INTERMEDIATE HOSPITAL KATUTURA,
KHOMAS REGION, NAMIBIA**

**A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE
REQUIREMENTS FOR THE DEGREE OF
MASTER IN PUBLIC HEALTH
OF
THE UNIVERSITY OF NAMIBIA**

**BY
CLAUDIA KAMBONDE
9313664**

APRIL 2019

MAIN SUPERVISOR DR W WILKINSON (UNAM)

ABSTRACT

Communication is the ideas and information exchanged and actions or reactions that arise from that exchange and contact. What really defines the communication is the relationship between the communicator and the recipient. Therefore, for a good nurse-patient relationship to be established, nurse patient communication must be effective.

The study described in this paper was to thoroughly investigate the factors influencing communication between registered nurses and patients at Intermediate Hospital Katutura, Khomas Region, Namibia. With a cross sectional research study design, simple random sampling technique, the researcher sought to discover factors perceived by registered nurses and patients that influence nurse-patient communication and how these affect the quality of nursing care. The tools for data collection used by the researcher were a close-ended questionnaires and an observational checklist, self-administered for registered nurses and the researcher filled in the one for patients.

The main research problem was that; communication problems have been raised by various stakeholders against the registered nurses which is resulting in poor nurses-patient relationship.

Sample characteristics were analysed using data collected from 67 registered nurses, 92 patients and 24 observed registered nurses. Based on the information given by respondents, statistical technique Epi Info software version 3.5.4. was employed to reduce, summarise, evaluate and communicate numerical information by presenting them in the form of tables and charts.

Findings revealed that the level of nurse-patient communication and relationship was influenced positively by good human relations, a friendly hospital environment and respect for both nurses and patients alike among others. Factors which were found to be hindering effective communication between registered nurses and patients were seen to be staff shortages, routine centred activities, shift work, non-supportive management, language, culture, fear, anxiety and level of noise. The study also brought to light the poor communication strategies which are used by registered nurses.

Based on these findings some recommendations were made. Among these were, development of a checklist on ward orientation, nursing education and continuous professional development and cultural sensitive nursing.

TABLE OF CONTENTS	Page
ABSTRACT.....	i
LIST OF FIGURES	vi
LIST OF TABLES.....	vi
LIST OF ABBREVIATIONS.....	viii
ACKNOWLEDGEMENTS.....	ix
DEDICATION.....	x
DECLARATION.....	xi
CHAPTER 1: INTRODUCTION AND BACKGROUND TO THE STUDY	1
1.1 INTRODUCTION	1
1.2 BACKGROUND	2
1.3 PROBLEM STATEMENT.....	5
1.4 PURPOSE OF THE STUDY	6
1.5 RESEARCH OBJECTIVES	6
1.6 SIGNIFICANCE OF THE STUDY.....	6
1.7 LIMITATIONS.....	6
1.8 DEFINITION OF CONCEPTS	7
1.9 SUMMARY.....	7
CHAPTER 2: LITERATURE REVIEW	8
2.2 THE COMMUNICATION PROCESS.....	8
2.3 PATIENT SAFETY AND COMMUNICATION	11
2.4 THE THERAPEUTIC RELATIONSHIP: CONCEPTUAL FRAMEWORK.....	12
2.4.1 MAJOR CONCEPTS OF PEPLAU’S THEORY.....	13
2.4.2 PEPLAU’S FOUR PHASES OF THE THERAPEUTIC NURSE-PATIENT RELATIONSHIP:.....	14
2.5 FACTORS INFLUENCING COMMUNICATION BETWEEN NURSES AND PATIENTS.....	21
2.5.1 HUMAN RESOURCE.....	21
2.5.2 APPLICATION OF FORCE.....	21
2.5.3 LANGUAGE.....	22
2.5.4 MEDICAL JARGON.....	22
2.5.5 CULTURE.....	23
2.5.6 PATIENT ABILITY TO FREELY EXPRESS THEIR CONCERNS.....	23
2.5.7 PATIENT EDUCATIONAL LEVEL.....	24
2.5.8 PROGRESS OF DISEASE /INJURY.....	24
2.5.9 PATIENT FEARS AND ANXIETY.....	24
2.5.10 PATIENT FAMILY INTERFERENCE.....	24

2.5.11 NOISY ENVIRONMENT	25
2.5.12 LACK OF PRIVACY	25
2.5.13 UNSUPPORTIVE MANAGEMENT AND ORGANISATIONAL STRUCTURE	25
2.6 BENEFITS OF EFFECTIVE COMMUNICATION IN HEALTH	25
2.7 CHALLENGES OF INEFFECTIVE COMMUNICATION	26
CHAPTER 3: RESEARCH METHODOLOGY	31
3.1 INTRODUCTION	31
3.2 RESEARCH DESIGN	31
3.2.1 QUANTITATIVE RESEARCH	31
3.2.2 DESCRIPTIVE DESIGN	31
3.2.3 CROSS-SECTIONAL DESIGN	32
3.3 RESEARCH SETTING	32
3.4 POPULATION	33
3.5 SAMPLING AND SAMPLING METHOD	33
3.5.1 INCLUSION CRITERIA	34
3.5.2 EXCLUSION CRITERIA	35
3.6 RESEARCH INSTRUMENT	36
3.7 DATA COLLECTION	36
3.8 VALIDITY AND RELIABILITY	37
3.8.1 PILOT STUDY	38
3.9 DATA ANALYSIS	39
3.10 RESEARCH ETHICS	39
3.10.1 INFORMED CONSENT:	40
3.10.2 AUTONOMY:	40
3.10.3 BENEFICENCE:	41
3.10.5 JUSTICE:	41
3.10.6 ANONYMITY AND CONFIDENTIALITY	42
3.11 SUMMARY	42
CHAPTER 4: DATA ANALYSIS AND STUDY RESULTS	43
4.1 INTRODUCTION	43
4.2 DATA MANAGEMENT AND ANALYSIS	43
4.2.1 DATA ENTRY, EDITING AND HANDLING	43
4.2.2 DATA STORAGE AND DISPOSITION	43
4.3 STUDY RESULTS	44
4.3.1 REGISTERED NURSES RESPONSES	44
4.3.1.1 SECTION A, DEMOGRAPHIC DATA	44
4.3.1.1.1 GENDER OF REGISTERED NURSES	44

4.3.1.1.2 AGE OF REGISTERED NURSES.....	44
4.3.1.1.3 MARITAL STATUS	45
4.3.1.1.4 HOME LANGUAGE.....	46
4.3.1.1.5 WARD OF ALLOCATION.....	46
4.4 SECTION B: TO DETERMINE WHETHER PATIENTS ARE ORIENTED TO THE WARD DURING HOSPITALISATION.....	47
4.4. 1 WARD ORIENTATION	47
4.4.2 POLICIES AND PROCEDURE OF THE WARD.....	48
4.5 COMMUNICATION.....	48
4.5.1 COMMUNICATION.....	48
4.5.2 REGISTERED NURSES ROLES	49
4.5.3 INTERPERSONAL RELATIONSHIP.....	49
4.5.4 NURSE-PATIENT COMMUNICATION.....	50
4.5.5 FACTORS INFLUENCING COMMUNICATION	51
4.5.6 PATIENTS’ NEEDS	53
4.5.7 COMMUNICATION TECHNIQUES.....	53
4.5.8 PATIENTS RESPONSES	54
4.5.9 GENDER	54
4.5.10 AGE	55
4.5.11 HOME LANGUAGES	55
4.5.12 WARD ADMITTED	55
4.5.13 DURATION OF STAY IN THE WARD	56
4.6 SECTION B.....	56
4.6.1 ORIENTATION TO THE WARD	56
4.6.2 POLICIES AND PROCEDURES OF THE WARD	57
4.7 SECTION C: NURSE-PATIENT COMMUNICATION	58
4.7.2 PATIENTS NEEDS RANKING	60
4.7.3 COMMUNICATION TECHNIQUES EMPLOYED BY REGISTERED NURSES	60
4.8 THE OBSERVATION CHECKLIST.....	60
4.8.1 SECTION A: THE WARDS.....	61
4.8.2 SECTION B: NURSING ACTIVITIES	61
4.8.3 SECTION C: COMMUNICATION	62
4.9 SECTION D:.....	63
4.9.1 COMMUNICATION FRAMEWORK.....	63
4.9.2 COMMUNICATION TECHNIQUES.....	63
4.10 SUMMARY	64
CHAPTER 5: DISCUSSIONS, CONCLUSION, RECOMMENDATION AND LIMITATIONS	65
5.1 INTRODUCTION	65

5.2 DISCUSSION	65
5.2.1 SECTION A: DEMOGRAPHIC FOR REGISTERED NURSES	65
5.2.2 DEMOGRAPHIC DATA OF PATIENTS	66
5.3 SECTION B:.....	67
5.3.1 ORIENTATION OF PATIENTS DURING HOSPITALIZATION.....	67
5.3.2 POLICIES AND PROCEDURES OF THE WARD	68
5.4 SECTION C: COMMUNICATION	69
5.4.1 COMMUNICATION CONCEPT.....	69
5.4.2 INTERPERSONAL RELATIONSHIP.....	69
5.4.3 NURSE-PATIENT COMMUNICATION.....	70
5.5 FACTORS INFLUENCING COMMUNICATION (OBJECTIVE 3).....	71
5.6 PATIENTS' NEEDS RANKING	74
5.7 COMMUNICATION TECHNIQUES EMPLOYED BY REGISTERED NURSES.....	75
5.8 OBSERVATION CHECKLIST	76
5.9 CONCLUSION.....	77
5. 10 RECOMMENDATIONS	78
5.10.1 FUTURE RESEARCH	79
5.11 LIMITATIONS.....	80
5.12 SUMMARY	80
6. REFERENCES	81
ANNEXURE A: ETHICAL CLEARANCE CERTIFICATE.....	93
ANNEXURE B: PERMISSION LETTER TO CONDUCT RESEARCH FROM MOHSS.....	94
ANNEXURE C: PERMISSION LETTER FROM IHK.....	96
ANNEXURE D: CONSENT FORM TO TAKE PART IN RESEARCH.....	97
ANNEXURE E: REGISTERED NURSES QUESTIONNAIRE	99
ANNEXURE F: PATIENT QUESTIONNAIRE.....	105
ANNEXURE G: OBSERVATION CHECKLIST.....	109

LIST OF FIGURES

Figure 2.1: Peplau's Theory of Interpersonal Relationship: Factors influencing the orientation phase.....	16
Figure 3.1: Intermediate Hospital Katutura.....	32
Figure 4.1: Distribution of respondents by gender (N = 67).....	44
Figure 4.2: Age groups of the respondents (N=67).....	45
Figure 4.3: Marital status of registered nurses (N=67).....	45
Figure 4.4: The numbers of respondents' home language (N=67).....	46
Figure 4.5: The number of the registered nurses per allocation (N=67).....	47
Figure 4.6: The proportion of registered nurses who orientated patients (N=67).....	47
Figure 4.7 Frequencies of patients gender respondents (N=92).....	54
Figure 4.8: Languages spoken by patients (N=92).....	55
Figure 4.9: Number of patients in different wards (n=11).....	61

LIST OF TABLES

Table 3.1: Sample Size.....	33
Table 4.1: Frequencies on establishing interpersonal relationship.....	50
Table 4.2: Frequencies on nurse-patient communication (N=67).....	51
Table 4.3: Frequencies of factors influencing communication (N=67).....	52
Table 4.4: Rating of patients to ward orientation.....	57
Table 4.5: Frequency of policies and procedures (N=92).....	57
Table 4.6 Patients perspectives and experience regarding nurse-patient's communication	59
Table 4.7: Frequency of registered nurses using the communication techniques (N=92).....	60
Table 4.8: Nursing activities.....	62
Table 4.9: Communication skills (n=18) observed.....	63
Table 4.10: Frequency of communication technique applied.....	64

LIST OF ABBREVIATIONS

CDC	Centre for Disease Control
IHK	Intermediate Hospital Katutura
MOHSS	Ministry of Health and Social Services
WHO	World Health Organisation
UNAM	University of Namibia
USA	United States of America

ACKNOWLEDGEMENTS

Firstly, I would like to thank my God, for giving me courage and strength to persevere after various setbacks. I would also like to thank my supervisor, Dr. Wilma Wilkinson, for her unwavering support, encouragement, mentorship and being my enormous guider and Unam lecturers for the good advice and support.

I am most grateful to my colleague Mr. Peter Jachi who offered his technical support as well the Ministry of Health and Social Services (MOHSS) for granting me permission to conduct the study in the two training hospitals. My mother Maria Shindongo, deserves a special word of thanks for her support both financially, spiritually and encouragement throughout the study period. Thank you to all those who have directly or indirectly contributed to my learning at the University of Namibia, more especially my former classmate of 2013 cohort of Master of Public Health, former coordinator of MPH Ms. Rochelle Van Wyk and Ms. Antoinette Blockstaan at the Faculty of Nursing and Public Health library. Family and friends were also instrumental during my study.

DEDICATION

This work is dedicated to my three sons Fredericks Waldo Tugwedha Kambonde., Isack Twanyanyukwa Kambonde and Vilho Wanda Junior Tetanga Kambonde.

DECLARATION

I, Claudia Kambonde, hereby declare that this study “Factors influencing communication between registered nurses and patients at Intermediate Hospital Katutura, Khomas Region, Namibia” is a true reflection of my own research, and that this work, or part thereof has not been submitted for a degree at the University of Namibia.

No part of this thesis may be reproduced, stored in a retrieval system, or transmitted in any form, or by any means (e.g. electronic, mechanical, photocopying, recording, or otherwise) without prior permission of the author, or the University of Namibia on her behalf.

I, Claudia Kambonde, grant the University of Namibia the right to reproduce this thesis in whole or in part, in any manner or format, which the University of Namibia may deem fit, for any person or institution requiring it for study and research; providing that the University of Namibia shall waive this right if the whole thesis has been or is being published in a manner satisfactory to the University.

.....

.....

Claudia Kambonde

Date

CHAPTER 1: INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 INTRODUCTION

Communication is the ideas and information exchanged and actions or reactions that arise from that exchange and contact (Business Dictionary 2014). What really defines the communication is the relationship between the communicator and the recipient. Therefore, for a good nurse-patient relationship to be established, nurse patient communication must be effective.

High quality nurse-patient communication is the backbone of the art and science of nursing. It has an important impact on patient well-being, quality and outcome of nursing care. It is related to patient's overall satisfaction with their care.

If patients are dissatisfied due to lack of effective communication, they express their displeasures to others, deterring them from visiting the hospital for proper health care. This can have a negative impact on the populace, economy and the hospital because when patients treat themselves without a qualified health care provider; it can lead to some complications which will increase morbidity and mortality rate. Furthermore, government may spend a lot on unexpected problems that may need government intervention and the hospital may lose revenues as well.

Communication is a two-way process of reaching mutual understanding, in which participants not only exchange ideas (encode-decode), information and feeling but create and share meaning. Key to communication is to convey meaning. Communication comprises both verbal and non-verbal aspects. Verbal communication consists of oral communication such as conversations, teleconference, and telephone calls whereas written communication includes letters, reports, and emails.

Non-verbal communication conveys meaning through facial expressions, gestures, speech, nitration, dressing and posture (Business Dictionary 2014). The relationship that is established between the nurse and the patient is the result of interplay or covert negotiations until a mutually satisfying relationship is reached. This depends on the duration of contact between the nurse and the patient, the needs of the patient, the commitment of the nurse and the patient's willingness to trust the nurse. Morse (2007) from the ethical point of view, the professional nurse must be empathic, sympathetic and approach able. However, from encountered experiences, many patients complain that most nurses do not explain procedures and treatments to their patients. They mostly carry out procedures on patients without

informing; explaining and finding out how these patients are faring and coping with life, ailment and treatment. This lack of communication can affect nurse-patient relationship. Formally and informally, the professional nurse cannot achieve anything meaningful with the patient without proper and effective communication. The nurse must understand that all forms of communication are equally important and he or she must properly develop the various communication skills.

1.2 BACKGROUND

Registered nurses play a crucial role in patient care. They have multiple roles in providing and coordinating patient care, educating patients and the public about various health conditions, and providing advice and emotional support to patients and their family members (Ministry of Health and Social Services (MOHSS), 2016). Thus, their communication with patients in the hospital /ward is paramount to the success of treatment outcome. The role of communication in nursing is to exchange information between a nurse and the patient. Registered nurses need information to assess the patient so that she/ he can plan effective care. Patients need information on procedures, medication, treatment and illness so that they can know what to expect and how to cooperate. If they know this, they are feeling less stressed and are calmer and that make them feel in control of the situation and that will improve their motivations to cooperate in their treatment (Macdonald, Stubbe, Tester, Vernall, Dowell, Dew , Kenealy, Sheridan, Docherty, Gray and Raphael, 2013).

Communication plays an important role in patient care. However, there are various factors that influence effective communication. In nursing literature following factors feature prominently being affecting communication. Culture and language are contributing to patient dissatisfaction mostly due to misunderstanding (Almutairi, 2015). The global challenges of shortage of qualified health workers have led to countries making use of expatriates, this is also happening in Namibia where the MOHSS employed nurses from Kenya, Zimbabwe, Tanzania (Almutairi, 2015). This affect communication as well cultural sensitivity of the nursing care as both isn't their first languages, not all patients are able to communicate in English. Most Namibians are not able to express fully in English language, which is the official language (Frydman, 2011). Therefore, the expatriates registered nurses have a challenge in communicating with locals using English language. Staff shortage goes hand in hand with increased work overload, this contribute to nurses to be more task oriented. Thus communicating less, (Zamanzadeh et al, 2014 & Shafipour, Mohammad & Ahmadi, 2014)

Lack of communication skills affects your ability to interact with others. This may lead to lack of empathy and respect, patient end up feeling neglected and not cared for (Shafipour et al., 2014). According to a study by Loghmani et al., (2014), professional ethics of nursing is lacking, thereby compromising on patient rights and care given. The numerous issues facing nurses such as stress, tiredness, frustrations, attitude, long working hours and incompetency level affect their interaction with patients. Even patients sometimes have problems such as fear, misconceptions and not adhering to instructions that contribute to poor communication (Loghmani et al., 2014 & Zamanzadeh et al, 2014).

Worldwide there are concerns about the quality of nurse – patient relationship. Zamanzadeh et al, (2014), stated that The Research Centre for Quality Care in India has indicate that 10.8% of patients' complaint about a lack of respect and communication from the healthcare personal. Compassion and respect for patients is essential in rendering quality nursing care. However, nursing care in Sub-Saharan Africa is commonly represented as lacking compassion and lacking respect for patients, and is furthermore criticized for an authoritarian approach to patients (Vaga, Moland, Evjen-Olsen, Leshabati, & Blystand, 2012). This may be attributed to ineffective communication between nurse-patient relationships, as communication is one sided from the provider.

In Ghana there is public outcry about the behaviour of nurses during interactions with their patients and the crisis in nurse patient interactions remains a serious problem in Ghana, despite criticism and concern expressed by the public (Korsah, 2011). This shows that there is also a communication problem in other African countries between nurses and patients, which may impact on the quality of care (Korsah, 2011). In South Africa similar incidents of poor communication between nurses and patients has also being reported (Dithole, 2014). This poor patient's interaction with nurses may be the similar situation in Namibia.

In Namibia general communication among health professionals and patients appears to be affected by number of factors, like culture, language, workload and psychological pressure from nurses. Causing the health professionals to spent insufficient time with patients during consultation to explain their conditions and systems available. (Mtambanengwe, Maguna, Keiseb, Uusiku, Kaiyamo, Karunga-Beukes, Karises and Nghipundjwa, 2013). The problem of communication was even recognized by both former President Pohamba and Honourable Minister of Health Dr.R.N.Kamwi (Musariri, 2012). Both former president and minister

alluded that communication is the key to quality service delivery, but was not upheld by all health professionals. This problem may affect service delivery to the population, because if the processes and procedures of health care are not properly communicated, it can impact on quality of care provision.

Three studies that were done in Namibia, one in Oshana and two in Khomas regions with some aspects of communication, all their results indicate that there is poor communication among nurses with patients (Joaguim, 2008, Sherif, 2010 & Kamenye, 2013). The first study by Joaguim (2008) indicated that although registered nurses claimed that they provided orientation for patients to the ward environment, patients' responses indicated that orientation was lacking or insufficient. In the same study discrepancy was noted in encouraging patient to participate in their care, which is attributed to poor communication.

Another study by Sherif,(2010) identified one factor that cause patient dissatisfaction within Namibia's health sector as communication breakdown between the patients and health providers. It can be concluded that patients experience communication problem with health providers in Namibia.

Kamenye's (2013) main findings established that nurses who were caring for patients diagnosed with tuberculosis exhibited inadequate communication skills in the following areas: creating a conducive environment for communication, assessing and understanding the patients' mood and level of understanding, listening, questioning, constructive feedback, understanding of non-verbal communication, respect, and empathy for patients.

The patient charter is the Ministry of Health & Social Service framework to promote patients' rights during consultations or visits to all health facilities. It also serves as a guide to health professionals in service provision. In this charter is stipulated that patient must be given a clear explanation and advice on their condition, illness and its proposed treatment. They are informed on their right to lodge any complaint so that is investigated. As well to be offered a detailed information on prescribed treatment, possible intervention and to be consulted on choices available (Ministry of Health & Social Services, 2016). Therefore, is expected that the registered nurse to be knowledgeable about the patients' rights, comply with it and implement on daily basis in conjunction with the scientific method of nursing process. Thus ensuring quality care through proper communication.

The Namibian Public Service charter state that, if Namibia is to prosper public servants must demonstrate their commitment to improving the quality of service delivered to everyone in

the country (Namibia Public Service Charter, 2006). Imparting information is a principle promulgated in the Public Service charter (Namibia Public Service Charter, 2006). To put this principle into practice the registered nurses need to provide information to all patients without prejudice or distinction and in an open manner that is both straight forward and easily understandable. It appears that in spite of all of these, registered nurses are struggling to maintain effective communication with patients.

1.3 PROBLEM STATEMENT

The general public in Namibia constantly complain about the behaviour of nurses during interactions with their patients (Awasses, Gbary, Nyoni and Chatora, 2004). The Intermediate Hospital Katutura (IHK) has been in local media about this particular issue. Moreover, some of local newspapers have published similar stories, including those about patients who had negative experiences during their stay at the Intermediate Hospital Katutura, allegedly as a result of poor communication by nurses (Kisting, 2012 & Shinana, 2013).

Furthermore, it was reported that among the constraints in IHK, specifically with regard to nurses' attitude and poor interpersonal relationship are amongst many of other factors hampering the rendering of quality care to patients (Intermediate Hospital Katutura, 2008). It has also been reported in the media about the attitude of nurses which is not friendly, displays of not having time to answer patients' questions and not informing patients of procedures (Kisting, 2012 & Musariri, 2012).

In 2012, the former president Dr Hifikepunye Pohamba, instituted a Presidential Commission of Inquiry into affairs of the Ministry of Health and Social Services. The Commission's findings comprise of various factors affecting quality health provision, such as severe staff shortage of different categories including registered nurses, lack of communication, lack of accountability, neglect of professional ethics, language barriers, to mention a few (Mtambanengwe et al., 2013).

The problem with poor communication exist, despite registered nurses receiving training about correct ways or manner of communication with patients. The existence of guiding documents such as the Scope of Practice of Registered Nurses (Namibia, 2014), Patient and Public Service Charter set out a mechanism or framework for communication (Namibia,

2016). It appears that in spite of all of these, registered nurses are struggling to maintain effective communication with patients.

1.4 PURPOSE OF THE STUDY

The purpose of this study was to determine the factors that influence registered nurse-patient communication at Intermediate Hospital Katutura (IHK).

1.4 RESEARCH OBJECTIVES

The research objectives were to:

- a) Determine whether the patients are oriented about the ward during their hospitalization.
- b) Observe and describe the communication between registered nurses and patients at Intermediate Hospital Katutura.
- c) Identify the factors which influence communication between registered nurses and patients at Intermediate Hospital Katutura.

1.5 SIGNIFICANCE OF THE STUDY

There has been an outcry for improved registered nurse- patient communication and subsequent quality of nursing care in Namibia. This study has attempted to contribute to this debate. The findings of this study will highlight factors that influence nurses-patients' communication. These factors will therefore inform policy makers, hospital management and training institutions in planning strategies to reduce these factors that influence registered nurses-patients' communication. This study may also influence the development of communication directive for registered nurses to enhance effective communication through continuous in-service training program to improve the communication.

1.5 LIMITATIONS

Since this study was based at one hospital, the IHK, the findings cannot be generalized to all hospitals in the country. This study is also limited to one category of registered nurses. This study focused on registered nurses not in promotional positions, those responsible for direct clinical care. Promotional positions of Registered nurses are: Control Registered Nurse, Chief Registered nurse and Senior Registered Nurse responsible for management and supervision. This also means that Enrolled nurses were excluded. The study has also only focused on specific identified wards. The study was also focused on selected patients and not all patients admitted at Intermediate Hospital Katutura (IHK) was included.

1.6 DEFINITION OF CONCEPTS

COMMUNICATION

The act or process of transmitting information (Merriam-Webster, 2015). It involves the reciprocal process in which messages are sent and received between two or more people. It can either facilitate the development of a therapeutic relationship or create barriers (Riley, 2013).

NURSE-PATIENT COMMUNICATION

Communication between nurses and patients is a mutual and comprehensive oriented communication whereby discussions takes place and actions are exchanged between nurses and patients. The nurses' aspect is consistent with symbolic interactionism, which is in turn the view of interaction between persons and not as a stimulus response connection, but as a meaningful and purposive action reaction interchange (Tejero, 2012).

PATIENT

A person who is under medical care or treatment or sick individual especially when awaiting or under the care and treatment of a physician or surgeon (Merriam-Webster, 2016)

REGISTERED NURSE

A person registered as such in terms of section 20, or regarded to be so in terms of section 64, of the Professions Act, 8 of 2004 as amended (Government Gazette 3249, 2004, p. 7).

1.7 SUMMARY

The focus of this chapter was the introduction and background to this study. It had also narrated the study problem statement, the purpose, objectives, significance, limitation and definitions of concepts used. Patient satisfaction of nursing care received will depend on the communication between them and the nurses. Registered nurse has a big role to play to create an atmosphere which will ensure a conducive relationship with patient. Therefore, communication is an important element that facilitate the provision of quality nursing care.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

In the presiding chapter, the researcher gave a snapshot overview and background of the study. In this chapter, the researcher will focus on the literature review on the aspects of communication that are related to the topic of the study. The aim is to enhance understanding of the topic under study by reviewing existing information that discusses the research findings of previous researchers. Building on these researchers' findings is imperative to discover any gaps in the relevant field of knowledge and to compare information by applying existing related knowledge. Relevant literature includes only those sources that are important in providing the in-depth knowledge needed to study a selected problem (Burns & Grove, 2011). Hence, in this chapter, the researcher will discuss and explore the process of communications, the utilizations of that process between a nurse and a patient, to exchange information, to ensure the safety of the patient and to provide the patients with a therapeutic relationship that will enhance their recovery. This will be done, in conjunction with the conceptual framework based on Hildegard E Peplau's theory of interpersonal relations as well as factors influencing communication and benefits of effective communication.

2.2 THE COMMUNICATION PROCESS

Communication is defined as the process of sharing information by exchanging verbal and non-verbal messages (Bramhall, 2014). It includes the reciprocal process in which the message is sent and received between two or more people. Effective communication depends on the clarity of the messages created by the sender and the ability of the receiver to decipher these messages. In nursing the nurse need to be able to create a message that the patient can easily understand and when the nurses are the receivers (Wright, 2012), they need to engaging active listening skills assist in ensuring a successful interaction by means of techniques that facilitate discussion. The success of the interaction depends on both parties understand the message clearly and refrain from judging each other.

Meier (2012) distinguishes the five stages of communication as set out below.

Starting with the sending of the message in stage one. This stage deals with creating, sending, transmitting or sharing the message. Senders validate the message they want to transmit to the receiver and encode their thoughts and feelings into words and gestures. The messages are

transmitted to the receiver by way of sound, sight, touch and sometimes smell and taste (Riley, 2013). For the message to be understood by the receiver, it should be direct and simple. According to Kozier, Erb, Berman and Snyder (2004), appropriate language, word construction, and tone of voice and body gestures all play a role in communicating a message.

When creating the message nurses should ensure that they use language that the patient can follow by avoiding medical terms and ensuring that medical terms are simplified to the level of a lay person, for example your bone is broken instead of fractured. They can even illustrate or /demonstrate to clarify verbal communication by showing and/or using a poster/picture of the specific organ/limb affected by illness. Messages demonstrated by way of pictures and visuals are more easily remembered or recognised than the spoken words. A pamphlet with health literacy can also being able to obtain, process and understand basic health information and services that are needed to make desired health decisions (Graham & Brookey, 2008). After the message was send, it does not mean that the message was heard, read or understood. The sender has to follow up to make sure that the message is clear and correctly understood.

The next stage (two) by Meier (2010) is the receiving. This is the stage where the message is received by the receiver and decoder using their knowledge, background educations and culture to understand it. When the nurse are the senders of the messages it is important to observe the patients' non-verbal communications for clues with problems of receiving the messages and react on it.

According to Windover et al. (2014), reflective listening enhances the therapeutic nature of a relationship and increases openness and disclosure of feelings. Because it affords patients the opportunity to express their concerns without interruptions. A nurse can only identify a patient's crucial nursing needs if he or she listens carefully and offers the patient a chance to freely express his or her concerns, hopes and fears. This is the key to successful communication in nursing. According to Jahromi, Tabatabaee, Abdar and Rajabi (2015), active listening is based on paying complete attention to what a person is saying, listening carefully while showing interest and by not interrupting.

The next step in this process is stage three or understanding. At this level, communication conflict or breakdown can occur. The sender can confirm that the message was understood by asking the receiver to repeat it. In nursing, this can reduce errors by ensuring that the information is clear. According to Riley (2013) it is very useful to give the receiver a moment

to do reflecting during which the receiver's directing his or her ideas, feelings, questions, or content back to the sender (Riley, 2013). Reflecting is to ensure that the communicators are in step with each other. The purpose of reflecting is to allow the speaker to "hear" his or her own thoughts and to focus on what he or she says and feels.

By listening actively and acknowledge the contribution that was made during the interaction by both parties can assists in building a relationship in as much as each role is acknowledged (Riley, 2013). A study has shown that building and maintaining a good nurse-patient relationship is an essential aspect of the treatment and healing process and that effective communication skills are key to achieving this (Wright, 2012). By inviting a response from the patient will creating a platform for the patient to be part of the conversation. Acknowledging their involvement in the communication process creates a platform for the patient to open up and give more details. Body language, such as a head nod or using a thumb, can also be used to show that one is listening, although not necessarily agreeing (Mindtools, 2016).

During the stage fourth (Meier 2010) an agreement are reached between the two parties. At this level, the sender and receiver come together to deal with wants, needs and concerns. Hopefully the message is clarified and consensus reached.

A good skill to use is to summarising the agreement by about shortening the conversation using own words and main ideas. It helps to differentiate between relevant and irrelevant information. Furthermore, it can serve as a review of and closure for the communication (Riley, 2013). According to Bramhall (2014), it is a way to prove that one heard the cues, concerns or questions posed.

Another good skill is to accommodate patient's own (Mindtools, 2016) words into this agreement. This enables the registered nurse to incorporate the patient's words in the discussion and nursing care plan. Patients' involvement in their plan of care is recommended for a better outcome of the health goal. Although predetermined forms and structures seem to be the bible for nurses, there is a need to accommodate patients' views in the nursing plan.

At this fifth stage, the outcome of communication is put into action. In nursing, this will allow the compliance and involvement of all parties. The best action is usually a decision that both parties agree to.

By apply teach-back technique (Mindtools, 2016) the nurse to confirm whether a patient understands and is able to play back what has been said. A patient may not indicate that he or

she does not understand, but by asking to play back, the health worker may pick up the true level at which a patient is encoding the message.

The assumptions that a patient understands should always be avoided; always ensure that he or she really understands. Literature has it that Yes/No questions may lead a patient to lie because he or she does not want to be embarrassed. It is better to request a patient to play back the message in order to ascertain whether the patient has coded the information received (Weiss, 2007).

People communicate with each other in different ways, which can be verbal and/or non-verbal communication. Verbal communication refers to the form of communication in which a message is transmitted verbally by word of mouth and/or a piece of writing (Riley, 2013). In nursing, communication mostly occurs by this means of directly speaking to a patient, handing over reports and writing records. Verbal communication is further divided into oral and written communication. Non-verbal communication uses the sending or receiving of wordless messages. The channel of communication is by way of gesture, body language, posture, tone of voice or facial expressions. It is all about the body language of a speaker. It comprises three elements, namely appearance, body language and sound.

2.3 PATIENT SAFETY AND COMMUNICATION

The basis of patients' rights is to protect and promote patients' safety. Hence communication plays a very important role in nurses' interactions with patients on a daily basis (Bramhall, 2014). Consequently, the multidisciplinary teams in health efficiency depend on effective communication among all the teams. Nursing, being the backbone of the healthcare system, compels nurses to know how to effectively communicate with patients. A lack of effective communication has detrimental effects on patients' well-being and treatment outcomes (Nadzam, 2009).

It is well documented that communication breakdowns cause the most negligent cases and poor recordkeeping. Nadzam (2009) mentions that differences in hierarchy, conflicting roles, ambiguity in responsibilities and power struggles can all lead to communication failures that compromise patients' safety and the quality of care. To unpack this in relation to nurses, the differences in hierarchy in the staff component at ward level between the sister in charge, the team leaders and the enrolled nurses/accoucheur can cause communication breakdowns.

Effective teams depend on continuous cooperation, coordination and communication for the best outcome. However, nursing literature shows that ineffective or insufficient communication among team members is a significant contributing factor to adverse events (Dingley, Daugherty, Derieg et al., 2008).

Patient safety is defined as the prevention of harm to patients, whereby errors are prevented, lessons are learnt from errors that do occur and a culture of safety that involves healthcare professionals is built on (Mitchell, 2008). High-quality healthcare depends on maintaining patient safety. Hence practising safe patient care has a positive, rewarding impact on the patients, nurses and the organisation. Safe patient care is achieved by nurses adhering to set standards, norms and the values of nursing. Communication between nurses and patients facilitates the effective rendering of quality nursing care. Communicative relationships may result in the identification of nursing needs and measures being put in place to mitigate it.

Quality nursing care is characterised by competency, a caring attitude and professional etiquette (Bramhall, 2014). Safe and quality nursing care is guaranteed when nurses are skilled and knowledgeable. Patients identified good communication skills and interpersonal competence as key elements of quality care, since they promoted individualised care and established good nurse-patient relationships (Izumi, Baggs, & Knafl, 2010). Patients value good communication with healthcare professionals.

2.4 THE THERAPEUTIC RELATIONSHIP: CONCEPTUAL FRAMEWORK

Peplau's theory defines nursing as "*An interpersonal process of therapeutic interactions between an individual who is sick or in need of health services and a nurse especially educated to recognize, respond to the need for help.*" It is a "*maturing force and an educative instrument*" involving an interaction between two or more individuals with a common goal (Wayne, 2014). The emphasis of this theory is on the interaction between the nurse and the patients, where both parties need to participate according to their feelings, values, attitudes, goals and knowledge of the subject matter. These communication plays an important role in ensuring quality nursing care by sending and receiving information towards a common goal. Therefore, the interaction is beneficial to both the nurse and the patient, as both learn and grow from what they share. This interaction is influenced by various factors, the selected stimuli in the environment and the reaction to stimuli (Wayne, 2014).

2.4.1 Major Concepts of Peplau's Theory

The major concepts of Peplau's theory involves a person, an environment, health and nursing

- The theory explains that the purpose of nursing is to help others identify their felt difficulties (Wayne, 2014). This implies that a nurse plays an important role to assist patients with their health needs. History taking enables the nurse to recognise previous and current conditions.
- Nurses should apply the principles of human relations to any problems that arise at all levels of experience. According to Mordi (2015), principles of human relations are based on self-confidence, accommodating others' points of view, explaining oneself thoroughly and listening. Integrating all these principles ensures good levels of communication between a nurse and patient.
- Peplau's theory explains the phases of interpersonal process, roles in nursing situations and methods for studying nursing as an interpersonal process (Bramhall, 2014). The predetermined curriculum of nursing training is the foundation of interpersonal process. The training prepares nurses on how to apply these process in providing the required care.
- Nursing is therapeutic in that it is a healing art, assisting an individual who is sick or in need of healthcare (Wayne, 2014). The core foundation of nursing is to take care of those in need of help, and the cornerstone of healing art is the ability to give patients the needed care.
- Nursing is an interpersonal process because it involves interaction between two or more individuals with a common goal. Through interaction the patient and nurse both aim to improve and bring about comfort in the situation at hand. Communication being the key to all human relations, is the most effective enabler to achieve common goals (Bramhall, 2014).
- The attainment of goal is achieved by using a series of steps following a series of patterns. In nursing, there are various processes to guide nurses in providing quality care by following those steps (Bramhall, 2014).

- The nurse and the patient work together and thus both become mature and knowledgeable in the process. This process ensures that the nurse and the patient share experiences with one another. The nurse and the patient need to work together as partners (Wayne, 2014). Therefore, the nurses and patients' need to be aware the factors that may influence their relationship as listed in figure 2.1
- According to the Peplau theory, the nurse has several roles, ranging from being a stranger, teacher, resource person, counsellor, surrogate and leader. In addition to this, the nurse needs to be a technical expert, consultant, health teacher, tutor, and socialising agent, manager of the environment, mediator, administrator, recorder, observer and researcher (Wayne, 2014). These different roles enable a nurse to optimally meet the patient's health needs. These roles may be applied simultaneously during the provision of care.

2.4.2 Peplau's Four Phases of the Therapeutic Nurse-Patient Relationship:

Orientation phase

In the first phase of interaction, the nurse and the patient meet as strangers. Communication and interviewing skills remain fundamental nursing tools during this phase without it the quality of care may be compromised (Wayne, 2014). Therefore, the nurse needs to know how to communicate clearly, which requires specific skills as was explained in the previously as well as with the correct attitude. Patients in a hospital are usually under stress and stress can have a negative influence on the communications process (Gulich, Ramas, Mendoza-Sassi et al, 2013). Being able to give a patient hope for his or her condition/illness is very important and a reassuring attitude comforts the patient and assist him or her in accepting the illness with more ease. Detailed explanations can assist the patient in overcoming his or her fears and reducing his or her anxiety (Gulich, Ramas, Mendoza-Sassi et al, 2013). It is important that nurses take in account that every patient is unique as an individual and therefore reacts differently to the same condition/illness.

The nurse creates the atmosphere to establish a relationship with the patient by greeting and introducing him- or herself. The tone and warmth of the nurse's voice promote the connectedness between them (Bramhall, 2014). Furthermore, the nurse needs to find out from the patient how he or she prefers to be addressed, since some people like to be called by their first names while others prefer to be called by their surnames to maintain formality. It is

important to establish rapport for the easy flow of later conversations. The nurse needs to provide reliable information in order to create a trusting relationship (Wayne, 2014).

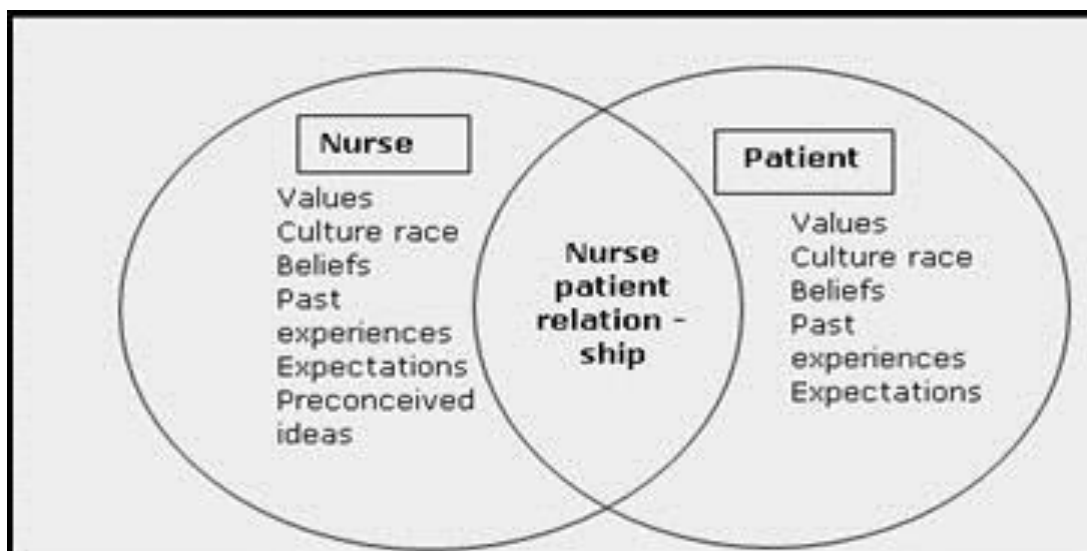
For the relationship to work it is also important that the patient feel safe enough to be an active participant in his or her health-related issues. It is the patient's responsibility to provide relevant and accurate information about his or her condition to assist the health team in diagnosing, treating, rehabilitating or counselling the patient (MOHSS, 2016). A sure way of creating a feeling of trust and safety in patients is when they are sure their private information will be treated with the confidentiality as set out in the Patient charter. That the information communicated between the registered nurse and the patient is not to be shared, except for treatment purposes and when required by the law. Confidentiality ensures that the patient is protected from victimisation resulting from information they shared with health workers. Defamation is also prohibited, for example disclosing sensitive patient health information to family members without the patient's consent (MOHSS, 2016).

Afterwards the nurse and the patient interact to define the patient's problem and to clarify the problem by asking questions and sharing known information, enabling the nurse to create a plan of care. Data collection and assessment require the active participation of both the nurse and the patient. The patient presents his or her health-related concerns with the aim to obtain assistance. The nurse needs to be open-minded and non-judgemental in order to understand the patient's nursing needs. Thus, creating a safe and supportive atmosphere is essential for making a personal connection, fostering trust and collaboration (Windover et al., 2014). Such interaction creates a comfortable environment in which a trusting relationship can be established. Based on the nurses' knowledge, they are in a better position to identify and explain the problems that patients might be facing from the information that they gathered from the patients. The nurse as a consultant analyses the patient information and gives proper advice (Windover et al., 2014).

This phase is crucial as both the nurse and the patient have presumptions and expectations caused by past experiences. Seeing that these presumptions and expectations might influence the interaction between them, it is critical to establish a therapeutic interpersonal relationship at the start of the first stage to create a platform where all the different presumptions and expectations can be discussed openly (Windover et al., 2014).

At the end of this phase, the nurse and patient have entered into a therapeutic contract. Although this not a formal or written document, the verbal contract ensures that the roles of the nurse and patient, as well as the goals of the relationship, are explained.

Figure 2.1 - Peplau's Theory of Interpersonal Relationships: Factors influencing the orientation phase



Source: Wayne (2014)

As indicated in figure 2.1 the nurse-patient relationship is influenced by some factors which emanate from individual background of the two. These factors include, values, culture, race, beliefs, past experiences, expectations and preconceived ideas.

- Values

Professional practice is guided by values. In nursing this values plays a critical role, hence is required that registered nurses understand it (Baillie & Black, 2015). Human behaviour is integral part of values, demonstrated by human actions and decisions. The professional values ensure that registered nurses conduct themselves in manners that are professionally and socially acceptable. It's required that registered nurses have awareness of own values as it can affect interactions with others either positively or negatively (Bramhall, 2014). MOHSS (2016), re-emphasis the core values of the MOHSS, which the registered nurses should apply on daily basis. These values are:

- Confidentiality
- Empathy and caring
- Honesty, integrity and dignity

- Impartiality
- Professionalism
- Respect
- Transparency and accountability
- Innovation and creativity customer focus

Equally important is the patients' values as it need to be part of clinical decisions. Patients' centered-care is the corner stone of respect, responsive to individualized preferences', needs and values of the patient (Windover et al., 2014). These are achieved in the orientation phase through establishing an interpersonal therapeutic relationship (Wayne, 2014).

- Culture

Communication and culture have a direct link. The way we communicate is directly influenced by our cultural background. Culture may be described as a system of interpretations shared by a group of individuals (Zimmermann, 2015). Communication become more noticeable difficult when the sender and receiver are from different cultures. Patients need to feel accepted and treated with respect even though they are culturally different (Bramhall, 2014). It's the role of the registered nurse to make the patient comfortable in the new environment, to learn and to find out from the patient his/her her cultural preferences. Culture differences can hamper effective communication if not handled with care.

Nurses need to recognise that they too are cultural beings, and should be aware that the things they say also reveal their cultural background, as well as other aspects of the self, and are important in the learning process of becoming competent communicators (Almutaivi, 2015). It is very important that the registered nurse respects the cultural values and beliefs of the patient, but at the same time must address misconceptions, prejudices or fixed ideas which are relevant to the care giving situation (Keller & Baker, 2015).

- Race

The basis of trust between registered nurse and patients lies in the registered nurse dedication to "universalism," that is, the responsibility to treat all patients alike without regard to particular attributes or ascribed traits (Keller & Baker, 2015).

If patient care is not universalistic, suspicion and caution will prevail over trust and confidence in the registered nurse-patient relationship. Individuals coming together in

nursing dialogue bring with them all of their personal characteristics, including their personalities, social attitudes and values, race, ethnicity, gender, sexual orientation, age, education, and physical and mental health (Bramhall, 2014). This applies to the registered nurse as well as to the patient, though research on registered nurse characteristics is less common.

- Believes

The registered nurse and patient religious believe may differ which may impact the communication. However, it is the responsibility of the registered nurse to seek to understand patient reasoning and respectfully try to find an accommodation that neither undermines patient authority to decline nursing intervention nor contradicts their professional commitment to patient health (Frush, Eberly & Curlin, 2018). If come up with such scenario, the virtues of humility and patience are essential for the registered nurse. The registered nurse must have the humility to acknowledge the limits of their knowledge, expertise, and authority and to seek help.

- Past experiences

Both registered nurse and patient past experience in health care may influence their interaction. The most crucial point is that registered nurse always to behave like a professional and communicating like a professional at all times is vital to becoming a competent nurse (Bramhall, 2014). Nurses should never presume things about their patients, and they should use their communication skills to ask relevant questions even about sensitive issues (Bramhall, 2014). This enables the nurse to be fully informed about the patient and for them to be able to treat the patient as an individual (Izumi, Baggs, & Knafel, 2010).

- Expectations

Registered nurse has expectation regarding patient interventions and treatment outcome. Therefore, is imperative during the identification phase to identify patient health needs and to plan his/her care accordingly (Wayne, 2014). On the other hand, patients have also expectations to be met by the registered nurse. Patient expect to be heard, listen, given opportunity to ask questions, given relevant information regarding his/her condition/illness in open and appropriate manner (MOHSS,2016).

Identification phase

The basis of this phase has been established in the previous phase. Therefore, this phase commences when the patient works interdependently with the nurse, expresses feelings and starts to feel stronger. The Ministry of Health and Social services patient charter (2016) also note that patients are entitled to be listened to and to be heard. This includes that the registered nurses are to listen to the patients and to act according to the information received. The two parties should ensure the same understanding of the message under discussion to minimise any miscommunication.

By the end of this phase health problems have been identified during data collection and appropriate nursing interventions developed. Desired health goals are achieved by means of the patients' active participation; with the support of the nurses, they can overcome their fears, anxiety, helplessness and become partners in order to find solutions together. Recognising the patients' strengths and using their resources increase their coping mechanisms. Communication being the basis of all human relations, registered nurses connect with their patients by establishing eye contact, being formal and by maintaining a warm tone of voice (Keller & Baker, 2015). As a result of this, patients begin to have a sense of control and their feelings of hopelessness and helplessness are reduced.

Exploitation phase

In this phase, the patient uses the services and resources that are available. The use of professional assistance depends on the patient's needs and interests. A patient is faced with two challenges when visiting hospital: One is being sick or injured, which causes disruption in his or her daily life activities, and the second one is the healthcare system with its many fragmented systems and language uses (Wayne, 2014). The registered nurse is in the position to digest the patient situation and to assist accordingly. The key to appreciating a patient's situation is to listen carefully, to understand the patient's point of view, to acknowledge it and to express concern.

The most important thing is to understand the patient's situation. The only way to gain a better understanding of the patient's nursing needs is to evaluate the interventions and to reassess whether it is still appropriate (Bramhall, 2014). In nursing, this is made easier by following the set standards of care.

Communication between the registered nurses and patients must provide a clear explanation of their conditions, illness and its proposed treatment. The patients must be offered the opportunity to ask questions so that they can gain understanding of how to cope and deal with the specific health condition. Once the patients understanding is clear, it increases their chances of recovery and optimises their daily activities on discharge. Health advice enables patients to make informed decisions about lifestyle changes once discharged from the hospital (MOHSS, 2016)

Empowering the patients with the right information about health-related issues will ensure that they become knowledgeable. Such knowledge will guide their patients to make informed decisions that will benefit the maintenance of good health. Once a patient is well equipped with information, it will assist in avoiding nurses to restrict patients to what they, the nurses, value. It is a well-known fact that nurses tend to be more routine- and task-oriented than to be patient-focused (Bramhall, 2014).

Resolution phase

This phase represents the stage where the patient is able to take ownership of his or her health. This phase indicates that the patient's needs and expectations were met through collaboration with the nurse. Full participation, solving the problem with resources from both sides, is a prerequisite (Breckon, Harvey, & Lancaster, 2008). This phase is reached when health goals are attained. Empowering a patient can assist with speedy recovery and cooperation. This could result in a very positive outcome that could lead to a stronger relationship (Keller & Baker, 2015). The relationship will be typified by both parties' healthier emotional balance and increased satisfaction. Patients are entitled to receive information to promote their own health and to contribute to building a healthy nation. Information can be disseminated by way of health talks and distributing printed leaflets. In return, the patient is expected to use the information in looking after themselves, using all the preventative measures available. It is also essential to engage in support groups to gain better coping skills and to manage different conditions. It has been proven that the more knowledgeable one is about a condition, the better the outcome (Riley, 2013). Therefore, the nurses and patients' needs to work together to accomplished the health goals and professional satisfaction.

2.5 FACTORS INFLUENCING COMMUNICATION BETWEEN NURSES AND PATIENTS

Effective communication between nurses and patients has been identified as crucial in improving patient satisfaction, treatment compliance and health outcomes (Shukla, Yadav, & Kastury, 2010). Effective communication between the nurse and the patient can decrease the stress levels of the patient that is why it is important that the nurse promote and articulates the flow of these processes. Nurses play an important role in establishing and facilitating communication (Ghiyasvandian, Zakermaghadam, & Peyravi, 2014). However, various factors can influence the communication between nurses and patients as described below.

2.5.1 Human resources

According to nursing literature, various factors affect effective communication (Korsah, 2011 & Loghmani et al., 2014). Human resource problems appear to be prominent among the factors affecting communication. This problem is coupled with many issues such as staff shortages, no defined registered nurse-patient ratios, task-oriented attitudes, work overload, competency and confident levels (Loghmani et al., 2014, & Zamanzadeh et al., 2014). It has been proven that staff shortages increase workload and decrease communication (Korsah, 2011). According to Ghiyasvandian et al. (2014), although nurses greatly value partnered communication as a key component of successful patient care, they usually do not employ it in their daily clinical practice. In the same study, the nurses also reported that stress, anxiety and workload are barriers to good communication. Increased workload is reported to distract nurses' attention from patients' needs. Routine-centred care is also mentions as a barrier to communication between nurses and patients (Shafipour, Mohammad, & Ahmadi, 2014). These barriers cause nurses to rather concentrate on predetermined routine tasks than to communicate with patients. However, in the identification phase of Peplau's theory, barriers must be identified in order design interventions.

2.5.2 Application of force

It is also documented that nurses sometimes apply force in their interaction with patients (Korsah, 2011). This causes unequal relationships, where the nurse is portrayed to be powerful and the patient powerless (Korsah, 2011 & Loghmani et al., 2014). This is seen as a barrier to effective communication between a nurse and a patient, as the patient must obey the nurse's instruction and does not have a voice. The quality of nurse-patient relationships is a worldwide

concern. The Research Centre for Quality Care in India has indicated that 10.8% of patients complained about healthcare personnel's lack of respect and communication (Zamanzadeh et al, 2014). Such unequal relationships should be addressed in the identification phase, where both the nurse and the patient work interdependently towards a common goal. Peplau's theory emphasises, that they work together as partners according to their expertise; the nurse imparting health knowledge to the patient and the patient expressing felt concerns. The nurse employs his or her listening skills to correctly identify the patient's problem and to understand his or her needs (Bramhall, 2014). In the identification phase, the patient is empowered to become hopeful through counselling and technical assistance pertaining to his or her health needs.

2.5.3 Language

Language plays a vital role in effective communication. The world is functioning as a global village. This state of affairs has contributed to the increased movement of registered nurses around the world (Tay, Ang, & Heqney, 2012). A lack of understanding of a patient's needs and status has an impact on what the nurses communicate to patients. If a patient is not familiar with the registered nurse's language, misunderstanding can occur. The patient may not be able to express him- or herself well in an unfamiliar language. Patients' misunderstandings of nurses sometimes result in adverse health outcomes (Loghmani et al., 2014). In order to prevent unnecessary misunderstandings, it is advisable that registered nurses apply communication techniques such as illustrations and asking patients to play back. If patients do not properly understand the information given by nurses, it can cause poor compliance and no change in lifestyle. Giving patients the correct information is imperative to positive treatment outcomes and preventing wrong instructions (Korsah, 2011). However, Anoosheh, Zarkhah, Faghihzadeh and Vaismoradi (2009) did not find language diversity to be a barrier for effective communication between nurses and patients in Iran. This finding may be explained by the fact that both groups were familiar with the local language that the patients used.

2.5.4 Medical jargon

A nurse, in the role of a health teacher, must refrain from using medical jargon in order to communicate in clear, simple terms (Bramhall, 2014).

The patient charter of Namibia requires all service providers to listen carefully, to communicate openly and honestly and to provide clear, comprehensive and understandable health information and advice to patients (MOHSS, 2016).

Professional assistance should be provided through clear communication, and distinct explanations; advice about their condition, illness and proposed treatment should be articulated in simple terms (MOHSS, 2016). Registered nurses are encouraged to offer patients the opportunity to ask questions. This may result in the patient making informed decisions and feeling part of the treatment team. The key here is to shift the mind of registered nurses from being presumptuous that patients are helpless to acknowledging them as resourceful and competent (Keller & Baker, 2015). Patient involvement is proven to result in achieving the ultimate goal of behavioural change (Breckon, Harvey, & Lancaster, 2008). Peplau's theory reiterates, in the exploitation phase, that professional assistance must be used for problem solving alternatives and the advantages of services should be based on the patients' needs and interests.

2.5.5 Culture

According to Zimmermann (2015), culture comprises the characteristics and knowledge of a particular group of people, defined by everything from language, religion, cuisine, social habits, music and arts. Culture causes people to see, hear and interpret things differently. Some cultural gestures/words are an insult to other cultures (Almutaivi, 2015). This may result in misunderstanding, especially if it is incorrectly translated. Multicultural teams of registered nurses may be another blocking factor, as not all are familiar with their patients' differing cultures (Almutaivi, 2015).

2.5.6 Patient ability to freely express their concerns

Patient factors play an important role in facilitating or inhibiting communication. A study found that those patients' reluctance to talk about their diseases and feelings, as well as their preference to seek emotional support from their family/friends and their use of implicit cues were some of the factors that inhibit communication (Tay et al., 2012). If a patient is not open to discuss wholly his or her concerns, disease or injury characteristics, it impacts on the treatment plan and intervention needed to address it promptly. Patients need information about procedures, medication, treatment and illness so that they can know what to expect and how to cooperate. If they know this, they feel less stressed and are calmer, which make them feel

in control of the situation. It will also improve their motivation to cooperate with the healthcare team in their treatment (Macdonald et al., 2013). In the exploitation phase again, the patient uses services that are offered after they have been imparted with the necessary information.

2.5.7 Patient educational level

A patient's educational level may affect communication. It is documented that patients with a high level of education facilitate communication by expressing their concerns more easily and asking more questions (Tay et al., 2012). Zamanzadeh et al. (2014) also stated that patient educational level have an impact on communication as those with high level tend to be able to articulate more than those with low level.

2.5.8 Progress of diseases/injury

Zamanzadeh et al., (2014) indicate that the changes that the disease and its long-term treatment impose on a patient and his/her family, also affect communication. This occurs in ill-health/injury conditions where a patient's appearance may change; especially if there is no improvement after prolonged treatment. This causes patients to be depressed or to react with anger and aggression, which may lead to less communication (Zamanzadeh et al., 2014).

2.5.9 Patient fears and anxiety

Patients' ability to communicate effectively with nurses may be influenced by their fears and anxiety (Bramhall, 2014). Ineffective communication is also associated with being afraid of judgement, being weak or breaking down and crying. Any discomfort, anxiety and pain will cause a patient to talk less (Zamanzadeh et al., 2014). Therefore, is very important that the nurse empowers the patient with correct information to dispel his or her fears, to reduce anxiety and to soothe the pain. Once this is achieved, the resolution phase of Peplau's theory is reached. At this stage, the patient is equipped to take ownership of the responsibility to maintain his or her health, which may end the therapeutic relation.

2.5.10 Patient family interference

The interference of a patient's family with nursing activities may also influence communication. A study done by Korsah (2011) indicates that nurses' interactions with patients' relatives featured prominently in negative nurse-client interactions. Korsah (2011) reports that confrontations with a patient's relatives occur on a regular basis. Such confrontations involve issues such as visitors not complying with stipulated visiting times,

which result in the disruption of nurses' work and impact on the time that nurses are to spend with patients.

2.5.11 Noisy environment

The environment also plays a role to ensure effective communication. If the noise level is high, the communicators may not send or receive the message in its full content and meaning. A noisy environment is prone to increased misunderstanding (Bramhall, 2014).

2.5.12 Lack of privacy

If there is no privacy, a patient may not divulge sensitive information, resulting in treatment interventions being compromised, seeing that comprehensive information is not imparted to the patient (Bramhall, 2014). Privacy is important during patient consultation and the registered nurse must ensure that it is maintained at all times.

2.5.13 Unsupportive management and organisational structure

Research has also shown that if the management does not support its staff members, it affects how the staff communicate with patients (Loghmani et al., 2014). Frustration stems from the staff's needs not being addressed, leading to stress. A study done in Iran indicates that a lack of formal and informal support in stressful situations is a major barrier to professional communication (Pfaff, Baxter, Jack, & Ploeg, 2014). Thus, management's support to staff plays an important role to ensure effective communication.

Zamanzadeh et al. (2014) identified three factors that emanate from an organisational structure that affect effective communication that is workload and time imbalances; imposed duties and a lack of supervision.

2.6 BENEFITS OF EFFECTIVE COMMUNICATION IN HEALTH

Various benefits of effective communication are documented in literature. Communication is the key indicator of quality care. It has been proven that most nursing/medical errors occur due to poor communication. O'Daniel and Rosenstein (2008), as well as Chan, Jone, Fung and Wu, (2011), indicate that effective communication has positive outcomes such as the following:

- Improved information flow, seeing that the two-way communication causes both the sender and the receiver to decode the message correctly and thus to have the same understanding. In this case, from registered nurse to patient and vice versa;
- More effective interventions, because the registered nurse receives the correct information and can plan accordingly;
- Improved safety, as misunderstandings are minimised;
- Reduced cost; this is a result of combined effort between correct treatment, patient involvement and compliance;
- Increased patient and family satisfaction; less complaints are raised as quality care is ensured and clear information is shared, resulting in less misunderstandings;
- Decreased lengths of stay and rapid recovery. This can be attributed to clear instructions and compliance on the registered nurse and the patient's part. This is also coupled with reduced complications;
- It also promotes productive teamwork, as proper handover between the shifts takes place and any changes are promptly shared among the team; and
- It also saves the nurses' time, as they are patient-focused instead of task-oriented.

On the flipside of the benefits of effective communication, there are negative consequences for both the nurse and the patient pertaining to ineffective communication. Researchers have identified various negative effects of poor communication like Shukla, Yadav, & Kastury, (2010); Gonzalo (2011); Riley (2013) and Zamanzadeh et al., (2014).

2.7 CHALLENGES OF INEFFECTIVE COMMUNICATION

It has been found that poor communication is the root cause of diagnostic errors. Inaccuracy in obtaining patient information, as well as not considering all the facts given by patients, also contributes to diagnostic errors (Frieden, 2015). Diagnostic errors are defined as those in which a diagnosis is unintentionally delayed, wrong or missed. This can emanate from not

using the indicated diagnostic test, misinterpretation of test results, as well as not acting on abnormal results (Singh, Naik, Rao, & Petersen, 2008). This matter is also caused by not documenting all the facts and a lack of teamwork between nurses and doctors. Some patients may mention their concern to a nurse but not divulge it to the doctor. A nurse's omission to record such information or the doctor not reading the nurse's notes, can lead to misdiagnose. A lack of appreciating all team members as part of the diagnostic team also has a negative effect on the patient's diagnosis (Singh, et al., 2008).

Diagnostic errors lead to malpractice, resulting in poor treatment outcomes (Bailey, 2016). Singh et al., (2008) reiterated that diagnostic errors are the major cause of medical errors in the United States of America (USA) and they found that malpractice was responsible for nearly 2 000 patient deaths, which could have been prevented through better communication. Communication failures contribute to 30% of malpractice cases in the USA (Bailey, 2016). Nurses' delays in reporting abnormal observations to doctors or their omission to observe patients properly have serious consequences for patients, which can even be fatal.

Long waiting times: Health providers are faced with one common problem, namely not informing their patients of time delays (Pun, Matthiessen, Murray, & Slade, 2015). This causes frustration among patients and they sometimes react by being rude towards the health providers. Having to wait in long queues without being communicated to, causes dissatisfaction (Sherif, 2010). Not continuing communication with patients to reassure them creates an unpleasant atmosphere. Research has established that communicating with patients is critical in providing them with care. Having to wait for an extended period is mainly contributed to staff shortages, time pressures and long working hours (Pun, et al., 2015).

Communication breakdowns create stress for nurses, patients and family members alike. Patients and family members look up to nurses to provide them with comprehensive information in order to address their questions and concerns. They become frustrated and dissatisfied when this is not done on time (Agarwal, Sands, & Diaz-Scheider, 2008). Nurses, being the primary healthcare providers, are expected to impart information and to clarify their patients' concerns. Thus, patients become impatient, and sometimes even rude, when nurses do not communicate with them.

Workplace conflict: Poor communication in the workplace causes conflicts attributable to various issues occurring in an organisation. If effective communication is not maintained, it

creates uncertainty, which further leads to stress and conflict (McKibben 2017). The effect of these concerns is poor teamwork, since tasks are not well coordinated and roles are not stipulated distinctly. Teamwork is affected by poor communication as some tasks may overlap and some be overlooked.

In addition, workplace conflict can occur due to poor leadership. If the leadership fails to give proper and clear direction, the employees tend to experience conflicts easily (Vertino, 2014). It is known that where leadership is lacking, the chances of poor communication increase. In response, staff will become demoralised.

Poor decision-making: Communication breakdowns can cause poor decision-making, which, in turn, impacts on the satisfaction of both patients and nurses (Hicks, 2017). Management can make poor decisions when they are not well informed and/or if they do not involve their entire staff. Organisations with a clear vision, mission and goals are known to all have a better chance to run an effective business. Together they identify the organisation's problems and possible solutions (Hicks, 2017). In return, management will encourage staff to have open communication about issues that affect the organisation. Therefore, feedback becomes a priority in order to keep all staff updated. These actions will mitigate negative effects such as low staff morale and turnover (Vertino, 2014).

Increased stress: It is well documented that stress is a normal occurrence in any workplace due to various events. In healthcare, unresolved stress-related issues have a huge impact on staff and patient satisfaction (McKibben 2017). A lack of communication is one of the causes of increased stress in hospitals. This is credited to withholding of information, which creates worries and concerns. Patients visit health facilities already worrying about their health-related issues, which is aggravated by poor communication. Consequently, poor coordination, unknown expectations and a lack of direction cause stress (McKibben 2017).

Staff's stress levels are also increased when management does not communicate properly, poor support and a lack of feedback. McKibben (2017) indicates that poor leadership contributes to staff's stress. The leadership role in and organisation is crucial to minimise the staff's stress by ensuring a conducive working environment. Stress causes low productivity and poor customer service (Eisenhauer, 2015). Therefore, it is important to address the staff's

concerns and to keep them updated on organisational matters. Feedback and continuous communication can reduce stress among the staff.

Poor communication is linked to incurring high costs in hospitals. These costs vary between the different units in the hospital. A study done in the United States determined that delays in getting hold of the right staff on the right time are one of the contributing factors to high cost (Argawal et al., 2010). Addition factors are the changing of notes and failing to communicate with the rest of the team. Communication breakdowns occur frequently, resulting in the inefficient utilisation of clinical staff and a high likelihood of mistakes. Therefore, poor coordination could have an impact on patients who are not being cared for in a timely manner, putting them at risk and possibly lengthening their stay in hospital.

It is estimated that in the United States, \$4.9 billion is lost annually in nursing time due to communication inefficiency (Agarwal et al., 2010). This causes an economic burden. The unproductive use of nurse's time creates a further artificial shortage of critical staff in an already resource-constrained and stressed healthcare system. Overall, poor communication contributes to high economic waste annually in the United States. Poor coordination and communication during the discharge of patients also cause increased length of stay. This is attributed to not providing the required information timely, not obtaining treatment to be taken home and not explaining adequately. These omissions result in delays in patient discharge, resulting in the patient still occupying the hospital bed (Agarwal et al., 2010).

Communication breakdown can occur between a provider and another provider and between a provider and a patient. Providers cause these gaps due to poor record keeping and not documenting all the information, as well as omitting to read the said records (Agarwal et al., 2010). Provider-to-patient communication breakdowns involve inadequate informed consent, unsympathetic responses to a patient's complaints, inadequate education (for example about medications), incomplete follow-up instructions, no or wrong information given to patients and miscommunication due to language barriers (White, 2016). The economic impact of poor communication on a healthcare system is enormous. It also impacts negatively on patient health and finance.

Providers are prone to cause communication breakdowns by failing to provide each other with proper reports and by forgetting to record critical information (Agarwal et al., 2010). In nursing it is imperative to hand over reports and to record all critical information about patients progress on his/her medical condition.

2.8 SUMMARY

In this chapter, the researcher dealt with various aspects of communication, starting with the definition of communication and ending with patient safety and communication. The researcher further reviewed the factors that influence communication in accordance with the study's conceptual framework, namely Peplau's theory of relation. Other notions that were discussed include communication strategies, the benefits of effective communication and the negative impact of poor communication on healthcare. In the chapter that follows, the researcher will cover the research methodology that was used as a guide to conduct this research successfully.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter entails to outline the research methodology which was employed to conduct this study. It includes the research design, population, sampling, sampling size, research instruments, research ethics and the control measures taken to ensure validity and reliability.

3.2 RESEARCH DESIGN

A research design is the process that is followed to answer the research objectives. Therefore, is a set of logical steps (Brink, Van der Walt & Van Rensburg, 2006). The researcher in this study wanted to observe and investigate the communication between registered nurses-patients at Intermediate Hospital Katutura. This was an observational descriptive cross-sectional study design. The word quantitative implies quantity or amounts, therefore information collected during the study was in a quantified /numeric form (White & Millar, 2014). Therefore, it was presented in percentages (%) and amount averages.

3.2.1 QUANTITATIVE RESEARCH

Quantitative research falls within the philosophical foundation of positivism. A positivist researcher believes in the concepts of objective reality (Jirowong, Johnson & Welch, 2014). In addition, quantitative research operates on strict rules of logic, truth, laws and predictions (Burns & Groove, 2009).

According to Moxham (2012), the four ideal criteria used for quantitative research are significance, research ability, feasibility and interest to the investigator. The researcher's interest in this study was communication between registered nurses and patients. This was quantitative research based on objective measurement and observation to determine the communication between registered nurses and patients. It did focus on various concepts and numeric information which was statistically analyzed.

3.2.2 DESCRIPTIVE DESIGN

In this study, descriptive design was used to focus on investigating the communication between registered nurses and patients at Intermediate Hospital Katutura. The descriptive design was chosen because it will provide the researcher with the tools to accurate portrayal of the

communications between nurses and the patients and the frequency with which certain phenomena occur using statistics to describe and summarize the data (Polit & Hunger, 2013).

3.2.3 CROSS-SECTIONAL DESIGN

Cross-sectional research design collects data on subjects at one point in time (Van der Walt & Van Ransburg, 2008; and Burn & Grove, 2011). Large amount of data is collected at one point, making the results more readily available (Brink, 2010). In this study it was employed by collecting data in one hospital from identified population at the specific time of the day (observations) and over a period of just one month.

Observational study is whereby the researcher observes the individuals without manipulation or intervention (Burns & Grove, 2011). In this research the researcher observed how the registered nurses communicate with patients in the specified wards using a checklist.

3.3 RESEARCH SETTING

The research was conducted at Intermediate Hospital Katutura. Intermediate Hospital Katutura is in Khomas region, which is situated in the capital city of Namibia, Windhoek. It is a hospital which serves multiple functions such as, District, Intermediate, Disaster centre, Referral and Training Hospital to various categories of medical/nursing students and allied health professionals. All three objectives of the research took place in 11 inpatients wards, namely 3 Orthopaedic, 3 Surgeries, 1 Gynaecology and 4 Medical.

Figure 3.1: Intermediate Hospital Katutura



Source: Researcher

3.4 POPULATION

According to Burns & Grove (2011), the population is defined as a particular group of individuals or elements, who are the focus of a research study. It is important to define the population of interest for the researcher to focus on specific participants. On the other hand Welman, Kruger & Mitchell (2007) define population as the study object that consists of individuals, groups, organizations, human products and events, or conditions to which they are exposed. A research problem relates to a specific population and the population encompasses the total collection of all units of analyses about which the researcher wishes to make specific conclusions (Welman, et al., 2007). This study population was registered nurses and patients as set in table 3.1.

Table 3.1 Sample size

Target	Population	Sample
Registered nurses	243	67
Patients	462	92
Total	706	159

3.5 SAMPLING AND SAMPLING METHOD

Burns & Grove, (2011) defined sampling as a process of selecting subjects who are representative of the population being studied. Random sampling usually provides a sample that is representative of a population because each member of the population is selected independently and has an equal chance of being included in the study. The sample defines the selected group of people (or elements) who will participate in the study and samples should represent a population of people (Burns & Grove, 2011). Once the population is clearly defined a researcher must decide whether to collect data from every member or element of that population (usually defined as a census) or from a representative subset or sample of it (Mc Givern, 2006). Registered nurses were selected using convenience sampling.

All registered nurses allocated in the 11 wards for the month of September 2017 were selected as a study population and they were (N=67). Therefore, stratified random sampling was used for registered nurses. The number of registered nurses were small; therefore, all registered nurses took part in the study. The number of registered nurses allocated in 11 wards were

medical 26, surgery 18, orthopaedic 17 and 6 for gynaecological, these registered nurses were for both shifts of day and night duty.

Simple random sampling is when each individual in the population has an equal chance of being selected for the sample (De Vos et al, 2012), this sampling method was used for patients. The calculation of patients sample size was done using the calculator from the Survey System (<https://www.surveysystem.com/sscalc.htm>) at 95% confidence level and a margin of error (confidence interval) of 7.32%, the sample of N=462, the research had a sample size of N=92 patients. Hence the number of patients per ward interviewed varies from 8-10. This was obtained by dividing the sample size among the wards, guided by number of eligible patients found in the ward. For example, in the gynaecological ward 20 patients were eligible to take part in the study and after the above mentioned calculation was done it indicated that just ten patients need to be included from this ward. The ten patients were randomly selected by drawing their names from a bag with all the names in.

Observation checklist was used in 11 wards to observe the communication between the registered nurses and patients. The number of day duty registered nurse's allocation per ward were ranging between 3-4, hence mostly it was only 2 registered nurses per morning shift on duty. In total 24 registered nurses were observed.

3.5.1 INCLUSION CRITERIA

Inclusion criteria are evaluated for eligibility on the basis of relevance and acceptability (Timothy, 2006). Inclusion criteria give researchers a set of inclusive standards to screen potential participants. The inclusion criteria is a crucial requirement for consideration which allowed the researcher to embrace the participants 'responses. The inclusion criteria in this study:

- Wards: 11 wards (4 medical wards, 3 surgery wards, 3 orthopaedic wards and 1 gynaecology ward) were selected based on the length of stay of patients between 3 or more days.
- In these wards bed occupancy rate was observed to be high.

Patients:

- Both males and females' patients admitted in (4 medical wards, 3 surgery wards, 3 orthopaedic wards and 1 gynaecology ward) for more than 3 days are eligible. These wards were selected because patients in these wards mostly stayed from 3 days and more, which is sufficient enough to build a relationship between the registered nurses and the patients.
- Their participation was on voluntary basis

Nurses:

- Registered nurses who not occupying managerial position
- Registered nurses allocated to specified wards according to the monthly nursing staff change list of September 2017.
- Registered nurses that are not on leave whether study or sick leave.

Observation checklist:

- Registered nurses found on duty to be observed for at least 45 minutes in each ward which is part of the study
- Registered nurse and patients to be aware of the observation by the researcher

3.5.2 EXCLUSION CRITERIA

Exclusion criteria help researchers eliminate candidates based on a specific set of requirements and ability. Exclusion criteria are basic features for consideration which allow the researcher to exclude the participant who did not have the characteristics that the researcher was interested in, despite the fact that their inclusion would not have met the purpose of the study (Welma et al., 2008). The following were excluded to participate in the study.

Nurses:

- The registered nurses who are not working at the identified wards.
- Senior registered nurses through promotion in those wards (supervisors)

Patients:

- Patients who are having speech impairment, mentally ill, deafness, unconscious and been admitted for less than 3 days.

Wards:

- Wards that were not included are acute care, head injury, stroke, maternity section, tuberculosis and paediatrics. It was based on their conditions and inability to

verbally communicate (acute care, head injury, stroke, Paediatrics). Maternity section and tuberculosis was based on length of stay, patient's conditions and time constraints of the researcher.

3.6 RESEARCH INSTRUMENT

Three research instruments were used, self-administered questionnaires for registered nurses, patient questionnaire and observation checklist.

The questionnaire for patients contained three sections: Section A for patients captured the demographic characteristics of the respondent such as gender, age, marital status, employment status, educational level, home language and the ward admitted; Section B captured orientation to the ward, policies and procedures of the ward, Section C captured communication aspects on factors influencing communication, patients' needs and communication techniques.

The registered nurse's questionnaire Section A captured the demographic data, gender, age, marital status, home language and the ward, Section B captured orientation to the ward, policies and procedure of the ward, Section C captured various aspects including communication knowledge, registered nurse role, interpersonal relationship, nurse-patient communication, factors influencing communication, patients' needs and communication techniques.

Finally, Section A of the observation checklist captured demographic information regarding the situations in the wards. Section B captured the nursing activities going on in the ward at that time that the observation was done, Section C captured examples of different communication techniques used by the registered nurses and Section D indicate the presence of the communication guidelines in the wards.

3.7 DATA COLLECTION

Data collection methods refer to the process of selecting subjects and gathering data from these subjects (Grove, Burns & Gray, 2013). During the data collections with the registered nurses the researcher first orientated each one of participant regarding the research objective and reiterate the anonymous of questionnaires filled to minimize them to be biased and to promote honest response. After obtaining consent from registered nurses the research instrument was given and was explained to them after which the researcher withdraw to allow the participant to fill in the questionnaire on their own. Data collected from patients also strictly followed the ethical principles as stated and was done through face-to-face interviews using a questionnaire.

Questionnaires were administered to eligible patients in the selected wards at Intermediate Hospital Katutura during the study from September to October 2017. The questionnaires were in English and translated verbally in the local languages (Damara and Rukavango) occasionally using nursing trained staff on duty. The trained staffs were cross checked with the same language nurses from another ward to verify that she /he was correctly translating the questionnaire. They were trained for three days on the research instruments.

Direct observation by the researcher using a checklist was conducted in all 11 wards to investigate the communication between the registered nurses-patients. The researcher went in ward by ward observing on how registered nurses and patients were communicating, recording down all observations made vis-a-vis the checklist. The researcher had started to observe during the morning hours from 06h45, when the ward is busy. The opportunity to observe the interaction of the registered nurses and patients is best during morning hours. The researcher, firstly informed the registered nurses on duty her mission for the day as well the patients in the particular room. The researcher sited in a room with bed capacity of six patients, although at the time of research it had patients between 4-8. Because this research follows a cross section research designs meaning the researcher aim to capture a “snapshot” of reality, the observations were done for 45 minutes at a time. The researcher had a note book to note her observation for scoring purpose before ticking on the checklist. The criteria to indicate Yes/No was: for yes if the registered nurses have been observed doing it for 3 or more out of 5 or half of the patients found in the room. No was when not observed or done only to one patient out 5.

The number of registered nurses on duty on the days of observation were 2-3 per ward, in total they were 24. Each registered nurse had a separate scoring observation list and activities were observed simultaneously.

Prior to data collection, permission was obtained from the Permanent Secretary of MOHSS and the hospital Medical Superintendent of Intermediate Hospital Katutura. The head of nursing services as well the floor nurse managers of specific domains of study interest were informed to be aware of my presence in their areas of supervision.

3.8 VALIDITY AND RELIABILITY

Validity is the degree to which an instrument measures what it intends to measure, given the context in which it is applied (De Vos et al (2011)). It is the extent to which a measurement could be trusted and it is also referred to as the closeness of a measurement towards a true

finding. The face-value validity is a subjective determination that an instrument is sufficiently adequate to obtain the desired information (De Vos et al (2011)). In this study, both the content and the face-value validity were assessed. The researcher established face-value validity by submitting the questionnaire to her supervisors, who evaluated the questions in relation to the objectives of the study. Nurse Managers were also consulted as expert in nurse-patient communication. Content-related validity was achieved through an extensive literature search communication between registered nurses -patients to ensure that the data collection instrument had all the necessary questions for addressing these issues. The questionnaires used was adopted from previous research and tested to be reliable (Steckler, 2012).

Reliability is to ensure the accuracy and consistency of the information obtained in the study (De Vos et al (2011)). In general, reliability refers to the extent to which the independent administration of the same instrument consistently yields the same results under comparable conditions. In order to ensure the reliability of the data collection instrument, the researcher pre-tested the questionnaire during a pilot study that yielded the same results as in the main study. And to ensure reliability in this study, the same questionnaire was used to collect data from all participants.

In summary, the assessment of reliability and validity of the questionnaires, collected data from the pilot study was coded and run using SPSS IBM version 22 and to generate a Cronbach's Alpha coefficient. The pilot study found that the research instruments were reliable and valid to be used since coefficient Alpha value was > 0.7 .

3.8.1 PILOT STUDY

According to Polit & Beck (2012) pilot study is a system which intends to test the plan and method of research. This is done by using resembling subjects, the same location and same data collection instruments administered to a small group of participants from the intended test population and these selected participants should not participate in the main study. A pilot study was conducted in order to identify unforeseen problems and to assess the validity and reliability of the research instruments (Brink, 2010).

The pilot study was conducted at Windhoek Central Hospital where registered nurses and patients were used to determine whether the recommended study was feasible and if the research instruments were valid and reliable. A small group of 8 registered nurses and 10 patients were selected to participate in the pilot study. Observation checklist was used to observe the communication between 8 registered nurses and patients in 4 wards, namely one

medical, one surgery, one gynaecology and one orthopaedic. The questionnaires were piloted at Windhoek Central Hospital with sample a size of 8 registered nurses and 3 patients in medical, 2 in surgery, 2 in orthopaedic and 3 in gynaecological ward. This pilot study was conducted using random sampling method. The researcher followed the principles of research ethics (confidentiality, privacy, informed consent) during this period. The questionnaires were minimally adjusted post pilot study with input of my supervisor.

The random selection was also applied during the pilot study. To address the objectives, the questionnaires and observation checklist had combination of some similar data sets. Hence all the objectives were catered for in the research instruments in different sections. The researcher assessed the relevance and accuracy of the questionnaire in terms of information retrieval and relevance. The same questionnaire was used to collect data for the main study with minimal adjustments. The assessment of reliability and validity of the questionnaires, collected data from the pilot was coded and run using SPSS IBM version 22 and to generate a Cronbach's Alpha coefficient. The pilot study found that the research instruments were reliable and valid to be used since coefficient Alpha value was > 0.7 . Therefore, all 3 research instruments were refined post pilot study at Windhoek Central Hospital, which is not part of the study.

3.9 DATA ANALYSIS

All the collected data was analysed quantitatively. The questionnaires were checked for consistency, accuracy and completeness. Data was entered onto Epi-info programme version 3.5.4. Therefore, the collected data was cleaned, coded and analysed using Epi-info programme. The computer programme Epi - info version 3.5.4 was used to analyse all the data collected into descriptive statistics as well presenting the study findings in different tables, graphs and charts.

3.10 RESEARCH ETHICS

The researcher was obliged to abide to the research principles, rules and regulations during this study. This was the frame for the researcher not to violate the rights of the participant and to ensure an ethical study. Ethical principles that were observed during the conduct of the study are the informant consent, autonomy, beneficence and non-maleficence, justice, anonymity and confidentiality. Underneath is the outline of what the researcher had applied for ethical consideration during this study.

Firstly, permission was obtained from the University of Namibia Postgraduate Studies Committee. The written proposal was reviewed by the committee to ensure that it adhered to

ethical standards of scientific research methodologies. Secondly, permission to conduct the study was sought from the Ministry of Health and Social Services. Thereafter a permission was applied from the office of the hospital medical superintendent, at Intermediate Hospital Katutura to carry out the study in the facility.

This study did involve human participants in which participants were asked to participate in the study. Ethics in research refer to moral principles that call for respect and protection of the rights of research participants by researchers (Tulchinsky & Varavikova, 2009). The right to privacy encompasses both the right to respect for the dignity of the patient, namely his/her physical privacy, and the right to respect for the patient's secrets, namely confidentiality (Pera & Van Tonder, 2011). Therefore, the following ethical considerations were adhered to during the execution of the study.

3.10.1 INFORMED CONSENT

Obtaining informed consent implies that all possible or adequate information on the goal of the investigation; the expected duration of the participant's involvement; the procedures which were followed during the investigation, the possible advantages and disadvantages to which respondents may be exposed; as well as the credibility of the researcher, be rendered to potential subjects (De Vos et al, 2011). Informed consent was voluntarily sought from the participants. The objectives of the study were explained to the research participants. The patients were informed that a series of questions related to communication with registered nurses will be asked. The researcher together with the registered nurses went through the questionnaires for clarification and understanding. Thereafter informed written consent was obtained from registered nurses and patients.

3.10.2 AUTONOMY

Participation in this study was voluntary. The rights of the participants not to participate was respected at all times and it was explained to them that they have the right to refuse to participate or to choose to withdraw their participation during the research without any prejudice or consciences to their further care (Resnik, 2011). The researcher maintained this principle by only conducting and issuing questionnaires to those patients or registered nurses who agreed. The participants were also informed that the research is independent from the hospital and had no influence on the registered nurse's management and patient care.

3.10.3 BENEFICENCE

The right of participants' wellbeing was protected through this research. The researcher had safeguard against any discomforts that might arise during the data collection process (Resnik, 2011). This was ensured through avoiding sensitive questions that can cause discomfort of patients. The principle of beneficence means people must take an active role in promoting good and preventing harm in the world around them, as well as in research studies (LoBiondo-Wood & Haber, 2010). The researcher has an ethical obligation to protect the respondents against any form of harm that could result from their participation in a study (de Vos et al, 2011).

3.10.4 NON-MALEFICENCE

Non-maleficence requires practitioners not to harm patients intentionally, through lack of knowledge or by negligence (de Vos et al, 2011). It's all about safety of the patient by protecting and preventing harm to them.

In this study, the researcher protected the participants from discomfort and harm by ensuring that for instance, she did not reveal the identity of registered nurses who didn't get the answers right, for example who didn't know the definition of communication or revealing the patient's responses to the nurses on the things they didn't do. In this study the questionnaires did ensure that no emotional tricking questions were included. The questionnaires were easy to answer, patients were made comfortable and wellbeing was checked by offering opportunity to ask questions afterwards. The registered nurses completed the questionnaires at their comfortable spaces and at own agreed time.

3.10.5 JUSTICE

The fundamental ethical principle to fair treatment is based on the ethical principle of justice which implies being fair and impartial (Burns & Grove, 2011). This principle was ensured in the study because the study subjects were all selected for the reasons directly related to the research, and not because they were readily available or could be easily manipulated (Brink, 2010). In this study, respondents of registered nurses were given the same questionnaire in order to ensure the principle of justice. All the patients were interviewed with same tool and all registered nurses were observed using the same checklist. The researcher ensured that any agreement made with the participants was also respected, for instance when is convenient time to collect the completed questionnaire from registered nurses.

3.10.6 ANONYMITY AND CONFIDENTIALITY

Anonymity means that no one, including the researcher, should be allowed to identify subjects afterwards. Anonymity was adhered to throughout this study, as subjects were not identified either by name or the ward where they were allocated or admitted. The results were also reported in frequencies and percentages, hence not able to indicate any subject specifically. Participants were assured that their information would be treated with strictest confidentiality and privacy. Therefore, the study documents were kept under lock and key (Matheson, 2007). No unauthorized person had access to the information. Participants' name did not appear on the instrument.

3.11 SUMMARY

The ended chapter presented an in-depth discussion of research methodology. The aim was to outline how the researcher approached the study from research design, research setting, population, sampling and sampling method, inclusion and exclusion criteria, data collection methods, data analysis and research ethics employed. Ethical issues of permission, informed consent, autonomy, beneficence and non-maleficence, justice, anonymity and confidentiality were discussed in this chapter.

CHAPTER 4: DATA ANALYSIS AND STUDY RESULTS

4.1 INTRODUCTION

This chapter presents the data analysis procedures that were used and the details of the findings of the research. Polit & Hungler (2013) identified the purpose of analysis as the organization of data, providing a structure for data and extracting meaning from data. Expressed another way, it can be said that the purpose of data analysis is to impose order on a large body of information so that it can be synthesized, interpreted and shared with others in a coherent manner.

Descriptive statistical analysis was used for the data obtained from all three research instruments. However, this will be presented in three folds, first will be the data from self-administered questionnaire by registered nurses, secondly from patients' interview and thirdly the observation checklist.

The study sample consisted of n=92 patients, n=67 registered nurses and 11 wards consisting of 4 main domains, namely orthopaedic, surgery, medical, gynaecology and 24 registered nurses were observed. All the patients and registered nurses sampled were able to respond to questions.

4.2 DATA MANAGEMENT AND ANALYSIS

Epi info version 3.5.4 was used to create data base, analyse and calculate the data. However, the researcher also ensured that data management and analysis procedure were followed.

4.2.1 DATA ENTRY, EDITING AND HANDLING

It's crucial for the researcher to make data entry and editing before data analysis. Therefore, the researcher checked whether every data file contained the necessary information before coding and transfer into computer. Although the researcher edited by checking information for consistency, omissions and legibility, no data was changed. Omitted data was recorded as missing, however this was minimal in occurrence or percentage.

A data base was created in Epi info version 3.5.4 for all three research instruments. This was to make the data entry easy and analysis legitimate. It was saved and only shared with an expert in the management and analysis of Epi info software.

4.2.2 DATA STORAGE AND DISPOSITION

The researcher used personal laptop with a password to ensure safety and security of data. In addition, a memory stick was kept to prevent loss of data in case of unforeseen circumstances

with the laptop. The paper based filled questionnaires were safely stored in inaccessible lockable cupboard.

4.3 STUDY RESULTS

As indicated earlier in this chapter, the results will be presented in three parts.

4.3.1 REGISTERED NURSES RESPONSES

The results were divided into three sections. Section A which presented the demographic data, Section B catered for objective 1, covering orientation, policies and procedures of the ward and Section C, components of communication, roles of registered nurse, interpersonal relationship, nurse- patient communication, factors influencing communication, patients' needs and communication techniques. Section C was to address objective 2 & 3.

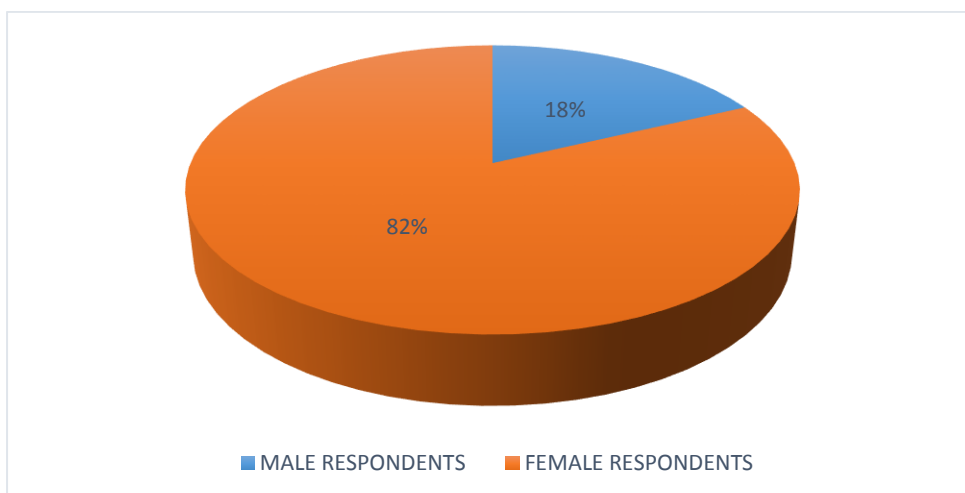
4.3.1.1 SECTION A, DEMOGRAPHIC DATA

The registered nurses who participated in the study were n=67. The demographic data that collected was gender, age, marital status, home language and ward

4.3.1.1.1 GENDER OF REGISTERED NURSES

From the retained questionnaires by registered nurses, females were n=55 (82%) and males n=12 (18%)

Figure 4.1 Distribution of respondents by gender (N = 67)

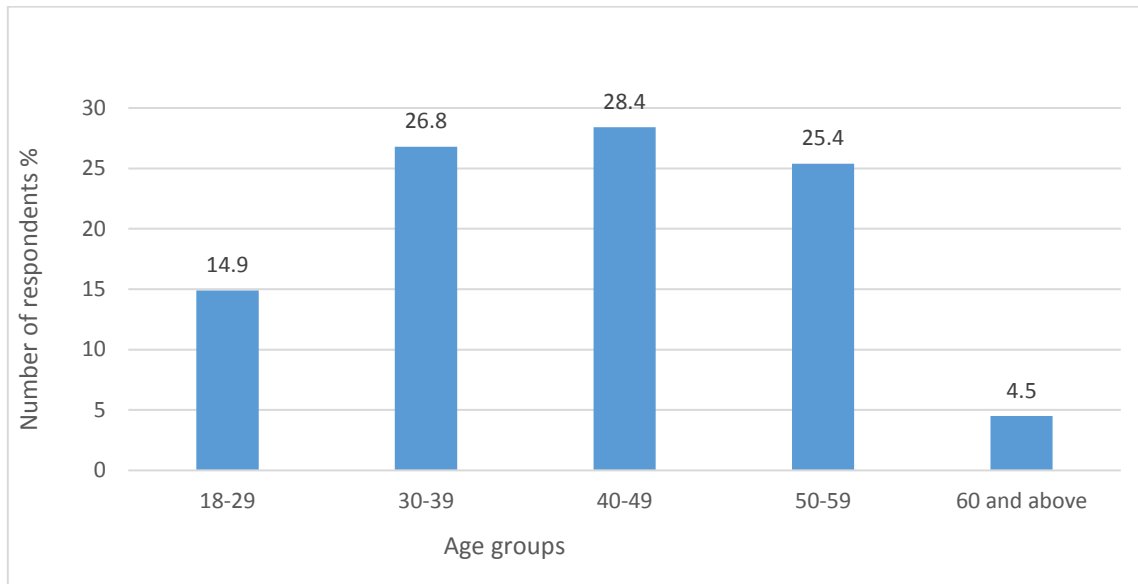


4.3.1.1.2 AGE OF REGISTERED NURSES

From the male and female respondents, the age distribution was, (14.9%) represented the age group between 18-29; (26.8%) represented the age group between 30-39; (28.4%) represented

the age group between 40-49; (25.4%) represented the age group between 50-59 and (4.5%) represented the 60 plus age group. The age distribution of the respondents shows that the highest age group was 40-49, and the lowest was 60 and above. The total mean age was 2.5970.

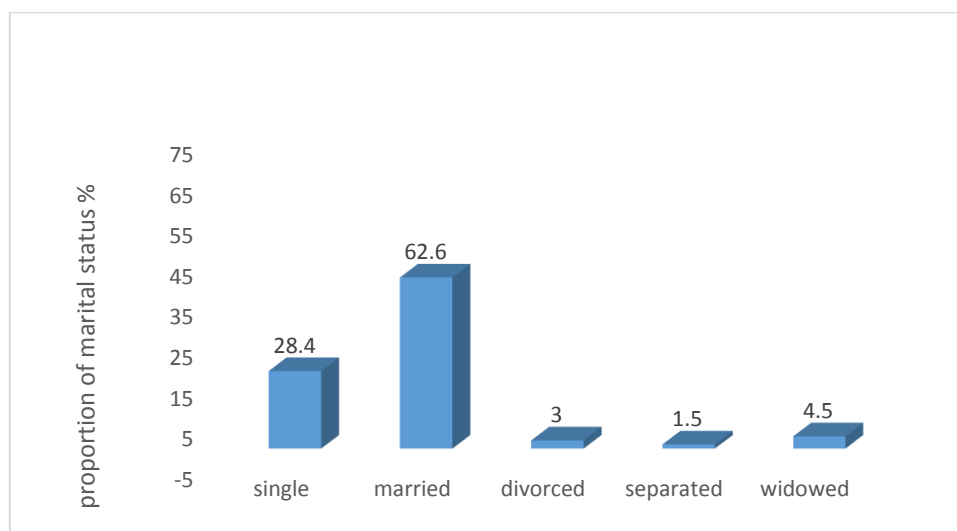
Figure 4.2 Age groups of the respondents (N=67)



4.3.1.1.3 MARITAL STATUS

In terms of marital status, it was highlighted by respondents that 19 (28.4%) were single, 42 (62.6%) were married, 2 (3.0%) were divorced, 1 (1.5%) were separated and 3 (4.5%) were widowed. The study results show that the majority of registered nurses were married, while only 1 separated.

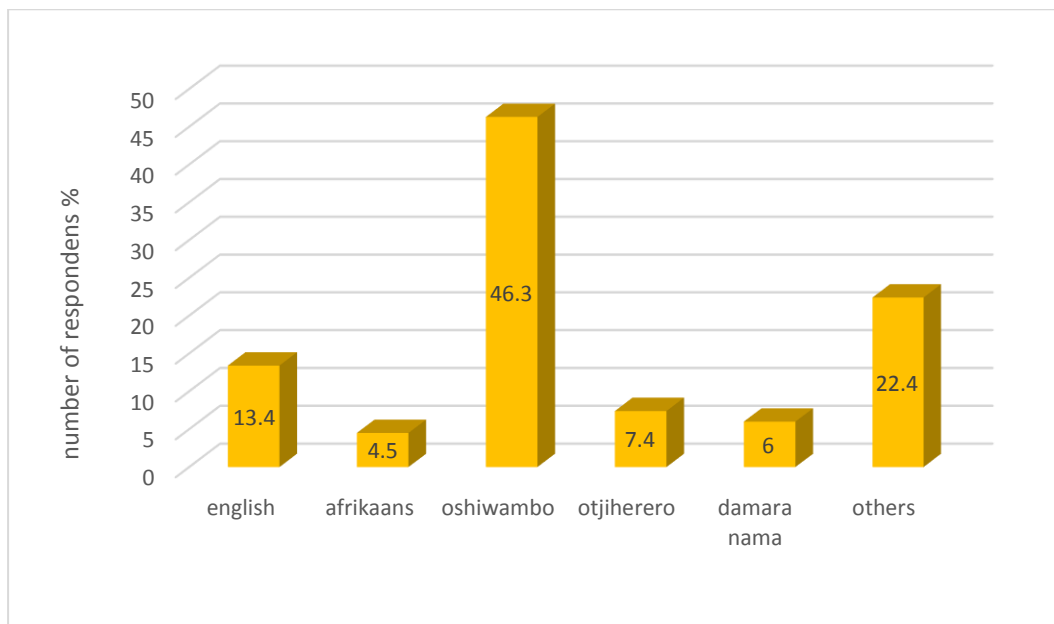
Figure 4.3: Marital status of registered nurses (N=67)



4.3.1.1.4 HOME LANGUAGE

Regarding the home languages of the respondents, the response from the participants was that 9 (13.4%) spoke English, 3 (4.5%) spoke Afrikaans, 31 (46.3%) spoke Oshiwambo, 5 (7.4%) spoke Otjiherero, 4 (6.0) spoke Damara Nama and 15 (22.4%) spoke other language including foreign languages. The study revealed that Oshiwambo speaking registered nurses were the most prevalent and Afrikaans speaking nurses were the fewest.

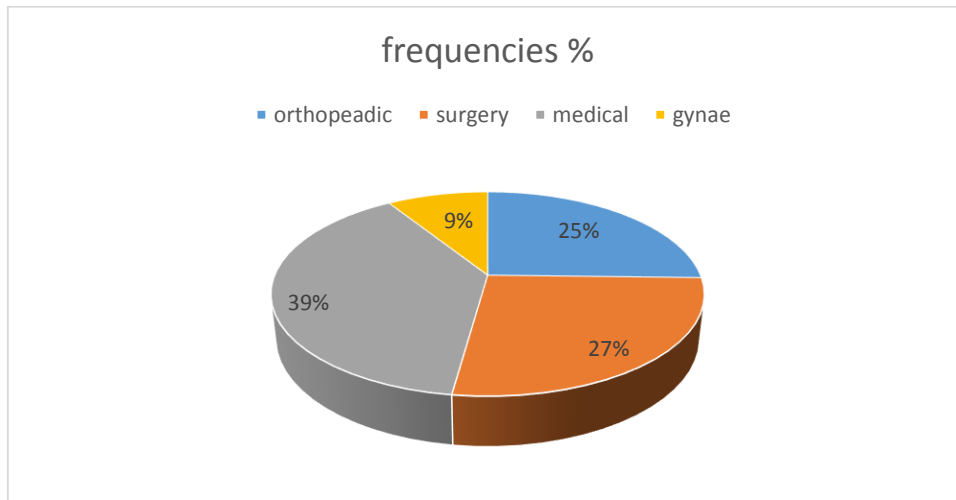
Figure 4.4: The numbers of respondents' home language (N=67)



4.3.1.1.5 WARD OF ALLOCATION

The study covered 4 main domains which consisted of n=11 wards where the study participant was based, namely orthopaedic 17 (25.4%), surgery 18 (26.8%), medical 26 (38.8%) and gynaecology 6 (9.0%). The study outcome showed that the most participants were from medical ward and the least from gynaecology ward.

Figure 4.5 the number of the registered nurses per allocation (N=67)

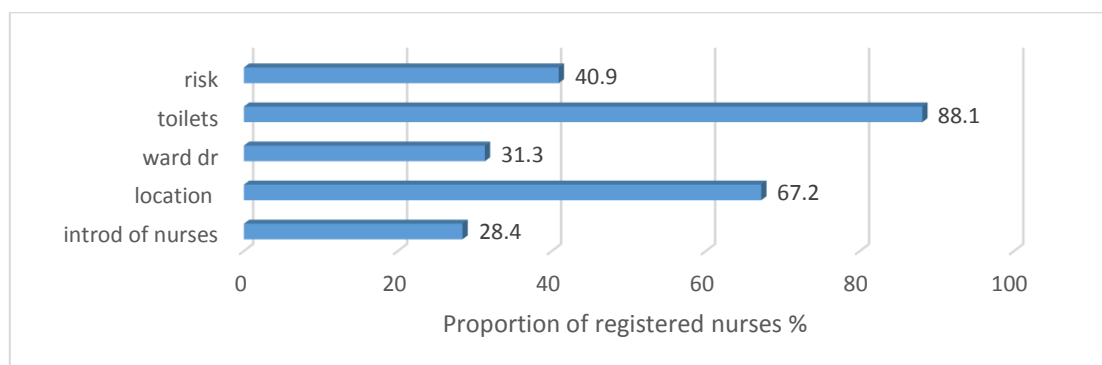


4.4 SECTION B: TO DETERMINE WHETHER PATIENTS ARE ORIENTED TO THE WARD DURING HOSPITALISATION

4.4.1 WARD ORIENTATION

The first question wanted to find out if nurses provided information to patients about location of the ward, ward doctor, toilets or bathrooms and Risks in wards. The proportion of nurses who said introduced themselves to patients was 19 (28.4%) whilst 48 (71.6%) said they did not. About providing general description of the ward to patients, 45 (67.2%) said yes they did provide whilst 22 (32.8%) said they did not. On informing patients of who the ward doctor was, 21 (31.3%) said they did whilst 46 (68.7%) said did not. About location of ward bathroom and toilet facilities, 59 (88.1%) said they informed patients whilst 8 (19.9%) said they did not. The last question was about informing patients of ward risks, 27 (40.9%) said they informed patients whilst 40 (59.1%) said they did not.

Figure 4.6 the proportion of registered nurses who orientated patients (N=67)



4.4.2 POLICIES AND PROCEDURE OF THE WARD

The second question sought to find out if nurses communicated their ward policies and procedures to patients. From the respondents, 31 (46.3%) said they communicated the bathing time whilst 36 (57.3%) said they didn't communicate. In terms of meals time, 40 (59.7%) said they communicated whilst 27 (40.3%) did not communicate. About communicating about doctor's ward rounds, 38 (56.7%) said they did communicate whilst 29 (43.3%) said they did not communicate. About procedures time, 31(46.3%) said they communicated whilst 36 (53.7%) did not communicate. On medication in the ward, 50 (74.6%) said they did communicate whilst 17 (25.4%) did not communicate. About the visiting time 60 (89.6%) said they communicated the visiting time whilst 7 (10.4%) did not communicate. On issues to do with smoking 53 (79.1%) said they communicated about smoking whilst 14 (20.9%) said they did not communicate and on alcohol use in the ward, 40 (59.7%) communicated whilst 24 (40.3%) said they didn't communicate with patients.

4.5 COMMUNICATION

This Section C covered various concepts that addressed the objectives 2 (To observe and describe the communication between registered nurses and patients at Intermediate Hospital Katutura) & 3 (To identify the factors which influence communication between registered nurses and patients at Intermediate Hospital Katutura).

4.5.1 COMMUNICATION

The knowledge of the communication concept is crucial to nursing, therefore the registered nurses were tested in terms of their knowledge on the definition of communication and the researcher found out that 55 (82.1%) answered correctly that communication is a process of sharing information verbally and non-verbally and 12 (17.9%) answered wrongly. In terms of how communicated messages were transmitted, 39 (60.9%) answered correctly that communicated messages are transmitted through sound, smell, taste, touch and sight; whilst 25 (37.3%) answered wrongly and (1.8%) did not answer. In trying to get how communication is done in nursing, 31 (46.3%) answered correctly that in nursing communication with patients is through speaking directly to patients, handing over reports, writing reports, and reading reports whilst 36 (53.7%) answered wrongly. In trying to get the skills in communication, 59 (89.4%) answered correctly that the skills of communication include active listening, reflection, acknowledging and summarizing except dominating whilst 7 (10.6%) answered wrongly and

1(1.5%) did not answer. In terms of reflection, 78.5% answered correctly that reflecting ensures nurses to focus on what has been said whilst 21.5% answered wrongly.

4.5.2 REGISTERED NURSES ROLES

The part 9 of the questionnaire wanted to find out on the roles of registered nurses. The role of nurses to ensure a safe therapeutic environment for the patients was agreed by 64 (98.5%), 1(1.5%) disagreed and 2 (3%) had no opinion.

On the other hand, 61(92.4%) agreed that their role was to make sure that the rights of patients was upheld whilst 3 (4.5%) disagreed, 2 (3%) had no opinion and 1(1.5%) did not answer. About the role of keeping abreast with new professional development, 49 (74.2%) agreed that they did so; 8 (12.1%) disagreed, (13.6%) had no opinion and 1 (3%) did not answer.

4.5.3 INTERPERSONAL RELATIONSHIP

In this section the interest was on establishing interpersonal relationship between the registered nurses, patients and their family. The registered nurses were given to rate it on Likert scale with strongly agree, agree, disagree and strongly disagree. From the first statement, it was important to establish a therapeutic relationship in nursing, 54 (80.6%) strongly agreed and 13 (19.4%) agreed respectively that therapeutic relationship in nursing was very important. The second statement was about expressing respect and attention to the patient by the nurse as necessary for the establishment of nurse-patient relationship, 44 (66.7%) strongly agreed and 21 (31.8%) agreed respectively. Only 1 (1.5%) disagreed with the statement. The third statement was that it is not part of their job description as nurses to establish a relationship with family of the patient, 1 (1.5%) strongly agreed, 9 (13.4%) agreed, 40 (59.7%) disagreed and 17 (25.4%) strongly disagree. The fourth statement was that being honest, respectful and explaining every nursing activity to the patient created trust, 42 (62.7%) strongly agreed, 24 (35.8%) agreed and 1 (1, 5%) disagreed. The fifth statement indicate that communication and interviewing skills were fundamental nursing tools, 32 (47.8%) strongly agreed whilst 34 (50.7%) agreed and 1 (1.5%) disagreed. The last statement was that both the patients and nurses learn as the result of therapeutic communication, and from this 15 (22.4%) strongly agreed, 50 (74.6%) agreed, 1 (1.5%) disagreed and 1 (1.5%) strongly disagreed.

Table 4.1: Frequencies on establishing interpersonal relationship (N=67)

Statement	Strongly agreed	Agreed	Disagreed	Strongly Disagreed	Missing
establishing therapeutic relationship is very important in nursing	54 (80.6%)	13(19.4%)	–	–	–
expressing respect and attention by the nurse is necessary for the establishment of a relationship	44 (66.7%)	21(31.8%)	1 (1.5%)	–	–
It is not part of the job description of nurses to establish relationship with family of the patient	1(1.5%)	9 (13.4)	40(59.7%)	17(25.4%)	–
Being honest, respectful and explaining every nursing activity to patients create trust	42 (62.7%)	24 (35.8%)	1(1.5%)	–	–
communication and interviewing skills remain fundamental nursing tools	32(47.8%)	34 (50.7%)	1 (1.5%)	–	–
Both patients and nurses learn as the result of therapeutic interaction	15 (22.4%)	50 (74.6%)	1 (1.5%)	1 (1.5%)	–

4.5.4 NURSE-PATIENT COMMUNICATION

These concepts were to explore more the communication between registered nurses-patients to understand how they associate with patients and the impact thereof. Questions for the registered nurses were structured through a Likert scale which was based on the following statements: good nurse-patient communication improves patients' health outcomes where 51 (76.1%) strongly agreed, 14 (20.9%) agreed, 2 (3.0%) disagreed. On spending time just talking to patients as having no nursing care value, 2 (2.9%) strongly agreed, 6 (9%) agreed, 43 (64.2%) disagreed; 14 (21.9%) strongly disagree and 2 (2.9%) did not answer. The other statement was that nurses have only enough time to focus on their daily routine duties and 15 (22.4%) strongly agreed, 18 (26.9%) agreed, 25 (37.3%) disagreed and 9 (13.4%) strongly disagreed. In terms of answering the patients' questions and their worries about their problems as the role of the

doctor, 2 (3.0%) strongly agreed, 21 (31.3%) agreed, 32 (47.8%) disagreed and 12(17.9%) strongly disagreed. Lastly, in terms of explaining procedures and test as the role of the doctor, 11(16.4%) strongly agreed, 35 (52.2%) agreed, 19 (28.4%) disagreed and 2 (3.0%) strongly disagreed.

Table 4.2: Frequencies on nurse-patient communication (N=67)

Statement	Strongly agreed	Agreed	Disagreed	Strongly disagreed	Missing
Good nurse-patient communication improves patients' health outcomes	51 (76.1%)	14 (20.9%)	2 (3.0%)	–	–
Spending time just talking to patients has no nursing care value.	2 (2.9%)	6 (9%)	43 (64.2%)	14 (21.9%)	2(2.9%)
Nurses have only enough time to focus on their daily routine duties	15 (22.4%)	18(26.9%)	25 (37.3%)	9 (13.4%)	–
Answering the patients' questions and their worries about their problems is the role of the doctor	2 (3.0%)	21 (31.3%)	32 (47.8%)	12(17.9%)	–
To explain procedures and test is the role of the doctor	11(16.4%)	35 (52.2%)	19 (28.4%)	2 (3.0%)	–

4.5.5 FACTORS INFLUENCING COMMUNICATION

The respondents were given opportunity to identify factors that influence communication by assessing themselves again using Likert scale. Ten factors were provided in this regard, namely; staff shortage contributes to poor communication with patients 52 (77.6%) strongly agree, 13 (19.4%) agree, 1 (1.5%) disagree; 1 (1.5%) strongly disagree.

Focusing on routine activities affects communication with patients negatively: 22 (32.8%) strongly agreed, 34 (50.7%) agreed, 10 (14.9%) disagreed; 1 (1.5%) strongly disagreed. The increased workload distracts nurses from giving patient individual attention 47 (70.1%) strongly agreed, 17 (25.4%) agreed, 3 (4.5%) disagreed.

It is very time consuming to give detailed explanations to patients 6 (9.0%) strongly agree, 32 (47.8%) agreed, 27(40.3%) disagreed; 2 (3.0%) strongly disagreed. Stress is caused by nurse being overwhelmed with number of patients 42 (62.7%) strongly agree, 19 (28.4%) agreed, 2 (3.0%) disagreed; 4 (6.0%) strongly disagreed. Non-supportive management affect communication with patient when staff needs are not met 28 (41.8%) strongly agreed, 32 (47.8%) agreed, 5 (7.5%) disagreed; 2 (3.0%) strongly disagreed.

Language and culture differences do not influence communication with patients 4 (6.0%) strongly agreed, 14 (20.9%) agreed, 35 (52.2%) disagreed; 14 (20.9%) strongly disagreed; patient educational level plays a role in ability to express his/her concerns 23 (34.3%) strongly agreed, 35 (52.2%) agreed, 4 (6.0%) disagreed; 5 (7.5%) strongly disagreed; fear and anxiety on the side of the patient inhibit communication 17 (25.8%) strongly agreed, 42 (63.6%) agreed, 3 (4.5%) disagreed; strongly disagree and the noise level in the ward affect communication with the patient negatively 15(22.4%) strongly agreed, 24 (35.8%) agreed, 24 (35.8%) disagreed; 4 (6.0%) strongly disagree.

Table 4.3: Frequencies of factors influencing communication (N=67)

Statement	Strongly agreed	Agreed	Disagreed	Strongly disagreed
Staff shortage contributes to poor communication with patients	52 (77.6%)	13 (19.4%)	1 (1.5%)	1 (1.5%)
Focusing on routine activities affects communication with patients negatively	22 (32.8%)	34 (50.7%)	10 (14.9%)	1 (1.5%)
The increased workload distracts nurses from giving patient individual attention	47 (70.1%)	17 (25.4%)	3 (4.5%)	–
It is very time consuming to give detailed explanations to patients	6 (9.0%)	32 (47.8%)	27(40.3%)	2 (3.0%)

Stress is caused by nurse being overwhelmed with number of patients	42 (62.7%)	19 (28.4%)	2 (3.0%)	4 (6.0%)
Non –supportive management affect communication with patient when staff needs are not met	28 (41.8%)	32 (47.8%)	5 (7.5%)	2 (3.0%)
Language and culture differences do not influence communication with patients	4 (6.0%)	14 (20.9%)	35 (52.2%)	14 (20.9%)
Patient educational level plays a role in ability to express his/her concerns	23 (34.3%)	35 (52.2%)	4 (6.0%)	5 (7.5%)
Fear and anxiety on the side of the patient inhibit communication	17 (25.8%)	42 (63.6%)	3 (4.5%)	4 (6.1%)
The noise level in the ward affect communication with the patient negatively (Noise level in the ward)	15(22.4%)	24 (35.8%)	24 (35.8%)	4 (6.0%)

4.5.6 PATIENTS' NEEDS

The registered nurses were required to rank patients' needs according to what they considered as most and least importance on a scale of 1 (represents most important) – 7 (represents least important). It consisted of seven variables, to be safe 41 (62.1%); that their information is kept confidential 15 (22.4%); to be treated with respect and politely 22 (32.8%); to be communicated to in a friendly and warm manner 20 (29.9%); to receive emotional support 16 (23.9%); to be pain free 21(31.3) and to understand their condition and treatment 16 (24.2%). The researcher took the highest percentage per variable where the researcher found out that most patients want to want to be safe and have their information kept confidentially.

4.5.7 COMMUNICATION TECHNIQUES

Part 13 of the questionnaire's aim was to find out if the communication techniques were being used properly. Therefore, the participants were requested to indicate how frequent they apply them when interacting with patients. In terms of listen attentively 26 (38.7%) said they did all the time; 33 (49.3%) said they often times listen attentively; 6 (9.0%) said not often did they listen attentively; 2(3.0%) said not at all did they listen attentively.

In terms of avoiding the use of medical terms, 39 (59.1%) said they avoided all the time; 21 (30.3%) said often times avoided the use of medical terms; 5(7.6%) said not often did they avoid; 2(3.0%) said they rarely avoided; 1(1.5%) said not at all did they ever avoided the use of medical terms.

When it comes to aaccommodating patient's words, 25 (37.3%) said they did all the time; 16 (23.9%) said they often times accommodate, 1(1.5%) said not at all did they accommodate patient's words, 21 (31.3%) said not often did they accommodate patient's words and 4(6.0%) said they rarely accommodate.

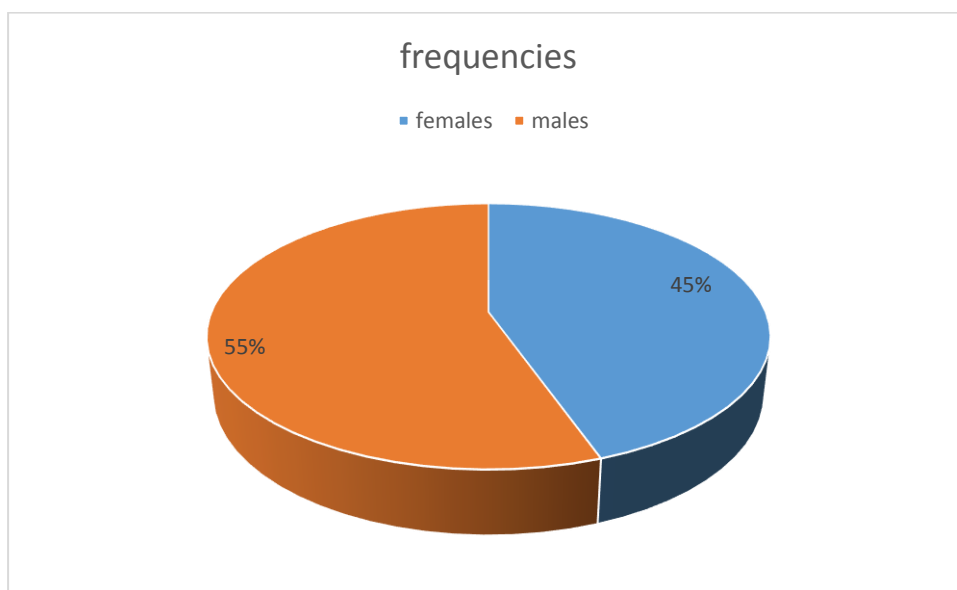
4.5.8 PATIENTS RESPONSES

Patients' data set were presented in the similar way of the registered nurses analysis. The importance of that were for easily comparison in the discussion chapter of the findings. The patients were n=92 who participated in the study. The demographic data set were consisting of the following variables: gender, age, marital status, employment status, educational level, home language, the ward and days in the ward.

4.5.9 GENDER

The study outcome shows that the males were 51 (55.4%) and female 41 (44.6%)

Figure 4.7: Frequencies of patient's gender respondents (N=92)



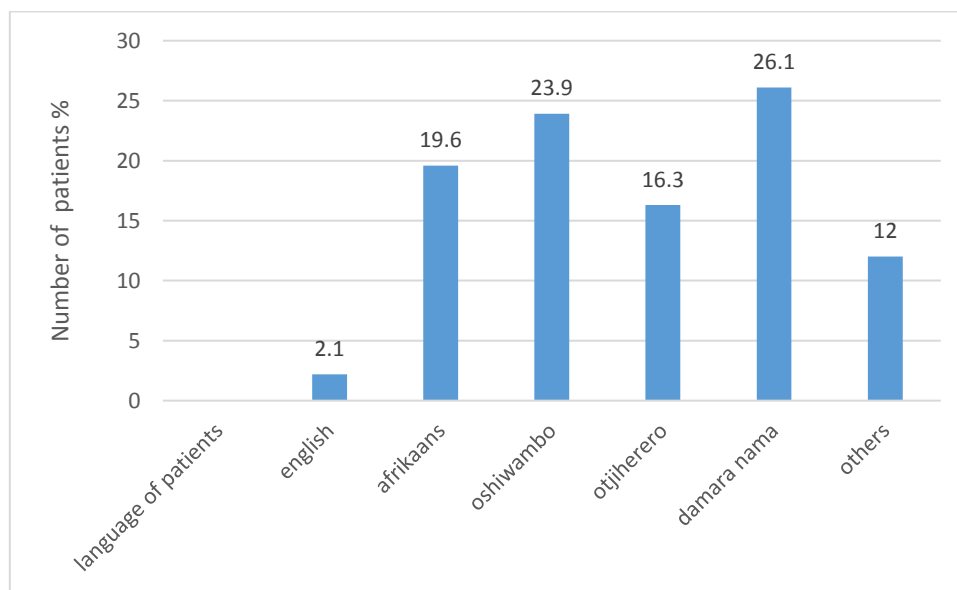
4.5.10 AGE

The age group for the patients study outcome was categorical as follows, those in the age group of 18-29 were 21 (23%), those in the age group of 30-39 were 16 (17.3%), those in the age group of 40-49 were 17 (18.4%), those in the age group of 50-59 were 27(29.3%) and those in the age group of 60 and above were 11 (12.0%). The age distribution of the respondents shows the highest age group was 50-59, and the lowest was 60 and above.

4.5.11 HOME LANGUAGES

The home languages of the patients in the study sample were; English 2(2.1%), Afrikaans 18 (19.6%), Oshiwambo 22 (23.9%), Otjiherero 15 (16.3%), Damara Nama 24 (26.1%) and others which constituted foreigners was 11 (12.0%). The study reveals that Damara Nama speaking patients were the most prevalent group and English speaking patients were the fewest.

Figure 4.8: Languages spoken by patients (N=92)



4.5.12 WARD ADMITTED

The study had 4 main domains which consisted of n=11 wards where the study participant were admitted, namely orthopaedic 24 (26.1%), surgery 26 (28.2%), medical 32 (34.7%) and gynaecology 10 (11%). The study outcome showed that the most participant were from medical wards and the least from gynaecology ward.

4.5.13 DURATION OF STAY IN THE WARD

The participants were requested to inform their duration in the ward, 36 (39%) said they stayed for a period of about 3-5 days, 55 (60%) said they stayed for 6 or more days and 1(1%) didn't know how many days he/she stayed in the ward. The high proportion of patients (60%) had been in the ward for 6 days and more.

4.6 SECTION B

Section B of the patients' questionnaire was to find out from them whether they have been oriented and informed about wards activities. Thus to confirm from them whether basic communication took place. These section was to cater for objective 1, which was to find out whether patients were oriented about the ward during their hospitalization.

4.6.1 ORIENTATION TO THE WARD

This section indicates the patient's responses about orientation in wards. The variables for orientation to the ward were introduction of the nurses, which recorded 86 (93.5%) of the patients who responded with a no whilst only 6 (6.5%) responded with a yes. In terms of patients receiving information about the location of their ward, 54 (58.7%) responded with a no whilst 38 (41.3) responded with a yes. On whether patients received information about the ward doctor, 83 (90.2%) responded with a no whilst 9 (9.8%) responded with a yes. In terms of getting information about the toilets / bathroom, 62 (67.4%) said they did not get whilst 30 (32.6%) said they did get information about the toilets and bathrooms. About the risks in the ward (medico legal hazards) 74 (80.4%) said they were informed whilst 18 (19.6%) were informed. The table below indicate the full results.

Table 4.4: Rating of patients to ward orientation

STATEMENT	RATING	FREQUENCY
Introduction of nurses	Yes	6 (6.5%)
	No	86 (93.5%)
Location of the ward	Yes	38 (41.3%)
	No	54 (58.7%)
Ward doctor	Yes	9 (9.8%)
	No	83 (90.2%)
Toilets/bathroom	Yes	30 (32.6%)
	No	62 (67.4%)
Risk in the ward	Yes	18 (19.6%)
	No	74 (80.4%)

4.6.2 POLICIES AND PROCEDURES OF THE WARD

It's important that the patients are informed about the times that certain activities would take place and what isn't allowed in the ward. The variables were bathing time, meals time, doctors ward rounds, procedure time, medication in the ward, visiting time, smoking and alcohol use in the ward. The high trend of the result was a no, see the table below.

Table 4.5: Frequency of policies and procedures (N=92)

VARIABLES	RATING	FREQUENCY
Bathing time	Yes	11 (12.0%)
	No	81 (88.0%)
Meals time	Yes	8 (8.7%)
	No	84 (91.3%)
Doctors ward rounds,	Yes	16 (17.4%)
	No	76 (82.6%)
Procedure time	Yes	8 (8.7%)
	No	84 (91.3%)
Medication in the ward	Yes	17 (18.5%)

	No	75 (81.5%)
Visiting time	Yes	29 (31.5%)
	No	63 (68.5%)
Smoking	Yes	19 (20.7%)
	No	73 (79.3%)
Alcohol use in the ward	Yes	14(15.2%)
	No	78 (84.8%)

4.7 SECTION C: NURSE-PATIENT COMMUNICATION

In this section, the objective was to explore the communication between patients ‘and registered nurses, and to determine how they observed the interaction with the registered nurses in an attempt to identify factors that influence the communication, to rank their needs and to indicate the frequency of communication techniques employed by nurses in the ward.

The variables were 12, close ended questions, with option to choose between Yes/No. The first question was to find out if there was a shortage of nurses and 86(93.5%) said yes there was whilst 6 (6.5%) said no. The second question asked if patients thought that the shortage of registered nurses affected their workload and 86(93.5%) said yes it affected whilst 6 (5%) said no it wasn’t. The fourth question asked if patients thought that nurses focused more on their daily routine more than individual patient care and 87 (94.6%) said yes they did whilst 5 (5.4%) said no they didn’t. The fifth question asked if patients were treated with respect by the registered nurses, 91 (98.9%) said yes they were whilst 1 (1.1%) said no they were not being treated with respect. The sixth question asked if patients understood the language used by the registered nurse and 64 (69.6%) said yes they did whilst 28 (30.4%) said no they didn’t.

The seventh question asked if patients were attended to differently due to their culture and the majority 83(90.2%) said no whilst 9 (9.8%) said yes they were attended in a different way. The next question asked if the patients’ family was interfering with the registered nurses’ duties and the majority 85(92.4%) said the family was not interfering whilst 7 (7.6%) said their families were interfering. The other question was if the noise levels affected patient’s communication with the registered nurses and 89(96.7%) said no it didn’t affect whilst 3 (3.3%) said yes it affected. The ninth question asked about patient’s privacy if it was respected and

80(87.0%) said yes their privacy was being respected whilst 12 (13%) said their privacy was not being respected. The next question asked if the registered nurses explained procedures to patients and 57(62.0%) denied saying the procedures were not explained to them whilst 35 (38%) said the procedures were being explained. The next question asked if patients got feedback from the registered nurses on procedures done and 71(77.2%) said no they didn't whilst 21 (22.8%) said yes they did. The last question asked if the registered nurses spent enough time to attend to all patients' needs, but the majority 69(75.0%) said no they didn't whilst 23 (25%) said yes they did.

Table 4.6: Patients perspectives and experience regarding nurse-patient's communication (N=92)

STATEMENT	YES n= (%)	NO n= (%)
shortage of registered nurses	86(93.5%)	6 (6.5%)
shortage of registered nurses affects their workload,	86(93.5%)	6 (6.5%)
focused more on their daily routine more than individual patient care ,	87(94.6%)	5 (5.4%)
were you treated with respect by the registered nurses	91(98.9%)	1(1.1%)
did you understand the language used by the registered nurse	64(69.6%)	28 (30.4%)
were you attended to differently due to your culture	9(9.8%)	83(90.2%)
did you observe your family interfering with the registered nurses' duties	7 (7.6%)	85(92.4%)
did the noise levels affect your communication with the registered nurse	3 (3.3%)	89(96.7%)
was your privacy respected	80(87.0%)	12 (13.0%)
did the registered nurse explain procedures to you	35 (38.0%)	57(62.0%)
did you get any feedback from the registered nurse on your procedures done	21 (22.8%)	71(77.2%)
did the registered nurses spend enough time to attend to all your	23 (25.0%)	69(75.0%)

4.7.2 PATIENTS NEEDS RANKING

The patients were requested to rank their needs from most important which is number 1 to the least important which is number seven. The patients ranked the most important was to be communicated in a friendly manner 46(50.0%), to be pain free 35(38.0%), to be treated with respect 27(29.3%), to be safe 25(27.2%) and that their information is kept confidential was the least important 24(26.1%). The table below indicate the full outcome.

4.7.3 COMMUNICATION TECHNIQUES EMPLOYED BY REGISTERED NURSES

Four communication techniques were listed to be ranked from all the time, often, not often, rarely and not at all. The highest frequency per statement that was indicated by respondents were as following: In terms of nurses listening attentively, 33(35.9%) of the patients said they were not often given the opportunity to express their concerns without interruptions, 24 (26.1%) said they often got the chance, 8 (8.7%) said they rarely got the chance and 1 (1.1%) never got the chance. When it comes to avoiding medical terms, 25 (27.2%) said nurses tried all the times to simplify the medical terminologies, 29 (31.5%) said they often avoided, 28 (30.4%) said they did not often avoid, 9 (9.8%) said they rarely avoided the use of medical terms and 1 (1.1%) said they never avoided the use.

Table 4.7: Frequency of registered nurses using the communication techniques (N=92)

Technique		Frequencies					
	All the time	Often	Not often	Rarely	Not at all	Missing	
Listen attentively	24(26.1%)	26(28.2%)	33(35.9%)	8(8.7%)	1(1.1%)	-	
Avoid medical terms	25(27.2%)	29(31.5%)	28(30.4%)	9(9.8%)	1(1.1%)	-	
Illustrate	4(4.3%)	7(7.6%)	4(4.3%)	10(10.9%)	67(72.8%)	-	
Reassurance	8(8.8%)	13(14.3%)	14(15.4%)	11(12.1%)	45(49.5%)	1(1.1%)	

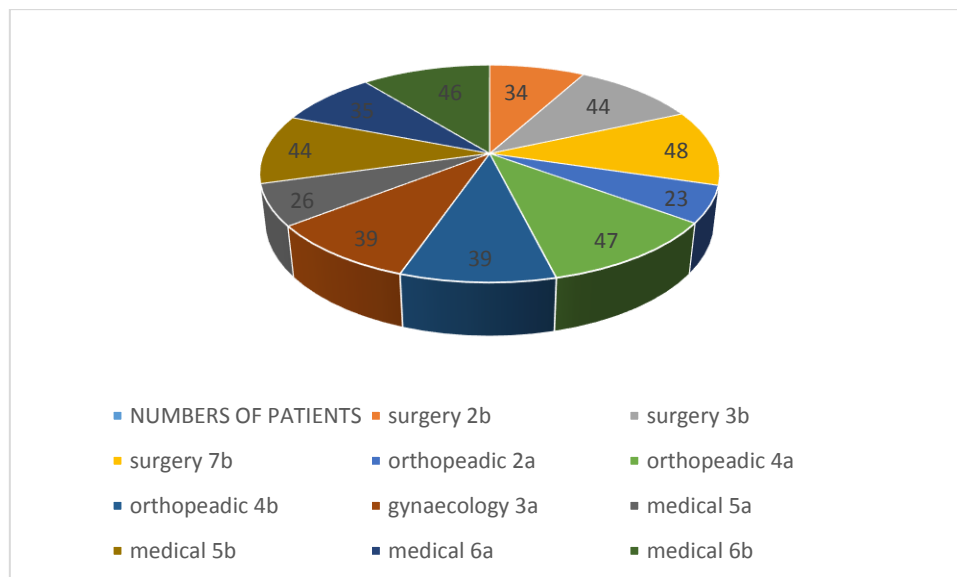
4.8 THE OBSERVATION CHECKLIST

The observation checklist consisted of 4 sections. All four main medical domains consisting of 11 wards with 24 registered nurses found on morning shift were observed for three hours in each ward during the morning hours.

4.8.1 SECTION A: THE WARDS

The number of patients in the wards varies between minimum 23 in 2A (orthopaedic), maximum 48 in 7B (surgery), the median was 39, mean 38.6 and STD 8.4. The number of patients found in the ward on day of observation: 2A: 23, 2B 34, 3A 39, 3B 44, 4A 47, 4B 35, 5A 26, 5B 44, 6A 35, 6B 46 and 7B 48. The number of patients per room in a ward were ranging lowest from 4 in 5A (medical) and highest of 8 in 6B (medical). The time spend in a room by registered nurse did ranged between 20-45 minutes, minimum was 15, median 25, maximum 45 and mode 20. The prevalent number of registered nurses on duty per ward were 2, which presented 18(75%) and only 2 wards had 3 registered nurses 6(25%). In total was 24 registered nurses observed.

Figure 4.9: Number of patients in different wards (n=11)



4.8.2 SECTION B: NURSING ACTIVITIES

This section investigated the activities of nurses during the orientation phase of patients. The activities were assessed using an observation checklist. The variables were observed by ticking between options of Yes, No or other, where the researcher made routine rounds in all 11 wards in which she found 24 registered nurses and observed their activities. Regarding admission of patients in the wards, 11 (100%) the activity was observed being conducted. Operations/ theatre procedures were observed in 7 (64%) wards whilst in 4 (36%) wards were seen not conducting them. With regards to greeting of patients 23(96%) of the registered nurses were seen greeting patients whilst 1 (4%) didn't greet. In all 11 wards the handover of report at bedside and review

of records was done by all 24 (100%) registered nurses. However, report writing was minimally done by 3 (12.5%) registered nurses, while the remaining 21(87.5%) were not writing. The explaining of procedures before asking the patient's consent was seen done by 4(17%) registered nurses, 20(83%) were seen not conducting the procedure.

Table 4.8: Nursing activities

VARIABLES	YES	NO
admission of patients in the ward	11(100%)	-
operations/ theatre procedures was observed	7(64%)	4(36%)
greeting of patients	23(96%)	1(4%)
handover of report at bedside	24(100%)	
review of records	24(100%)	
report writing	3(12.5%)	21(87.5%)
explaining of procedures before asking the patient consent,	4(17%)	20(83%)

4.8.3 SECTION C: COMMUNICATION

This section had six statements which was observed on communication in all 11 (100%) wards. Firstly, on whether the registered nurses addressed patients by names 24(100%) of them were seen conducting it. Regarding applying listening skills and probing questions 23 (96%) were seen not doing that whilst only 1 (4%) was seen doing it. About offering patients opportunity to ask questions, 24 (100%) were seen not doing that. Regarding the willingness to answer patients questions 6(25%) were positively seen doing it whilst 18 (75%) were seen not doing it. Regarding referring of patients concerns to doctors 23(96%) were positively seen doing that whilst 1 (4%) were seen not doing that. and to show understanding by summarising was not observed done by registered nurses 24(100%). The criteria to indicate Yes/No was: for yes if the registered nurses have been observed doing it on 3 out of 5 patients found in the room. No was when not observed or done only to one patient among the patients in the room.

Table 4.9: Communication skills (n=24) observed

Skill	YES	NO
addressed patients by names	24 (100%)	-
applying listening skills and probing questions	1 (4%)	23(96%)
offering patients opportunity to ask questions	-	24(100%)
willingness to answer patients questions	3(12.5%)	21(87.5%)
referring of patients concerns to doctor	23(96%)	1(4%)
show understanding by summarising	-	24(100%)

4.9 SECTION D:

4.9.1 COMMUNICATION FRAMEWORK

This section sought to investigate if the wards had some communication frameworks available in each ward of the 11 sampled wards.

The researcher found that the public service charter was in 8(72.7%) wards and was not seen in 3 (27.3%) wards. The patient charter was found in 6(54.5%) wards, whilst 5(45.5%) wards did not have it. The scope of practice for registered nurses was found in 9(81.8%) wards, whilst it was not seen in 2 (18.2%) wards. The communication book was available in 10 (90.9%) wards, whilst 1(9.1%) did not have it. The ward policy was found in 7(63.6%) wards, whilst 4(36.4%) wards did not have it. The ward procedures list was seen in 9(81.1%) wards whilst, 2(18.2%) wards did not have and suggestion boxes were found in 5(45.5%) and were not found in 6(54.5%) wards.

4.9.2 COMMUNICATION TECHNIQUES

Four techniques of communication were observed on a scale of all the time, often, not often, rarely and not at all. This scale had ratings ranging from 5 (All the time) being the highest to 1 (not at all) being the least. The results show that listening attentively and offering patients opportunity to express their concerns was rated 3 (not often) from 22 (91.7%) registered nurses and rated 3 (often) from 2(8.3%) registered nurses. The avoidance of medical terms during interaction was rated 5 (all the time) from registered nurses 22(79%) and rated 4 (often) from 2 (21%) registered nurses. The illustration with pictures/posters to clarify verbal explanation

was rated 1 (not at all) from 19 (79%) registered nurses and rated 2 (rarely) from 5(21%) registered nurses. Asked to play back was rated 3 (not often) from 2 (8%) registered nurses, rarely from 11 (46%) and not at all from 11 (46%).

Table 4.10: Frequency of communication technique applied (N=24)

Technique	All the time (5)	Often (4)	Not often (3)	Rarely (2)	Not at all (1)
listening attentively	-	2(8.3%)	22(91.7%)	-	-
avoid medical terms	19(79%),	5(21%),	-	-	-
illustrate with pictures/ posters	-	-	-	5(21%),	19(79%),
Ask to play back	-	-	2(8%)	11(46%)	11(46%),

4.10 SUMMARY

This chapter presented the outcome of a descriptive, cross sectional study about the factors that influence communication between registered nurses-patients at Intermediate Hospital Katutura. The respondents were N=159 in total, consisting of registered nurses N=67 and patients N=92. In addition, observation checklist was used in N=11 wards to 24 registered nurses. The data was presented in graphs, charts and tables. Epi Info version 3.5.4 was used to analyse the data. The observation checklist data was mainly done descriptively and tables used.

CHAPTER 5: DISCUSSIONS, CONCLUSION, RECOMMENDATION AND LIMITATIONS

5.1 INTRODUCTION

This chapter presents a full discussion of the data presented and analysed in chapter 4. Hence is the last chapter of the research that was conducted on “The factors that influence communication between registered nurses-patients at Intermediate Hospital Katutura “. Descriptive statistical analysis was mainly used to analyse data from the registered nurses, patients and the observation checklist. In addition, previous studies findings were used to concur or disagree with the outcome of this research. Finally, conclusion and recommendation was made. The objectives of the study were to find out whether the patients are oriented about the ward during their hospitalization, to observe and describe the communication between registered nurses and patients and to identify the factors that influence communication between registered nurses and patients at Intermediate Hospital Katutura.

5.2 DISCUSSION

This chapter presents the discussion of the data analysed obtained from three data sets, which consisted of self-administered questionnaires of the registered nurses, researcher administered patient questionnaires and observation checklist. This study offers the first kind of data on factors that influence communication between registered nurse-patient at Intermediate Hospital Katutura, Khomas region, Namibia. From the previous studies done in the country none had addressed this specific topic, although some had identified the fact that was problems of poor communication among the nurses. It also helped to identify the current gap in patients’ orientation and factors that contribute to ineffective communication between registered nurses-patients. Hence the need to identify the gap to ensure future safe nursing care.

5.2.1 SECTION A: DEMOGRAPHIC FOR REGISTRED NURSES

The study revealed that the female registered nurses are more prevalent to males. This finding isn’t unusual as nursing profession is traditionally regarded as female profession. In Turkey, there are also more female nurses than males (Ozdemir & Tunk, 2008). Ross (2017) attributes high proportion of female nurse into nursing profession from the founder of nursing Florence Nightingale being a female.

The age distribution indicated or reflected maturity of the registered nurse to disseminate information to patients under their care and to initiate communication process.

There was a difference in the home language spoken by nurses and patients. The study found that Oshiwambo speaking registered nurses were the most predominant group, while Damara Nama speaking patients were the most predominant group. Damara/ Nama language is generally a difficult language, which spoken rarely by other groups, hence a high chance/potential for miscommunication.

5.2.2 DEMOGRAPHIC DATA OF PATIENTS

Subsequently, patients were also assessed for their educational level. A large proportion of patients' attended school up to secondary level. Therefore, it can be seen that the majority of patients could interact with registered nurses in English because secondary education is English in Namibia. This gives the assumption that, both patients and nurses had sufficient education to be able to bridge the communication gap between them. This concurs with a research by (Longmani et al., 2014) that nurses tended to have a good therapeutic communication with patients who had a bit educational background.

The highest proportion of patients who have been in the ward for 6 days or over were (60.4%). In medical and surgical wards, with respect to length of stay in the hospital, there seems to be no significant difference between the proportions of patients who stayed for less than 5 days compared to those who stayed for more than 6 days. However, a trend from the study sample is suggestive that a higher proportion of patients are admitted in the hospital for longer, that's for 6 days or more in both gynaecological and orthopaedic wards. Hence, it can be concluded that the length of stay was sufficient days to build a therapeutic relationship between them and registered nurses. Although, underlying principles of the therapeutic relationship are the same regardless of the length of the contact (Belcher & Jones, 2009).

Regarding home language, the study can allude that most patients spoke their native language and this can be a cause of miscommunication. These findings are supported by Albagawi (2014) who alluded that studies of key communication barriers to providing culturally and linguistically appropriate care found that language and cultural differences remain the greatest impediments to effective communication. Nurses need to interact sensitively, effectively and professionally when communicating with patients from diverse racial and ethnic backgrounds

5.3 SECTION B:

5.3.1 ORIENTATION OF PATIENTS DURING HOSPITALIZATION

The information that was to be determined was grouped under ward orientation, policies and procedures of the ward. Patients tend to be more relaxed when they know whom they are dealing with, which also enable them to recognize the professional expertise of the nurses (Bramhall, 2014). Therefore, knowing the registered nurse by name creates a safe and supportive atmosphere that's essential for making a personal connection, fostering trust and collaboration (Windover *et al.*, 2014). As a result of this interaction, it creates a comfortable environment which leads to establishing a trusting relationship. According to Kourkouta & Papathanasiou (2014), the nurse, who wants to create the right relationship with the patients, must win him/her from the first moment. The study revealed according to registered nurses claim that orientation of new patients when admitted to the hospital was done regularly and that they always introduce themselves. According to the answers of 71.6% patients this hardly ever happens hence, introduction of nurses' plays an important role in this regard, but in this study it was poorly done.

Location of the ward, the patients indicated a lower occurrence of 38(41.3%) being informed about it, contrary to 45(67.2%) registered nurses who claimed to impart this information to the patients. The processes of being admitted in the hospital may cause anxiety to patients, this may be increased if the environment is not familiar (Gullich, Ramas, Zan, Scherer & Mandoza-Sassi, 2013). If the patients are not made comfortable by being informed where they are admitted, it may create sense of not belonging. Peplau theory indicate the need for sense of belonging to be important in the identification phase to reduce helplessness and hopelessness. Therefore, this unnecessary anxiety can be eliminated, if registered nurses take measures to ensure that all patients are introduced to their new environment. It is proven that once the patients are oriented to the ward, they tend to relax more and adjust easily to the new environment (Perry, Potter, Stockert & Hall, 2013).

On whether the registered nurses informed the patients about the treating ward doctor, the patients were highly in disagreement. This may be contributed to the fact that Intermediate Hospital Katutura is a training institution, the team of doctors can be confusing for someone who is not familiar with the set up. Because there are sometimes too many doctors in a team ranging from specialist to medical students. Additionally, medical officers, medical interns and medical students do rotate at predetermined intervals, this can also contribute that registered

nurses themselves may not know who the new treating doctor is. The other reason that cause patients not to know their treating doctors is the inter-departmental and specialization referrals.

Toilets/ bathroom facilities is a necessity for humans to respond to nature demands of excretion. Again the outcome of this study shows a high discrepancy of what the registered nurses 59 (88.1%) claim to be doing, compared to patient's response 30(32.6%) of those being informed/ shown the whereabouts of the ablution facilities.

The risks in the ward (medico legal hazards) are part of any health environment. Therefore, is necessary that patients to be alerted on possible risk in the wards. However, the outcome of the data analysed showed a lower level of patients were informed. In support of this finding, Perry et al., (2013) alluded the importance of imparting knowledge of risks in the wards to decrease patients' anxiety and complications, which will ensure patients safety. Raveesh, Nayak & Kumbar (2016), they clearly stated that the hospital has a liability to provide a safe and suitable environment for treatment. Patient safety is defined as the prevention of harm to patients, whereby errors are prevented, learns from errors that did occurred and built on culture of safety that involved health care professionals (Mitchell, 2008).

5.3.2 POLICIES AND PROCEDURES OF THE WARD

This subsection was poorly done by registered nurses according to the patients. Worth noting here is the researcher experience during interaction with the patients who mostly indicated that they just observed/ noticed themselves the time intervals of ward policies and procedures. Hence, maybe the huge variation in the responses of registered nurses and patients.

Bathing time outcome did imply that patients were poorly informed on possible times they are expected to take a bath.

Procedure time had the same pattern of registered nurses rating themselves high n=31(46.3%) against the low ratings of patients n=8(8.7%). This means that patients aren't prepared on times they can expect to be attended in the ward for different activities such as observations/ wound dressings.

Medication dispensing times in the wards shows again extreme variation in frequencies of registered nurses and patients. The probable explanation here maybe that the registered nurses may have missed the point of informing the patients about the intervals or times the medications are administered to administering of medications to patients.

Visiting time outcome were also of unexplained trend, (89.6%) registered nurses claiming of communicating this important social activity availed to patients to interact with their loved ones. However, the patients had a different encounter or experience, which mostly they learned on their own through co- patients or notices at the doors.

Smoking is prohibited in public places in Namibia and is also a national concern due to its health risks. Hence a public health concern. This study outcome indicated that patients are not adequately informed about smoking in the hospital, as only n=19 (20.7%) could respond positively. Although (59.7%) registered nurses claimed to talk about it. This is probably also mistaken by registered nurse with a standard question on clinical record asking the patient whether he/she is smoking. This clinical record is completed at admission for all patients admitted in the ward. These results concur with Frydman (2011) who made an investigative study at Kenya's State Hospital where he found that nurses were only basing on wall stickers which communicated the prohibition of smoking. They rarely spoke to patients concerning smoking and how it had negative effects.

5.4 SECTION C: COMMUNICATION

This section will consist of data analysis derived from all three data sets to cover for objective 2 & 3.

5.4.1 COMMUNICATION CONCEPT

The study outcome on this concept showed that the registered nurses were knowledgeable about communication concepts according to their responses. An interesting result on how most nurses are communicating with patients was indicated by n=31(46.3%) that they only speak directly to patients. A worrisome outcome from the registered nurses was that they didn't regard handing over reports, writing reports and reading reports is part of communicating with the patients. According to Eggins & Slade (2015) clinical handover is by definition an inherently communicative event to transfer professional responsibility and accountability of patient care to another person.

5.4.2 INTERPERSONAL RELATIONSHIP

The results from the part of the questionnaire on interpersonal relationship show that the registered nurses were well oriented on how to establishing a therapeutic relationship with patients. See table 4.1. Peplau theory clearly state that establishment of the nurse-patient relationship is a conscious commitment on the part of the nurse to care for a patient. Therefore,

they should work together for the good outcome of patients nursing needs. The importance of creating therapeutic relationship is supported by Dithole (2014) that communication is an integral part of nursing practice because nurses communicate with patients not only for therapeutic reasons such as providing reassurance, discussing feelings and emotions, but also for sharing information and for advice and counselling.

The results as well showed that expressing respect and attention by the nurse is necessary for the establishment of a relationship between nurses and patients. Respect is a fundamental issue when dealing with patients. Patients in some cases are well grown up and matured people who look for nurses who can respect them and require much attention. This is in conjunction with Dithole's (2014) that, the dignity of patients' needs to be respected through communication. Communication is a vehicle through which rapport between nurses and patients is developed and maintained.

Being honest, respectful and explaining every nursing activity to patients create trust as alluded by respondents. In Saudi Arabia, a notable aspect of the focus group discussions was a belief that many Saudi patients preferred the international nurses since they felt they could trust them more, as the international nurses were perceived to abide by more ethical and professional conduct. From the participant's perspective, this had a positive effect on the Saudi patients, as they commented that the foreign nurses were very nice people with whom they could communicate freely (Albagawi, 2014). Patient's families begin to trust nurses with their relatives whenever there is honesty and respect in communication. Loghmani et al., (2014) in their study in Kerman, Iran concurs that, communication with the families causes that they trust you.

5.4.3 NURSE-PATIENT COMMUNICATION

Regarding nurse-patient communication, a high proportion of registered nurses n=51(76.1%) strongly agreed that good nurse-patient communication improves patients' health outcomes. This was a good outcome, as the study interest was that a higher percentage of them should strongly agree on statement and that was a good indication that they are aware of the impact of the good nurse-patient communication.

The statement "Spending time just talking to patients has no nursing care value" also show positive outcome as most of the registered nurses disagree with it. Meaning that they value the time they spend with patients, because time spent talking with patients is also important when working with patients (Belcher & Jones, 2009). Previous studies indicated a positive

association between the amounts of time nurses spent with patient, as well patient outcomes and safety (Armstrong, Rispel & Penn-Kekana, 2015). Thus time spent with patients has a quality implication for care and satisfaction. Patients expect nurses to spend time with them and their presence is one of the major dimensions of actual care (Kalyani, Kashkooki, Molazem & Jamshidi, 2014). In addition, the presence of nurses by the patient's bedsides leads to patients feeling of security and tranquillity (Molazem & Ahmadi, Mohammadi & Bolandparvaz, 2011). Therefore, spending time with patient has high value to patient's care.

"Nurses have only enough time to focus on their daily routine duties", on this statement the outcome was also satisfactory. There was a mixture of outcomes as almost 50/50 share of those who agreed/disagreed. However, the outcome wasn't strange, as other studies also showed that nurses performed the nursing process as a routine care action and executing habitual tasks established by the organization (Delgado & Mendes, 2009). A higher proportion of patients just like the registered nurses, revealed that nurses were focusing on their daily routine. This indicate poor focus to individualized nursing care, meaning they are not patient centred. This was also expressed by patients during the study that nurses mostly don't attend to them when calling, but that they will just see the nurses when the nurses come to do routine work in the ward like observations or giving out medication.

On the statement "Answering the patients' questions and their worries about their problems is the role of the doctor" the results showed that high proportion of registered nurses recognize their role in attending to patients concerns, not merely the doctors. In contrast to the last statement "to explain procedures and test is the role of the doctor, that this is the role of the doctor". Patients had also responded with high frequency that the registered nurses don't explain procedures. During her direct observations of the communications between the patients and the nurse the researcher also did not observe nurses explaining any procedures in 5 wards, but was done in 6 wards. The role of the nurse is to make sure or to confirm that the patient did understand the doctor's explanation.

5.5 FACTORS INFLUENCING COMMUNICATION (OBJECTIVE 3)

All the responses from the respondents indicated that there was a high degree of staff shortage in the wards. Staff shortage contribute to poor communication with patients, During the direct observations the researcher observed that the prevalent number of registered nurses on duty were two, only two wards was found having 3 registered nurses at the given time in a wards with an average of 48 patients. Hence, it can be concluded that staff shortage is one of the

factors influencing communication among the registered nurses-patients at Intermediate Hospital Katutura. It is proven that where there is staff shortage, work load increases and communication become less (Korsah, 2011 and Carayon & Gurses (2008). Adequate staffing influences how patients experience the quality of care and insufficient deployment of nursing staff has a direct negative impact on patient experience (Kieft, de Brouwer, Francke & Delnoij, 2014)

The research result point out that a high presentation of the nurses (50.7%) as well as the patients (94.6%) confirm that, routine activities affects communication with patients negatively. This concurs with Shafipour et al, (2014) assertions that focusing on routine work influence communication. Routine-centred care is among the barriers of communication between nurses-patient. This cause the nurses to concentrate on predetermined routine task, then to give individual patients care in the process neglecting to properly interact with patients (Ghiyasvandian et al., 2014 & Shafipour et al, 2014).

The high volume of nursing workload was reported by the nurses to affect the way that they were able to deliver services. They reported frequently feeling overworked due to the limited patient time coupled with the need to attend to other responsibilities such as administration; this they felt influenced their quality of care. Most participants acknowledged that with a heavy workload, they had limited time to put into communicating with the patient effectively. This lack of time was sometime seen to cause patients to become frustrated or angry, as they felt neglected and under-informed. The results however concur with Korsah, (2011) & Loghmani et al., (2014) who also indicated that increased workload have effect on communication. A research by Albagawi (2014 p. 135) also found this response from registered nurses which further strengthens the views of nurses at IHK, "Surely it [workload] affects our work because we have limited time to do many assignments and treatments and we have not enough time to talk with the patient and speak. If there are a few nurses in the shift and we have a lot of patients, we don't have enough time. Numerous patients are frustrated from that because they need to discuss something [patient situation] but we have no time for that.

The results above showed that it is very time consuming to give detailed explanations to patients, as this was interpreted that registered nurses didn't spend time to explain in details to patients. Patients had also made similar observations that they didn't spend enough time with them. A study done in America, supports these findings where it indicated that under a heavy workload, nurses may not have sufficient time to spend with patients and can lead to poor

nurse-patient communication (Carayon & Gurses, 2008). The responses from registered nurses and indication that the patients received minimal explanation from registered nurses, which isn't a good outcome for quality nursing care. Medical and orthopaedic registered nurses showed to explain less, which is a concern as those patients need detailed explanation for compliance and to prevent complications.

It was reported by some nursing participants that they felt tired and in low moods due to the demands of shift work leading to poor communication. When combined with increased responsibilities, this led to further distress. Stress is caused by nurses being overwhelmed with number of patients, the response were positive that high number of patients' contribute to stress of registered nurses. This also concurs with Albagawi's (2014 p. 135) study where he got some response from nurses that, "Sometimes, I'm in distressed in the morning shift because of the family and relatives. They want to know more information about the patients and I don't know how to speak good fluent Arabic. I know some phrases and they keep questioning me about the patient; I'm just smiling at them. That's why I prefer afternoon shift or night shift because there's less visitors."

Non-supportive management was another factor identified by registered nurses as affecting communication with patients when staff needs are not met, the high frequency of agreeing, shows that the registered nurses feel not being supported by hospital management. Therefore, the researcher is of the view that the management of Intermediate Hospital Katutura isn't supportive to the registered nurses' needs. This finding was also indicated by another research in Kenya' State Hospital that nurses reported that managers were unsupportive and unresponsive to nurse's needs (Loghmani, et al.2014).

In this study the answers of both the nurses and the patients' respondents indicate that they do not experience language and culture as a factors that interfere with communications. This finding was also confirm by the researcher when she was doing her direct observation of communications in the wards. But, it cannot be concluded that the factor does not influence communication because the hospital is made up of different nurses from different backgrounds and cultures who would prefer speaking English as compared to local languages. Studies of key communication barriers to providing culturally and linguistically appropriate care found that language and cultural differences remain the greatest impediments to effective communication. Nurses need to interact sensitively, effectively and professionally when communicating with patients from diverse racial and ethnic backgrounds, (Albagawi, 2014).

The differences exist in nursing staff dialects as well as in the multiple dialects of the patients. In the presence of such linguistic and cultural differences, local language speaking nurses also report barriers to communication when the patients belong to different dialectical language and ethnic group. For example, El-Amouri and O'Neill (2011) reported on cultural influences in the diverse nursing population in the UAE, which was recently 28% of Arabic, 63% Asian and 2% other nationalities (El-Amouri & O'Neill, 2011).

It is evident from the results that patient's educational level plays a role in the ability to express his/her concerns, the demographic data of the patients showed a high level of education, with 81.7% who had attended school. This concurs with a research by Longmani et al., (2014) that nurses tended to have a good therapeutic communication with patients who had a bit educational background. In Saud Arabia, in a research carried by Albagawi's (2014), foreign registered nurses have a big challenge in addressing patients in English due to patient's limited educational back ground. This gap is mainly found whenever English is spoken, translators are always on standby trying to explain to patients in Arabic.

Fear and anxiety on the side of the patients as an inhibition of communication was also identified as a factor. However, it was revealed by El-Amouri & O'Neill, (2011) that patients faced complications in conversation with the nurses and felt a level of anxiety, sometimes resulting in avoidance by the nurses. These strains prevented the building of relationships with their peers and others health providers that nurses worked with and added to the deteriorating image of these patients.

The noise level in the ward affect communication with the patient negatively as highly shown in the study. Responses of the registered nurses showed that noise level can influence communication, however, the patients didn't experience a high noise level in the ward. But the results cannot be concluded that noise doesn't interrupt communication.

5.6 PATIENTS' NEEDS RANKING

The outcome of the patients' needs ranking were different dramatically between the responses of nurses and the patients. The nurses being in the forefront of healthcare teams, is imperative that they understand and meet patient's needs. According to the ranking of the nurses the most important needs for the patients were to be safe, treat with respect and pain free. The outcome for the patients showed that patients ranked listening attentively, avoidance of medical terms and reassurance the highest, which is an indication that the patients value communication the most. And the study focus was on communication which appears to be at undesired level

according to media reports and patient's perceptions. Therefore, it could be concluded that registered nurses are not meeting the needs of patients due to not knowing their needs and not spending enough time to interact with them. Hence, it's important for nurses to pay attention to the patient's expectations that will results in provision of better care based on their needs (Kalyani et al., 2014).

5.7 COMMUNICATION TECHNIQUES EMPLOYED BY REGISTERED NURSES

The outcome of the application of communication technique by registered nurses was inadequate. Nursing practice depend on various components, which isn't limited to scientific knowledge only, but include interpersonal, intellectual and technical abilities and skills (Bramhall, 2014 & Kourkouta et al., 2014).

"Listening attentively" on this statement it is alluded that nurses mostly used this communication technique when communicating with patients. The application of listening skills is a critical component in the nursing field. This is mainly due to the nature of the job and in every situation one is not expected to have mistaken because of failing to understand what patients are saying or instructions. According to Bramhall (2014) a nursing professional, the desire to comfort patients can sometimes interfere with sound professional judgment. In such instances, it is vital that practitioners compartmentalize their personal feelings regarding a patient or case. It is, however, important to attempt to understand medical cases from the perspective of the patient. Although occasionally difficult, understanding how a patient feels during a hospital visit is important for gaining an understanding of how that individual might think, or how that patient might respond to treatment. Nurses who can empathize in this way often find they can better treat patients on many levels.

"Avoid medical terms" on this this statement the research found out that nurses were avoiding medical terms when communicating with patients. The medical field is a very technical field full of jargon and terms that some patients might not have heard of. Thus, the onus is for the nurses to try and limit or to be simply when delivering instructions or explaining to patients. This view can be supported by Koch-Weser, DeJong and Rudd (2009) who alluded that a working assumption of patients' lack of understanding of terminology, specifically, and their laity, more generally, may have benefits, as assuming that patients comprehend medical terms, when this is not the case, can jeopardize communication and thus health outcomes, as well as be ethically dubious.

“Accommodate patient’s words” regarding this statement, the researcher found out that the majority accommodated patient’s words. It can be argued that in every conversation bit at work place or social, one party always wish to be heard. In the medical field, listening and accommodating what patients say lead to a better conversation, relationship and care. These findings are supported by Mindtools (2016) that this enables the registered nurse to incorporate the patient’s words in the discussion and nursing care plan. Patients’ involvement in their plan of care is recommended for a better outcome of the health goal.

“Illustrate how the illness/condition affects the patient” regarding this statement from the results obtained, as highlighted by nurses, they often times use facial expressions, signs or pictures to clarify their points. This observation can be supported by Graham and Brookey (2008) that messages demonstrated by way of pictures and visuals are more easily remembered or recognised than the spoken words. A pamphlet with health literacy can also being able to obtain, process and understand basic health information and services that are needed to make desired health decisions.

5.8 OBSERVATION CHECKLIST

The researcher found that most of the nurses’ activities was the admission of patients into wards, operations theatre procedures, greeting of patients and report hand over at bedside. The admission of patients into wards is the first and most critical procedure, where one has to assess and take steps of treatment. However, this is where communication starts and this is where relationship between a nurse and patient is founded. This view is supported by Dithole (2014) who asserts that effective communication between nurses and patients can be facilitated by assessing patients’ during admission. He further advocates for patient’s assessment in order to facilitate communication.

It was found that some wards were overcrowded with over 48 patients thought the ward capacity is for 42 patients, with high discrepancy of nurse-patient ratio in all wards. Regardless of type, number of patients in the ward, the prevalence of registered nurses on duty were two. As a result of this it can be comfortably be concluded that there is a shortage of registered nurses, which may impact on quality of nursing care and causing pressure which leads to poor communication. Consequently, with overcrowding patients, privacy was compromised, as some were in corridors without any measures to ensure privacy. The current study revealed that time shortages due to understaffing and insufficient interpersonal competences led to

deterioration of the communication between patients and nurses and consequently not meeting patients' supportive and information needs (Krimshstein et al., 2011).

The outstanding observation from the nursing activities was that registered nurses rarely wrote patients report, even when they had explained a procedure. The communication skills employed by registered nurses throughout the wards appeared to be at low level. The researcher did not observe the application of any listening skills nor probing of questions, neither offering the patients opportunity to ask questions, besides sticking to the standard questions on the clinical record at admission. Although 25% registered nurses were willing to answer questions, 75% had also referred the patients' queries to the doctor. The importance of recording and writing of reports was reinforced by Dithole (2014) where he stressed that nurses are compelled by law to document all nursing activities and this includes documenting the communication information between the nurses and the patients. The Government of Botswana through its Ministry of Health is committed for improvement of quality of health care services (Centre for Disease Control [CDC] 2012:1). In order to make change in all areas of health care efficient, accurate documentation of nursing activities should be emphasised by nurse managers. Emphasis should be made on the importance of documenting nurse-patient communication and it should not be considered as an extra activity but as part of nursing responsibilities. Good documentation of all activities is evidence that care is carried out. Nurses should be proactive in ensuring that nurse-patient communication is done by all health care providers.

5.9 CONCLUSION

Effective communication between nurses towards patients is an important feature for patient satisfaction, treatment outcomes and patient compliance. Nurses cannot perform their clinical roles such as delivering physical care, emotional support and exchanging information with patients without effective communication.

Throughout the discussion, the researcher intended to determine whether the study objectives were achieved from the data collected and analysed. Objectives were set to find out whether the patients are oriented in the ward during their hospitalization, observe and describe the communication between the registered nurses and patients and to identify the factors which influence communication between the registered nurses and patients at Intermediate Hospital Katutura. It emerged that all objectives were met.

It can be concluded from the majority of patients and average number of registered nurses that patients are poorly oriented about the ward, policies and procedures during their

hospitalization. This can result that patients aren't made comfortable in their new environment and no sense of belonging is created.

The outcome of the research finding indicated that communication between the registered nurses and patients wasn't adequate in some of wards assessed. The gap in data collected and observed was significant for example patient not being offered opportunity to ask questions. Therefore, the implication is that the registered nurses are lacking to communicate effectively in providing safe nursing care.

The following factors were identified to be the possible factors that influence communication between the registered nurses and patients at Intermediate Hospital Katutura:

Staff shortage: the hospital was said to have few registered nurses and this can be attributed to the lack of funds to employ more. This however affected communication since the few available nurses have to keep to the high demand of patients.

Workload: registered nurses were faced with lot of work due to staff shortages at the hospital. One person has to do multitasking in order to achieve their daily goals thereby affecting communication with patients.

Stress: nurses highlighted the high level of stress which affected them due to work loads. This also affected the way they communicated with patients. Some nurses will end up being frustrated with patients and some will end up not answering patients in a good manner.

Non-supportive management: nurses pointed that management wasn't supportive enough in promoting good communication and this can be seen with the level of stress recorded, staff shortages and work load.

According to the results showed, patients have not been satisfactory oriented about the wards policies and procedures, the contributory factor maybe lack of written guide or checklist in the wards. The other gap was in the skills /technique of communication. Hence, communication between registered nurses- patients wasn't at desired level and possible factors were identified.

5. 10 RECOMMENDATIONS

- **Development of a check list:** The management should come up with a checklist that may help the registered nurses in patients' orientation, which is a basic activity to ensure patient feeling welcomed. A task team can be identified involving operational nurses, so that they own the checklist and to ensure successful implementation thereof. The checklist can

become part of quality assurance activity or clinical audit, whereby for example on monthly basis a spot check on compliance are carried out. This can be performed through a short exit patient survey that the patient be conducted upon discharge

- **Nursing education and continuing professional development:** The onus is on the healthcare organizations of Namibia to provide relevant, accessible educational packages, both orientations as well as ongoing refresher courses, to improve their health workforce and in particular nursing understanding of communication processes. The current study identified specific continuing of nurse education in order to increase the quality of care and maintain patient safety in a multicultural environment.
- **Cultural sensitive nursing:** In relation to cultural sensitive nursing, it is recommended that nurses have a background knowledge of cultural beliefs of their patients. Educational seminars should be structured which cover basic teaching of different cultures in Namibia. This will improve communication because some cultural beliefs are more sensitive to language or to how nurses might try to put emphasis on what they will be saying through demonstrations and signs.
- Moreover, policies and procedures training should be implemented for all hospital staff.

5.10.1 FUTURE RESEARCH

According to the findings of this study the nurses did not display any high communications skills but according to their own assessment they claim to do it, therefore more detail study that would capture their use of communication skills (video) could improve the understanding of this problem.

The findings highlighted that nurses were using poorly some forms of communication techniques. Future studies should cover communication techniques by nurses for patients to enhance communication.

The study did not find much interesting information or literature on patients ranking needs. However, since patients were ranked using various needs, more studies should dwell on the topic in order to see what patients need from their nurses.

This study only focused on one station which IHK which is a government institution, thus future research should also address other government institutions and private hospitals. More

studies should focus on the comparative analysis of both government and private institution in order to find the gap and ways to address poor communication between nurses and patients.

5.11 LIMITATIONS

According to Burns & Groove (2009), limitations are defined as a restriction in the study that may decrease generalization of the findings. The fact that this study was conducted at one institution in Namibia, using only selected number of adult patients in specific wards and registered nurses only allocated in the same wards as the patient's population, it could be regarded as a limitation, if they could argue that the sampling isn't a representative of the admitted patients in the country. Therefore, generalization to the entire country patients and registered nurses would be impossible. However, it could be generalized within the Intermediate Hospital Katutura where the study was conducted. The limitation to one research setting was mainly due to time and financial constraints.

Another main limitation of this study was that no attempt was made to control acquiescent response bias, which is the tendency of many respondents to agree or strongly agree to most questionnaire items, irrespective of whether or not they actually do agree to them in reality. Although there was a high level of agreement with many of the items in this study, it is not known whether this was due to biased responses. An unknown proportion of the participants' responses may have reflected the cultural communication style of some respondents to consistently provide biased responses to questionnaire items irrespective of what they really believe to be the 'true' answer (Fink, 2009). The nurses could potentially have provided biased answers for many reasons, including the fact that they are naturally very polite and respectful people. It is not known whether any of the results of this study were influenced by acquiescent response bias, but it is possible that a few answers may have been misleading, thereby limiting the validity and reliability of the conclusions.

5.12 SUMMARY

This chapter presented a discussion of the findings, conclusions, recommendations and limitations of the study. In this chapter, the discussion of the findings, self-interpretation and findings from other studies were done in accordance with all three objectives of the study. Communication being the basis of human interactions, had a great impact on nurse-patient's therapeutic relationship. Hence the necessity to improve communication for better outcome of patients' health needs.

6. REFERENCES

Abbas, A. D. (2014). Nursing intervention for management of patients with dyspnoea at emergency units in Baghdad Hospitals. *American Journal of Nursing Research*, 2(3), 38-43. doi: 10.12691/ajnr-2-3-2

Albagawi, B., S. (2014) *Examining Barriers and Facilitators to Effective Nurse-Patient Communication within a Saudi Arabic Cultural Context*, unpublished thesis, RMIT University, Saudi.

Almutaivi, K. M. (2015). Culture and language differences as a barrier to provision of quality care by the health workforce in Saudi Arabia. *Saudi Medical Journal*, 425-431.

Anoosheh M, Zarkhah S, Faghihzadeh S, Vaismoradi M. (2009) Nurse-patient communication barriers in Iranian nursing. *International Nurses Journal* 56(2): 243-9.

Armstrong, S. J, Rispel, L. C., & Penn-Kekana, L. (2015). The activities of hospital nursing unit managers and quality of patient care in South African hospitals: A paradox? *Global Health Action*. doi: 10.3402/gha.v8.26243

Argawal, R., Sands, D. Z. & Diaz-Schneider, J. (2010). Quantifying the economic impact of communication inefficiencies in US hospitals. *Journal of Healthcare Management*, 55(4), 265. Accessed on 22 May 2017, retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/20812527>

Awases, M, Gbary, A, Nyoni, J and Chatora, R. (2004). *Migration of Health Personnel in six countries: A Synthesis Report*. Brazaville: United Nations

Bach, S. and Grant, A. (2011). *Communication and Interpersonal Skills for Nurses*. Berlin: TJ International Ltd.

Bailey, M. (2016). *Communication failures linked to 1,744 deaths in five years, US malpractice study finds*. Retrieved from <https://www.statnews.com/2016/02/01/communication>

- Baillie, L. and Black, S. (2015) *Professional Values in Nursing*. London: Taylor & Francis.
- Belcher, M., & Jones, L. K. (2009). Graduate nurses' experiences of developing trust in the nurse–patient relationship. *Contemporary Nurse*, 31(2), 142–152.
- Bramhall, E. (2014). Effective communication skills in nursing practice. *Nursing Standard*, 53-59.
- Burns, N. & Grove, S. K. (2005). *Study guide for the practice of nursing research*. 5th edition. Philadelphia: W.B. Saunders.
- Burns, N., & Grove, S. K. (2009). *The practice of nursing research: Appraisal, synthesis and generation of evidence*. Maryland, Missouri: Saunders Elsevier.
- Burns, N., & Grove, S. K. (2011). *Understanding nursing research*. (3rd ed.). Philadelphia: Saunders.
- Burns, N., Grove, S.K. & Gray, J. (2013). *The practice of nursing research*. Philadelphia: Saunders.
- Business dictionary. (2016). *Information* accessed on 22 September 2017, retrieved from www.businessdictionary.com
- Breckon, P. M., Phillips, J. L., Dennison-Himmelfarb, C., Thompson, S. C., Luckett, T., & Currow, D. C. (2008). Providing palliative care for cardiovascular disease from a perspective of sociocultural diversity: a global view. *Current opinion in supportive and palliative care*, *Journal of Health Science* 10(1), 11-17.
- Brink, H. (2010). *Fundamentals of research methodology for healthcare professionals*. (2nd ed.). Cape Town: Juta.
- Brink, H., Van Der Walt, D., & Van Rensburg, G. (2006). *Fundamentals of research methodology for healthcare professionals*. Cape Town: Juta.

Carayon, P., & Gurses, A. P. (2008). Nursing workload and patient safety - A human factors engineering perspective. In R. G. Hughes, Ed., *Patient safety and quality care: Evidence-based handbook for nurses*. Rockville (MD): Agency for Healthcare Research and Quality.

Chan, E. A., Jones, A., Fung, S., & Wu, S.C. (April 2011). Nurse perception of time availability in patient communication in Hong Kong. *J Clinical Nursing*, 7-8. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/21917032>

Delgado, S. & Mendes, H. (2009). A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcomes. *Academic Medicine*, 78(6), 577–587.

De Vos, A. S., Strydom, H., Fouche, C. B., & Delpont, C. S. L. (2011). *Research at grass root*. (4th ed.). Pretoria: Van Schaik.

Dingley, C., Daugherty, K., Derieg, M. K., & Persing, R. (2008). *Improving patient safety through provider communication strategy enhancement*. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK43663/>

Dithole, K., S (2007) *Nurses' communication with mechanically ventilated patients in the intensive care units*, unpublished thesis, University of South Africa: Johansburg.

Dithole, K., S, Thupayagale-Tshweneagae, G., Akpor, O., A and Moleki, M., M. (2017). Communication skills intervention: promoting effective communication between nurses and mechanically ventilated patients. *BMC Nursing*, 1-6.

Eggy, C., & Slade, M. (2015). Oncology nurses' attitudes toward prognosis-related communication: a pilot mailed survey of oncology nursing society members. *Oncology Nursing Forum*, 38(4), 468–74.

Eggy, S., Penner, L., Albrecht, T. L., Cline, R. J., Foster, T., Naughton, M., Peterson, N., & Ruckdeschel, J. C. (2006). Discussing bad news in the outpatient oncology clinic: Rethinking current communication guidelines. *Journal of Clinical Oncology*, 24, 716-719.

Eisenhauer, T. (2015). *Why lack of communication has become the #1 reason people quit*.

Retrieved from <https://www.axerosolutions.com/articles/press/210/tim-eisenhauer>

El-Amouri, S. & O'Neill, S. (2011). Supporting cross-cultural communication and culturally competent care in the linguistically and culturally diverse hospital settings of UAE. *Contemporary Nurse*, 39 (2), 240–255.

Fink, A. (Ed.). (2009) *How to conduct surveys: A step-by-step guide*. Thousand Oaks: Sage.

Frieden, J. (2015). *Diagnosis errors are a system problem, not just doctor's fault*. Retrieved from <https://www.ahcmedia.com/articles/136459-diagnosis-errors-are-a-system-problem-not-just-doctors-fault>

Frydenberg, K., & Brekke, M. (2012). Poor communication on patients' medication across healthcare levels leads to potentially harmful medication errors. *Scand J Prim Health Care*, 30(4), 234-240. Retrieved from <https://www.ncbi.nlm.gov/pubmed/20350954>

Frydman, C., N (2011) Nurse-perceived barriers to effective communication regarding prognosis and optimal end-of-life care for surgical ICU patients: a qualitative exploration. *Journal of Palliative Medicine*, 15(8), 910–5.

Frush, B.W, Eberly Jr, J.B & Curlin, F.A (2018) What Should Physicians and Chaplains Do When a Patient Believes God Wants Him to Suffer? *AMA J Ethics*, 20(7): E613-620

Gulich, I., Ramas, A. B., Zan, T. R., Scherer, C., & Mendoza-Sassi, R. A. (2013). Prevalence of anxiety in patients admitted to a university hospital in southern Brazil and associated factors. *Rev Bras Epidemiol*, 16(3), 644-57.

Ghiyasvandian, S., Zakerimoghadam, M., & Peyravi, H. (2014). Nurse as a facilitator to professional communication: A qualitative study. *Glob J Health Sci*, 7(2), 294–303. doi: 10.5539/gjhs.v7n2p294

Gonzalo, A. (2011). *Theoretical foundation of nursing: Hildegard E. Peplau theory of interpersonal relations*. Retrieved from <https://nursingtheories.weebly.com/hildegard-e-peplau.html>

Graham, S. & Brookey, M.D. (2008). *Do patients understand?* Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/article/PMC3037129>

Haugan, G. (2013). The relationship between nurse-patient interaction and meaning-in-life in cognitively intact nursing home patients. *Journal of Advanced Nursing*, 70(1), 107-120.

Hitch, M. I., (2017). Nursing perspectives on palliative care 2015. *Annals of palliative medicine*, 4(3), 150-155.

Intermediate Katutura Hospital. (2008). *Annual report 2008/2009: Intermediate Katutura Hospital*. Windhoek: MOHSS.

Izumi, S., Baggs, J. G., & Knafl, K. A. (2010). Quality nursing care for hospitalized patients with advanced illness: Concept development. *Res Nurse Health*, 33(4), 299-315.

Jahromi, G. B., & Price, S. D. (2015). Team working: palliative care as a model of interdisciplinary practice. *The Medical Journal of Australia*, 179 (6), S32-4.

Jirojwong, S., Johnson, M., & Welch, A. (2014). *Research methods in nursing and midwifery*. (2nd ed.). Sydney: Oxford University Press.

Joaguim, C. (2008). *Interpersonal communication between registered nurses and surgical patients on admission to surgical wards at the Oshakati Intermediate Hospital*. (unpublished thesis) Windhoek: University of Namibia.

Kamenye, E. (2013). *Guidelines to enhance communication skills of nurses caring for patients diagnosed with Tuberculosis at Public Health Facilities in Khomas region of Namibia*. Windhoek: University of Namibia.

Kedyani, E., Kashkooki, A., Brunner, E., and Himmel, W. (2014). A parametric analysis of ordinal quality-of-life data can lead to erroneous results. *Journal of Clinical Epidemiology*, 61, 475–480.

Keller, V., & Baker, L. (2015). *Treating patients with C.A.R.E.* Annotated Bibliography Institute for Health Care Communication, accessed on 01 September 2017, retrieved from <https://www.healthcarecomm.org>

Kieft, R. A. M. M., De Brouwer, B. B. J. M., Francke, A. L., & Delnoij, D. M. J. (2014). How nurses and their work environment affect patient experiences of the quality of care: A qualitative study. *BMC Health Services Research*, 14, 249.

Kisting, D. (2012, June 18). Katutura Hospital in "hot water" again. *The Namibian*, pp.25 .

Koch-Weser, C., Boyle, D. K. & Kachana, D., T. (2004). Enhancing collaborative communication of nurse and physician leadership in two intensive care units. *Journal of Nursing Administration*, 34(2), 60–70.

Kourkouta, L., & Papathanasiou, L. V. (2014). Communication in nursing practice. *Mater Sociomed*, 26(1), 65–67, accessed on 01 September 2017. retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/pmc3990376/>

Korsah, K. A. (2011). Nurses stories about their interactions with patients at the Holy Family Hospital, *Journal of Medicine*, 5 (2) 15-33

Kozier, B., Erb, G., Berman, A., & Snyder, S. (2004). *Fundamentals of nursing concepts process and practice*. New Jersey: Prentice Hall.

Krimshtein, N. S., Luhrs, C. A., Puntillo, K. A., Cortez, T. B., Livote, E. E., Penrod, J.D., & Nelson, J. E. (2011). Training nurses for interdisciplinary communication with families in the intensive care unit: An intervention. *Journal of Palliative Medicine*, 14, 1325-1331. doi:10.1089/jpm.2011.0225

LoBiondo-Wood, G., & Haber, J. (2010). *Nursing research: Methods and critical appraisal for evidence-based practice*. 7th edition. China: Elsevier.

Loghmani, L., Borhani, F. & Abbaszadeh, A. (February, 2014). Factors affecting the nurse-patients family communication in intensive care unit of Kerman: A qualitative. *Journal of Caring Science*, 67-82.

Matheson, J. L. (2007). The voice transcription technique: Use of voice recognition software to transcribe digital interview data in a qualitative research. *The Qualitative Report*, 12(4), 547-560.

Macdonald, L., Stubbe, M., Tester, R., Vernall, S., Dowell, T., Dew, K., Kenealy, T., Sheridan, N., Docherty, B., Gray, L., & Raphael, D. (2013). Nurse-patient communication in primary care diabetes management: an exploratory study. *BMC Nurs*, 12 (1), 20

McGivern, Y. (2006). *The practice of market and social research*. Essex: Prentice Hall.

McKibben, L. (2017). Conflict management: importance and implications. *British Journal of Nursing*, 26(2), 100-103.

Meier, J.D. (2012). *The 5 levels to communicating more effectively*, accessed on 01 September 2017 Retrieved from <https://www.sourceofinsight.com/the-5-levels-to-communicating-more-effectively/>

Merriam-Webster. (2015). *Communication*, accessed on 01 September 2017 retrieved from <https://www.merriam-webster.com/dictionary/communication>

Merriam-Webster. (2016). *Patient* accessed on 01 September 2017 retrieved from <https://www.merriam-webster.com/dictionary/patient>

Mindtools, R. (2015). Communication skills in palliative care: a practical guide. *Neurologic clinics*, 19(4), 989-1004

Ministry of Health & Social Services. (2016). *The patient charter of Namibia*. Republic of Namibia: Windhoek.

Mitchell, P. H. (2008). Defining patient safety and quality care. In R.G. Hughes, Ed., *Patient safety and quality care: Evidence-based handbook for nurses*. Rockville (MD): Agency for Healthcare Research and Quality.

Molazem, Z., Ahmadi, F., Mohammadi, E., & Bolandparvaz, S. (2011). Improvement in the nursing care quality in general surgery wards: Iranian nurses' perceptions. *Scandinavian Journal of Caring Science*, 25(2), 350-356.

Mordi, B. A. (2002). Strategies for culturally effective end-of-life care. *Annals of Internal Medicine*, 136(9), 673-679.

Moxham, L. (2012). *Nurse education, research and evidence-based practice*. French Forest, Sydney: Pearson Australia.

Morse, J. (2007). *Negotiating commitment and involvement in the nurse-patient relationship*. *Journal of advanced Nursing* 16 (4) April, pp. 455-468.

Mtambanengwe, J. S., Maguna, E. T., Keiseb, J., Uusiku, C., Kaiyamo, L. K., Karunga-Beukes, L., Karises, R., & Nghipundjwa, J. (2013). *Report of the presidential commission of inquiry: Ministry of Health & Social Services*. Republic of Namibia: Windhoek.

Musariri, C. (2012, August 19). Just fire Kamwi. *The Villager*, pp 1.

Nadzam, D. M. (2009). Nurses role in communication and patient safety. *J Nurs Care Qual*, 24(3), 184-188.

Namibia. (2011). *Population and housing census indicators*. Retrieved from <http://cms.my.na/assets/documents/p19dmlj9sm1rs138h7vb5c2aa91.pdf>

Namibia, R.O. (n.d.). *The public service charter*. Windhoek: Government Printers.

Namibia, R.O. (2014). *Regulations relating to the scope of practice of persons registered or enrolled under Nursing Act*. Republic of Namibia: Windhoek.

Ozdemir, E., & Tunk, C. J. (2008). Family satisfaction with care in the intensive care unit: Results of a multiple center study. *Critical care medicine*, 30(7), 1413-1418.

O'Daniel, M., & Rosenstein, A.N. (2008). *Chapter 33 Professional communication and team collaboration*. Rockville: Agency for Healthcare Research and Quality (US). Retrieved from <https://www.ncbi.nlm.gov/books/NBK2637/>

Pera, S. A., & Van Tonder, S. (2011). *Ethics in healthcare*. Cape Town: Juta.

Pfaff, K., Baxter, P., Jack, S., & Ploeg, J. (2014). An integrative review of the factors influencing new graduate nurse engagement in inter-professional collaboration. *Journal of Advanced Nursing*, 70,4–20. Retrieved from <https://dx.doi.org/10.1111/jan.12195>

Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice*. (9th ed.). China: Lippincott Williams & Wilkins.

Polit, D. F., & Hungler, B. P. (2013). *Essential of nursing research: Methods, appraisal, and utilization*. (8th ed.). Philadelphia: Wolters Kluwer/Lippincott Williams and Wilkins.

Pun, J. K., Matthiessen, C. M., Murray, K. A., & Slade, D. (2015). *Factors affecting communication in emergency department: Doctors and nurses' perceptions of communication in a trilingual ED in Hong Kong*. Retrieved from <https://www.ncbi.nlm.nih.gov/m/pubmed/26667242/>

Raveesh, B. N., Nayak, R. B., & Kumbar, S. F. (2016). Preventing medico-legal issues in clinical practice. *Indian Acad Neurol*, 19(1), S15–S20.

Resnik, D. B. (2011). *National Institute of Environmental Health Sciences*. Retrieved from <https://www.niehs.nih.gov/research/resources/bioethics/whatis/>

Riley, J. B. (2013). *Communication in nursing*. (5th ed.). United States of America: Mosby.

Ross, D. (2017). Challenges for men in a female dominated environment. *Health and Social Care*, 2(1), 4-20.

Steckler, R. (2012). *Improving communication skills among nursing students: Assessing the comfort curriculum as an intervention. Theses and Dissertations-Communication. Paper 7.*

Retrieved from https://www.uknowledge.uky.edu/comm_etds/7

Selman, L., Higginson, I. J., Agupio, G., Dinat, N., Downing, J., Gwyther, L., Mashao, T., Mmoledi, K., Moll, A. P., Sebuyira, L. M., Panajatovic, B., & Harding, R. (22 April, 2009). Meeting information needs of patients with incurable progressive disease and their families in South Africa and Uganda: Multicentre qualitative study. *British Medical Journal*, 1127-1131.

Singh, H., Naik, A. D., Rao, R., & Petersen, L.A. (2008). *Reducing diagnostic errors through effective communication: harnessing the power of information technology.* Pubmed. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/18373151>

Sherif. HEL. (2010). Patient satisfaction with public primary health care services in Khomas Region, Windhoek, District. *University of Western Cape.* Retrieved from <https://www.hdl.handle.net/11394/3495>.

Shinana, K. (2013, September 12). Katutura hospital turns away patient. *Windhoek Confidante*, pp 1.

Shukla, A. K., Yadav, V. S., & Kastury, N. (2010). Healthcare provider-patient communication: An important but often ignored aspect in clinical medicine. *Journal Indian Medical*, (11) 3 p. 23-40

Steckler, C. F. (2012). Current status of palliative care-clinical implementation, education, and research. *CA: a cancer journal for clinicians*, 59(5), 327-335.

Tay, L. H, Ang, E., & Hegney, D. (15 February, 2012). Nurses' perception of the barriers in effective communication with in-patient cancer adults in Singapore. *Clinal Nursing*, 17-18.

Tejero, L., & Marie, S., (2012). The mediating role of the nurse-patient dyad bonding in bringing about patient satisfaction. *Journal of Advanced Nursing*, 68(5), 994-1002.

Timothy, M. (2006). *Selecting studies for systematic review: Inclusion and exclusion criteria*. Edinburg: The University of Texas-Pan American.

Tulchinsky, H. T., & Varavikova, A. E. (2009). *The new public health*. (2nd ed.). London: Elsevier Academic Press.

Vaga, B. B., Moland, K. M., Evjen-Olsen, B., Leshabati, S. C., & Blystand, A. (2012, August 8). Rethinking nursing care: an ethnographic approach to nurse-patient interaction in the context of a HIV prevention programme in rural Tanzania. *Pubmed*. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/?term=rethinking+nursing+care+vaga>

Vertino, K. A. (2014). Effective interpersonal communication: A practical guide to improve your life. Retrieved from <https://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-19-2014/No3-Sept-2014/Effective-Interpersonal-Communication.htm>

Wayne, G. (2014). *Hildegard Peplau's interpersonal relations theory*. Retrieved from <https://www.nusreslabs.com/hildegard-peplau—interpersonal-relations-theory/>

Warelow, P., Edward, K.,L & Vinek,J. (2008, June 22). Care: what nurses say and what nurses do. *Pubmed*. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/?term=warelow%2C+edward+%26+vinek>

Welman, C., Kruger, F., & Mitchell, B. (2007). *Research methodology*. (3rd ed.). Cape Town: Oxford University Press.

Weiss, B. D. (2007). *Health literacy: Can your patients understand you?* (2nd ed.). Chicago: American Medical Association and AMA Foundation.

White, J. (2016). *How communication problems put patients, hospitals in jeopardy*. Retrieved from [https:// www.healthcarebusinesstech.com/communication-patient-harm/](https://www.healthcarebusinesstech.com/communication-patient-harm/)

White, L., & Millar, R. B. (2014). *Quantitative approaches*. South Melbourne: Oxford University Press.

WHO. (2009). *Bulletin of World Health Organization*, 87, 247-247. doi:10.2471/BLT.08.056713

Windover, A., Bottomley, A., Blazeby, J. M., Conroy, T., Coens, C., D'haese, S., & Rodary, C. (2015). An international prospective study of the EORTC cancer in-patient satisfaction with care measure (EORTC IN-PATSAT32). *European Journal of Cancer*, 41(14), 2120-2131.

Wright, R. (2012). *Effective Communication Skills for the 'Caring' Nurse* Pearson Longman. Retrieved

https://www.pearsonlongman.com/tertiaryplace/pdf/ros_wright_effective_comm_skills_for_the_caring_nurse_aug2012.pdf

Zamanzadeh, V., Rassouli, M., Abbaszadeh, A., Nikamfar, A., Alavi-Majd, H., & Ghahramanian, A. (2014). Factors influencing communication between the patients with cancer and their nurses in oncology wards. *Indian Journal of Palliative Care*, 20, 12-20.

Zimmermann, K. A. (2015). *What is culture?* Retrieved from <https://www.livescience.com/21478-what-is-culture-definition-of-culture.htm>

ANNEXURE A: ETHICAL CLEARANCE CERTIFICATE



ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: SONPH/129/2016

Date: 5 December, 2016

This Ethical Clearance Certificate is issued by the University Of Namibia Research Ethics Committee (UREC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the Faculty/Centre/Campus Research & Publications Committee sitting with the Postgraduate Studies Committee.

Title of Project: Factors That Influence Registered Nurse-Patient Communication At The Intermediate Hospital Katutura , Khomas Region, Namibia

Nature/Level of Project: Masters

Researcher: C. Kamonde

Student Number: 9313664

Faculty: School of Nursing and Public Health

Supervisors: Dr. W. Wilkinson (Main) Dr. K. Shikongo (Co)

Take note of the following:

- (a) Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the UREC. An application to make amendments may be necessary.
- (b) Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the UREC.
- (c) The Principal Researcher must report issues of ethical compliance to the UREC (through the Chairperson of the Faculty/Centre/Campus Research & Publications Committee) at the end of the Project or as may be requested by UREC.
- (d) The UREC retains the right to:
 - (i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected, request for an ethical compliance report at any point during the course of the research.

UREC wishes you the best in your research.

Prof P. Odonkor: UREC Chairperson

Ms. P. Claassen: UREC Secretary

ANNEXURE B: PERMISSION LETTER TO CONDUCT RESEARCH FROM MOHSS**REPUBLIC OF NAMIBIA***Ministry of Health and Social Services*

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: 061 - 203 2562
Fax: 061 - 222558
E-mail: hnangombe@gmail.com

OFFICE OF THE PERMANENT SECRETARY

Ref: 17/3/3

Enquiries: Dr. H. Nangombe

Date: 28 April 2017

Ms. Claudia Kambonde
University of Namibia
School of Public Health
Namibia

Dear Ms. Kambonde

Re: Factors that influence registered nurses-patients communication at Intermediate Hospital Katutura, Khomas region, Namibia

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
 - 3.1 The data to be collected must only be used for academic purpose;
 - 3.2 No other data should be collected other than the data stated in the proposal;
 - 3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;

- 3.4 A quarterly report to be submitted to the Ministry's Research Unit;
- 3.5 Preliminary findings to be submitted upon completion of the study;
- 3.6 Final report to be submitted upon completion of the study;
- 3.7 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,



Andreas Mwoombola (Dr)
Permanent Secretary



ANNEXURE C: PERMISSION LETTER FROM IHK



Republic of Namibia

Ministry of Health and Social Services

Private Bag 13215
WINDHOEK
Namibia

Intermediate Hospital Katutura
Independence Avenue
WINDHOEK

Telephone (061) 203 4004/5
Telefax (061) 222706

Enquiries: Ms. F.M. Shiweda

Date: 10 May 2017

OFFICE OF THE MEDICAL SUPERINTENDED

**Ms. Claudia Kambonde
University of Namibia
School of Public Health
Namibia**

Dear Ms. C. Kambonde

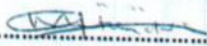
**RE: FACTORS THAT INFLUENCE REGISTERED NURSES-PATIENTS COMMUNICATION
AT INTERMEDIATE HOSPITAL KATUTURA**

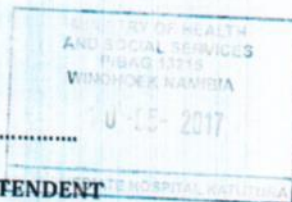
The above mentioned subject refers:

This office hereby grants you permission to do research on factors that influences registered nurses-patients communication at Intermediate Hospital Katutura.

Thank you

Yours in health


**DR. A. MUKENDWA
ACTING MEDICAL SUPERINTENDENT**



ANNEXURE D: CONSENT FORM TO TAKE PART IN RESEARCH

CONSENT FORM

FACTORS THAT INFLUENCE REGISTERED NURSES AND PATIENTS COMMUNICATION AT INTERMEDIATE HOSPITAL KATUTURA, KHOMAS REGION, NAMIBIA.

Researcher: Claudia Kambonde

Dear participant

I Claudia Kambonde am registered with University of Namibia, doing a Master degree in Public Health. I wish to conduct a research project entitled: “Factors that influence communication between registered nurses and patients at Intermediate Hospital Katutura, in Khomas region, Namibia. The study will be conducted under the supervision and guidance of Dr. W. Wilkinson lecturer at School of Nursing and Public Health, University of Namibia.

The objectives of this research are three, to find out whether the patients are oriented about the ward during their hospitalization, observe and describe the communication between registered nurse- patients and to identify the factors which influence communication between registered nurse and patient at Intermediate Hospital Katutura.

Your participation will provide information that might enable decision makers to assist in this regard. Participation in this study will take approximately 15-20 minutes. The procedure includes responding to all questions in section A, B and C.

Your participation in this study is voluntary and you have the right to withdraw at any time should you feel so. You should feel free to ask the researcher to clarify the question where you don't understand and you will be expected to answer all questions. Registered nurse, you will receive the questionnaire and fill it on your own and hand it to the researcher. The researcher will fill in the patient responses to the questionnaire.

The study data will be coded so they will not be linked to your name. Your identity will not be revealed during the study or when the study is being reported or published with the permission granted by the Ministry of Health and Social Services for the benefit of improving communication. The researcher and supervisor are the only people that will have access to the data collected.

Registered nurses and inpatients in this wards: medical, surgery, gynaecology and orthopaedic are the study population. These wards are selected on the ground that most of the patient's length of stay in the ward are more than 3 days. Should you agree to participate, please sign your consent with full knowledge of the purpose of the study.

If you have any questions or concerns about the research, please feel free to contact Mrs Claudia Kambonde at (061-2034011), cell 08126063 62 or E-mail *ckambonde5@gmail.com*. The main supervisor Dr.W. Wilkinson at 0812832703: E-mail: *wwilkinson@unam.na*

You may withdraw your consent at any time and discontinue participation without penalty. Should you agree to participate, please sign the consent provided. If you have any question that need clarification you are welcome to contact me.

I.....
Agree to participate in this research project on my own will.
Signed at
Signature.....Date:

ANNEXURE E: REGISTERED NURSES QUESTIONNAIRE**2. QUESTIONNAIRES: FOR REGISTERED NURSE**

The following questionnaire is part of a study to be conducted to explore communication between registered nurse-patients. To ensure confidentiality, please do not write your name on the questionnaire as this study is anonymous. Please be honest with your response. Thank you very much for taking the time to complete our questionnaire, your effort is greatly appreciated.

SECTION A: REGISTERED NURSE DEMOGRAPHIC DATA**TICK IN THE CORRECT BOX****6.1 GENDER**

1.FEMALE		2.MALE	
----------	--	--------	--

6.2 AGE

18-29	1	
30-39	2	
40-49	3	
50-59	4	
60 and above	5	

6.3 MARITAL STATUS

Single	1	
Married	2	
Divorced	3	
Separated	4	
Widowed	5	

6.3 HOME LANGUAGE

English	1		Otjiherero	4	
Afrikaans	2		Damara Nama	5	
Oshiwambo	3		Others	6	

6.4 IN WHICH WARD ARE YOU?

Orthopaedic	1		Medical	3	
Surgery	2		Gynaecology	4	

SECTION B

ANSWER ALL QUESTIONS BY CHOOSING (1) YES OR (2) NO

7.1 ORIENTATION TO THE WARD

Did you provide information on the followings to the patient at admission in the wards?

	1 (yes)	2 (no)
Introduction of the nurses		
Location of the ward		
Ward doctor		
Toilets / Bathroom		
Risks in the ward (Medico legal hazards)		

7.2 POLICIES AND PROCEDURES OF THE WARD

Did you communicate following to the patient about ward guideline?

	1 (yes)	2 (no)
Bathing time		
Meals time		
Doctors ward rounds		
Procedure time		
Medication in the ward		
Visiting time		
Smoking		
Alcohol use in the ward		

SECTION C: COMMUNICATION

8. ANSWER ALL QUESTIONS: CIRCLE THE MOST APPROPRIATE RESPONSE.

8.1 Communication is defined as :

- a) Process of sharing information (b) Verbally (c) Non verbally
(d) All above (e) b and c

8.2 Communicated messages are transmitted through:

- a) Sound (b) Sight (c) Touch (d) Smell & taste (e) All above

8.3 In nursing communication with patients mostly is through:

- a) Speaking directly to patients (b) Handing over reports (c) Writing report (d) Reading reports (e) All above

8.4 The following are skills of communication except:

- a) Active listening (b) Reflection (c) Acknowledging (d) Summarizing
e) Dominating

8.5 Reflecting ensures:

- a) That communicators are not at the same page (b) Thoughts are not heard (c) Decrease openness (d) Focus on what's said
(e) Decrease disclosure of feelings

8.6 Acknowledging help to:

- a) Recognize contribution (b) Build relationship (c) Ensure agreeing (d) Create a platform to open up (e) A, b and c.

9. REGISTERED NURSE ROLE

ANSWER ALL QUESTION WITH THE FOLLOWING INDICATE WITH A TICK ✓ **Agree** **No opinion** **Disagree**

9.1 Is the registered nurse responsibility to ensure a safe therapeutic environment for the patients? Agree No opinion Disagree

9.2 It is the role of the registered to ensure that the rights of the patients are upheld by all health workers. Agree No opinion Disagree

9.3 The way the registered nurses dress send a message to the patients about their attitudes. Agree No opinion Disagree

9.4 The registered nurses are accountable for the manner in which other health workers communicate with patients in their care.
Agree No opinion disagree

9.5 Keeping abreast with new professional development is a must in today era
Agree No opinion disagree

9. INTERPERSONAL RELATIONSHIP

ANSWER THE FOLLOWING QUESTIONS On a scale of 1-4 (1=strongly agree; 2=Agree; 3=Disagree and 4=Strongly Disagree), rank yourself against the following statements). (Tick your answer in the appropriate block)

	Strongly agree(1)	Agree (2)	Disagree (3)	Strongly disagree (4)
9.6 Establishing a therapeutic relationship is important in nursing				
9.7 Expressing respect and attention to the patient by the nurse is necessary for the establishment relationship				
9.8 It is not part of job description of a registered nurse to establish a relationship with family of the patient				
9.9 Being honest, respectful and explain every nursing activity to the patient create trust				
9.10 Communication and interviewing skills remain fundamental nursing tools				
9.11 Both patient and nurse learn as the results of therapeutic interaction				

10. NURSE – PATIENT COMMUNICATION

On a scale of 1-4 (1=strongly agree; 2=Agree; 3=Disagree and 4=Strongly Disagree), rank yourself against the following statements). (Tick your answer in the appropriate block)

	Strongly agree(1)	Agree (2)	Disagree (3)	Strongly disagree (4)
10.1 Good nurse-patient communication improves patients' health outcomes				
10.2 Spending time just talking to patients has no nursing care value.				
10.3 Nurses have only enough time to focus on their daily routine duties				
10.4 Answering the patients' questions and their worries about their problems is the role of the doctor				
10.5 To explain procedures and test is the role of the doctor				

11. FACTORS INFLUENCING COMMUNICATION BETWEEN NURSES AND PATIENTS. CHOOSE THE APPROPRIATE RESPONSE

On a scale of 1-4 (1=strongly agree; 2=Agree; 3=Disagree and 4=Strongly Disagree), rank yourself against the following statements). (Tick your answer in the appropriate block)

	Strongly agree (1)	Agree (2)	Disagree (3)	Strongly disagree (4)
11.1 Staff shortage contributes to poor communication with patients				
11.2 Focusing on routine activities affects communication with patients negatively				
11.3 The increased workload distracts nurses from giving patient individual attention				
11.4 It is very time consuming to give detailed explanations to patients				
11.5 Stress is caused by nurse being overwhelmed with number of patients				
11.6 Non –supportive management affect communication with patient when staff needs are not met				
11.7 Language and culture differences do not influence communication with patients.				
11.8 Patient educational level plays a role in ability to express his/her concerns				
11.9 Fear and anxiety on the side of the patient inhibit communication				
11.10 The noise level in the ward affect communication with the patient negatively				

12. Rank the following patient needs in order of importance with 1 as the most important and 5 least important. (Please circle a number to best indicate your rating of the following statements once).

12.1 To be safe

Most important 1 2 3 4 5 6 7 least important

12.2 That their information is kept confidential

Most important 1 2 3 4 5 6 7 least important

12.3 To be treated with respect and politely

Most important 1 2 3 4 5 6 7 least important

12.4 To be communicated to in a friendly and warm manner

Most important 1 2 3 4 5 6 7 least important

12.5 To receive emotional support

Most important 1 2 3 4 5 6 7 least important

12.6 To be pain free

Most important 1 2 3 4 5 6 7 least important

12.7 To understand their condition and treatment.

Most important 1 2 3 4 5 6 7 least important

13. Indicate how often you are using these communication techniques.

13.1 Listen attentively: Give the patient opportunity to express his/ her concerns without interruptions.

1.All the time	2.Often	3. Not often	4.Rarely	5.Not at all
----------------	---------	--------------	----------	--------------

13.2 Avoid medical terms: Try by all means to simplify the medical terminology to the level of non-medical staff.

1.All the time	2.Often	3. Not often	4.Rarely	5.Not at all
----------------	---------	--------------	----------	--------------

13.3 Accommodate patient's words: Making use of patients words to describe his or her illness and use them in the discussion of nursing care plan.

1.All the time	2.Often	3. Not often	4.Rarely	5.Not at all
----------------	---------	--------------	----------	--------------

13.4 Illustrate how the illness/condition affects the patient. During discussion showing available pictures/posters to clarify the verbal explanation.

1.All the time	2.Often	3. Not often	4.Rarely	5.Not at all
----------------	---------	--------------	----------	--------------

13.5 Ask patient to play back: Check whether patients grasped what they need to know and do by asking them to play back.

1.All the time	2.Often	3. Not often	4.Rarely	5.Not at all
----------------	---------	--------------	----------	--------------

ANNEXURE F: PATIENT QUESTIONNAIRE

1. QUESTIONNAIRES: A FOR PATIENT
SECTION A: PATIENTS DEMOGRAPHIC DATA

TICK IN THE CORRECT BOX

1.1 GENDER

1.FEMALE		2.MALE	
----------	--	--------	--

1.2 AGE

18-29	1	
30-39	2	
40-49	3	
50-59	4	
60 and above	5	

1.3 MARITAL STATUS

Single	1	
Married	2	
Divorced	3	
Separated	4	
Widowed	5	

1.4 EMPLOYMENT STATUS

Employed	1	
Unemployed	2	
Self –employed	3	

1.5 EDUCATIONAL LEVEL

Primary (Grade 1-5)	1	
Secondary (Grade 6-12)	2	
Tertiary (College/University)	3	
None	4	

1.6 HOME LANGUAGE

English	1		Others	6	
Afrikaans	2				
Oshiwambo	3				
Otjiherero	4				
Damara Nama	5				

1.7 IN WHICH WARD ARE YOU ADMITTED

Orthopaedic	1		Medical	4	
Surgery	2		Don't know	5	
Gynaecology	3				

1.8 DAYS IN THE WARD

3-5days	1		
6 and more days	2		
Don't know	3		

SECTION B

ANSWER ALL QUESTIONS BY CHOOSING (1) YES OR (2) NO .Please tick ✓

2.1 ORIENTATION TO THE WARD

Did you receive information on the followings at admission in the wards?

	Yes (1)	No (2)
Introduction of the nurses		
Location of the ward		
Ward doctor		
Toilets / Bathroom		
Risks in the ward (Medico legal hazards)		

2.2 POLICIES AND PROCEDURES OF THE WARD

Did the nurses communicate to you the following in the ward?

	Yes (1)	No (2)
Bathing time		
Meals time		
Doctors ward rounds		
Procedure time		
Medication in the ward		
Visiting time		
Smoking		
Alcohol use in the ward		

SECTION: C

ANSWER ALL QUESTIONS BY CHOOSING A RESPONSE 1. YES/ 2.NO Please tick ✓

	Yes(1)	No(2)
3.1. From the looks of it, is there a shortage of registered nurses?		
3.2. Do you think that the shortage of registered nurses affects their workload?		
3.3. Do you think they focused more on their daily routine more than individual patient care?		
3.4. Were you treated with respect by the registered nurses?		
3.5. Did you understand the language used by the registered nurse?		

3.6. Were you attended to differently due to your culture?		
3.7. Did you observe your family interfering with the registered nurses' duties?		
3.8. Did the noise levels affect your communication with the registered nurse?		
3.9. Was your privacy respected?		
3.10. Did the registered nurse explain procedures to you?		
3.11. Did you get any feedback from the registered nurse on your procedures done?		
3.12. Did the registered nurses spend enough time to attend to all your needs?		

4. As a patient rank your needs from 1 as the most important and 7 least important.

(Please circle a number to best indicate your rating of the following statements once).

4.1 To be safe

Most important 1 2 3 4 5 6 7 least important

4.2 For my information to be kept confidential

Most important 1 2 3 4 5 6 7 least important

4.3 To be treated with respect

Most important 1 2 3 4 5 6 7 least important

4.4 To be communicated to in a friendly manner

Most important 1 2 3 4 5 6 7 least important

4.5 To be pain free

Most important 1 2 3 4 5 6 7 least important

5. Indicate how often the registered nurses used these communication techniques.

All the time, Often. Not often, rarely, not at all. Please circle the appropriate number

5.1 Listen attentively: Give you the opportunity to express your concerns without interruptions.

1.All the time	2.Often	3. Not often	4.Rarely	5.Not at all
----------------	---------	--------------	----------	--------------

5.2 Avoid medical terms: Try by all means to simplify the medical terminology to the level you are comfortable to understand.

1.All the time	2.Often	3. Not often	4.Rarely	5.Not at all
----------------	---------	--------------	----------	--------------

5.3 Illustrate how the illness/condition affects you. During discussion showing available pictures/posters to clarify the verbal explanation.

1.All the time	2.Often	3. Not often	4.Rarely	5.Not at all
----------------	---------	--------------	----------	--------------

5.4 Reassurance: Give you expression of hope for treatment

.All the time	2.Often	3. Not often	4.Rarely	5.Not at all
---------------	---------	--------------	----------	--------------

ANNEXURE G: OBSERVATION CHECKLIST**3. CHECKLIST: C OBSERVATION OF REGISTERED NURSE COMMUNICATION WITH PATIENT****SECTION A****14.1 WARD**

QUESTION	CODING		QUESTION	CODING	
Orthopaedic (2A	1		Medical (5A	7	
Surgery (2B	2		Medical (5B	8	
Gynaecology (3A	3		Medical (6A	9	
Surgery (3B	4		Medical (6B	10	
Orthopaedic (4A	5		Surgery (7B	11	
Orthopaedic (4B	6				

14.2 Number of patients in the ward ()

14.3 Number of patients in the room ()

14.4 Time spend in a room by nursing staff ()

14.5 Number of registered nurses on duty ()

SECTION B: NURSING ACTIVITIES	CODING		
	1	2	3
	Yes	No	Other
15. Ward routine:			
15.1 Admissions			
15.2 Operations / theatre procedures			
16.1 Greet the patient			
16.2 Hand over report at bedside			
16.3 Review records			
16.4 Report writing			
16.5 Explain the procedures before asking the patient consent.			

SECTION C: COMMUNICATION: PATIENT SAFETY	CODING		
	1	2	3
	Yes	No	Other
18.1 Did the registered nurse address the patients by name all the time?			
18.2 Did the registered nurse listen carefully by probing more questions from the patient?			
18.3 Did the registered nurse offer opportunity to patient to ask questions?			
18.4 Was the registered nurse willing to answer the questions by the patient?			
18.5 Did the registered nurse refer the patient's concerns to the doctor instead of answering herself?			
18.6 Did the registered nurse show understanding of patient's concerns by summarising?			

SECTION D: COMMUNICATION FRAMEWORK AVAILABLE IN THE WARD	CODING	
	1	2
	YES	NO
19.1 Public service charter		
19.2 Patient charter		
19.3 Registered nurses scope of practice		
19.4 Communication book		
19.5 Ward policy		
19.6 Ward procedures		
19.7 Suggestion box		

20. Indicate how often registered nurse use these communication techniques.

20.1 Listen attentively: Give the patient opportunity to express his/ her concerns without interruptions.

1. All the time	2. Often	3. Not often	4. Rarely	5. Not at all
-----------------	----------	--------------	-----------	---------------

20.2 Avoid medical terms: Try by all means to simplify the medical terminology to the level of non-medical staff.

1.All the time	2.Often	3. Not often	4.Rarely	5.Not at all
----------------	---------	--------------	----------	--------------

20.3 Illustrate how the illness/condition affects the patient. During discussion showing available pictures/posters to clarify the verbal explanation.

1.All the time	2.Often	3. Not often	4.Rarely	5.Not at all
----------------	---------	--------------	----------	--------------

20.4 Ask patient to play back: Check whether patients grasped what they need to know and do by asking them to play back.

1.All the time	2.Often	3. Not often	4.Rarely	5.Not at all
----------------	---------	--------------	----------	--------------