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THESIS

Nursing care given by registered nurses to cancer patients who are admitted to the hospitals of the North-West Health Directorate

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NURSING CARE GIVEN BY REGISTERED NURSES TO CANCER PATIENTS WHO ARE ADMITTED TO THE HOSPITALS OF THE NORTH-WEST HEALTH DIRECTORATE

BY

KATRIINA-KUNA IDHIDHIMIKA SHIKONGO

SUBMITTED IN ACCORDANCE WITH THE REQUIREMENTS FOR THE

DEGREE

OF

MASTER OF NURSING SCIENCE

IN THE DEPARTMENT OF NURSING SCIENCE OF THE

FACULTY OF THE MEDICAL AND HEALTH SCIENCES

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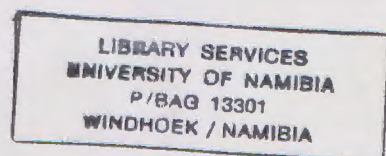
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JANUARY 2000

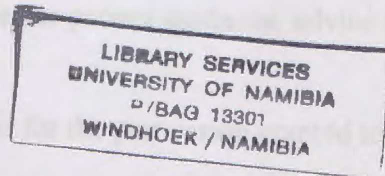
DECLARATION

I declare that "Nursing care given by registered nurses to cancer patients who are admitted to the hospitals of the North-West Health Directorate" is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of a complete reference.

Signed: **K K I Shikongo**

Date: **January 2000**

Place: **Windhoek**



ACKNOWLEDGEMENT

"O, sing unto the Lord a new song; for He hath done marvellous things: His right hand and His holy arm, hath gotten Him the victory" - Psalm 98:1.

I am dedicating this dissertation to my husband whose encouragement, support and positive attitude towards my study has made it possible for me to achieve another step forward.

My children, although still young, sacrificed my tender loving care and attention to their needs for the sake of my study and achievement.

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SUMMARY

Nursing care given to patients with cancer by registered nurses is of vital importance. Nurses care for patients for almost twenty four hours while other health professionals have contact with patients for a few hours only.

This study was employed to investigate how this care is given to the cancer patients in the four hospitals of the North West Health Directorate, now phasing out to become the four North West Health Regions (Oshana, Omusati, Ohangwena and Oshikoto health regions).

The approach used in this research is a descriptive survey. For the purpose of collecting data two questionnaires were used, one for completion by registered nurses, and one to interview cancer patients respectively, which in the latter case was done by the researcher.

The questionnaires to registered nurses were sent through the Directorate to the hospital nursing managers for distribution to registered nurses, some were delivered by the researcher at the hospital managers' offices and collected in the same way.

The total population of registered nurses was 70 out of which 41 (58,6 %) responded. The population of patients was not calculated, but any patient admitted during the interview period and available in the wards/units were included in the study.

The findings indicated that patients at these four hospitals cared for by registered nurses was not always in line with the approach of nursing process. The type of care given to these patients was found to be more generalized than individualized. The nursing care plans of patients are of general aspects of nursing, based on generalised assessment for identification of patient's needs. In some cases, it was found that, according to the interview of patients, nothing was done to the patients, complaints/problems, as the specific need of the patient was not assessed and therefore not planned for.

The findings also revealed that in all four hospitals there is no single registered nurse who has

undergone a specialised training in oncology nursing. Therefore, registered nurses caring for such patients, are using their knowledge gained in General Nursing Science and not specific to Oncology Nursing care.

The counselling process seems not to be effective. The patients seemed not to be well informed regarding their conditions and the care they received.

The findings therefore, indicated a need for nurses who are caring for the cancer patients to be specifically trained under an approved curriculum in Oncology care, and an in-service training programme for those who are already caring for these patients.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND OF THE PROBLEM

1.1 INTRODUCTION

Oncology is the study of malignant neoplastic diseases generally referred to as cancers (Baldonado & Stahl, 1982:1). Cancer has been known throughout the recorded history though little was done to care for such patients who are considered and believed to be mortal.

Traditionally, in some African countries, cancer was believed to be caused by witchcraft which is why it was not curable at western medical facilities. In some cultures in Namibia cancer patients who are diagnosed through laboratory investigations are taken in their final stages, to traditional healers or witch doctors who in their attempts, try to find who is the culprit, what has she/he done to bring about such a disease and the possibility of cure or not. In many cases, people end up hating each other for a disease which neither the witchdoctor nor the accused can diagnose, treat and bring about, respectively.

From the moment of detection and diagnosis, the certainty of mortality influences the behaviour of both the patient and medical care team of which the nurse is a member. The registered nurse plays an important role in the multi-professional treatment regime and is accountable for rendering quality nursing care of which the caring is of most importance. The inability of the registered nurse to objectively and formally evaluate the quality of oncology nursing care is sometimes due to lack of determined standards.

Nursing staff working with oncology patients need knowledge and caring skills to meet the basic needs of the patients. Watson (1997:79) emphasized this and stated also that caring by a registered nurse requires knowledge and understanding of individual needs and health related problems, knowledge of how to respond to others' needs, and knowledge of her own strength and limitations. She must understand the situation and how to offer compassion and empathy.

Furthermore the professional responsibilities also include preventive, curative and rehabilitative aspects of nursing care, and recognition of the patient as a part of a family and community. Thus, the nurse's roles are to assist the patient in adjusting to different ways of meeting his/her daily requirements, establishing new techniques of self care, modifying self image, revising his/her routine of daily living and developing a new life style compatible with the effect of any disabilities (Dietzy, 1981:170). What is expected from the registered nurse is to be able to care for the patient with cancer. Care therefore includes the knowledge of nursing the patient as a whole and implies the knowledge and skills to do so.

According to the statistics of the North West Health Directorate (NWHD) of the Ministry of Health and Social Services, there are a high number of cancer and leukemia cases in the regions. A number of 614 patients have been admitted in the four main hospitals in 1995. These four hospitals are: Oshikuku, Onandjokwe, Oshakati and Tsumeb. Oshakati State Hospital is a district as well as a regional hospital in the North West Health Directorate.

Patients from the three district hospital, i.e. Onandjokwe, Tsumeb and Oshikuku are also referred to Oshakati Hospital. Oshakati on its own refers cases to Windhoek State Hospital where most of the diagnoses are made and confirmed. It is therefore such that Oshakati Hospital caters for many cancer cases which are admitted to it directly, and some referred from the other three hospitals. After confirmation of cancer diagnosis, patients can then be referred back to the district hospitals from where they came.

In 1995 from January to December the total admission of patients with cancers at the four hospitals in the North West Health Directorate was 636 (100 %) of which 614 (96,5 %) are adults and 22 (3,5 %) are children.

Oshakati had total admissions of 489 (76,9 %) adults and 21 (3,3 %) children. Oshikuku admitted 16 (2,5 %) adults, but no children were admitted that year. Onandjokwe admitted 95 (14,9 %) adults and 1 (0,2 %) child. Tsumeb's total admissions were 14 (2,2 %) adults only.

For the year 1996 from January - June a total number of 390 cases were admitted in those four

hospitals in the North West Health Directorate. This number reflects an increase in diagnosis and admissions to the hospitals. A rough calculation of cases per year (1996) could be more than 700 cases compared to 614 in 1995.

Table 1.1 Number of cases admitted 1995

Hospital	Adults	Children	Total
Oshakati	489 (76,9 %)	21 (3,3 %)	510 (80,2 %)
Onandjokwe	95 (14,9 %)	1 (0,2 %)	96 (15,1 %)
Oshikuku	16 (2,5 %)	0 (0,0 %)	16 (2,5 %)
Tsumeb	14 (2,2 %)	0 (0,0 %)	14 (2,2 %)
Total	614 (96,5 %)	22 (3,5 %)	636 (100 %)

Table 1.2 Number of cancer admissions January - June 1996

Hospital	Adults	Children	Total
Oshakati	265 (67,9 %)	2 (3,08 %)	277 (71,03 %)
Onandjokwe	97 (24,9 %)	1 (0,26 %)	98 (25,12 %)
Oshikuku	9 (2,3 %)	0 0,0 %)	9 (2,31 %)
Tsumeb	5 (1,3 %)	1 0,26 %)	6 (1,54 %)
Total	376 (96,4 %)	14 (3,6 %)	390 (100 %)

On the basis of statistics, one should conclude that the nurses, more especially the registered nurses have a vast responsibility to care for the increasing number of patients admitted at their hospitals. Nonetheless, it is not only the number of patients that is increasing but also needs of patients which demand special attention and care for every specific patient.

Better care of the cancer patients while admitted in hospitals will pave the way for community care when they are discharged. During their stay in the hospital units they should be prepared for self and family care through health education, demonstrations of activities, setting good examples to them and education of their family members. The main question remains whether such

education and care is taking place. Are the patients being cared for in the manner that is expected?

The answer to this question will be exposed by embarking on a study aiming at finding out the extent to which such activities are performed by registered nurses in the hospital in the Northern regions.

For the registered nurse to act effectively in the care of her patients, she has to possess the following:

- respect for dignity and uniqueness of man in his social-cultural and religious context;
- skills in the diagnosing of man's health problems, the planning and implementing of therapeutic actions and nursing care for the individual;
- ability to direct interactions with patients;
- ability to collaborate harmoniously within the nursing and multi-disciplinary team; and
- an enquiring and scientific approach to the problems of practice.

Cancer is not just another disease, it brings out many of the deepest fears of human beings. It is accompanied by a great deal of psychological and physical suffering. Many patients have the chance of living two or more years with their families. This is of indescribable value to the human being (Katjiri, 1995:11).

In caring for cancer patients, the registered nurse has two major functions to fulfill; the expressive and the instrumental functions. From the literature it is evident that the two dimensions can be applied to this study. The instrumental dimension includes all the actions of the nurse which lead to the concrete realization of her objectives. These actions can to a greater or lesser extent be technological, while the expressive part of her task is based on the establishment of an environment and relations that will contribute to a realization of her objectives (Nolte, 1992:22). It is important that both of these dimensions should be present in everything the nurse does for the cancer patient.

1.2 STATEMENT OF THE PROBLEM

It has been believed that cancer patients are not well cared for in the hospitals and health facilities, more especially by registered nurses as they are expected to be more knowledgeable and have necessary skills in care of these patients.

The care and support of the cancer patients by registered nurses in the northern regions of Namibia is considered to be poor and they also give poor guidance to the lower nursing categories. This has brought about a situation whereby patients diagnosed with cancer still look for traditional healers as they are not properly informed about their conditions, care to be given and how to care for themselves.

This phenomenon was also stated by Brink (1990:38) in that a wide range of services are required to care for the cancer patients, yet despite the fact that caring is a central theme in nursing there is growing evidence that nurses are not as effective as they ought to be in their caring roles.

Thus, the problem is that there is uncertainty to what extent registered nurses render the care they should to cancer patients.

1.3 PURPOSE OF THE STUDY

The purpose of this study is to attempt to determine the extent of care that is given to cancer patients who are admitted in the hospitals of the North West Directorate of the Ministry of Health and Social Services, by registered nurses.

1.4 RESEARCH QUESTION

As a point of departure the following should be the basic question on which the research study is based: How are cancer patients being cared for during hospitalization by registered nurses in the North West Health region?

1.5 OBJECTIVES OF THE STUDY

The need for care for cancer patients is as important as for any other patient. It is his/her right to be cared for and supported as it is done for patients who are believed to be curable. The registered nurse is a co-ordinator and constant source of support for such patients. Therefore the objectives of this study are to determine the expressive and instrumental functions of the nurse in caring of these patients.

The objectives therefore are to determine:

- the qualifications and experience of registered nurses concerning cancer nursing care;
- whether the nursing process is applied during nursing practice;
- how pain is managed by registered nurses;
- whether cancer patients received information and counselling by registered nurses and or other health professionals concerning their conditions;

1.6 DEFINITIONS AND TERMS

Cancer

Any malignant tumour, including carcinoma and sarcoma. It arises from the abnormal and uncontrolled division of cells that then invade and destroy the surrounding tissues (Medical Concise Dictionary, p. 87).

Cancer patient

A person suffering from some form of neoplastic pathology (Baldonado & Stahl, 1982:5).

Oncology nursing

The nursing of patients suffering from cancers and it can be curative, restorative, palliative or

supportive depending on the medical diagnosis of the patient (De Kleijn & Muller, 1991:24).

Caring

As a verb, the concise dictionary gives the meaning as feeling concerned or interest (Nolte, 1992:22), however, it stated that caring is a science as well as an art and the practice of the science of caring draws on basic knowledge and an understanding of how people feel and behave under various circumstances. Leininger (1981:10) has called caring the "essence of nursing ..... of the central and unifying domain for the body of knowledge and practice in nursing.".

Nursing Process

A systematic, rational method of planning and providing nursing care. It goes about identifying a client's actual and potential health care needs by following the steps in a logical sequence to meet those needs (Kozier, 1987:214).

Hospital

A health institution where health care services are provided (Kozier, 1987:2). An institution providing medical or surgical care and treatment for people who are ill or injured, obstetric treatment for pregnant women, psychiatric treatment for mentally ill and the like (Ilson, 1984:816).

Registered Nurse

A person registered with the Nursing Board according to the Nursing Profession's Act, Act no. 30 of 1993.

Nursing

Identification and treatment of human response to actual or potential health problems and includes

the practice and supervision of functions and services that includes the nursing process (Kozier & Erb 1987:6).

1.7 PRESENTATION OF THE REPORT OF THE STUDY

Title of the report

The report is presented under the title:

> ***Nursing Care given by registered nurses to cancer patients who are admitted to the hospitals of the North West Health Directorate***

Organisation of the report

The report is presented under five chapters:

Chapter 1:	Introduction and background of the problem
Chapter 2:	Review of literature
Chapter 3:	Methodology
Chapter 4:	Analysis and discussion of data - Questionnaire A
Chapter 5:	Analysis and discussion of data - Questionnaire B
Chapter 6:	Summary of findings, conclusions, limitations and recommendations

1.8 SUMMARY

Cancer is a major health problem facing Namibians. As it was not well understood over the past years, nursing care in this regard has also not been well understood. The nurses caring for cancer patients were unsure of what specific care for patients who are not curable. Patients were not certain of the curability of their conditions, therefore they were not sure of what to expect and what was to happen to them. This situation of uncertainty has in most cases created fear and tension among the patients as well as the nurses caring for such patients. In this study the aim is to look at the care given to such patients in the hospitals by the senior categories, who are registered nurses.

CHAPTER TWO

REVIEW OF LITERATURE

2.1 INTRODUCTION

This chapter reviews the literature on caring in relation to cancer patients. Literature review is an essential step in the research process, which equips the researcher with knowledge and skills of how to go about researching the problem concerned. It also helps the researcher to review what has already been done about the problem, i.e. previous researches, findings and necessary recommendations made. By reviewing literature the researcher is put in a boat to sail along the right path, to fill in gaps left open by others, to avoid errors committed and apply necessary information in his/her methodology for proper selection of methods, strategies and analysis of data. Human beings are said to be interdependent and related, none can live in isolation. We interact in different ways and these interactions make life interesting and meaningful. For research to be meaningful, it should be done interestingly, ideas need to be compared, brought into relation so as to "catabolize" the different concepts and embark upon the exploration thereof.

2.2 PURPOSE OF THE LITERATURE STUDY

The purpose of the literature review is to search for similar studies by other researchers. The research identifies diversity and universality of views; what is already known about caring of patients; earlier assumptions of this study and to establish effective ways of conducting the present study (Polit & Hungler 1991:127-133). The objectives of the literature review for this study is to:

- explore the role of the registered nurse in caring for cancer patients;
- look into the relationship of the nurse and the patients she is caring for;
- obtain the information on what the expectations of cancer patients are from the registered nurse;
- get background knowledge of the nurses in respect to the care they give to patients;

- identify the functions of the nurse in respect to the needs of the patients suffering from cancer as well as the level of involvement of family members and relatives in the care of patients; and
- identify mechanisms established in different situations for pain and symptoms relief and experience of nurses in other countries pertaining to cancer care.

2.3 BROAD FRAMEWORK OF THE STUDY

According to Polit and Hungler (1991:117) conceptual framework deals with abstractions (concepts) that are assembled by virtue of their relevance to a common theme. For the purpose of this study the following concepts were considered to serve as the framework for the study:

- Exploration of the meaning of the term caring.
- Themes of caring in nursing by Jean Watson.
- Transcultural theory of nursing by Madeleine Leininger.
- Interpersonal relationship.
- Nursing process - basic and specific needs of the cancer patients.

2.4 EXPLORATION OF THE MEANING OF THE TERM "CARING"

Caring is a universal phenomenon. Caring is essential to human existence, growth, development and survival. Health care is a type of human caring and can be socially and culturally defined. The concept of caring has been widely explored in nursing. Researchers such as Leininger (1981) and Benner Wrubel (1989) have made substantial contribution to the understanding of caring as an integral part of nursing. Leininger has called caring "The essence of nursing, the central and unifying domain for the body of knowledge and practice in nursing.". She claims that "caring acts and decisions make the crucial differences in effective caring consequences. Therefore it is caring that is a most essential and critical ingredient for any curative process.". In 1988 Leininger has posed a very important question the "If generic and professional caring is not taught and modelled in nursing, how can the nursing profession continue to make claim of being a caring profession?" (Cohen 1991:900).

The point highlighted by Leininger is what is looked into present nursing care in our hospitals. Nurses caring for cancer patients, should make sure that their care is worth to be considered as caring. A nurse giving medication or water and food to patient is not caring - caring is more than that. Patients need someone to be concerned with their problems, needs and who tries to do something about it and evaluates her actions to see whether it has effect on the conditions of her patients. Then that caring can be said to be "essence of nursing".

The same idea as contained in Leininger's concept of caring, are found in Benner & Wrubel's work titled "Primacy of caring" in 1989. In their work caring was seen to be fundamental to all nursing actions considered to address the needs of patients. It was mentioned that there can be caring without curing as it is seen with cancer patients. We know that many types of cancers patients are suffering from are incurable but careable. This is also mentioned in Watson's (1985) ten carative factors where she emphasized that caring is aiming at helping the patient to attain health (where the condition is curable) or die a peaceful death (like in case of cancer patients).

Caring is used in many situations where it denotes "a feeling of being concerned for or interested in something or somebody or event". This is not always the case with some of our nurses, in this case, registered nurses. Some patients are neglected and activities are just performed for routine work to be completed and duty to be fulfilled but such nurse may not have any concern or interest in those patients as human beings. Cancer patients in most cases are just seen as cases on the grounds that, their conditions are incurable and terminal, somebody on his/her way out of life who do not need to waste anybody's time.

In this study caring is a term which is a science as well as an art and the practice of science of caring which draws on basic knowledge and understanding of how people feel and behave under various circumstances (Nolte 1992:22).

Brink in her abstract (1990) of a study on "Teaching Caring in Nursing", has indicated that nurses are not as effective as they ought to be in their role of caring. For that reason, her study was aiming at paving the way to initiate the process of research on teaching caring. For students to implement caring practice, it is necessary to implement caring in their lives and in their educational

environment. It was seen that nurses who never experience caring in their training also lack the sense of caring towards their patients.

Oncology nursing as a specialized nursing discipline, needs care from competent nurses. Therefore, for this care to be facilitated, nursing standards in oncology are of vital importance. For oncology care to be the "essence of nursing" like any patient care, it should be based on certain standards which could serve as a guide to ensure quality oncology nursing (De Kleijn & Muller 1991:80). Every type of care is to be based on nursing standards. For oncology care standards to be attained are: to assess the needs specific to every cancer patient; to plan for actions to be taken to satisfy such needs; to implement actions, evaluate the results and to reformulate actions or reinforce existing ones. This means that no cancer patient's care should be routinely organized but be specific and special to the patient's condition.

Oncology nursing care is also said to be a multifaceted speciality which deals with patients who may be on a health-illness continuum, ranging from high risk patients needing information about prevention, to patients needing comfort and support during dying (De Kleijn & Muller 1991:80). Registered nurses in hospitals need to take this point into consideration when they have cancer patients in their care. As patients are never the same their care needs are also not going to be the same. Everyone's needs need to be identified, and their level of suffering as well as the categories in which they fall on the health illness continuum. Cancer, though incurable, is sometimes preventable therefore high risk patients need to be identified and the necessary education be given by registered nurses on preventive measures.

Although caring is considered to be vital to the recovery of and part of healing, it should be taken into account that caring takes place at preventive, promotive, curative and rehabilitative levels. Therefore, nursing care of cancer patients should address needs at all those levels from preventive information to rehabilitation of non-curable condition. The process of caring is as central to nursing as it is to problem solving or communicating (Brink 1990:56).

The medical diagnosis of cancer and the high mortality rate attached to the diagnosis, determine the behaviour of the patient and the health care provider, in the health care situation. Caring

needs to be carefully planned by the nurse. This care is based on the assessment made regarding the condition of the patient to determine his/her needs and objective formulation which guides her to achieve. The nurse should always establish what methods or strategies are appropriate in every situation.

The process of caring has three attributes: purpose, organization and creativity. The purpose of caring has three attributes: purpose, organisation and creativity. Purpose goes together with love and enabling one to fulfill oneself and thus leading to self-actualization or mutual self-actualization. Caring helps people to overcome separateness; achieve and transcend individual life. Organization is the system of achieving growth of self and facilitating growth of the one cared for. Creativity is the ability to think and come out with something applicable to the situation of caring (Kuhse 1997:144).

Caring therefore, in this respect means what matters to a person and what counts stressful as well as what options are available for coping. Caring creates possibilities. Caring comes first and events become stressful only when they matter to people. If a person does not care, the events won't be stressful. This is what is termed primacy of caring. It can be stated that if the nurse cares for a patient and she is concerned with him she may observe/experience the suffering of the patient as a stressful situation because she finds it to matter. Those nurses for whom patients conditions do not matter so much, they also care less for such patients and caring has no meaning to them. "Today, caring not only has connotations of concern, compassion, worry, anxiety and burden; there are also strong connotations of inclination, fondness and affection; of commitment to a person and ideal or a cause; connotation of carefulness, that is, of attention to detail, of responding sensitively to the situation of the other; and there are connotation of looking after or providing for the others." (Kuhse 1997:145).

As the caring profession is emanating, more empirical meanings change the direction of how this caring is provided. Nurses themselves are also constantly exploring meanings of concepts in their caring system, new visions are developed and new missions are being formulated. All new trends will have great impact on the definition of caring, which is then expected to change from generation to generation. As a caring definition is formulated, it is also broadening more and

more and takes up diverse directions where nurses may start to see it differently. One nurse may consider caring to be feeling, sentiment or disposition that characterizes the nurse-patients encounter. Another may see caring as "sentiment" akin to compassion, sympathy and empathy. Bevis speaks of it as a feeling of dedication to the extent that it motivates and energizes action to influence life constructively and positively by increasing intimacy and mutual self-actualization in Kuhse (1997:146).

The meaning of caring as having being explored above has been made a very important concept in various theories of caring. Many theorists have discussed caring under various perspectives. Some of the theories have the same view while some may have diverse views what caring is about.

2.5 THEORIES ON CARING IN NURSING

Nursing is a human science and is therefore concerned with human care. It is contained in Watson's theory who tried to highlight how caring for human beings can be viewed in terms of human science. The human can be portrayed in her theory together with a theory of Leininger. Several theorists have seen caring as the essence and unifying domain of nursing and have devoted their careers to studying and involving the meaning of this central focus. The main focus is going to be put on the theory of Leininger and Jean Watson.

Leininger's theory goes about transcultural nursing while Watson's theory is an interpersonal or trans-personal relationship in nursing.

Transcultural Theory of Nursing

Leininger is the founder of transcultural nursing and the proponent of human caring. She first developed her ideas in the mid 1950s. As a psychiatric clinical nurse specialist she worked with children of diverse cultural backgrounds. She identified lack of understanding among the staff about how cultural backgrounds influence the behaviour of children. She recognized the need to develop strategies that would incorporate different cultural patterns and life ways. She completed her doctoral degree by focussing on cultural anthropology at the University of Washington. For

the patient with cancer, the type of caring which takes the cultural backgrounds into consideration is very essential and necessary. It is the essence because the patients need to be assisted, be supported or facilitated to anticipate their needs, to improve their condition of life ways even if their conditions are incurable. They need comfort, freedom from pain, fear and worry, to enable them to accept their conditions with dignity (Cohen 1991:900-901).

Leininger's transcultural theory of nursing reflects her key assumptions. One of the assumptions is that human caring is a universal phenomenon, but the expressions, processes and patterns vary among cultures. Caring has biophysical, psychological, cultural, social and environmental dimensions which can be studied once practised to provide holistic care to people.

In her theoretical conceptual model of transcultural care diversity and universality Leininger stated that human beings cannot be separated from their cultural background and social structures. Nursing and health care systems are folk and professional and influenced by socio-cultural factors (Cohen 1991:900).

All of us in nursing know how our patients react to being ill. Illness, diseases and health are culturally defined. What means to be feverish, vomiting and having diarrhea is not the same in all cultures. For us in Oshiwambo it may be interpreted as being bewitched or if it is a baby it means that the mother is having an undesirable growth, ridge or elevated part between the buttocks or at perineum which brings this symptoms in a baby through breast milk. And if somebody believes in that she will go and look for help from a traditional healer who will cut it out for the purpose of curing the baby.

In other cultures like western ones, such symptoms are more indication of infection. The cultural view of diseases illness and health determines health seeking behaviour of the individual or family. For example, if the patient is not properly informed about his condition during his care, he may think that being unable to cure is because of witchcraft whereas it is cancer.

Every nurse caring for cancer patients should remember that she is not just a cancer patient but also a cultural being. This will help nurses not only to focus on the diagnosis and all special care

attached to it, but also see the diagnosis upon a certain type of cultural belief of such a disease.

Leininger used her model (Sunrise Model) to illustrate the major components in her theory as well as the way that this information influences nursing care. The first level, world view and social structure dimension, influences the persons perception of health, illness and care. According to Leininger, all these factors are culturally universal, but also culturally diverse.

Level two provides information about specific meanings and expressions of individuals, families, groups as they relate to health.

Level three is the level where the nurse plans her intervention. According to Leininger the nurses's unique position is between the professional and the folk system. The nurse will use information obtained from the above two levels to involve the patient in planning of his/her care.

Level four is the level of intervention. At this level the nurse makes decisions about care delivery based on information previously collected (Leininger 1991:51-78).

Leininger's theory of transcultural nursing has some underlying assumptions which sum up her main ideas in that theory.

Some of her assumptions are:

- Every nursing care situation has transcultural caring behaviour, needs and implications.
- Caring acts and processes are essential for human development, growth and survival.
- There is no curing without caring, but there can be caring without curing.

Nursing is a unique humanistic art and science directed towards promoting and maintaining health behaviour or recovery from illness.

Nurses usually do not have time to study the total life ways of people but they are interested in health patterns nursing care phenomenon. The transcultural concept is transformed into a new

concept Ethno Nursing (Cohen 1991:901, 906).

WATSON'S THEORY OF CARING

Watson in George (1995:318) views caring as the most valuable attribute nursing has to offer to humanity, yet caring has, over time, received less emphasis than other aspects of practice of nursing.

All human caring is related to inter-subjective human response to health illness, environment personal interaction and knowledge of the nurse. Watson conceptualizes caring as an interpersonal process between two people with trans-personal dimension. She stated the process of caring when the nurse enters the phenomenal field of the patient and responds to the patients condition of being/spirit and soul in such a manner that the patient releases subjective feelings or thoughts, that the patient has longed to release.

The cancer patient needs such protection from physical complications, psychological trauma and social isolation and his level of health needs to be enhanced and as a human being he needs to be cared for so that his dignity is preserved and respected until death. The caring occasion leads to discovery of the "self" either by the nurse or the patient. Because caring is interpersonal, it gives the nurse a chance to bring her entire self to interaction with patient. The patient and the nurse both experience a sense of self and universe. The nurse brings in the phenomenal field of caring, her own self together with that of the patient (Cohen 1991:903-904).

In the caring occasion both the patient and the nurse make decisions. This caring occasion makes the new opportunities for both the patient and the nurse of inter-subjectivity based on the belief that, people learn from each other about how to be human, by identifying themselves with others. The nurse enters into the patient's experience and the patient into the nurse's experience (Watson 1985:58-60). In a trans-personal relationship, the nurse will use the entire self.

In this relationship between the nurse and the patient, some personal differences may be identified as lying in focus, intensity and perspective.

Focus: The problem of the patient and its effect is different. The patient is affected but the nurse just comes into the situation.

Intensity: The patient is experiencing the distress more than the nurse.

Perspective: Of the two differs: the patient suffers from pain internally and the nurse suffers externally. This goes about emotional involvement. The art of nursing is centred on a trans-personal caring relationship when the nurse, having realized the feeling of another, is able to detect and sense those feelings and in turn is able to express them in such a way that the other person is able to experience it more fully (Watson 1985:65-66).

Watson has made some assumptions which she considered to be the basis for interpersonal care. Three major assumptions are as follows:

- Nursing has always held a human care and caring stance in regard to people with health illness concerned.
- Caring values of nursing have been submerged.
- Human care can be effectively demonstrated and practised only interpersonally (Cohen 1991:905).

She has also gone so far as to identify some carative factors which are fundamental in the human caring process. The day to day practice of professional nursing requires a grounding in humanist value system that the nurse continues to cultivate. The humanist value system must be combined with scientific knowledge that guides the nurse's action. Carative factors is the term contrast to curative.

To indicate the difference between nursing and medicine, carative factors are the factors that the nurse uses in the delivery of health care to the patients or clients. It is developed from humanist philosophy that is central to caring for another human being. Where curative factors aim at curing, carative factors aim at the caring process to help another person to attain health or die a

peaceful death. Caring is transmitted from generation to generation by means of professional culture.

Some of the ten carative factors are:

- The cultivation of sensitivity to one's self and others.
- The development of a helping-trust relationship.
- The acceptance of the expression of positive and negative feelings.
- The systematic use of the scientific problem solving methods for decision making.
- Assistance with gratification of human needs.
- The provision for supportive, protective and corrective mental, physical, social, cultural and spiritual environment (Watson 1979:91).

Watson's theory considers four major concepts, i.e. human beings, health, environment/society and nursing.

Human being goes about a valued person to be cared for while **health** is unity and harmony between the body, mind and soul. **Environment/society** goes about people who care for others and **nursing** is human science of caring (George 1995:319).

Leininger and Watson's theories are interrelated and both go about human beings and culture. Trans-cultural care emphasizes care of people of different cultures where as trans-personal/interpersonal care denotes care of human beings by human beings. The relationship of the two theories is that the human beings when cared for belong to different cultures and those who are caring for them have their own cultures, but both, those who are cared for and those who care for them are human beings. Human beings belong to different cultures which influence their perception and definition of diseases, ethics and health (Cohen 1991:899-908).

2.6 BASIC AND SPECIFIC HUMAN NEEDS AND THE NURSING PROCESS

BASIC HUMAN NEEDS OF CANCER PATIENTS

A need is something that is desirable and necessary (Kozier 1991:67). Basic needs may be common to all patients but may not be experienced at the same level depending on the patients diagnosis and conditions. Basic needs like water, food, clothing, safety and love are also as important for oncology patients as for any other patient being chronically ill, and the condition being incurable, may increase the intensity at which these needs are felt. Fear for the unknown and death may cause a state of insecurity.

To care for a cancer patient does not just start in a vacuum, but is dependent on the needs of the patient. A registered nurse should know how to identify basic and specific needs of the oncology patient and how to fulfill and satisfy them. Therefore the care she/he is giving to the oncology patient should be need oriented and should consider the needs presented with by each patient admitted to her/his unit.

Although cancer patients may have some common specific needs, these needs should be clearly identified and not just assumed.

Any human being has basic needs which must be met or satisfied and if not, a health person has physiological as well as the psychological mechanisms by which unmet needs may be reduced or effects be neutralized. The effect may come out minimal or not felt at all.

Henderson (1985) considered basic needs to be activities that contribute to health or recovery. These needs are components of basic nursing. A person is a composite of physical, social, emotional, cognitive and spiritual components and his needs fall into these categories (George 1995:77).

Specific Needs of Cancer Patients

There are needs which were found to be specific to patients suffering from cancer.

These needs include the following:

The need to know

This may be general to all human beings but also specific to cancer patients. They need to know what is wrong with their bodies and what it means.

Patients must be informed about their condition when the diagnosis is made. The fact that patients must be informed about the nature, consequences and possible treatment of their disease is not a matter for debate. In principle, patients have the right to as much information as possible about their condition and its management, and constant attention should be paid to having this information updated and clarified throughout the course of treatment (Wolde 1996:10).

According to Rasmussen (1996:11) the demand for more information from patients on health professionals increased. Therefore, information should not only be presented to patients verbally, but also in writing. This will enable patients to commit themselves to their own independent choices.

The extent to which a patient and his/her family is informed, and the way in which this should be done, depends, to a large degree, on their attitude. The patient's emotions and sense of reality, patient-doctor relationship and other related factors play a role in this. However, in spite of all the viewpoints concerning provision of information to patients concerning their condition remains inadequate (Wolde 1996:10).

On the other hand there are also patients who avoid to know what is wrong with them and this may be to maintain hope.

Coughlan (1993:67) had stated that in Herity's study (1987) of IBU patients, 82 % of the patients knew they had cancer, however, of these 164 patients, 40 stated they were not specifically told, 36 patients said they were not told and 25 of them wanted to know their diagnosis while 5 were undecided (Coughlan 1993:67). It can be concluded that the desire for information differs from patient to patient and the response after being told also depends on the individual. The patient may want to know, but after being told she/he may accept but hope for cure; or deny that he/she has cancer or that she/he was never told. The denial is an indication that some cancer patients do not want to be told that they have cancer even if they demand to know.

The need for communication

Cancer patients at clinics or hospitals need to communicate with staff as well as relatives and friends. Most of the time they communicate with each other and discuss about the character of the staff. In such a communication they learn from each other the nature of cancers. Tiffany (1978:43) stated that patients are inquisitive and try to overhear doctors and nurses whispering in corridors to listen whether they can hear something about themselves. A survey done at Royal Marsden Hospital, London, by Cartwright has indicated that 46 % of general patients have regarded medical staff as their main source of information (Tiffany 1978:44).

Communication is part of treatment, for it helps the patient to adapt to the conditions imposed by illness by making him aware of his situation. Because of the nurse's continuing contact and involvement with the patient, she becomes the focus of communication, not only with the patient, but on an interdisciplinary level (Searle & Pera 1995:319).

Some nurses have no time and do not see the need to communicate with patients. If they have administered pain killers to cancer patients, they feel it is enough. There is no care without communication and if a nurse claims to be caring for patients she has to maintain a sound nurse-patients relationship.

Travelbee (1996:121) defines the nurse-patients relationship as the means through which the purpose of nursing is accomplished, namely, to assist an individual (or family) to prevent or cope

with the experience of illness and suffering, and to help him (or his family) in finding meaning in his experiences.

Mores (1992: 809-821) has also studied "Caring beyond Empathy" in which he highlighted the nurse-patient interaction. It was found that most of the time, nurses focus on themselves rather than on the patients. In this study it was also found that empathy is emphasized in nursing education as a model of combination in caring of patients rather than sympathy, pity or commiseration.

The latter are bound to be harmful and not beneficial to the patients in clinical set up, but in general sympathy and pity is also needed in caring for cancer patients more especially when they are in state of crisis and cannot accept their diagnosis and changes they have undergone. Therefore, Mores and others' study is subjected to debate and criticism and should not just be accepted as a general rule. Communication styles with cancer patients would be selected contextually.

The need for support

Patients suffering from cancer are in need of supportive measures from health workers and from their family members. Some studies have also indicated that family members are also in need of support to be able to cope with the burden of their family members who are suffering from cancer. The level of support will differ from family to family and from patient to patient. It also differs depending on whether the patient is an adult or a child.

Cancer is a serious and extensive health problem, which can disorganize social processes, daily functioning and mental stability.

According to Redmond (1997:91) there is increasing recognition of the psychological effects of having or having had cancer. Together with this awareness there is corresponding increase in the recognition of a need for psychological and spiritual care of the person throughout the course of the disease.

However, the literature studies continue to indicate that these needs are often inadequately met. Amstrong (1995:24) stated "one of the problems with modern nursing is that we have concentrated so hard on the needs of the patient, we have forgotten to ask what he wants".

Providing of psychological care is inherent in nursing. It has been indicated so many times that it is nurses at the sharp end who play a pro-vital role in cancer care.

Although not all nurses are experts in psychotherapeutic techniques, given the opportunity to extend their knowledge and skills, nurses should be able to combine counselling skills with other nursing activities. This entails the extended role of the nurse.

Holland (1990:120) maintained that the cornerstone of psychological support would appear to be the relationship between the nurse and the patient.

Nursing care is aimed at assisting the individual to deal with and find meaning from this crisis. This is achieved through the relationship between the nurse and patient in which the nurse establishes a therapeutic presence in caring for the patient (Soohbany 1999:35-40).

Nurses assess patients and by that determine any change in the patients status. Patients on the other hand prefer to raise difficult issues with nurses usually during the night shifts. The skills needed to handle all these issues are fundamental to nursing care (Hansen et.al. 1995:46).

According to O'Toole (1999:10) there remains a challenge for nurses to investigate more vigorously the skills and interventions that are needed to provide psychological care.

Furthermore, nurses will have to seek to work collaboratively with all the other members of the health team and the family of the patient for psychological support.

In Namibian culture, in the northern black population in particular, family members keep a close relationship with the patient during the period of admission. They visit him/her frequently, talk to him/her about his/her suffering as something which can happen to everybody and as the will

of God. The patients, therefore, get strong moral support from that. Even the far relatives are strongly and emotionally involved when one member is ill. They give their support even if they don't know the exact nature of the disease. In cases where the family may know, either told or just through mere guessing (suspicion), they still encourage patients to take treatment seriously (sometimes hoping for miracles). Physical support is eminent by bringing him food and type of assistance they feel can help him like money to buy something he/she may need.

The patient's support by nurses can then be strengthened by that of family members, relatives and friends if the nurses do proper assessment during history taking and involve the family members in their planning session. The nurse practitioner must eliminate all the indirect aspects of communication that undermine patients trust.

Nurses should then be careful not to shift their own responsibilities onto the shoulders of family members and relatives, as sometimes happens, but only to be guided in their actions by what they hear, observe and assess from them.

The Need for Freedom from Pain

Pain or fear of pain is a significant part of the cancer patient's experience. Epidemiological studies have shown that between 30 and 50 % of all cancer patients experience pain and more than 80 % of those with advanced cancer have pain (Ntoane 1993:32).

Despite major technological advancements, inadequate treatment of pain is a persistent problem. Prolonged pain may have a demoralizing effect on the cancer patient.

Nurses in every area of clinical practice are confronted daily with the challenge of pain management. The incidence of unrelieved pain has been documented widely.

Betty (1986) did a study on under-treatment of pain in practice. The study looked at how pain assessment was done and how nurses come to a decision on what to do about pain. It was found that many nurses found it difficult to assess pain, which sometimes leads to poor intervention, pain

is assumed rather than observed/assessed and there is a lack of documentation about pain which leads to a lack of evaluation on pain relief methods (Camp 1988:237; Paice et.al. 1990:49).

In management of pain each registered nurse should follow the steps of the nursing process, otherwise he/she will fail in his/her duty to effectively and efficiently free the patient from pain.

The first step in the treatment of the patient with pain is the assessment thereof. Although it is such an important step it seems that it is not properly done. Clinical research has consistently confirmed that even the most basic assessments of patients in pain are not being done (Donovan 1990:126).

Assessment of pain consists of determining the exact location of the pain or pain sites, the intensity of the pain, how long has the pain been present, how long does it last, the factors which intensify the pain and the effectiveness of therapy. Planning on how to relieve pain should be done according to the assessment outcome. In planning pain management various therapeutic approaches should be taken into consideration. These approaches can be drug therapy, non-drug therapy or modification of behaviour. Drug choices and effective pain management in cancer patients is dependent on the cause, the type and the severity/intensity of pain as well as response of the patient. Analgesics should be given regularly and "when necessary (PRN) drugs should be avoided as these do not provide enough pain relief" (Ntoane 1993:32-33;34).

During the implementing phase it is also found that nurses withhold medication from patients. Meinhart & McCarthy (1983:1) remind us that moral judgements such as whether pain is "real" and how the patient must express his/her pain for staff to consider the expression acceptable, along with misconceptions such as exaggerated fears about addiction, often result in the nurse withholding prescribed pain killers. Lisson (1989:1) also stated that nurses professional judgements may also be moral judgements, because of values held by the person in pain and the person who chooses to, or not to, relieve pain.

A study by Nieweg from Netherlands Academic Medical Centre, Amsterdam, has revealed that pain is managed (relieved) because it causes distress accompanied by nausea, loss of appetite,

sleeplessness, loss of mobility, constipation, diarrhea, tiredness and moods. Many patients do not complain because they believe that pain is inevitable. Also, the nurses do not encourage patients to express pain and there was a lack of initiative to record pain in the patient's records/documents (Nieweg 1994:42).

According to Ntoane (1993:33) Rarsen & Halskov (1990:124) in implementing pain management in cancer patients various therapeutic approaches should be taken into consideration, namely drug therapy, non-drug therapy and behavioural modification.

Another important aspect is the evaluation of pain relief after treatment. This stage is also often neglected. When a high pain intensity is assessed the nurse should take immediate action to relieve the pain. A pain flow sheet or pain record requires minimum time, it also cues the staff to obtain pertinent data allowing for meaningful comparisons to be made over time (Evans et.al 1991:312).

Documentation of all aspects of pain is an important function of the nurse because this nurse is the health professional with the most patient contact. Lack of pain documentation reflects more than inadequate recognition of pain as a problem for many patients. Information not charted is often lost to other members of the health team. This results in poor planning and implementation of activities (Evans et.al. 1991:308). All these activities are maintained in the nursing process.

NURSING PROCESS

The nursing process which is a systematic, rational and purposeful method of planning and providing nursing care, is a mechanism through which basic and specific human needs can be realised. The nursing process consists of five components which can be followed systematically in a logical sequence. Two or more components can be applied at the same time (Kozier 1987:214-215). For the nursing process to be sequentially applied, the needs of the patient /client have to be identified first (assessment), followed by planning for nursing care to be given; interventions taken (implementation) to meet the identified needs by means of planned actions, evaluation of the implemented plans and throughout recording of what has been done at every

phase.

Each nurse that is caring for a cancer patient should apply all the steps of the nursing process.

2.7 DECLARATION OF PATIENT'S RIGHTS

The nurse caring for the oncology patients should know that the patients have certain rights. These rights are not legal rights but fundamental rights to well-being of people with cancer. These rights form the basis for how the needs of cancer patients can be met and how nursing care for cancer patients can be improved.

The declaration was made by Cancer Link which was founded in 1982 in the UK. It grew out of perception that there was no cancer support available for people affected with cancers. Cancer Link acts as resource to cancer support and self-help groups. In its documents Cancer Link defined the "Bill of Rights" for cancer patients and has now been translated in six languages. The declaration has gained widespread approval and endorsement from all branches of the medical professions, cancer patients and many community representatives.

The rights declared are as follows:

- Equal concern and attention irrespective of gender, race, class, culture, religion, belief, age, life styles of able-bodiness.
- Consideration with respect and dignity and to have physical, emotional, spiritual, social and psychological needs taken seriously whatever the prognoses.
- To know that he/she has cancer, to be told in a sensitive way and share in all decision making about his/her treatment and care.
- To be informed fully in treatment options benefit, side effects and risks of any treatment; to be asked for informed consent before any clinical trial.
- To know a second opinion, to refuse treatment or to use complementary therapies without prejudices.
- To be employed, promoted or accepted on return to work according to his/her abilities

and experiences.

- To have easy access to information about local and national services, cancer support and self help groups and practitioners.
- To receive support and information which help in understanding and come to terms with the disease (Link 1992:5).

These rights may be applicable to some and not all patients at the same time, e.g. some of the patients may wish to know whether they are suffering from cancer or not while others may not want to know at all.

2.8 SUMMARY

This literature study has given guidelines on the care of oncology patients and has opened the ways to what should be considered when such patients are cared for by registered nurses. It has given the background of the needs of patients with cancers and how these needs were catered for by nurses in other hospitals elsewhere in the world. It has also, through previous studies done, shown the weaknesses and strengths of care of nurses caring for cancer patients, e.g. where analgesics are being prescribed by doctors, but keep the doses constant where it resulted in inadequate pain relief (ICNN Vol. 14, No. 6, 1991).

This literature review will therefore serve as a guideline to the study of care given to cancer patients in these regions.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

This chapter deals with the research methods and strategies employed, the identification of population and sampling, instruments for collection of data, ways of data analysis and decision attached thereto.

It is a culture in research that every researcher should be able to describe the methodology of his/her research. Methodology helps the researcher to ensure that he/she arranges his/her work logically and systematically. It also helps those who will study the report to know whether the correct steps of doing research have been followed. It guides other researchers on the same problem or other problems to see how the researcher has arrived at the final findings and conclusions of the research.

3.2 RESEARCH APPROACH

This research is based on finding out how the cancer patients are cared for by registered nurses by means of a descriptive survey.

A descriptive survey is a factor-searching study which can be used in the clinical area. It is a type of non-experimental research that focuses on obtaining information regarding the *status quo* of the situation which is usually through direct questioning of respondents.

Descriptive studies are also defined as studies that have as their main objective the accurate portrayal of the characteristics of persons, situations, or groups and or the frequency with which certain phenomenon occur. The purpose is to observe, describe and document aspects of a situation (Polit & Hungler 1997:456, 168).

3.3 HYPOTHESIS

No hypothesis is formulated for this study. It is not considered necessary to establish any relationship between attributes. A descriptive study aims at exposing the nature of the situation and is valuable to nursing care of patients with cancer. The aim is to provide an opportunity to see how registered nurses are caring for patients without preconceived conditions even if there are certain assumptions made on how this care is given.

3.4 RESEARCH POPULATION

The target population consisted of:

- All registered nurses, working/practising in the North-West Health Directorate in four district hospitals: Oshakati, Onandjokwe, Oshikuku and Tsumeb, who are allocated to the wards where cancer patients are being admitted. These hospitals are all hospitals in the North West Health Directorate of the Ministry of Health and Social Services.

- All patients with cancer diagnoses confirmed and admitted to four district hospitals during the time the study was done.

The study was designed before the Directorate was transformed into four health regions resembling the four political regions, that is Oshikoto (where Onandjokwe and Tsumeb are situated), Oshana (Oshakati), Omusati (Oshikuku) and Ohangwena (Engela which is not under the study). Every district had its own population of registered nurses at the time of the design:

- Oshakati 30
- Onandjokwe 28
- Oshikuku 7
- Tsumeb 5

It has also been found that the admission of patients to the four district hospitals has changed since 1994. With the establishment of an oncology clinic in Windhoek these four hospitals are

only serving as a transitional service where patients overnight or are temporarily admitted to or from Windhoek or only admitted as terminally ill patients and when they have undergone surgical interventions.

Although the study did not exclude children as patients, no children, parents or guardians were interviewed as no child was admitted during the data collection period. Also very few children were diagnosed having cancer that time.

3.5 THE METHODS OF CONDUCTING THE SURVEY

THE RESEARCH SAMPLE

As the population of the registered nurses working in the wards where the cancer patients are admitted was small, no sample was drawn but the research population of registered nurses was taken as a whole to serve as a study sample (N = 70).

From the cancer patients all patients who have been admitted in the hospital for care during January 1999 to June 1999 were interviewed (N = 21).

THE RESEARCH INSTRUMENT

The researcher used two (2) types of questionnaires for collecting data. The registered nurses filled in self administered questionnaire, while patients were interviewed by means of questionnaires.

The purpose of using questionnaires with registered nurse is (with biological data on Section I and questions on specific questions as questionnaire A):

- they are free to give answers being alone;
- they could do it in their free time at their own pace;
- all can read and write;

- the researcher continues with her other work, therefore it saved her time and money to travel to all four hospitals; and
- as the questionnaire was sent through the Ministry transport, no postage was involved.

The disadvantages could be that some items may be left unanswered, response rate can be low and answers may be wrong or unclear due to lack of understanding.

The second instrument was a questionnaire for interviews with patients and or parents/guardians of cancer diagnosed patients. This was marked questionnaire B. It was a formal structured quantitative interview.

This method was employed as it was found to:

- have a high response rate;
- allow for all questions to be answered;
- provide chance for a researcher to clarify in understandable questions; and
- enable the researcher to record non-verbal communications.

3.6 QUESTIONNAIRE DESIGN

Many research books were consulted by the researcher as well as study reports on other authors' studies on how to design the questionnaire. The books consulted were on nursing as well as social science research and author's studies were on nursing perspectives.

The questionnaire format, sections, type of questions working and phrasing were perused from such literatures. Katjire's question types (1995) were closely followed on certain issues asked on the questionnaire with patients or parents/guardians.

Questions on questionnaire A (for registered nurses) were formulated based on the nursing process followed by registered nurses in units when caring for patients. It began with questions on assessment up to questions on recording patients care items. A point was also taken into

account to ask questions dealing with certain issues, e.g. pain or vomiting from assessment to evaluation phase.

Questions on questionnaire B (for patients or guardians to patients) were formulated and derived from questionnaire A to serve as comparison between how they are cared for by registered nurses and how they experience and perceive that type of care they are given by registered nurses.

The layout for both questionnaires was the same in that:

- both have section one with personal particulars; and
- both have section two for specific information pertaining to caring.

CONTENT OF QUESTIONNAIRES

Questionnaire A

Section one on personal particulars was asking questions regarding:

- age of registered nurse;
- years of practice as a registered nurse;
- qualifications held;
- clinical area where the nurse is practising and duration in that area;
- oncology training; and
- any involvement in further study.

Section two has questions on care of the cancer patient with special consideration of:

- cancer patient's basic needs assessment;
- care of patient with pain, vomiting, surgical interventions, medication and nutrition/fluid balance;
- counselling of patients and telling of patients diagnosis and or results of tests;

- responses of patients on being told about their diagnosis;
- health care team involvement;
- sources of knowledge and information at their disposal; and
- recommendations/suggestions they have toward cancer care.

Questionnaire B

Section one is on personal particulars of a patient or guardians and his/her patients:

- age of patient;
- diagnoses (confirmed with patient's files);
- marital status and dependent children of the patient; and
- employment and source of income.

Section two has questions regarding:

- admissions in hospitals;
- information about their diagnoses;
- type of treatment they receive;
- involvement in planning session;
- major problem of pain, nausea, vomiting;
- any intervention on major problems;
- nutrition and how they are assisted;
- opportunities to air their views or make their feelings known about their diseases;
- knowledge on what to do on discharge;
- possible loss of parts of body;
- the patient's feeling on type of care they receive and evaluation of their caring environment; and
- suggestions on what more could have been done, if any.

3.7 VALIDITY AND RELIABILITY

VALIDITY OF THE INSTRUMENTS

According to Polit & Hungler (1997:374) validity is the degree to which the instrument measures what it is intended to produce and reliability is the degree of consistency on dependability with which an instrument measures the attribute it is designed to measure. The instruments were tested for content validity.

Content validity was tested to determine whether the items in the questionnaires presented the purpose and conceptual framework of the study. To test for content validity the questionnaires were presented to five lecturers of the Faculty of Medical and health Sciences of the University of Namibia to critically evaluate the questionnaires for content validity. The questionnaires were also presented to the statistician and the study leaders.

RELIABILITY

Polit and Hungler (1991:367) describe reliability of an instrument "as the degree of consistency with which it measures the attribute it is supposed to be measuring".

The respondents that were used to complete the preliminary questionnaires could answer most of the questions. Those items who could be interpreted as not applicable or not be answered were deleted. After the amendments were made reliability of the questionnaires could be accepted.

3.8 ETHICAL CONSIDERATION

Permission was already obtained even before pretesting of the instrument. A letter requesting permission to conduct this survey was addressed to the Director of the North-West Health Directorate of the Ministry of Health and Social Services (Annexure C).

A cover letter was written accompanying the questionnaires as addressed to the Chief Control

Nurses of every hospital where the research was conducted (Annexure B). A second cover letter was enclosed together with questionnaires for every respondent requesting for co-operation of every registered nurse completing the questionnaire (Annexure B). The purpose and importance of the study was clarified in the letter as well as the issue of anonymity and confidentiality of individuals as well as the health facility were assured. No names were requested.

3.9 COLLECTING OF DATA

The chief/control nurses of hospitals were requested for their co-operation in the distribution of questionnaires and given the due date by which the researchers involved would collect the questionnaires.

A problem was encountered with the due date at some hospitals due to the following:

- Some respondents had been off duty at the time of delivering the questionnaires and were only to come on duty on/or after the due date.
- Some questionnaires were not delivered at the hospitals in time or were misplaced in the hospital offices instead of the Chief Control Nurses's office.

Therefore, an extension of the due date was given and postponed with two weeks from the due date stated in the letters. This arrangement was done telephonically by the researcher. Respondents of Oshakati and Tsumeb Hospital were left to continue undisturbed as they had no problem with the due date.

The collection of data took place from the 20th November 1998 to the end of June 1999.

Questionnaire B was not delivered but taken along by the researcher for each interview conducted.

3.10 RESPONSES TO THE QUESTIONNAIRES

Questionnaire A to registered nurses was not delivered by the researcher herself but entrusted into the hands of the Chief Control Nurses of the hospitals. Because of lack of control of registered nurses during completion of questionnaires, and the fact that registered nurses know that completion of questionnaires is not compulsory, a number of questionnaires were not returned (missing) and some questionnaires were returned uncompleted.

Questionnaire A was distributed as follows:

Onandjokwe	28
Oshakati	30
Tsumeb	5
Oshikuku	7
Total	**70**

Responses received was as follows:

Table 3.1 Responses to questionnaire according to hospitals

Hospitals	Questionnaire distributed	Questionnaire completed		Questionnaire uncompleted	Questionnaire missing	Total
		Unusable	Usable			
Onandjokwe	28	-	12	10	6	28
Oshakati	30	-	19	5	6	30
Oshikuku	7	-	6	0	1	7
Tsumeb	5	-	4	0	1	5
Total	70	-	41	15	14	70

Questionnaire B was printed for interviews with the patients admitted to the four (4) above-mentioned hospitals. The number of patients to be admitted to the hospitals was difficult to estimate due to the fact that patients are mostly admitted on a transitional basis from and back to

Windhoek for their oncology therapy. Windhoek has established an Oncology Clinic since 1994 and all the patients from regional hospitals are transferred there for treatment and only admitted in the hospital of the North on a temporary basis.

Interviews with these patients were conducted at the time when patients were admitted there and for the terminal ones who do no longer go to Windhoek and are on palliative care.

Arrangements were made with supervisors and registered nurses in charge to inform the researcher whenever a patient with cancer was admitted in the wards. Furthermore, the supervisors and registered nurses in charge were also contacted by the researcher from time to time to determine if there are any new patients admitted to the wards who were never interviewed. When there were patients, appointments with the patients were made through the registered nurses and the date and time were fixed. The purpose of the interview was explained to the patients but for fear that patients may not know their diagnoses, they were not informed that the study was about care of cancer patients, but on care to some patients admitted in the hospital wards the patient was also told that he/she had the right to agree or to refuse to be interviewed without fear of repercussion. They were told by the researcher that they did not need to mention their names, but because their names appeared on t heir files, which they knew that the researcher had access to, they were assured of anonymity regarding the information given. They were also told by the researcher that what they said would be kept confidential and not discussed with other patients or nurses caring for them until the time of reporting back on the findings of the study.

The questions formulated did not in any way reveal to the patient that they were suffering from cancer although they were related to cancer diagnoses. If the patient said he/she was not told the diagnosis or what he/she was told did not indicate cancer, the interview was continued as if the patient and the researcher did not know the true diagnosis, and questions were posed as they were prepared with reference to the diagnosis the patient had mentioned.

The interview was conducted in a quiet atmosphere either in a single room, or at the patient's bed while disturbances were kept to a minimum or totally excluded. As many of the interviews were done with old people, the discussions proved to be successful and they looked at it as

opportunities they had to talk to somebody more than a mere research study. Most of the old people were open, free and appeared to be honest in their answers. Some patients went to the extent of inviting the researcher to view the affected areas for her to confirm what they were talking about. Even if the researcher discouraged them not to pull down or pull up their hospital gowns, they insisted on showing here where their problems lay. For the sake of avoiding disappointments, the researcher took a quick look at the shown areas and ensured them that she had seen and did understand what they were talking about.

Number of patients interviewed at each hospital

The interviews with patients were conducted by the researcher at each hospital:

Onandjokwe	4
Oshakati	17
Oshikuku	0
Tsumeb	0
Total	**21**

3.11 SUMMARY

This chapter addressed the way in which the study of caring for cancer patients was conducted. The steps of the research process that was followed were highlighted. The methods and strategies employed in selecting the population and sample relevant to the study, development of the data collecting instruments and the collecting of the information were discussed.

CHAPTER 4

ANALYSIS OF DATA AND DISCUSSION OF FINDINGS

QUESTIONNAIRE A

4.1 INTRODUCTION

This chapter presents the analysis, presentation and interpretation of data and the discussion of findings based on information gathered from both questionnaires N = 21 (100 %) patients who were diagnosed with cancer and N = 41 (100 %) registered nurses who nursed these patients.

Both questionnaires contained a Section I which gathered demographic data from both the patients and registered nurses and both have a Section II which contained questions on how patients perceived the care given to them and how nurses cared for these patients respectively.

Questionnaire A for registered nurses was analysed first and then Questionnaire B for patients. The latter will be discussed in Chapter 5. A summary of differences and major comparisons between the most related items was done in Chapter 6 (Findings).

Statistics were rounded off to the nearest full numbers.

4.2 ANALYSIS AND DISCUSSION OF FINDINGS - QUESTIONNAIRE A

SECTION I: PERSONAL (BIBLIOGRAPHICAL) DATA

Item 1: Age of respondents (registered nurses)

Table 4.1 Age of Respondents (N = 41)

Age	Frequency	Percentage
25 - 28	5	12,2
29 - 32	8	19,5
33 - 37	9	22,0
38 - 42	8	19,5
43 - 46	3	7,3
47 - 50	7	17,1
51 - 54	1	2,4
Total	N = 41	100

According to Table 4.1, the range of age of registered nurses varies from 25 - 54 years. This is an indication of a sample of adult nurses who are expected to be mature and responsible enough to give necessary care to the suffering patients. Most of these nurses should have undergone difficult times of suffering and agony either for themselves, their family members or for relatives and other community members. Empathy and sympathy should prevail when they care for patients.

Item 2: Period of registration as a nurse

Table 4.2 Length of registration

Length of Time	Frequency	Percentage
< 1 year	3	7,3
1 - 5 years	13	31,7
6 - 10 years	9	22,0
> 10 years	16	39,0
Total	N = 41	100

According to Table 4.2 3 (7,3 %) have been registered for less than a year, 13 (31,7 %) have been registered for more than one year but less than 5 years, 9 (22 %) are between 6 and 10 years and the majority 16 (39 %) are those who have been registered for more than 10 years.

The long period of registration may mean more experience to care for patients while on the other hand they may have become outdated and not have the current information on what is supposed to be done for cancer patients.

Young nurses with shorter period of registration may not have the necessary experience to care for cancer patients but they also stood a good chance of having oncology care included in their curriculum.

Item 3: Professional qualification

Table 4.3 Professional qualification (N = 41)

Qualification	Frequency	Percentage
General Nursing	7	17,1
Midwifery	2	4,9
General Nursing and Midwifery Psychiatry	16	39,0
General, Midwifery, Psychiatry and Community Heath Nursing	14	34,2
General, Midwifery, Community Health, Nursing Administration/Management	1	2,4
General, Midwifery, Psychiatry	1	2,4
	41	100

According to the findings in Table 4.3, 39 (95,1 %) have qualified as general nurses and that is the course in which oncology care is incorporated as basic nursing. The majority of the nurses should have a background of oncology and type of care given to the patients. No nurse is qualified as an oncology nurse therefore no specialized knowledge on oncology care can be expected from them.

Item 4: Allocation of registered nurses

Table 4.4 Clinical area working in

Clinical area allocated	Frequency	Percentage
Surgery and Orthopaedics	17	41,5
Pediatrics	5	12,2
Gynaecology	3	7,3
General Wards	10	24,4
No response	6	14,6
Total	41	100

Some nurses have specified that they work in surgical and orthopaedic wards/units 17 (41,5 %), others gynaecology 3 (7,3 %) or paediatric 5 (12,2 %) wards. Out of those 35 nurses, 3 (7,3 %) have mentioned general wards without any specification of which general wards and 6 (14,6 %) indicated ward 5 and 1 (2,4 %) ward 6 which are orthopaedic and surgical ward respectively. 6 (14,6 %) have not indicated where they are currently allocated.

By implication it means that 35 (85,4 %) nurses are allocated in wards where cancer patients are being admitted.

Item 5: Time in the present unit/ward

Table 4.5 Time in present unit

Time in unit/ward	Frequency	Percentage
1 - 3 months	4	9,8
4 - 6 months	4	9,8
7 - 9 months	3	7,3
10 - 12 months	0	0,0
1 - 3 years	7	17,0
4 - 6 years	12	29,0
7 - 9 years	2	4,9
10 - 12 years	3	7,3
13 - 14 years	2	4,9
No response	4	9,8
Total	41	100

A number of nurses have been allocated to the wards where cancer patients are cared for, for a relatively long time. This time should have exposed them to the care of cancer patients. Even if they were not specialized in oncology the expectation is learning from experience. Most of the care given to these patients is basic nursing, which every registered nurse has learned in his/her training.

From the 41 nurses, 12 (29 %) have been in the units for 4 - 6 years, 2 (4,9 %) for 7 - 9 years, 3

(7,3 %) 10 - 12 years, while 2 (4,9 %) have been in such units for 13 - 14 years.

Item 6: Are you presently engaged in any further study?

Table 4.6 Present engagement in further study (N = 41)

Further study	Frequency	Percentage
Currently studying	8	19,5
Not studying	31	75,6
No response	2	4,9
Total	41	100

The findings contained in this item indicate that 8 (19,5 %) of the registered nurses are currently studying. Further, 31 (75,6 %) are not studying and 2 (4,9 %) did not respond. The percentage of those studying further is encouraging. By further study a registered nurse is going to enrich his/her knowledge which can help him/her to improve nursing care of patients.

Item 7: Indicate the course of study

Table 4.7 Course of study

Course	Frequency	Percentage
Bachelor of Nursing Science	7	87,5
Bachelor Degree in Psychology	1	12,5
Total	8	100

On the question which course do they study, 7 (87,5 %) respondents indicated that they are studying for a Bachelor of Nursing Science degree while 1 (12,5 %) indicated a Bachelor degree

in Psychology.

It can only be trusted that when these respondents complete their degrees successfully, they will have a broader vision which will strengthen the concept of caring in nursing.

Item 8: Program completed to become a registered nurse

Table 4.8 Basic program completed (N = 41)

Programme	Frequency	Percentage
Basic Diploma in General Nursing	5	12,2
Diploma in Midwifery	8	19,5
Diploma in General Nursing & Midwifery (3½ years)	8	19,5
Four year degree course	1	2,4
Diploma in Nursing (General, Psychiatry, Community Health) & Midwifery Science (4 years)	16	39,0
Others	3	7,3
Total	41	100

Oncology nursing is a sub-unit in General Nursing Science in the curriculum of the four year basic nursing course (Diploma in Nursing (General, Psychiatry, Community Health) and Midwifery Science. The 16 (39,0 %) respondents who indicated that they have done this diploma should have a sound knowledge on how to care for patients suffering from cancer.

Item 9: Inclusion of oncology nursing in the curriculum the registered nurses followed

Out of 41 (100 %) registered nurses, 28 (68,3 %) had content of oncology in their curricula, while for 9 (22 %) the content was not included and 4 (9,8 %) did not indicate anything regarding the content. For the 28 (68,3 %) it indicates that they are trained in the care of oncology patients and should be in the position to care for them.

Items 10 & 11: Registration as an oncology nurse and for how long (N=41)

All 41 (100 %) respondents have indicated that they are not registered for oncology nursing care. By implication it could mean that cancer patients are not exposed to experts in the field of oncology nursing.

This finding does not correlate with what is believed about oncology nursing. (Krcmar (1999:16) stated that oncology nurses are needed because oncology nursing is due to many reasons a specialized discipline within nursing. The role of the oncology nurse varies from health and personal education to support of patients and their families. Furthermore, it requires specialized nursing care that must be given over the lifespan of the human being.

Item 12: How long being caring for cancer patients

Table 4.9 Period of care to cancer patients (N = 41)

Length of period	Frequency	Percentage
0 - 6 months	13	31,7
7 - 12 months	0	0,0
1 - 2 years	6	14,6
3 - 5 years	4	9,8
> 5 years	10	24,4
No response	8	19,5
Total	N = 41	100

Out of 41 registered nurses working with/caring for cancer patients, 10 (24,4 %) have done it for more than 5 years, which is quite a long time to gain experience even if they were not specifically trained in the field of Oncology. Thirteen (31,7 %) have been caring for patients for less than 6 months and this indicates that they are still in the process of learning and gaining experience in cancer care.

Item 13: Awareness about cancer journals available in the library (N=41)

18 (43,9 %) nurses know/are aware that there are journals available in the library but 22 (53,7 %) are not aware. One respondent has not responded to this question. For those who do not know, it shows that they do not refer to these cancer care journals for information.

Item 14: Other resources used to update knowledge

Respondents did not respond well on this item. Only 3 (7,3 %) indicated that they consulted books in the library. According to Item 14, 3 (7,3 %) of those who are not aware of the journals use other books in the library while the rest have not indicated their sources of information.

Item 15: Attendance of workshops/seminars/conferences on cancer (care) nursing

Out of 41 (100 %) only 11 (26,8 %) have admitted to having attended workshops and 28 (68,3%) never did while 2 (4,9 %) did not respond. A great number of registered nurses have no opportunity to expand their knowledge on oncology nursing.

Item 16: The reason for non-attendance (N = 41)

Table 4.10 Reasons for not attending

Reason	Frequency	Percentage
Not invited	13	31,7
No opportunity	3	7,3
Missing	25	61,0
Total	41	100

According to this table there is an indication that registered nurses attending to the cancer patients do not have access to workshops/conferences or seminars either because they are not invited (13

= 31,7 %) or there is no opportunity (3 = 7,3 %). The rest (25 = 61,0 %) have not responded which may imply that they have no idea of any workshop/conference or seminar held on cancer care in their regions.

Item 17:Necessity for in-service education programme on cancer nursing (N=41)

All 41 (100 %) respondents have indicated that in-service education on cancer care is necessary for them. As they have indicated that they do not attend (28 = 68,3 %) workshops, in-service training could serve as a platform where they discuss recent trends on cancer care and fill a gap left in their knowledge on how to care for such patients. In in-service education, opportunities could be created to acquire information on changing patterns of cancer diseases as the prevalence of cancer does also change which brings about change in the management and treatment thereof.

SECTION II: QUESTIONNAIRE A

Item 18: Number of cancer patients in ward (N = 41)

Twenty (48,8 %) of the registered nurses had cancer patients admitted to their units where they are allocated while 21 (51,2 %) had no patients admitted in their units during the time of the study.

Item 19: How many male and female patients?

Table 4.11 Number of cancer patients in units according to their gender (N = 41)

Number of patients cared for by nurses in their units	Male patients		Female patients	
	Nurses responses	Percentage	Nurses responses	Percentage
1	2	4,9	4	9,8
2	0	0,0	2	4,9
3	1	2,45	5	12,2
4	0	0,0	1	2,4
5	0	0,0	0	0,0
6	1	2,45	0	0,0
10	0	0,0	1	2,4
20	0	0,0	1	2,4
No patient form	37	90,2	27	65,9
Total	41	100	41	100

This table indicates that registered nurses allocated to female units had more patients to care for than those allocated to male wards. The highest in the male wards is six patients while in female wards nurses could have up to 20 cancer patients in a ward. The number of twenty cancer patients in a unit at a time is contrary to what the researcher has found during interview with patients. The highest the researcher could find is four patients at a time. Nevertheless it cannot be denied as sometimes patients overnight for either transfer to Windhoek or from Windhoek waiting to be discharged.

Item 20: Methods of assessment of patients

Table 4.12 Assessment methods employed (N = 41)

Method	Frequency	Percentage
History taking	1	2,4
Observation	2	4,9
Admission records	1	2,4
Seeing patients	1	2,4
Examining patients	1	2,4
Observation, passport and admission records	5	12,2
All six methods	4	9,8
History, observation, passport and admission records	5	12,2
History, observation, passport, seeing patient and examination	1	2,4
History and passport	2	4,9
Passport and examining	1	2,4
History and observation, passport, admission record and examining	10	24,4
History, observation and examining	3	7,1
History, observation and admission records	2	4,9
Missing	2	4,9
Total	41	100

From this table it can be seen that there are 6 (14,6 %) registered nurses who use a single method to do assessment of the cancer patients admitted in their units. This is an indication of poor assessment.

Assessing is the first phase whereby the data base is established before nursing diagnosis is made. Assessing is also carried out during other phases of the nursing process (Kozier 1989:103). Assessment is collecting data about the client's health status, which are obtained from various sources and serve as basis for actions and decisions taken in other phases of the nursing process (Kozier 1995:83).

A number of 4 (9,8 %) of the registered nurses employ all the six listed methods in their assessment. Which gives them most of the indications of how the patient presents, and enables them to identify all their needs if the methods are used correctly.

Eleven (26,8 %) of the registered nurses have assessed patients through passport and admission record checking and by doing examinations but no history was taken. It is vitally important to double check even if it was already taken at Outpatient Department or in the screening area. In total, history taking and checking passport was employed by 28 (68,3 %) of the registered nurses with other methods or a single method used by only one registered nurse. Observation is one of the most used methods employed by 31 (75,6 %) registered nurses for their assessment. It is quite surprising to observe that only 22 (53,6 %) registered nurses do check on the patients admission records. One wonders how a nurse can care for the patient and assess his/her condition without checking admission records.

To establish a proper data base the nurse should obtain health history, conduct physical assessment, review client's records (passport, admission and laboratory records) and also review literature (Kozier 1995:84).

Assessment differs from patient to patient, depending on the diagnosis and symptoms the patients present with and severity of the condition. For a patient suffering from pain, location, intensity of pain and factors associated with pain, as well as how the patient responds to pain relief therapy or actions (Donovan 1990:127-128) are being assessed. For a patient suffering from nausea and vomiting, frequency, severity and time intervals are assessed. Nurses also look at whether nausea and vomiting is associated with other symptoms like pain, or with therapy or diet. Comparisons between what the nurse observes and what the patient is reporting is being made and recorded. The latter cannot be done with pain because the nurse cannot experience the patient's pain (Bachman-Mettler 1990:130-132).

Item 21: What registered nurses assess about the patient's condition

Table 4.13 Assessment of patients (N+41)

Assessment	Frequency	Percentage
Needs	1	2,4
Degree of illness	15	36,6
Plan of action	1	2,4
Reactions	5	12,2
Weight, haemoglobin	6	14,6
Appearance and condition	2	4,9
Condition, length, plan	1	2,4
Missing	10	24,4
Total	41	100

This table indicates that from the sample of forty one registered nurses only 1 (4 %) does assess the patient needs, 15 (36,6 %) assess degree of illness, 5 (12,5 %) assess reactions to disease, 6 (14,6 %) check on haemoglobin, weight and condition while 2 (4,52 %) look at the appearance of the patients.

In the previous question only 2 (4,9 %) did not indicate any assessment method they use but in this table 10 (24,4 %) could not state what they assess. It is not clear how nurses do assessment if they are not able to tell what they obtain from the assessment they do. If assessment is done properly, one will have to say what one assesses on the patient.

According to these findings, the registered nurses had mentioned the assessment of needs, but did not specify what needs they assessed. In Chapter 2 it was indicated that cancer patients have basic and specific needs. In this regard no nurse could highlight or pinpoint specific needs of the patients. This gave in impression that registered nurses might not know what were the needs of the patients they were caring for and therefore proper assessment was not done. However, Watson (1979:111) pointed out that some needs are more familiar and concrete because of the tangible ways in which they manifest themselves, while others are more abstract and elusive.

Item 22: Basic needs patients present with on admission

Table 4.14 Needs present at admission (N = 41)

Needs	Frequency	Percentage
Emotional problems	4	9,8
Pain	3	7,3
Diet problem and pain	3	7,3
Hygiene and discomfort	2	4,9
Diet and hygiene problems	6	14,6
Discomfort and diet problems	2	4,9
Emotional problems, discomfort and hygiene problems	13	31,7
Pain, bleeding, swelling	1	2,4
Missing	7	17,1
Total	41	100

This table contains a list of problems rather than needs. It indicates that registered nurses handle problems as synonyms to needs and needs as problems.

A number of 4 (9,8 %) registered nurses identified emotional problems; 3 (7,3 %) observed pain; 3 (7,3 %) diet problems and pain; 2 (4,9 %) hygiene and discomfort while 13 (31,7 %) found emotional problems, discomfort and hygiene. Only 1 (2,4 %) did observe pain, bleeding and swelling with admission.

The way in which this question was answered indicates that registered nurses do not fully understand the difference between the needs and the problems. Instead of identifying pain relief, emotional support, hygiene and diet, they referred to pain, emotional or discomfort as if that is what the patients need to be there.

Item 23: Assessment of pain

Table 4.15 Assessment of Pain (N = 41)

	Frequency	Percentage
Observation	6	14,6
Complaints	3	7,3
Observation and complaints	22	53,7
No assessment	10	24,4
Total	41	100

The findings of Item 23 indicated that 6 (14,6 %) registered nurses assessed pain through observation only; 3 (7,3 %) assessed pain by listening to the complaints of the patients; 22 (53,7 %) registered nurses did employ both observation and listening to complaints of patients as methods of pain assessment. Ten (24,4 %) of the registered nurses did nothing to observe pain. It is difficult to understand how a registered nurse, having been caring for cancer patients in the wards, did not observe any pain on patients at one time or another. Even if she/he did not have any cancer patient in the unit the time of study, it won't deprive him/her from knowing how to assess pain. Moreover, it is not only cancer patients who do suffer from pain, but other patients as well.

It is correct to observe pain in the patient but the nurses need to talk to patients and ask them about pain. This is necessary because if the patient is not asked then his/her pain is assumed especially the intensity therefore and this will negatively affect the treatment plan of the patient.

Item 24: Pain Management

From the 41 (100 %) respondents, 21 (51,2 %) of the registered nurses have indicated giving only medication to patients with pain, 5 (12,2 %) indicated medicine and emotional support, 1 (2,4 %) gave therapeutic treatment, 2 (4,9 %) medicine and comfortable position, 5 (12,2 %) medicine and emotional support, 1 (2,4 %) gave only emotional support and 6 (14,6 %) did not respond

to the question.

Table 4.16 Pain Management (N = 41)

Management	Registered Nurses responses (N = 41) Frequency	Percentage
Nothing	0	0,0
Medicine	21	51,2
Emotional support	1	2,4
Medicine and emotional support	5	12,2
Therapeutic treatment	1	2,4
Medicine and a comfortable position	2	4,9
Medicine and emotional support, protein diet	5	12,2
Missing	6	14,6
Total	41	100

From the table a calculation made revealed that in total 33 (80,5 %) of the registered nurses had mentioned medicine as a method of pain management. It is evident that 21 (51,2 %) registered nurses gave medication only while others have mentioned medication combined with other methods like emotional support and a comfortable position.

In some countries like Finland pain is managed by administering analgesics according to the proposal of the World Health Organisation (WHO). Furthermore, they use other pain relief methods like making the patient comfortable, holding conversation with patients and application of cold or dry heat. There is one hospital which used acupuncture but this method was not popular (Hovil 1994:40). Pain management in cancer patients should take into consideration various approaches; drug therapy, non-drug therapy and behavioural modifications (Ntoane 1993:34).

Item 25: Evaluation of pain relief (N = 41)

All 41 (100 %) nurses have indicated that they do evaluate the effect of their employed methods of pain relief.

Item 26: Up to date knowledge on:

26.1 Prescribed medication (N = 41)

The number of 24 (58,5 %) of the registered nurses felt that sometimes they are equipped with knowledge of chemotherapy prescribed for patients while 14 (34,1 %) felt that they are always equipped with knowledge on medication.

26.2 Knowledge of side-effects of prescribed medication (N = 41)

Four (9,8 %) registered nurses are never equipped with knowledge on side-effects of medication, while 21 (51,2 %) are sometimes equipped and 13 (31,7 %) are always equipped with knowledge on side-effects.

Item 27: Do you plan nursing care for each patient (N = 41)

Forty (97,4 %) of the registered nurses said yes, they do plan nursing care for each patient, 1 (2,4 %) said no to planning of nursing care. It is expected that every nurse caring for a patient should be able to plan for his/her care to be given to each patient.

Planning of nursing care is an essential part of the nursing process. If assessment is done properly, it will also influence proper nursing care planning whereby all the needs of the patient are to be met. If planning has failed, there is always a chance for re-planning. Planning is also a continuous phase as long as the patient is under care. There is no end point of the phases in the nursing process until the patient either is discharged or dies.

Item 28: Involvement of patient in planning of care

Table 4.17 Involvement in planning of care (N = 41)

	Frequency	Percentage
Nurses	2	4,9
Doctors and nurses	5	12,2
Family members	2	4,9
Religious workers	1	2,4
Family, social workers and religious workers	1	2,4
Doctors, family and nurses	13	34,7
Doctors, nurses, dieticians	2	4,9
Professional team	12	29,3
Total	41	100

This table indicated that a number of health workers are involved in the planning process. Registered nurses have indicated nurses, doctors, social and religious workers as well as family members and dieticians as being involved in the planning. The involvement of nurses only, family only or religious workers appears less significant as only a small number of nurses has mentioned them. Doctors and nurses were mentioned by 5 (12,2 %) nurses; doctors, family and nurses by 13 (31,7 %) nurses and professional team by 12 (29,3 %) nurses. Doctors, nurses and dieticians, although mentioned by only two nurses, is quite important as the cancer patient is in need of nutritional treatment to cater for the replacement of what they loose through vomiting and dehydration due to loss of appetite.

"It is common experience that cancer patients are malnourished when admitted to hospital, and restoration of their nutrition may play an important part in helping them to gain the maximum benefit from treatment." (Tiffany, 1978:63). For this reason a dietician is found to be of great need in the care plan of the patient.

As a rule nursing care is always a team effort which needs a number of health workers according

to their responsibilities and specialities to effectively cater for all the needs of the patient. A social worker may give social support; a religious worker emotional support and doctors and nurses cater for medical and nursing care while family members give help in informing the team of the preferences of the patients. Even if family involvement was mentioned by 16 (56,1 %) nurses, patients disproved this as only one patient indicated that his/her family was involved. No nurses indicated involvement of the patient in his/her care plan although one patient has said he was involved.

Item 29: Guidelines in the units regarding cancer patients managements (N = 41)

Only 11 (24,4 %) of the registered nurses answered that there are guidelines, while 30 (73,2 %) indicated no guidelines, and 1 (2,4 %) did not respond to the question.

On the question of what those guidelines are, the responses were as follows:

- Policy manuals = 2;
- Standard manuals = 5;
- Both policy and standard manual = 1; and
- Nursing care plans = 3.

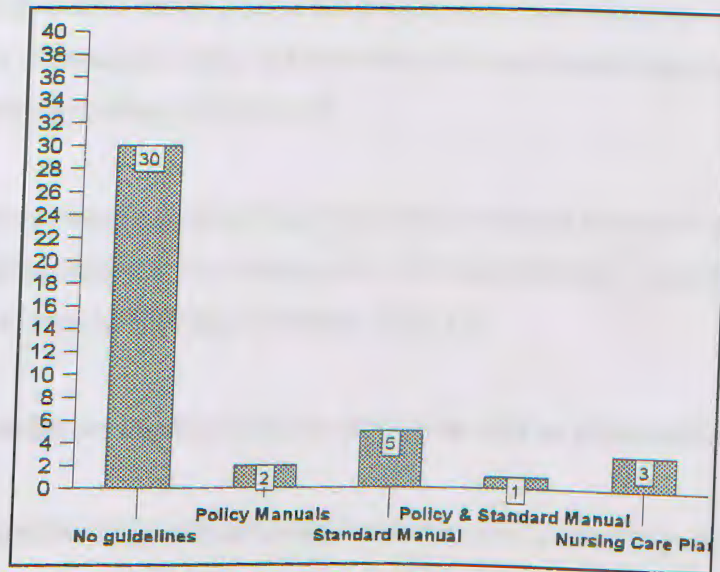

Figure 4.1 Guidelines available in Units

According to this figure, the findings revealed that a great percentage, 30 (73,2 %) of registered nurses did not have the guidelines in their units. It put them in a very difficult situation to know how they could really care for patients in their units. Lack of guidelines in only working situation is a dangerous sign which hampers progress.

Item 30: Consultation for type of care to patients (N = 41)

The sources of information for registered nurses were listed as doctors, other nurses and other health professionals.

Item 31: Do you plan any specific nutritional treatment for cancer patients (N = 41)

Twenty five (61,0 %) of the respondents said yes, 13 (31,7 %) said no and 3 (7,3 %) are missing. Nursing care of a cancer patient needs to include nutrition. A definite eating schedule should be planned and adhered to and no meal or between meal snacks should be omitted. Constant eating ensures adequate supply of energy and nutrients and it should include necessary vitamins to replace those lost through metastasis, for example ascorbic acid for patients with cancer of the breast to the skeleton (Tiffany 1978:72-73).

The diet prescribed should suit the patient's individual needs and tolerance which may differ from soft diet to fluid or alimentation diets, and from diet which can be taken per mouth to tube feeding or parenteral nutrition (Tiffany 1978:74-79).

"Megadoses of vitamins and nutritional supplements can entrance the body's own natural immune defence systems and counteract the ravaging effect of chemotherapy". Some vitamins like A and D are dangerous if taken in high doses (Ntoane 1993:37).

Item 32: Knowledge on implementation of nursing care as planned (N = 41)

Those who responded that they have adequate knowledge are 22 (53,7 %) while 17 (41,5 %) said they have no adequate knowledge and two did not respond.

Item 33: Supervision for implementation of nursing care (N = 41)

According to the respondents nursing care implementation is being supervised by registered nurses and this was mentioned by 40 (97,6 %) registered nurses. One (2,4 %) registered nurse abstained from answering.

The response is acceptable because registered nurses are responsible to see to it that they themselves and their subordinates implement the planned nursing care.

Item 34: Do you have counselling sessions for patients? (N = 41)

Fourteen (34,1 %) have indicated that counselling for their patients is being done, while 25 (61,0%) have no such sessions. Two (4,9 %) did not respond on this item.

Item 35: When is counselling being done? (N = 41)

Table 4.18 Time for counseling session

	Frequency	Percentage
For every patient during admission	4	9,8
Some patients during admission	1	2,4
If the patient is confused	1	2,4
When there is a need	12	29,3
Missing	23	56,1
Total	41	100

According to Table 4.18, 4 (9,8 %) registered nurses indicated that counseling is done for every patient admitted, 1 (2,4 %) said it is done for some patients only, 1 (2,4 %) said it is done when the patient becomes confused, 12 (29,3 %) said it is done if there is a need to do it, while 23 (56,1%) have not responded to the question.

Item 36: Who are involved in counselling? (N = 41)

Table 4.19 Persons involved in counselling

	Frequency	Percentage
Registered nurses	2	4,9
Doctors	5	12,2
All nine health workers listed	2	4,9
Nurses and doctors	2	4,9
Nurses and religious persons	1	2,4
Family and religious persons	1	2,4
Nurses, doctors and social workers	3	7,3
Nurses, doctors and family	1	2,4
Nurses, doctors and religious persons	2	4,9
Doctors, social workers and family	1	2,4
Nurses, social worker, family and religious persons	1	2,4
Nurses, occupational therapist, psychiatrist, and religious persons	1	2,4
Nurses, doctors, social workers, family and religious persons	3	7,3
Nurses, doctors, occupational and physio-therapist, family and religious persons	2	4,9
Nurses, doctors, psychiatrist, family and religious persons	2	4,9
Nurses, doctor, social worker, dietician, occupational therapist, family and religious person	1	2,4
Missing	11	26,8
Total	41	100

Table 4.19 has indicated that according to a number of registered nurses, counselling is a team-based process and not only done by few members of the disciplinary team. Less than half of those who have responded to this question have indicated counselling as a responsibility of nurse or doctors alone, and for some doctors and nurses, making it a medical and nursing effort excluding other groups which form a multi-disciplinary team.

If counselling is limited to these two professional groups, then the vital contributions of other groups are excluded and the emotional, social and spiritual support the patients may need, is deprived of them.

The number of and different counsellors to a patient depends on the need assessed, the reaction of the patient to being ill and his/her history since becoming ill as well as social and psychological background.

Item 37: Does counselling have any positive effects on a cancer patient? (N = 41)

According to 32 (78,0 %) respondents, it does have positive effects while for 2 (4,9 %) it does not. Seven (17,1 %) do not know. This indicates that a number of nurses do observe the importance of counselling their patients even if they themselves were not involved in counselling, for example where nurses responded that counselling is only done by doctors.

Item 38: Are the family members involved in treatment and care of their patients? (N=41)

Item 39: If not, why? (N = 41)

On the question of family involvement 36 (87,8 %) said yes, while 3 (7,3 %) said no. The other 2 (4,9 %) did not respond to the question.

On the question of why they are not involved, no reason was stated.

Item 40: Health information to the patients (N = 41)

Table 4.20 When information is given

	Frequency	Percentage
On admission	3	7,3
During hospitalization	4	9,8
On discharge	2	4,9
All three stages	24	58,5
On admission and on discharge	2	4,9
During hospitalization and discharge	6	14,6
Total	41	100

All 41 (100 %) responded to this question. Twenty four (58,5 %) indicated giving health information to their patients from admission to discharge, 2 (4,9 %) only on admission, 4 (9,8 %) during hospitalization and 2 (4,9 %) on discharge. This giving of information at one stage only deprives the patients of information which they constantly need. Therefore the 24 (58,5 %) nurses are those who apply health education at the right time because at every stage the patients need to be told what is and will be is imperative.

Item 41: Health information sessions on the following

Item 41.1

On the question to registered nurses on management of pain and other symptoms, 1 (2,4 %) said that information was never given to the patients, 21 (51,2 %) said that they gave information sometimes, 17 (41,5 %) said that they always gave the information to the patients on pain and other symptoms, while 2 (4,9 %) registered nurses did not respond to the question.

Item 41.2

Management of basic needs is addressed by giving information to patients sometimes according to 20 (48,8 %) registered nurses, 17 (41,5 %) registered nurses indicated that they always include information on basic needs in the health education while 2 (4,9 %) did not respond.

Item 41.3

On the question about dietary needs, 4 (9,8 %) registered nurses said they never give information on diet at home, 17 (41,5 %) said they give it sometimes, 18 (43,9 %) said they always give such information while 2 (4,9 %) did not respond.

Item 42: Are patients with cancer informed about their diagnosis? (N = 41)

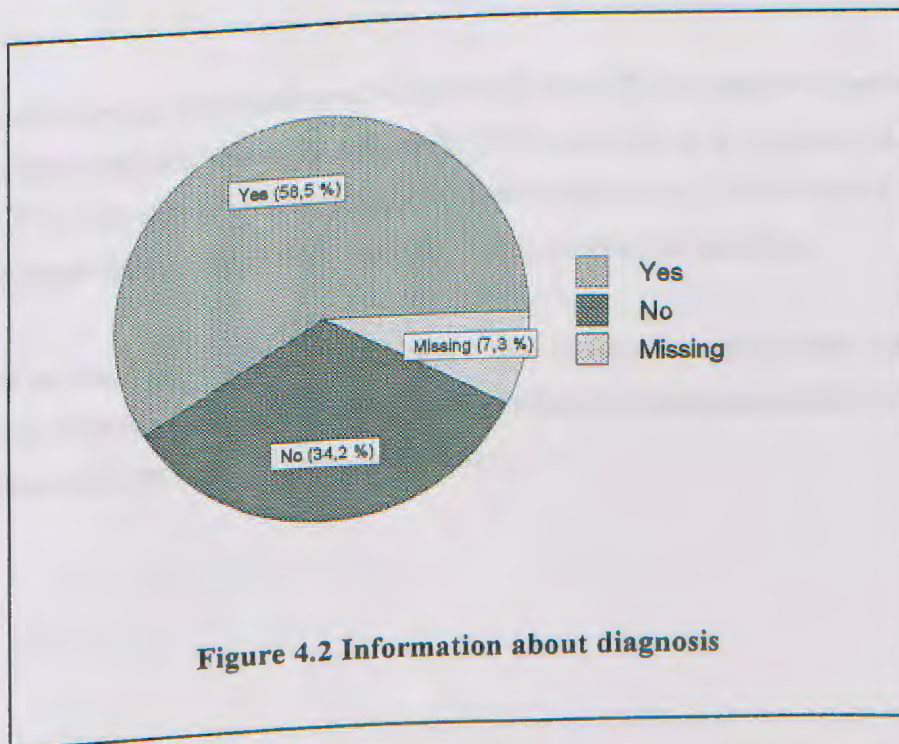

Figure 4.2 Information about diagnosis

According to Figure 4.2, 24 (58,5 %) respondents indicated that patients are informed about their diagnosis, while 14 (34,2 %) indicated that patients are not informed and 3 (7,3 %) did not

respond. It seems then that the majority were informed (Item 43).

Item 44: If no, what are the reasons for withholding such information from them? (N=41)

Table 4.21 Reasons for withholding information from patients (N = 41)

Reason	Frequency	Percentage
Medical state of patients	3	7,3
Psychological state of patients	5	12,2
Medical and psychological state of Patient	1	2,4
Communication problem	2	4,9
Missing	30	73,2
Total	41	100

The reason that were given are indicated in Table 4.21 that 3 (7,3 %) registered nurses withhold information due to patient's medical state, 5 (12,2 %) did it due to the patients psychological status, 1 (2,4 %) was due to both medical and psychological state, 2 (4,9 %) did it because of communication problems while 30 (73,2 %) did not respond to the question.

The reasons as stated in this table are not clear. One wonders whether it was due to lack of understanding of the question, whether it is what they felt to be the reasons or due to the language problems they could not express themselves clearly.

Item 45: Who informs the patients about their diagnosis?

Table 4.22 Who informs the patients? (N = 41)

	Nurses responses (N = 41)	
Informer	**Frequency**	**Percentage**
Nurse	0	0,0
Doctor	34	83,0
Doctors, nurses & psychologist	1	2,4
Doctors & nurses	1	2,4
Doctors & psychologist	4	9,8
Missing	1	2,4
Total	41	100

The findings indicated that 34 (83,0 %) of the registered nurses said that the patients are informed about their diagnosis by the doctors, 1 (2,4 %) said it is done by the doctors, nurses and psychologists, 1 (2,4 %) mentioned doctors and nurses, while 4 (9,8 %) mentioned the doctors and psychologist. One (2,4 %) registered nurses did not respond.

Even if the majority have indicated doctors only giving information on diagnosis, in the real practical situation, when doctors go to the patients they are always accompanied by the nurses and mostly it was the nurses who are requested to carry the message to the patient in the presence of the doctors. In the northern regions, most of the doctors are foreigners and do not speak the language of the patient, therefore the nurse interprets it to the patient as told by the doctor.

Item 46: If the patient is not informed about the diagnosis, how do you prevent accidentally disclosing such information?

The number of forty (73,2 %) registered nurses have not responded to the question. One does not know whether this is due to the fact that they never had an uninformed patient or if they did, they do not know how to handle the situation. Only 11 (26,8 %) have mentioned that they give no information but refer the patient to the doctor. Again here it is a point that they may not have

understood the question because one cannot refer a person if the person does not demand to know. A patient who is not informed may accidentally hear from nurses and doctors who are discussing him either in his room or when whispering in the corridor. During this time they may mention something concerning the patient which gives away information regarding the diagnosis.

Item 47: Level of confidentiality

Table 4.23 Level of confidentiality (N = 41)

Confidentiality level	Frequency	Percentage
As for other diseases	18	43,9
As for HIV/AIDS	3	7,3
Higher than other diseases but lower than for HIV	17	41,5
None	1	2,4
Do not know	2	4,9
Total	21	100

From this table it can be seen that nurses do attach the different levels of confidentiality to the diagnosis of cancer. These levels will determine how they are going to handle their patients. Except for 1 (2,4 %) registered nurse who said that there is no confidentiality attached to cancer, 38 (92,7 %) nurses consider cancer to be handled with some degree of confidentiality either like any other disease or HIV, or with higher confidentiality of than other diseases, but lower than that of HIV/AIDS. The important point is that confidentiality is anticipated in caring of cancer patients and not to make it a point of discussion with friends or relatives. Dignity is therefore maintained.

Item 48: Do you ever observe fear in cancer patients?

Item 49: If yes, what intervention do you apply?

From the question on observation about fear, 25 (61,0 %) did observe it while 13 (31,7 %) never

did, 3 (7,3 %) did not respond to the question.

On the question of what has been done to the fearful patients, the interventions applied included the following:

- psychological support - 17 (41,5 %);
- discussion on surgery - 2 (4,9 %);
- psychological support and ask help from social worker - 1 (2,4 %);
- referral to the doctor - 3 (7,3 %); and
- no response to the item was 18 (43,9 %).

Item 50: Are you able to give adequate emotional support? (N = 41)

Those who felt able to give emotional support were 27 (65,9 %) and 11 (26,8 %) did not have the self-confidence to give it.

Item 51: Encouragement of family members

On the question of whether registered nurses do encourage family members and cancer patients to discuss their fear, 39 (95,1 %) do and 2 (4,9 %) do not do it.

Item 52: Time of encouragement

When asked when they encourage patients and family members to discuss their fear, the responses ranged from admission, through hospitalization to discharge with most respondents 18 (43,9 %) indicating that they do encourage at all stages.

Items 53, 54, 55, 56: Evaluation of patients' conditions (N = 41)

Item 53: Do you evaluate patients' conditions?

Item 54: If yes, how many times a day?

Item 55: Do you adjust nursing care after evaluation?

Item 56: Do you keep accurate record?

Out of 41 respondents, 40 (97,6 %) do evaluation on patients' conditions and 1 (2,4 %) did not respond.

On the question (Item 54) when they do evaluations 3 (7,3 %) do it daily, 4 (9,8 %) twice a day, 11 (26,8 %) do it three times a day, 10 (24,4 %) do it four times a day, while 12 (29,3 %) do it more than four times a day.

About the question (Item 55) whether registered nurses do adjust nursing care according to the outcome of the evaluation, 35 (85,4 %) do adjust their planned nursing care while 3 (7,3 %) do not adjust it, 3 (7,3 %) nurses did not respond.

Accurate records on patients' conditions (Item 56), 38 (92,7 %) do keep it, but 1 (2,4 %) do not.

Item 57: Who are responsible for keeping records? (N = 41)

The person responsible for keeping records (Item 57) is indicated as registered nurse - 24 (58,5%), enrolled nurse - 1 (2,4 %), while 15 (36,6 %) indicated all three categories of registered, enrolled and auxiliary nurses as being responsible. It is quite apparent from the responses (Item 57) that all 39 (95,1 %) nurses know that record-keeping is the responsibility of registered nurses even if others also do.

Item 58: How is the patients' condition communicated to the rest of the health team? (N=41)

On this question registered nurses have indicated the ways of communicating the patient's condition as record-keeping and reporting. Record-keeping as the only way was mentioned by 1 (2,4 %) registered nurse and both record-keeping and reporting was mentioned by 22 (53,7 %) registered nurses. Eighteen (43,9 %) nurses did not indicate the ways in which they communicate the information to other members of the health team.

Recording and reporting is one of the most essential parts of the nursing process which should not be omitted. It is necessary to record every action taken at any stage from assessment to evaluation and to report any action taken during another member of the health team's absence.

Item 59: What do you recommend to be done, for nursing care to cancer patients to be effective? (N = 41)

Registered nurses who responded to this question were 38 (92,7 %) while 3 (14,3 %) have not given any recommendations. Those who have responded have suggested the following in order of frequency:

- More workshops, seminars and conferences to be held in the North.
- In-service training in cancer care for all categories of nurses.
- Oncology training for registered nurses and cancer care training for basic curriculum.
- Supportive care, emotionally, morally, financially and spiritually, including home-based care of terminally ill patients.
- Patient education on causative factors like, alcohol, smoking and exposure to sunrays.
- Establishment of cancer unit in the Northwest Health Directorate, with day clinics at every hospital equipped with chemotherapy for cancer patients.
- Counselling sessions at every hospital to encourage acceptance of condition with patients and family members.
- Education of community and patients on early diagnosis, early treatment and not to go to

traditional healers.

- Involvement of community and family members in planning care, how to give proper care and prescribed medication and pain relief measures.

The recommendations made by registered nurses on this question are mainly based on the questions they answered in this questionnaire.

Thirteen (31,7 %) registered nurses feel that more workshops and seminars could be conducted to give nurses a chance of sharing ideas and experiences on care for cancer patients in the regions.

Eight registered nurses (19,5 %) indicated the need for in-service education regarding cancer nursing issues. Three (7,3 %) have mentioned the importance of cancer care training in all basic programmes for nurses. Eight (19,5 %) registered nurses suggested oncology training for registered nurses to acquire specialized knowledge in care of cancer patients.

Seven (17,1 %) registered nurses have indicated an issue of supportive care to patients which should be emotional, moral or financial care support. Three have specifically pointed out home care support to terminally ill patients and their families.

Six (14,6 %) registered nurses have mentioned patients and community education on causative/contributing factors to cancer. Five (12,2 %) have mentioned alcohol and smoking as a factor while 3 (7,3 %) mentioned exposure to direct sunrays more specifically for Albinos.

Five (12,2 %) registered nurses have suggested that a cancer unit be established in the Northwest Health Directorate. Two (4,9 %) indicated the need for a day clinic at every hospital while two (4,9 %) indicated that chemotherapy should be available at local hospitals in the Directorate.

Four (9,8 %) registered nurses suggested counselling session in hospitals where patients are diagnosed. One (2,4 %) nurse has indicated the importance of assisting and encouraging the patients to accept their conditions.

Four (9,8 %) nurses indicated that community and patient's involvement in planning for the care of cancer as very important. Three (7,3 %) have mentioned that after planning, proper care should be given to patients and 2 (4,9 %) indicated that treatment should be given as prescribed whereas 1 (2,4 %) has specified on administration of painkillers.

Three (7,3 %) registered nurses have indicated the need for education to community and patients on early diagnosis, signs and symptoms and early treatment of cancer and to discourage patients to go to traditional healers.

4.3 SUMMARY

In this chapter the findings of questions that were posed to registered nurses were analyzed and discussed.

CHAPTER 5

ANALYSIS OF DATA AND DISCUSSION OF FINDINGS

QUESTIONNAIRE B

5.1 INTRODUCTION

In this chapter the responses of patients that were obtained through interviews will be discussed.

5.2 ANALYSIS AND DISCUSSION OF FINDINGS - QUESTIONNAIRE B

SECTION I

Item 1: Sex of respondents

Table 5.1 Gender of patients (N = 21)

Gender	Frequency	Percentage
Female	15	71,4
Male	6	28,6
Total	N = 21	100

Out of 21 (100 %) respondents, 15 (71,4 %) were females while only 6 (28,6 %) were males. This gives the picture of more females being admitted with cancer conditions than men. The incidence of females with cancer is high in the North West Health Directorate most of whom are mothers with children to take care of at home.

Item 2: Diagnosis of the patient which are confirmed

Table 5.2 Diagnoses of patients (N = 21)

Diagnosis	Frequency	Percentage
Cancer of breasts	5	23,8
Metastatic		
Cancer of lymph nodes	1	4,8
Cancer of perineum	2	9,5
Cancer of ovaries	2	9,5
Cancer of pancreas	1	4,8
Cancer of prostate	3	14,2
Invasive cell carcinoma	4	19,0
Cancer of neck and arm	1	4,8
Cancer of rectum	1	4,8
Cancer of bladder	1	4,8
Total	N = 21	100

Breast cancer was the most diagnosed (5 = 23,8 %) in the sample of the study followed by the cancer infiltrated the body affecting different organs of the body which makes up 19 % (4) of the sample. The rest of the cancers diagnosed are those affecting different organs of the body like ovaries, perineum, pancreas, prostate glands, neck and arm, rectum and bladder. The table indicates that cancer can affect most parts of the body most of which have something to do with reproduction, digestion and urinary system.

Item 3: Age of respondents

Table 5.3 Age of respondents (N = 21)

Age	Frequency	Percentage
29 - 36	3	14,28
37 - 44	3	14,28
45 - 52	1	4,76
53 - 60	1	4,76
61 -68	6	28,57
69 - 76	2	9,5
77 -84	2	9,5
85 - 87	1	4,8
No response	2	9,5
Total	N = 21	100

According to this table the age of patients ranges from 29 - 87 years. This shows that cancer conditions can occur in all ages. The majority of the patients in this study are between the ages of 61 - 68 years. It can therefore be concluded that the majority of patients admitted during the time of the study fell in that category.

Item 4: Marital status of respondents (N = 21)

Out of a total number of 21 (100 %) respondents, 17 (81,0 %) are married, 1 (4,8 %) is single, 2 (9,5 %) are divorced and 1 (4,8 %) could not give a clear indication of whether he/she is married or not. The high percentage of respondents are married, having partners and two have divorced while two are single. For the married patients it could mean better chance of moral support from their partners and family members while for the divorced and single it can mean that they have to carry their burden alone and lack moral and emotional support of having been diagnosed with cancer which is an incurable disease. This may aggravate their suffering and cause emotional pain and fear.

Item 5: Number of dependent children

Table 5.4 Dependent children (N = 21)

Number of children	Frequency	Percentage
1	2	9,5
2	2	9,5
3	7	33,3
4	2	9,5
5	2	9,5
6	1	4,8
7	3	14,3
8	0	0,0
9	1	4,8
No children	1	4,8
Total	N = 21	100

From this table it has become evident that all the patients in this study except one, have dependent children in their care. These children are either their own or grandchildren and those born to their relations.

As they are admitted in the hospital, these children may in one way or another suffer from lack of care by these patients.

The number of children varies from one to nine per patient. The latter too heavy a load for a patient, especially the chronically ill ones.

Item 6: Number of dependent children under 12 years and between the age of 13 - 18 years

The total number of dependent children to the respondents (patients) varies from one to seven. Four of the respondents (19,0 %) have only one child, 4 (19,0 %) have two, 4 (19,0 %) have three, 1 (4,8 %) has four, 2 (9,5 %) have five each while one (4,8 %) has seven dependent

children, while 5 (23,8 %) have children between the ages of 13 - 18 years. This indicates that the patients with cancer are not only burdened with stress caused by their diseases but also with care of very young children who are to attend schools, and have to be dressed and need adequate nutrition and socialization. A person who is already ill, cannot be expected to care properly for the children under his/her care more especially those that are old (over 60 years) and are in need of social care themselves. In this study, though not indicated, it has become evident that many of these children are grandchildren whose parents are not caring for them but leave them with old people to manage on their own.

Item 7: Employment (N = 21)

Out of a number of 21 respondents, only 4 (19,0 %) are employed while 17 (81,0 %) are not employed. The burden of financial care to the dependent children is aggravated by the fact that the majority of the patients are not employed.

Item 8: Source of income

Table 5.5 Source of income to respondents (N = 21)

Source	Frequency	Percentage
Pension	11	52,4
Pension and children	4	19,0
Husband employed	2	9,5
Self-employed	1	4,8
Invested money	1	4,8
No source	2	9,5
Total	N = 21	100

Most (52,4 %) of the respondents' income is from pension money, 19,0 % is from pension and from their children who care for them. 9,5 % are dependent on their partners who are employed. 9,5 % have no source of income while 2 (9,5 %) are self-employed or use money which has been

invested during employment time respectively.

Item 9: Hospitalization for the first time (N = 21)

Out of twenty one patients, only one (4,8 %) patient was hospitalised for the first time with a confirmed diagnosis of cancer. This indicates that the patient is at the beginning of the treatment period. This patients investigations were done as an outpatient.

Item 10: Number of admission in hospitals

Seven (33,3 %) patients have been admitted twice since their diagnosis was made, one (4,8 %) had been admitted three times, while 13 have been admitted more than three times. Being a cancer patient one is subjected to a number of admissions, which causes one to be absent from one's family several times. This may create tension for the patient as well as for the family.

Having been admitted in the hospitals several times, the patients are in a better position to explain the nursing care they receive from the registered nurses in those hospitals when interviewed. The repeated admissions to hospitals cause isolation from the family and the family stability may be hampered. In some cases, if the wife is the one being admitted, the husband may get tempted and may have some extramarital affairs reasoning that he cannot bear the loneliness for so long. This may lead to family disorganisation and adds more stress on the patients who is already distressed.

Item 11: Centres where patients have been admitted

Table 5.6 Centres of admission

Name of centre	Frequency	Percentage
Oshakati	8	38,1
Oshakati and Windhoek	3	14,3
Onandjokwe and Windhoek	2	9,5
Onandjokwe	1	4,8
Onandjokwe, Oshakati and Windhoek	1	4,8
Onandjokwe and Oshakati	1	4,8
Kampaku, Oshakati and Windhoek	1	4,8
Tsandi, Oshakati and Windhoek	1	4,8
Tsumeb, Oshakati and Windhoek	1	4,8
Oshikuku and Oshakati	1	4,8
Engela and Oshakati	1	4,8
Total	21	1000

From this table we find that Oshakati is the admission centre for almost every patient who has been diagnosed with cancer from the northwest region. Only two (9,5 %) have been admitted in Onandjokwe and transferred directly to Windhoek and 1 (4,8 %) who has been admitted in Onandjokwe only. All 18 (85,7 %) patients under this study have been admitted to Oshakati and any other hospital in the region and 7 (33,3 %) of the eighteen patients has been to Windhoek from or via Oshakati. Eight (38,1 %) patients has been admitted directly to Oshakati only.

The reason why Oshakati has admitted nearly all the patients under the study is because it is the district and also a regional referral hospital in the North West Health Directorate, and 17 (81 %) interviews were done at Oshakati Hospital.

SECTION II

Item 12: Were you told about your diagnosis?

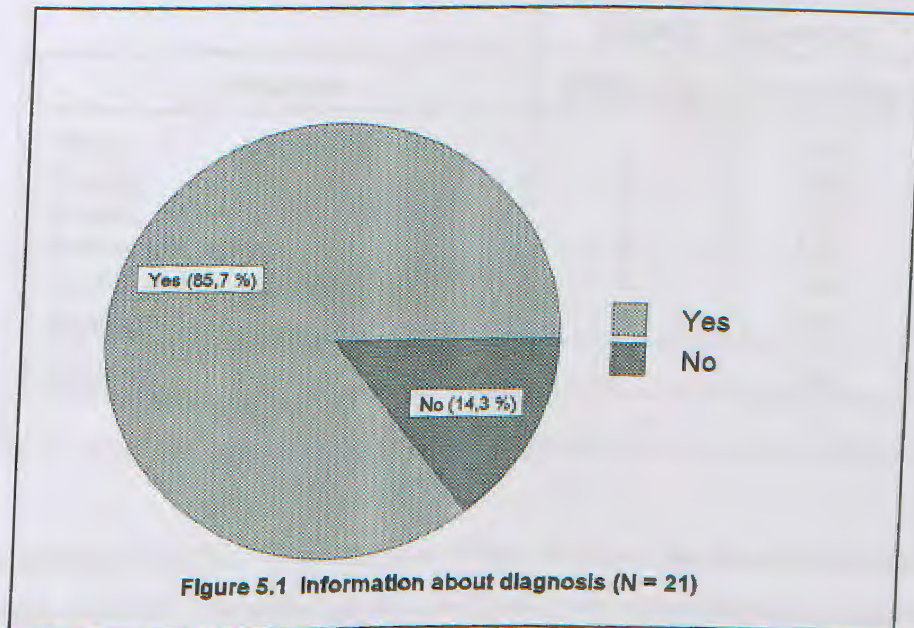

Figure 5.1 Information about diagnosis (N = 21)

According to figure 5.1, 18 (85,7 %) of the patients indicated that they have been told their diagnosis and 3 (14,3 %) have not been informed.

This indicates that the majority of the patients are being informed as it is indicated by the majority of the registered nurses. It is the patient's right to be informed about what affects them and what is to be done to them if they prefer to hear about it.

From the researcher's side she was careful not to disclose the diagnosis of the patient until she was sure of what the patient has been told. In doing research on cancer patients, one should be careful not to disclose the diagnosis to the patient accidentally and confirm to the patients that they have cancer. It was already observed that patients may not have been told that they have cancer, but instead had construed that they had cancer (De Reave 1996:89).

Item 13: If yes, by whom?

Table 5.7 Informer of patients (N = 21)		
	Patients' Responses	
Informer	**Frequency**	**Percentage**
Nurse	1	4,8
Doctor	8	38,1
Doctor, nurses and psychologist	0	0,0
Doctor and nurses	8	38,1
Doctor and psychologist	0	0.0
Missing	4	19,0
Total	21	100

According to Table 5.7 8 (38,1 %) of the patients have indicated the doctor informed them about their diagnosis, and 8 (38,1 %) of the patients mentioned doctors and nurses informed them about their diagnosis, 1 (4,8 %) was informed by a nurse and 4 (19,0 %) did not respond.

According to the table it has become apparent that nurses alone do not inform the patients about their diagnosis but it is always in conjunction with the doctors or the doctor and any other health workers.

It is proper for doctors always to be involved when it comes to informing the patients because they have sound knowledge of the disease and know what and how to explain it clearly.

Item 14: If no, have you asked to be told? (N = 21)

On this item patients could not really understand why they were not informed about their diagnosis, and did not know that they could ask.

Item 15: Are you on chemotherapy? (N = 21)

Eight (38,1 %) patients answered yes and 13 (61,9 %) answered no. Only a small number of cancer patients participating in this study were on chemotherapy.

Item 16: Have you undergone radiotherapy? (N = 21)

Only 1 (4,8 %) patient has undergone radiotherapy, 20 (95,2 %) have not undergone it and one of those twenty was not sure or clear on whether or not it was done.

Item 17: Have you undergone surgery? (N = 21)

Eleven (52,4 %) of the patients responded yes, 9 (42,9 %) said no and 1 (4,8 %) did not exactly know what was done, whether it was surgical operation or just a procedure to examine the body for diagnostic purposes.

Item 18: Where radiotherapy and/or surgery was done? (N = 21)

One patient (4,8 %) who has undergone radiotherapy, indicated that it was done in Windhoek, 9 (42,9 %) indicated that surgery was undergone at Oshakati, for 9 (42,9 %) Onandjokwe and 2 (9,5%) patients indicated both Windhoek and Onandjokwe.

Item 19: Were you informed on the side-effects of chemotherapy, radiotherapy and surgery?

Table 5.8 Effects of chemotherapy, radiotherapy and surgery (N = 21)

	Chemotherapy		Radiotherapy		Surgery	
	Frequency	**Percentage**	**Frequency**	**Percentage**	**Frequency**	**Percentage**
Yes	8	38,1	1	4,8	7	33,3
No	13	61,9	15	71,4	12	57,1
Missing	0	0,0	5	23,8	2	9,5

Of those who were informed regarding side-effects, 8 (38,1 %) were informed on chemotherapy, only 1 (4,8 %) was informed on radiotherapy and he was the only one who has undergone radiotherapy, while 7 (33,3 %) were informed of the side-effects of surgery.

Item 20: Who informed you on the effects? (N = 21)

Table 5.9 Informer about effects (N = 21)

Informer	Frequency	Percentage
Doctor	5	23,8
Nurse	3	14,3
Doctor and Nurse	6	28,6
Don't know	7	33,3
Total	21	100

From Table 5.9 it can be concluded that 5 (23,8 %) patients are informed by doctors, 3 (14,3 %) by nurses, 6 (28,6 %) are told by both doctors and nurses, while 7 (33,3 %) are not told.

Item 21: 21.1 Are you clear on your treatment plan?

21.2 Are you kept informed on what to be done?

The responses of patients to these two questions were as follows:

Figure 5.10 Patients knowledge on treatment plan

	Yes	No	Total
For question 21.1	11 (52,4 %)	10 (47,6 %)	21 (100 %)
For question 21.2	17 (81,0 %)	4 (19,0 %)	21 (100 %)

This table gives the picture of the patients knowledge concerning their treatment plans. Eleven (52,4 %) do understand their treatment plans and seventeen are kept informed on what is to be done even if some do not understand the plans. Ten (47,6 %) do not understand their plans of treatment and 4 (19 %) are not kept informed of what is to be done. Some have mentioned the examples that sometimes they are just told that they are supposed to go to theatre for operation, but they do not understand what is to be done during that operation. Although they are few (4 = 19 %) the fact remains that every patient needs to know everything done to him/her. This is one of their needs, "the need to know", which needs to be fulfilled by both the nurses and doctors.

Item 22: If yes, were you involved in drawing of your care plan?

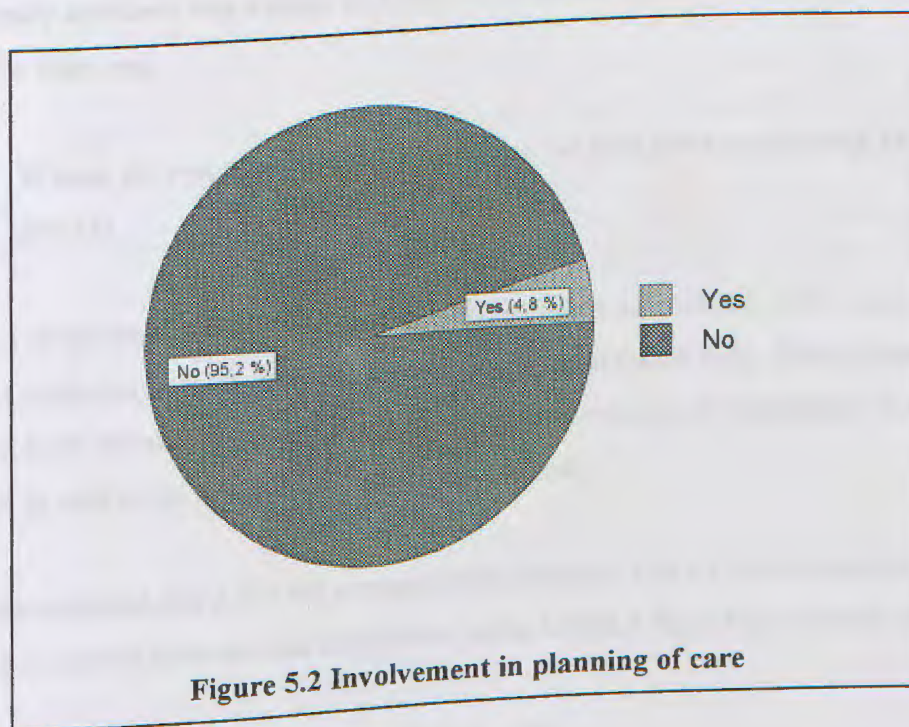

Figure 5.2 Involvement in planning of care

According to Figure 5.2 only 1 (4,8 %) patient was involved in planning for his/her nursing care, 20 (95,2 %) patients were not involved.

This information indicates that the Primary Health Care approach in Namibia which emphasizes the involvement of the community and patients in their care planning is not being applied to cancer patients. Health care professionals are still the ones who decide and plan everything for and on behalf of the clients/patients. Every patient should have the opportunity to participate in the planning of their care.

Item 23: If no, was any other member of your family involved? (N = 21)

One patient (4,8 %) indicated that his/her family was involved in the planning of his/her care. Again the same patient who was involved, his family was also involved in the planning of his care. No other patient's family was consulted. That is why many of the patients, when this question was posed to them, reacted in surprise as if they felt that the researcher was asking about issues

which are either impossible or not supposed to be done. Some went as far as clarifying that none of their family members was a nurse or a doctor, therefore there was nothing they could do in planning for their care.

Item 24: Whom do you contact for information on any issue pertaining to your care? (N=21)

The source of information for registered nurses are listed as: doctors, other nurses and other health professionals (while for patients they are doctors and nurses only. This indicates that both nurses and their patients do have common persons as sources of information for the cancer conditions, as well as for the type of care to be rendered.

The findings indicated that 2 (9,5 %) contacted their doctors, 5 (23,8 %) contacted nurses, while 4 (19,0 %) contacted both doctors and nurses, while 10 (41,6 %) did not contact anybody.

Item 25: Contact person for information (N = 21)

For patients who do choose the doctors, their reason was doctors do know everything about the disease and have clear information based on their knowledge of the disease. For those who chose to ask nurses, their reasons were as follows:

- nurses can get information from doctors;
- they understand the language because many doctors speak English, which patients do not always understand;
- some do not know whom to ask other than nurses; and
- some patients are afraid to ask questions of other health workers.

Item 26: Do you know of any association dealing with your condition here in Namibia?

Item 27: Do you make use of the service provided by that association?

Table 5.11 Knowledge & usage of Cancer Association (N = 21)

	Knowledge		Usage	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Yes No	1 20	4,8 95,2	1 20	4,8 95,2
Total	21	100	21	100

Only 1 (4,8 %) of the total 21 patients knew about the Cancer Association and has made use of that service. This indicates that many of the cancer patients from the north do not have information on the association which is supposed to deal with their condition, therefore they do not make use of it.

Item 28: Are you taught how to care for yourself after discharge? (N=21)

Item 29: If yes, what are you taught about? (N = 21)

On the question about being taught of self-care only 6 (28,6 %) have been taught, the rest were not taught anything.

From those four who were taught how to care for themselves, 2 (9,5 %) were taught appropriate care and 2 (9,8 %) about what is bad for them.

Item 30: Do you suffer from pain? (N = 21)

Out of twenty one patients, 18 (85,7 %) suffered from pain and only 3 (14,3 %) did not suffer from any pain. Many of these patients have been in their advanced stage of cancer where pain is suffered.

Item 31: Pain management (N = 21)

Table 5.12 Pain Management (N = 21)

Management	Patient's responses (N = 21)	
	Patients' Frequency	Percentage
Nothing	2	9,5
Medicine	14	66,7
Emotional support	0	0,0
Medicine and emotional support	0	0,0
Therapeutic treatment	0	0,0
Medicine and comfortable position	0	0,0
Medicine and emotional support. Protein diet	0	0,0
Missing	5	23,8
Total	21	100

From the 21 (100 %) patients, 2 (9,5 %) said nothing was given to them for pain, while 14 (66,7 %) have indicated that they were given medication, and 5 (23,8 %) did not suffer from pain at that stage.

Item 32: Are you informed on what to do to get pain relief? (N = 21)

The findings indicated that 2 (9,5 %) respondents indicated that they were informed on what to do to get pain relief, while 19 (90,5 %) were not informed.

Item 33: Who informs you to report on pain relief? (N = 21)

On the question by whom were you informed the two respondents indicated as follows: 1 (4,8 %) was informed by a doctor, and 1 (4,8 %) was informed by a doctor and a nurse.

Item 34: Do you experience nausea?

Item 35: Do you vomit?

Item 36: What is done to assist you?

Table 5.13 Nausea and vomiting

	Nausea		Vomiting	
	Frequency	**Percentage**	**Frequency**	**Percentage**
Yes	11	52,4	7	33,3
No	10	47,6	14	66,7
Total	21	100	21	100

Table 5.13 indicates that more than half of the patients, 11 (52,4 %) experienced nausea but only 7 (33,3 %) did vomit. It was indicated in literatures that patients with cancer do vomit due to therapeutic interventions like radiotherapy and medication; food intake if it irritates the gastro-intestinal tract or bad smells; disturbance by tumors as well as psychological stress (Kozier 1995:1414).

It is therefore expected from registered nurses to be able to identify the need for relief of nausea which can lead to vomiting and give them information on food to eat, or food to avoid and to know that some treatments do result in vomiting and how to behave themselves after such treatments. To assist the patients (Item 36) the nurses should give regular diet (medication) anti-emetics if ordered, analgesics for pain and put the patient at ease (Kozier 1995:1414).

Item 37: Do you sleep well? (N = 21)

All 21 responded to the question. Six (23,6 %) said they sleep well while 15 (71,4 %) do not. Asked on the question of causes of not sleeping well, 12 (57,1 %) mentioned pain and discomfort, 1 (4,8 %) said it is because of old age.

The type of help they got to enable them to sleep is medicine according to 7 (33,3 %) patients, 5 (23,8 %) said nothing was done to them. Sleeplessness is caused by many factors, it also needs to be dealt with in several ways including medication. Psychological, emotional and social support make up a major intervention to this problem.

Item 38: Is your appetite good? (N = 21)

38.1 Do you have specific preferences for certain foods?

38.2 Is that type of food available?

38.3 What do the registered nurses do to help you to overcome loss of appetite?

Eleven (52,4 %) of the 21 patients have a good appetite but 10 (47,6 %) patients' suffer from loss of appetite.

Nine (42,9 %) have specific preferences for certain types of food, 7 (33,3 %) do not have any preference, 5 (23,8 %) did not respond to the question, because their appetite is good.

Availability of food preferred is admitted by 9 (42,9 %) patients.

Nurses do help the patients with loss of appetite by giving them medicine according to 6 (28,6 %) of the patients and nothing was done to 3 (14,3 %) patients with a loss of appetite. It is believed that patients with cancer experience appetite problems, 10 (47,6 %) and that is why registered nurses have to cater for that in the planning stage by looking at their dietary needs.

Item 39: Do you have a problem with elimination?

39.1 What problem is that?

Item 40: What was done to assist you coping with that problem?

The problem of elimination is experienced by 14 (66,7 %) patients while 6 (28,6 %) have no problem. The problems they experience are as follows:

Table 5.14 Problems experienced by patients with elimination

Diarrhoea	1
Constipation	12
Incontinence of urine	5
Frequency of urine	3
Retention	7
Any other: colostomy	1

The assistance these patients get (Item 40) are mentioned as being appropriate help which patients could not explain clearly, enema and catheterization.

Table 5.15 Assistance given for elimination problem

Type of help given	Frequency	Percentage
Nothing	5	23,8
Appropriate help	2	9,5
Enema	3	14,3
Catheterization	3	14,3
Total	21	100

Item 41: Is your environment conducive for improvement? (N = 21)

Most patients found their environment to be conducive to the improvement of their condition while others do have one or more problems with it. 5 (23,8 %) have complained that their rooms are too hot and they cannot sleep properly during the night.

Item 42: Do you communicate your feelings about your illness?

To this question 11 (52,4 %) said yes, they did while 10 (47,6 %) said no.

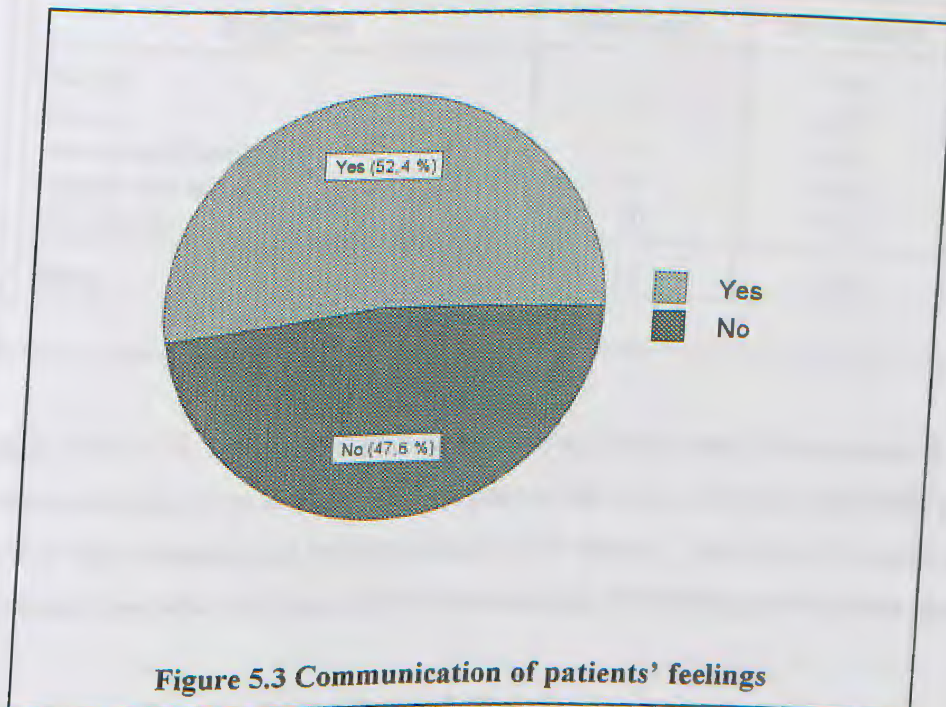

Figure 5.3 Communication of patients' feelings

This figure indicates a greater percentage of patients (47,6 %) were not able to communicate their feelings. In nursing practice, patients need to be given the opportunity to air their views and problems so that health professionals can be able to assess their needs derived from what they say. If patients do not have a chance to talk, then nurses are left to assume their needs which hamper proper planning and implementation of the nursing care to patients.

Item 42.1: If yes, to whom?

Table 5.16 To whom patients communicate feelings (N = 21)

Responses	Frequency	Percentage
Doctor	1	4,8
Nurse	5	23,8
Doctor and family	1	4,8
Doctor and nurses	4	19,0
No response	10	47,6
Total	21	100

According to Table 5.16, 1 (4,8 %) patient said he/she communicated to the doctor, 5 (23,8 %) said they communicated to the nurses, 1 (4,8 %) patient was both to doctors and family members, while 4 (19,0 %) communicated to both doctors and nurses. Ten (47,6 %) who have not responded were those who said they did not communicate their feelings about their illnesses.

Item 42.2: If no, why not communicating feelings?

Table 5.17 Reasons for not communicating (N = 21)

Reasons	Frequency	Percentage
The way how was socialized at school	1	4,8
Difficult to ask if you have no knowledge	2	9,5
Just do not ask	2	9,5
Do not know why	5	23,8
Not applicable	11	52,4
Total	21	100

From the ten patients who do not ask, 1 (4,8 %) patient said at school he/she was taught not to ask too many questions, 2 (9,5 %) said they did not know what to communicate about, 2 (9,5 %)

said they did not know why they did not communicate their feelings. The indication here is that many of these patients did not know what they were entitled to.

Item 43: What are your expectations from registered nurses?

Table 5.18 Expectations of patients (N = 21)

	Frequency	Percentage
Care, medication and comfort	1	4,8
To consult with doctors about problems	14	66,7
Care, medication, prayers and comfort	2	9,5
No expectations	4	19,0
Total	21	100

From this table it has become evident that a number of patients do expect nurses to act as an intermediary between them and the doctors with regard to their problems, as indicated by 14 (66,7%) patients. Care medication and prayers are also mentioned but with less emphasis.

Item 44: How do you rate level of care by registered nurses?

Table 5.19 Rating of level of patient care (N = 21)

Rating	Frequency	Percentage
Very good	3	14,3
Good	12	57,1
Fair	5	23,8
Poor	1	4,8
Total	21	100

From this table it can be seen that nursing care of patients by registered nurses is considered good on the average (57,1 %), fair by 23,8 % of the respondents and very good by only 14,3 %. Only

one (4,8 %) has rated it to be poor.

Item 45: Does your illness interfere with your movements? (N = 21)

Item 46: Do you get exercise of the muscles? (N = 21)

Item 47: Are you visited by a physiotherapist? (N = 21)

For 13 (61,9 %) of the patients their illness does interfere with their movements (Item 45).

Only 4 (19 %) of the patients do exercise their muscles (Item 46).

Three (14,3 %) of the patients are being visited by a physiotherapist for exercise of their affected parts to prevent immobility.

Item 48: Have you lost a part of the body? (N = 21)

Item 49: Are you able to make use of the parts left? (N = 21)

Item 50: Have you lost your voice? (N = 21)

Item 51: Are you able to communicate without a voice? (N = 21)

Only 3 (14,3 %) of the cancer patients have lost a part of the body and all were females whose breasts have been removed (Item 48). Out of those three under Item 48, two are able to use their parts which are left (Item 49).

On the question of loss of voice (Item 50) and the ability to communicate without a voice no patient had this problem.

Item 52: Do you feel a need for more to be done than what is done? If yes, what is that you need? (N = 21)

On the question of a need for more, 8 (38,1 %) said yes while 13 (61,9 %) said not more is needed by them. Those who felt more needs to be done, have listed them as follows:

- time to talk;
- to be treated as human beings and not to be scolded when asking for help;
- clarity about what one must do and not have to do;
- massage of limbs to be able to move; and
- more assistance when one needs to move around.

There were those who felt that something more needs to be done but they could not come out with suggestions. This is an indication of some patients not being able to identify their needs. They are dependent on the nurses to such an extent that they fail to convince nurses that their care to them (patients) is not sufficient. That is why on the question of expectations, (Item 43) patients could hardly come out with a list of proper expectations.

The conclusion which can be drawn here is that it seems as if there is lack of health education to the patients to enable them to know their rights as patients. If patients know their rights, only then can they receive what they are entitled to.

5.3 SUMMARY

In this chapter the data of Questionnaire B was analyzed and the findings were discussed.

CHAPTER SIX

SUMMARY OF FINDINGS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter provides a brief overview of the study with emphasis on major findings, conclusions and recommendations for improvement of nursing care to cancer patients.

Nursing care of cancer patients is increasingly becoming an important topic in our profession. Cancer is one of the major health problem of our times. Where the Primary Health Care approach is being emphasized, implemented and prioritized in all health professions, cancer is increasingly demanding a lot of manpower, financial support and technology to deal with the neoplasms of different kinds.

In the past a cancer patient was considered as an incurable case. A cancer patient is not only a diseased body, but also a person with a thinking mind and stirring soul. He has attitudes and aptitudes, interests and instincts, hopes and dreams, which are affected by his condition. Cancer care therefore needs a team approach to meet the different demands of the patient at different levels (Tiffany 1978:Vol. 1).

6.2 PURPOSE OF THE STUDY

This study was undertaken to look into how cancer patients are being cared for by the registered nurse while under their care in the hospitals and how they prepare them for further care when discharged.

6.3 METHOD EMPLOYED

The descriptive survey and two questionnaires were used. The questionnaire for registered nurses

was answered by registered nurses assigned to units where cancer patients are being admitted in four hospitals: Onandjokwe, Oshakati, Oshikuku and Tsumeb, in the North-West Health Directorate. A questionnaire for patients was used to interview patients only from Onandjokwe and Oshakati hospitals. A sample was not drawn as the total population of registered nurses were used and have responded. The population of patients could also not be sampled as all the patients admitted during the time of the study and who could be found in the wards/units of the time of interviews, were included.

6.4 FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

SECTION I

For each questionnaire, section one, the profile and personal particulars of both registered nurses and patients are described.

On the registered nurses (Questionnaire A) the following major profile was recorded:

- Registered nurses under the age 33 - 37 were 9 (22 %), while 8 (19,5 %) were between the ages 29 - 32 years and between 38 - 42 years respectively.
- The minority of the respondents, namely 7 (17,1 %) were between the ages 47 - 50 years of age.
- The majority of the respondents - 16 (39,0 %) - have been registered for more than 10 years, while 13 (31,7 %) have been registered between 1 and 5 years.

In the case of patients, Questionnaire B, Section One revealed the following major demographic data:

- The majority - 15 (71,4 %) - of the N = 21 patients were females. They are the ones responsible for care at home and in some cases they are mothers of small children of school going age or pre-school age and they have been admitted in the hospital.
- A number of patients - 17 (81 %) - are married with families to take care of.

- These patients have dependent children in their care which range from 1 - 9 children and most of these children are of age 0 - 12 years.
- All 17 (81,0 %) patients are unemployed and their major source of income is pension money and some depend on their children who are employed.

6.5 FINDINGS, CONCLUSIONS AND RECOMMENDATIONS ACCORDING TO THE OBJECTIVES

OBJECTIVE ONE

To determine the qualifications and experience of registered nurses concerning cancer nursing care.

FINDINGS

- Experience of respondents allocated in the present units to care for cancer patients varies from one month to fourteen years. According to the findings 12 (29,3 %) have had experience of 4 - 6 years, followed by 17 (41,5 %) who have had 1 - 3 years of experience. Only 2 (4,9 %) had experience ranging from 13 - 14 years in the units.
- The registered nurses' qualifications range from single registration as a nurse to multiple registration as general nurse, midwife, community health and nurse administrator. Sixteen (39,0 %) are registered as general nurses and midwives and only one (2,4 %) has additional qualifications (post-basic) as a community health nurse and administrator. This was the only nurse with clinical specialisation after basic training.
- Although the percentage of those who are currently studying is small (19,5 %) it is encouraging to see that there are nurses who engaged in further study to improve their knowledge and qualification.
- No registered nurse was qualified as an oncology nurse. This may have an impact on the nursing care given by these registered nurses who are not specifically trained to care for the cancer patients. The issue of registered nurses not being qualified as oncology nurses should not be used as an excuse for not being able to care for cancer patients. There are

certain issues like knowledge on drugs for cancer patients, special diet and observations to be done on patients, counselling skills for oncology patients after care to radiotherapy and surgical interventions, which a general nurse may not be able to master but, nevertheless, with basic nursing care knowledge the nurse can do a lot for the patient.

- Registered nurses attending to cancer patients do not have access/exposure to workshops, seminars or conferences where they can gain additional knowledge. As none of them are registered in oncology nursing, there could be the opportunity for nurses to learn some strategies of how to deal with health problems specifically pertaining to cancer diagnoses.
- In-service education which could specifically be given focussing on cancer care is lacking according to 41 (100 %) registered nurses who responded. Even if there were nurses who are trained in oncology nursing, in-service training is inevitable. Nurses should establish a culture of in-service training as part of every treatment regime.
- Sources of information from the library are not utilized effectively as only 18 (43,9 %) registered nurses know that there are cancer journals available and 22 (53,7 %) are not aware of what is available. Only three use other sources like books on cancer nursing care.
- At the time of the study only 20 (48,8 %) nurses had cancer patients in their units while 21 (51,2 %) had no cancer patients. This indicates that registered nurses do not nurse cancer patients on a continuous basis but do so occasionally.

General Conclusion

In conclusion, the professional background of the registered nurses was found to be inadequate. As they are not trained for oncology nursing they do not receive information on how to care for such patients and there are no forums or structures in place from where they can learn new trends of cancer care. Those who participated in the study need special attention on how they can be assisted to know and gain experience which they can use to give better care as desired.

General Recommendation

- The science of nursing, the need for nursing care, and the ways of meeting such a need, are growing rapidly. Although it is the responsibility of each professional nurse to expose

herself/himself to growth and development in her/his profession, it cannot be accepted that the employer has no role to play in this responsibility.

Employers, the nursing association and educational institutions should organize workshops, seminars, conferences on specifically cancer care on a regular basis.

- An in-service education programme for all categories of nursing staff on nursing cancer patients, should be implemented by concerned institutions.

- It is no longer possible for a nurse skilled as a generalist nurse to undertake highly developed specialisation unless he/she has been specifically prepared for this. It is therefore recommended that an advanced diploma in oncology nursing be implemented by the concerned authorities.

OBJECTIVE TWO

To determine whether the nursing process is applied during nursing practice.

FINDINGS

Assessment

This is the phase in which the patients' needs are identified. A number of assessment methods need to be employed if the needs of the patient are to be identified effectively. In this study it has been revealed that some nurses do not adequately assess the patients. They use one, two or four methods of assessment and leave others out. The needs or problems which could be identified by the unused methods will not become known and therefore not attended to. Of all 41 = N registered nurses in this study only 4 (9,8 %) have indicated that all the listed methods in the questionnaire are employed in their assessment. It is said in the literature that "although cancer patients may have some common specific needs, these needs should be clearly identified and not just assumed" (Chapter 2). To establish a proper data base, health history, physical assessment,

review client's records (passport, admission and laboratory records) and review of literature is essential (Kozier, 1995:1414).

On initial assessment at admission registered nurses mentioned pain, hygiene, diet, emotional problem, discomfort, bleeding and swelling. Some of these needs are those discussed in our literature review like need for freedom from pain, for support and relief of other symptoms.

Planning of nursing care

The planning session of the patient's treatment is a most important issue in care of cancer patients. As part of the nursing care process, it is admitted as having been done by 40 (97,6 %) of the registered nurses. The study has revealed that not all the patients are clear on their treatment plan accept for only 11 (52,4 %) patients who admitted that they are clear on their treatment plan. Their family members are also not being involved. Although sixteen registered nurses have indicated the involvement of family members in planning of patient's care, only one (4,8 %) patient has admitted that he/she and his/her family members were involved. The other 20 (95,2 %) patients have responded that their involvement with their families is non-existent.

The sixteen nurses may have responded according to what they knew should be done while patients may have responded according to what they themselves have experienced. Knowledge of what should be done may have guided the nurses to respond while patients who did not know have just indicated what they have seen being done or not done.

The planning session for the patient's care should include diet/nutrition. From this study it has become evident that not all registered nurses plan for patients' nutrition. This is a very serious omission. Any patient, cancer patient or not, needs food as his basic need. The body needs food to cope with stress caused by the disease. If a registered nurse can plan for the patient's care excluding nutrition, then such a nurse cannot expect good results. Food/nutrients builds up the body, gives energy and vitamins strengthens tissues and resistance to infections. For a patient it helps to maintain this functioning the time before severe infiltration and metastasis has taken place in the body. It is also believed that many cancer patients do not tolerate all types of food which

differ from patient to patient and from diagnosis to diagnosis. A nurse who fails to plan for nutrition, has failed in treating the patient in totality. Nursing care is not only giving medication and care for patient's hygiene, but all aspects physically, emotionally and socially. Nutrition is part of physical care, which caters for the metabolic balance of the body and enhances the effects of drugs administered to the patient. Intake of drugs without proper feeding may lead to damage of the body rather than help in relief of pain and suffering (Tables 4.17 & 5.7).

Involvement of health workers in the planning of care has been indicated in the study but the extent or degree of such an involvement is not clear or well defined. From what the patients have experienced it has become evident that it is not as regular as it is supposed to be. It has also been indicated that nurses use other health professionals for information regarding care of patients, while patients rely heavily on the nurses and very occasionally on doctors. The study has made it clear that these registered nurses are not specially trained for oncology care, and for them to be a major source of information for patients could be disastrous. If they themselves are not clear on oncology care, they cannot be expected to give clear and helpful information to the patients on cancer.

The doctors in the hospitals are better equipped with knowledge and skills to inform the patients but many of them do not talk the language of the patients. Nurses have to play a role of mediators between patients and doctors. Many of the registered nurses in the North West Health Directorate are poor in the official language. For them to mediate is not an easy task. Incorrect or unclear messages may be carried from the patients to the doctors and vise versa.

The assistance given to the patients in the north may also be inadequate because the registered nurses do not have clear guidelines to them. The lack of guidelines for the nurses will reflect lack of guidance for the patients. Out of 41 (100 %) registered nurses, 30 (73,2 %) indicated that they had no guidelines on how to care for cancer patients in their units.

Implementation of care

The effects of chemotherapy, surgery and radiotherapy on patients was not effectively explained. Many of them may have suffered unnecessary worry simply because what they have experienced could not be clearly understood by them. If registered nurses were equipped with skills on oncology care they could be in the better position to explain to the patients what to expect as effects or side-effects of drugs, surgical intervention or radiotherapy. The registered nurses themselves have also indicated that they, 17 (41,5 %), are not adequately equipped to give nursing care to cancer patients.

The nurse-patient relationship is central to the administering and acceptance of care. In order to be able to nurse intelligently and effectively the professional nurse must have knowledge of the biological, natural and social sciences, and an understanding of man in his totality (Du Preez 1990:26).

Record-keeping

Registered nurses - 38 (92,7 %) - have indicated keeping records of patients (Item 56), but only 22 (53,7 %) (Item 58) mentioned record-keeping and reporting as ways to communicate the patient's condition to other members of the health team, while 18 (43,9 %) have not indicated the ways in which they communicate the information to other members.

The persons responsible to keep records were indicated as registered nurses (24 = 58,5 % responses), enrolled nurses (1 = 2,4 % responses) and all three categories of nurses, registered, enrolled and auxiliary nurses (15 = 36,6 % responses).

Any nurse caring for the patients, is kept responsible to keep records of everything he/she has done to the patients and if he/she is going off duty, to report to others who would continue with the care of that patients. The overall responsibility on record-keeping will be on the registered nurses who should assist, guide, teach and supervise other categories of nurses to make sure that it is correctly done.

General Conclusion

It was found that the nursing process was applied, but not to its full extent by all registered nurses. Assessment was found to be inadequate as not all the methods to assess patients were always applied. For example in many instances a history was not taken or the patients were not examined.

By implication this hampered the planning of nursing care. Although registered nurses indicated that they plan nursing care, patients were not clear on what was planned for them.

Implementation of planned nursing care was exercised by registered nurses, they have indicated that they don't have adequate knowledge to implement all the activities they should with regard to specific care.

Evaluation of patients conditions were done by registered nurses, but adjustment of planned care was not always done.

Record-keeping has been done by registered nurses and other categories of nursing staff. However, the record of the patient was not always used as a medium of communication to the rest of the health team.

According to Watson (1979:51) systematic use of the scientific problem-solving method is just as important for the science of caring as is a humanistic approach. One of the biggest problems for nursing has been the lack of a scientific method, lack of quantifying data, reliance on intuition.

General Recommendation

- Phases of the nursing process should be revised, refined and explained to every registered nurse caring for patients, through formal and informal educational sessions.

- Registered nurses to be provided with guidelines on how to care for cancer patients and

how to apply the phases of the nursing process. Those guidelines should be formulated and standardized and be made available in all hospitals and utilized for the purpose for which they are prepared. In-service education is necessary to achieve this goal.

- Development of nursing care standards on cancer nursing care and proper supervision for the implementation of such standards in all the hospitals and health care facilities where cancer patients are cared for is needed.

- Searle and Pera (1995:285) maintained that such standards should be realistic and be applicable in the areas where it is implemented and be revised according to the changing pattern of cancer conditions.

OBJECTIVE THREE

To determine how pain management is done.

FINDINGS

Observation of pain was indicated to be important by registered nurses caring for patients, but not all nurses do observations in the correct manner. Some do look at the patients responses while some do ask the patients whether they have pain. Pain is assessed by taking a history of pain at the site, type and intensity of pain. On intensity the patient should be asked about whether slight, moderate or severe (Tønnessen 1990:212; Donovan 1990:127).

Sometimes pain is assumed rather than assessed and there is a lack of documentation which leads to a lack of evaluation on pain relief methods. Therefore a standard of pain assessment should be established (Pake 1991:303 - 304). In this study, relief of pain was indicated to be by means of giving medicine. This was indicated by 33 (82,9 %) registered nurses and 14 (66,7 %) patients. Other nurses have indicated other methods such as emotional support and a comfortable position. Patients have not indicated any other methods. According to Gilbert (1996:55) different studies

have indicated the attempts made to relieve pain which differ from culture to culture. Another study has also revealed that some patients do not complain of pain because they believe it is inevitable, or that God will help them because pain is part of life and Gods's wishes (Goh 1994: 37 - 39; Nieweg 1994:41, 42). Evaluation of pain relief is done according to registered nurses, but not done according to patients.

General Conclusion

It is found that a number of patients who were suffering from pain were given medication as prescribed. Pain relief is believed to be given by the registered nurse to cancer patients. It has become evident that nurses depend heavily on medication and only a few make use of other methods to relieve pain. Patients were not taught how to get pain relief themselves. Pain management is not only a responsibility of nurses, but patients themselves could be told what to do, when and how. Health education in this respect should be emphasised because pain may persist even after administration of analgesics.

General Recommendations

- Registered nurses can find support and enhance awareness of their experiences, knowledge and expertise in in-service education, workshops regarding pain management.
- Units where cancer patients are admitted should be provided with guidelines concerning pain assessment, management and evaluation of pain relief.
- Management of pain is a multi-dimensional task and should involve application of pharmacological and behavioural interventions.
- Individualized pain treatment programmes should be planned and implemented for each patient.
- Pain treatment should be followed systematically and pain flow sheets or pain treatment

records should be used in pain management.

OBJECTIVE FOUR

Determine whether cancer patients received information and counselling by registered nurses and/or other health professionals concerning their condition.

FINDINGS

Patients were informed about their diagnosis but not all knew they had cancer according to 18 (85,7 %) patients but only 24 (58,5 %) registered nurses agreed on this. The study revealed that patients knew their diagnoses but there is a belief among some nurses that many patients are not told that they have cancer and they have stated the reasons why some patients are not told: medical state, psychological state, communication problem and that some patients are children and cannot be told. In the literature study it was indicated that in Royal Marsden Hospital 68 % of the patients avoided to know what was wrong and this allowed them to maintain hope. Even if there is such a high percentage of patients who do know their diagnoses, not all were told that they had cancer. Some patients only knew what was wrong physiologically or physically, but not specifically that it is cancer.

The desire to know the diagnosis differs from patient to patient and the response after being told also depends on the individual. The patient may want to know but after being told he may accept but still have hope for cure or deny that he has cancer or he was never told. The researcher has experienced the situation of patients having hope after being told and deny that they were never told (Tiffany 1978:54 - 55).

On interview with patients, four who said they were told that they had cancer talked about operation to remove the mass or medication to dissolve it. Three patients who were told according to registered nurses said they do not know. Two of them revealed that they were told only after the researcher has mentioned the name of the doctors who have explained the condition

to them.

Cancer conditions seem to be unclear to most of the patients. One patient was told that he has a cancer mass and the doctor will remove the mass through operation. The patient told the researcher that he is praying to God for the operation to be successful so that he can be healthy again. By regaining his health, the patient meant to be free from cancer.

On the level of confidentiality, the study has revealed that the registered nurses consider cancer as a disease which needs to be treated with confidentiality either at the level of any other disease or at higher level than some of the diseases. Because there is no stigma attached to the cancer diagnoses, registered nurses feel that it does not have the same confidentiality like HIV/AIDS. This indicates that registered nurses and doctors may tell other family members that their patient is suffering from cancer, which they do not do in case of HIV/AIDS unless the patient has requested them to do so.

The patients suffering from cancers have the right to choose whether their family members can be told that they have cancer or not. Therefore, confidentiality needs to be levelled depending on the patient's own attitude and feelings towards his/her diagnosis. If there is a belief that the knowledge of the patient's diagnosis may cause more anxiety, the family member(s) may be informed but not the patient himself (Tiffany 1978:55-56).

Counselling is part of nursing care to patients. Counselling is poorly done as it was indicated by 25 (61 %) of the registered nurses. Although the registered nurses could indicate a number of health workers involved in counselling, they do not all do it. Counselling is a very important in nursing care of our patients not only for oncology. If it is not being done, the patients are left to suffer at the hands of people who do not know how to handle the situation when the need arises. Through counselling the patient can reveal his feelings like fear, uncertainty, willingness to co-operate in treatment, understanding of the condition and it is a opportunity to prepare the patient for the unknown.

Because of lack of counselling in hospitals, some issues may not become clear. A number of 13

(31,7 %) said that they have never observed fear in cancer patients which does not mean patients they cared for never suffer from fear. If counselling could be held then the patients would express how they felt. Expressing fear is not a spontaneous reaction but needs to be given an opportunity which could be created during counselling. Even if patients are encouraged to express the fear as indicated in the study they may not do it as there is no platform created for them to do so.

General Conclusion

The study revealed information (health education) and counselling for cancer patients to be weak.

It found that some of the patients have never been given health information or been counselled, even if their diagnosis was confirmed long ago.

Proper health education sessions and counselling teams are lacking in these hospitals where the study was conducted.

General Recommendations

- Patients should be informed about their diagnosis, treatment and progress.

  Searle and Pera (1995:285) stated that a doctor who is in charge of a patient is legally responsible for giving the patient information regarding his/her illness, where a doctor is not available and a diagnosis has been made by a nurse, she should inform the patient or a responsible relative that something is suspected.

- Health education to patients and the broader community concerning all aspects of cancer should be done through all available means. Van Wyk (1999:33) supported this by the following statement: "a participative professional person should take the responsibility for health education ...".

- Counselling services for patients who are diagnosed with cancer and their families should

be established or strengthened in all the health care facilities where cancer patients are treated.

Counselling, encouragement and the sharing of information as far as is reasonable will help the patients to marshal their resources to fight that which threaten them (Searle & Pera 1995:315).

6.6 LIMITATION OF THE STUDY

The researcher has collected the basic data as was envisaged. About questionnaire A, the issue of English language being a problem became evident from the way some questions were answered. On questionnaire B, the interview was conducted in the language spoken by the patients as interviewees and they all spoke the same language as the researcher.

No interview was conducted with the guardians of children as no child patients with cancer was admitted at the time of the study. No interview was conducted with patients at Oshikuku and Tsumeb Hospitals because during data collection, patients were not admitted long enough at these hospitals for the researcher to be able to find them there. Their admissions could not fit in the researcher's time schedule. Only four patients were interviewed from Onandjokwe and the rest were all from Oshakati Hospital which is accessible to the researcher and interviews could be arranged within a short time before patients are discharged or transferred.

The number of interviews is very small because of the transitional admission of patients. Many patients were missed by the researcher, more especially those admitted over the weekend and transferred to Windhoek on Monday mornings.

Registered nurses who were on leave during the study could not fill in the questionnaire. Due to a competence gap some questions for registered nurses could not be asked to patients for a better comparison. Some questions appearing on the questionnaire for patients were not asked to registered nurses who could be expected to know better than patients, for example, knowledge about Cancer Association in Namibia, patients' appetite, sleeping habit and vomiting. Patients

were not asked about the counselling sessions or who was involved in the counselling.

6.7 CONCLUSION

The research question that was addressed was:

> "How are cancer patients being cared for during hospitalization by registered nurses in the North West Region?"

The nursing care given to the patients was average. Nurses do anticipate the needs of the patients with cancer. In general, health assessment of patients conditions seemed to be poorly done more especially the assessment regarding pain.

It has become evident that no registered nurse caring for cancer patients has specialised in oncology nursing and workshops, seminars or conferences are attended. No in-service education is given.

The issue of materials available in the library and sources of information in cancer care are not known to many of the registered nurses. The period of experience is quite long for many nurses but they are not well equipped with knowledge and skills to care for cancer patients. Patient's needs seem not to be individualised but generalised.

Service rendered to cancer patients is not quite specific but general. Patients in the four hospitals are not cared in special units but are found in surgical wards with any other patients. The aim of this study as well as the objectives was therefore reflected in the findings as indicated in the discussion.

It is hoped that this study will assist nursing managers and registered nurses in general to care properly for patients who are diagnosed with cancer.

It is also believed that the recommendations can assist nurse managers and registered nurses to

reduce shortcomings in rendering nursing care to cancer patients and to give registered nurses the opportunity to improve their knowledge on oncology nursing.

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ANNEXURE A

QUESTIONNAIRES

QUESTIONNAIRE A

REGISTERED NURSE

Please answer the questions below by placing a tick in the appropriate box or by filling in the information in the space provided.

SECTION ONE - DEMOGRAPHIC DATA

1. State your age. ☐

2. For how long have you been appointed as a registered nurse?

Less than a year	☐	1
1 - 5 years	☐	2
6 - 10 years	☐	3
More than 10 years	☐	4

3. Tick your professional qualification(s):

3.1	General Nursing	☐	1
3.2	Midwifery	☐	2
3.3	Psychiatry	☐	3
3.4	Community Health Science	☐	4
3.5	Nursing Education	☐	5
3.6	Nursing Administration/Management	☐	6
3.7	Clinical specialization	☐	7

3.8 If you have any clinical specialization, specify: ______________________

-

4. In which clinical area are you now working? ______________________

5. For how long are you in your present unit? ______________________

6. Are you presently engaged in any further study?

Yes		1
No		2

7. If yes, indicate your course of study? ______________________

8. Which programme did you complete to become a professional nurse?

8.1	Basic Diploma in General Nursing		1
8.2	Diploma in Midwifery		2
8.3	3½ year Diploma in Nursing and Midwifery		3
8.4	Four year Degree course		4
8.5	Diploma in Nursing (General, Community Health, Psychiatry) and Midwifery Science - 4 years		5
8.6	Others		6

9. In the curriculum that you have followed, was there any content included on nursing of the oncology patient?

Yes	
No	

10. Are you registered as an oncology nurse?

Yes	
No	

11. For how long have you been registered as an oncology nurse? ______________

12. How long have you worked with/cared for cancer patients?

Option		Code
0 - 6 months		1
7 - 11 months		2
1 - 2 years		3
3 - 5 years		4
> 5 years		5

13. Are you aware of any Cancer Nursing Journals available in the library?

Option		Code
Yes		1
No		2

14. If no, what sources do you use to keep yourself up to date?

____

____

15. Do you ever attend workshops/seminars/conferences on cancer nursing?

Option		Code
Yes		1
No		2

16. If no, why not? __________________________________

____

17. Do you think it is necessary to have Cancer Nursing In-service education programmes?

Option		Code
Yes		1
No		2

SECTION TWO - SPECIFIC INFORMATION

Tick the answer in the appropriate block or write down the answer in the space(s) provided.

18. Do you presently have patients who are diagnosed with cancer in your unit?

Yes		1
No		2

19. If yes, how many?

Male	
Female	

20. What assessment method do you apply for cancer patients?

History taking		1
Observation		2
Checking patients health passports		3
Scrutinize the admission records		4
Just by seeing the patient		5
Examining the patient		6

21. What do you assess on patients with cancer? ______________________

____

____

22. With what basic needs do your patients present when admitted in the units?

____

____

23. It is believed that cancer patients suffer from pain in advanced stage. How do you assess pain in cancer patients?

____

____

____

24. What do you include in the nursing care plan with regard to the management of pain?

____

____

____

25. Do you evaluate the effect of pain relief on your patients?

Yes		1
No		2

26. Is your knowledge up to date on:

26.1 Effects/action of prescribed medication:

Never		1
Sometimes		2
Always		3

26.2 Side-effects of prescribed medication:

Never		1
Sometimes		2
Always		3

27. Do you plan

Yes		1
No		2

28. Whom do you involve in planning for these patients' care?

____

____

____

29. Are there any guidelines in the unit regarding management of cancer patients?

Yes		1
No		2

If yes, what are those guidelines?

Policy Manual ☐

Standard Manual ☐

Any other procedure ______________________ ☐

30. Whom do you consult for assistance about treatment/care when assessing difficult problems in a patient?

The doctor ☐ 1

Other nurses ☐ 2

Other health professionals, please specify: ______________________ ☐ 3

____

31. Do you plan any specific nutritional treatments for the cancer patients in your ward?

Yes		1
No		2

32. Do you have adequate knowledge to implement nursing care that is planned for the cancer patient?

Yes		1
No		2

33. Who supervises the implementation of nursing care in your units?

Registered nurse

Enrolled nurse

Auxiliary nurse

34. Do you have counselling sessions for cancer patients in your unit?

Yes		1
No		2

35. If yes, when is the counselling being done? (Indicate all the possible opportunities)

With admission — 1

During their stay in the unit for: — 2

- Every patient — 3
- Some of them only — 4
- Only if they complain too often — 5
- When a patient becomes confused — 6
- For those who threaten to commit suicide — 7
- Anytime when the need for counselling is identified — 8

36. Who are involved in counselling of patients?

Option		Code
Registered nurses	☐	1
Doctors	☐	2
Social workers	☐	3
Nutritionists/Dieticians	☐	4
Physiotherapist	☐	5
Occupational therapist	☐	6
Clinical psychologist/psychiatrist	☐	7
Family members	☐	8
Religious persons	☐	9

37. According to your experience, does counselling have any positive effects on cancer patients?

Yes	☐	1
No	☐	2

38. According to your experience, are the family members of cancer patients actively involved in the treatment and care of the patients?

Yes	☐	1
No	☐	2

39. If no, why not?

____

____

____

40. When do you give health information to the patients?

Option		Code
On admission	☐	1
During hospitalization	☐	2
On discharge	☐	3

41. Do health information sessions also include the following:

41.1 Management of pain and other symptoms at home

Never	☐	1
Sometimes	☐	2
Always	☐	3

41.2 Management of basic needs at home

Never	☐	1
Sometimes	☐	2
Always	☐	3

41.3 Management of dietary needs at home

Never	☐	1
Sometimes	☐	2
Always	☐	3

42. Are all patients with cancer being informed about their diagnosis?

Yes	☐	1
No	☐	2

43. If no, those who are not told, are they in the

Majority	☐	1
Average	☐	2
Few	☐	3

44. If no, what are the reasons of withholding such information from them?

____

____

____

45. Who informs the patients regarding their diagnosis?

Doctors	1
Nurses	2
Psychologist/psychiatrist	3

46. If the patient is not informed about the diagnosis, how do you not accidentally disclose the information to him/her?

____

____

47. What level of confidentiality is attached to the cancer diagnosis?

As for any other disease	1
The same as HIV/AIDS	2
Confidentiality is higher than other disease but not as HIV/AIDS	3
No confidentiality at all	4
I do not know	5

48. Did you ever observe fear in cancer patients?

Yes		1
No		2

49. If yes, what intervention do you apply?

____

____

50. Are you able to give adequate emotional support to facilitate emotional adaptation?

Yes		1
No		2

51. Do you encourage the cancer patients and their family members to discuss their fear, problems and expectations?

Yes		1
No		2

52. If yes, when do you do it?

On admission	☐	1
During hospitalization	☐	2
On discharge	☐	3

53. Do you evaluate the patients' condition?

Yes		1
No		2

54. If yes, how many times a day?

Daily	☐
2x daily	☐
3x daily	☐
4x daily	☐
More > 4x	☐

55. Do you adjust the nursing care that was planned after evaluation of the patient's condition?

Yes		1
No		2

56. Do you keep accurate records of the patient's condition?

Yes		1
No		2

57. If yes, who keeps the records?

Registered nurse	☐	1
Enrolled nurse	☐	2
Auxiliary nurse	☐	3

58. How is the patients' conditions communicated to the rest of the health team?

____

____

____

59. What do you recommend to be done for nursing care to cancer patients to become effective?

____

____

____

____

____

____

____

____

QUESTIONNAIRE B

PATIENTS/GUARDIANS

SECTION ONE - DEMOGRAPHIC DATA

1. Sex: ________________________________

2. Diagnosis: ________________________________

3. Age in years: ________________________________

4. Marital status:

Married	☐	1
Single	☐	2
Divorced	☐	3

5. Number of dependent children: ________________________________

6. Age of dependent children (if applicable):

0 - 12 years	☐	1
13 - 18 years	☐	2

7. Are you employed?

Yes		1
No		2

8. If no, what is your source of income? ________________________________

____

SECTION TWO - SPECIFIC INFORMATION

9. Are you hospitalized for the first time?

Yes		1
No		2

10. If no, how many times have you been hospitalized?

Twice		1
Three times		2
More than		3

11. Name(s) of hospitals/centres you have been admitted to: ______________________

____

____

12. Were you told about your diagnosis?

Yes		1
No		2

13. If yes, by whom?

Doctors		1
Nurse		2
Family		3
Others (please specify)		4

14. If no, have you asked to be told? ______________________

15. Are you on chemotherapy?

Yes		1
No		2

16. Have you undergone radiotherapy?

Yes		1
No		2

17. Have you undergone surgery?

Yes		1
No		2

18. If yes, to question 16 and 17, where have you undergone this:

Radiotherapy ____________________

Surgery ____________________

19. If yes to questions 15, 16 & 17, were you informed on the effect of:

Chemotherapy

Radiotherapy

Surgery

Yes	No	1
Yes	No	2
Yes	No	3

20. Who informed you on the effects?

20.1 Doctors

20.2 Nurse

20.3 Another patient

20.4 A friend

20.5 A social worker

20.6 Another person (please specify): ____________________

	1
	2
	3
	4
	5

21.1 Are you clear on your treatment plan?

Yes		1
No		2

21.2 Are you kept informed about what is to be done?

Yes		1
No		2

22. Were you involved in drawing up of the plan?

Yes		1
No		2

23. If no, was any other member of your family involved?

Yes		1
No		2

24. Who do you contact if you want information/explanation on any issue pertaining to your condition and care?

24.1 Doctor ☐ 1

24.2 Nurse ☐ 2

24.3 Social Worker ☐ 3

24.4 Relative ☐ 4

24.5 Other (please specify): ______________________

25. What is the reason for your choice(s) under question 24?

____

____

____

26. Do you know about any association established to deal with your condition here in Namibia?

Yes		1
No		2

27. Do you make use of the service from that association?

Yes		1
No		2

28.	Are you taught of how to take care of yourself when you are discharged?	Yes		1
		No		2

29. If yes, what are you taught about? ______________________________
____

30.	Do you suffer from any kind of pain?	Yes		1
		No		2

31. If yes, what is done to you regarding pain? ______________________________
____

32.	Are you informed on what to do to get pain relief?	Yes		1
		No		2

33.	If yes, by whom?		1
33.1	Doctor		2
33.2	Nurse		3
33.3	A friend		4
33.4	Other person (specify): ______________________		

34.	Do you experience nausea?	Yes		1
		No		2

35.	Do you vomit?	Yes		1
		No		2

36. What have the nurses done to assist you on Item 34 and 35?

____

____

37. Do you sleep well?

Yes		1
No		2

37.1 If no, what do you think is the cause? ______________________

____

37.2 What is being done to you to help you sleep? ______________________

____

____

38. Is your appetite good?

Yes		1
No		2

38.1 Do you have specific preferences for specific foods? ______________

____

____

38.2 Is that type of food available to you?

Yes		1
No		2

38.3 What do the registered nurses do to help you to overcome the problem of loss of appetite?

____

____

39. Do you have a problem with elimination?

Yes		1
No		2

39.1 What problem is that:

	Yes	No	
Diarrhoea			1
Constipation			2
Incontinence of urine			3
Frequency of urine			4
Retention			5
Any other			6

40. What was done to you to assist you coping with each problem?

____

____

____

41. Is your environment conducive to your improvement with regard to the following:

	Yes	No	
Cleanliness			1
Quietness/silence			2
Comfort			3
Temperature			4
Safety			5
Accessibility			6

42. Do you communicate your feeling about your illness?

Yes		1
No		2

42.1 If yes, to whom?

Doctor		1
Family member		2
A friend		3

42.2 If not, why not? ______________________________

____

43. What are your expectations from the registered nurses when caring for you in the hospital?

____

____

44. How do you rate the level of care you receive from the nurses (registered nurses)?

44.1 Very good		1
44.2 Good		2
44.3 Fair		3
44.4 Poor		4

45. Does your illness interfere with your movements?

Yes		1
No		2

46. Do you get exercise of your muscles?

Yes		1
No		2

47. Are you visited by a physiotherapist?

Yes		1
No		2

48. Have you lost a part of your body?

Yes		1
No		2

49. Are you able to make use of parts left?

Yes		1
No		2

50. Have you lost your voice?

Yes		1
No		2

51. Are you taught how to communicate to others without a voice?

Yes		1
No		2

52. Do you feel a need for more to be done than what is done to you?

Yes		1
No		2

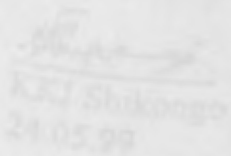
53. If yes, what is that what you want to be done? ____________________

____

____

ANNEXURE B

COVERING LETTER FOR QUESTIONNAIRE



UNIVERSITY OF NAMIBIA
OSHAKATI-DIVISION
OSHAKATI

24.05.99

Dear Registered Nurse,

I am lecturer at the abovementioned Division of UNAM doing my research for my Masters Degree study on

"Care of Cancer patients by Registered Nurses in the NWH Directorate of MoHSS"

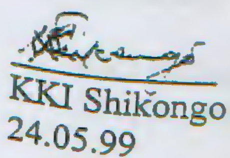
For data collection, you are hereby requested to fill in the attached questionnaire designed for this study. I therefore, humbly, do request you to assist me in answering my questions contained in the questionnaire as complete as possible.

Remember that your name will not be made known in no circumstance as you do not need to fill it in. The information you give will be highly treated confidentially but be used for academic purpose.

I appreciate your kind attention to my request and assistance you are ready to render me in my study even if you do it anonymously.

Thanking you in advance,

Sincerely yours



KKI Shikongo
24.05.99

NAMIBIA | UNIVERSITY OF

DIVISION | OSHAKATI -

OSHAKATI

29-09-1998

Dear Registered Nurse,

I am a lecturer at the abovementioned Division of UNAM doing my research on
"Care of Cancer patients by Registered Nurses in the NWHDirectorate of MoHSS"
In this study I am going to employ the "Questionnaire" and "Interview"as research methods.

For a Pilot study, your name has been selected as a respondent to the questionnaire designed for this study. I therefore, humbly, do request you to assist me in answering my questions contained in the questionnaire as complete as possible.

Remember that your name will not be made known in no circumstance as you do not need to fill it in. The information you give will be highly treated confidentially but be used for acacemic purposes.

I appreciate your kind attention to my request and assistance your are ready to render to me in my study even if you do it anonymously.

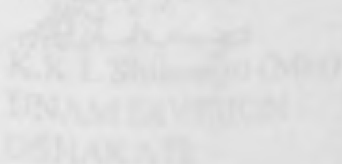
Thanking you in advance,

Sincerely yours

KKI Shikongo
29-09-1998

ANNEXURE C

LETTERS FOR PERMISSION TO DO THE STUDY



TO: **DR N.T. HAMATA**
DIRECTOR OF NWHD
OSHAKATI

FROM: **MRS. K.K.I. SHIKONGO**
UNAM DIVISION
OSHAKATI

DATE: ***04 -06 - 1998***

RE: Permission to collect data from nurses and patients in the NWHD

I hereby wish to apply for permission to do my research, for a Masters Degree with UNAM, at the four hospitals; Oshakati, Onandjokwe, Oshikuku and Tsumeb.

My study title is "**A survey to determine how cancer patients, who are admitted to the hospitals in the North West Health Directorate of the Ministry of Health and Social Services, are cared for by the registered nurses.**"

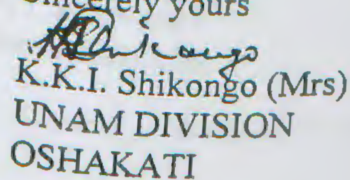
My research population is all the registered nurses and cancer patients who are admitted to these hospitals during the period of data collection.

Research strategies to be used are: (1) for the registered nurses, a questionnaire is designed to be filled by them; (2) for patients, an interview questionnaire is to be used for formal interview with the patients.

I am already through with phase one and two and need only to start with data collection if permission is granted to me.

Your kind attention and prompt response to this request will be highly appreciated.

Sincerely yours



K.K.I. Shikongo (Mrs)
UNAM DIVISION
OSHAKATI

TO: DR N.T. HAMATA
DIRECTOR OF NWHD
OSHAKATI

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UNAM DIVISION
OSHAKATI

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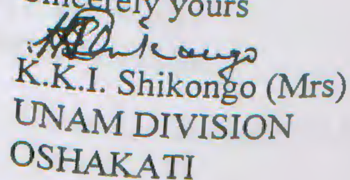


K.K.I. Shikongo (Mrs)
UNAM DIVISION
OSHAKATI

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

DIRECTORATE NORTH WEST HEALTH REGION

Office of the Director
Private Bag 5538
OSHAKATI

Tel No: (06751) 20211 x 2234
Fax No. (06751) 20303

Enquiries: Dr N.T. Hamata

06 June 1998

Mrs K.K. Shikongo
UNAM Division
Oshakati

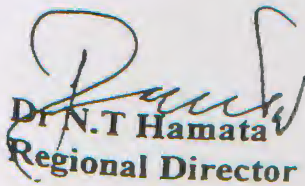
PERMISSION TO COLLECT DATA FROM NURSES AND CANCER PATIENTS IN SOME NWD HOSPITALS

Thanks for your letter dated 04 June 1998. As you remember, this is a continuation of the work you started in 1996 for which permission was granted

Your request is approved to conduct questionnaires among nurses and cancer patients at the following hospitals:
Oshakati Reg. Hospital
Onandjokwe Lutheran Hospital
Oshikuku R.C. Hospital
Tsumeb District Hospital

Please note that if you wish to publish your findings, permission must be requested and granted by the Permanent Secretary of MOHSS

Yours sincerely



Dr N.T Hamata
Regional Director

cc. Doctors in-charge of the four hospitals