INTERPERSONAL COMMUNICATION BETWEEN REGISTERED NURSES AND SURGICAL PATIENTS ON ADMISSION TO SURGICAL WARDS AT THE OSHAKATI INTERMEDIATE HOSPITAL

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ABSTRACT

The quality of nursing practice is determined by a variety of factors. One of the most important of these factors is the way in which communication takes place and the information given to patients in the health care facility; in particular between nurse and patient.

The study focused on patients that were admitted to surgical wards to be operated on. Patients who have been admitted for surgery are usually anxious because the procedure will be performed under general anaesthesia, and the procedure is subject to many risks.

The overall purpose of the study was to explore and describe inter-personal communication between nurses and patients who have been admitted to a surgical ward, with specific reference to the kind of information that is conveyed to them.

An exploratory, descriptive, quantitative, non-experimental approach was used for this study. The study population consisted of two groups, namely patients admitted for surgery and registered nurses working in surgical wards at Oshakati Hospital. A sample for patients were selected by random sampling. To ensure a confidence interval level of 95 % hundred (100) patients were selected. The second group in the population, registered nurses working in adult surgical wards, numbered ten (10) individuals. For purposes of this study in this group the population and the sample was the same.

Two structured questionnaires were developed and used to gather information from patients and registered nurses. The questionnaires for registered were personally handed to the registered nurses and all the questionnaires were completed and returned back to the researcher. The researcher and a research assistant collected data from patients by interviewing them using structured questionnaires.

Data were analysed according to an ordinal scale that ranked responses on a scale of one to four (1-4). The average frequency of an occurrence, i.e. the value of each item, was calculated y adding the numerical value of all responses to a question, and dividing the sum by the number of responses.

The findings of the study indicated that the surgical patients are not provided with adequate information on admission.

It was highly recommended from this study that registered nurses must receive proper in-service education on the communication process to orientate surgical patients on admission and to share the necessary information that is needed.

Ethical principles were adhered to during the study.

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DEDICATION

This thesis is dedicated to my late grandmother, Elina Mofuka, to Jambo and my late father, Marcelino Antonio. To my children, Junior, Lurdes, Mildred and Nathaniel, let this be a source of inspiration.

DECLARATION

I hereby declare that, the work contained in this study project is my own and has not, in part or as a whole, previously been submitted at any University for the purpose of obtaining a degree.

SIGNATURE Date

Ms Christine Joaguim Place

CHAPTER 1

ORIENTATION OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

This study will investigate the nature of interpersonal communication that occurs between registered nurses and their patients on admission to surgical wards at the Oshakati Intermediate Hospital, concerning information that they should receive.

The nurse is the first person with whom a surgical patient comes in contact when admitted to a surgical ward at a hospital. The nurse sets the tone for interpersonal communication and therefore creates the climate in which the therapeutic situation occurs.

Nursing is not only a care giving profession. As a profession it also tends to evolve based on the acquisition of experience and evidence. With care giving, a nurse develops the ability to facilitate interpersonal communication. The aim of this study is to contribute to this developmental process.

Lemone and Burke (2004, p. 179) are of the opinion that quality interpersonal communication is an essential nursing responsibility in the pre- and postoperative period. Together with emotional support it has a positive effect on a patient's physical and psychological well being, both before and after surgery.

The basis of all human relations is communication. Everything that people achieve arises from their ability to communicate. It is the cement that stabilizes a human being's existence within a family, social group, community, nation and the world at large. Communication is not only a person's way of expressing his or her humanity, dignity, needs, strengths, objectives and concern for other people, it comprises the very bricks and mortar that build civilizations (Searle, 2004, p. 254).

Communication may be described as the matrix of thought and the relationships that exist between people, as well as the matrix in which meaning is generated and transmitted (Jooste, 2003, p. 201). Consequently, the profession of nursing demands good communication between nurses and patients for it provides the context in which a vibrant bond between them can form that will facilitate the healing or recovery process.

The quality of nursing practice is determined by a variety of factors. One of the most important of these factors is the way in which communication takes place in the health care facility, in particular communication between nurse and patient.

Interactions between a nurse and patient involve a wide range of activities which can be subsumed under the umbrella term, communication. This assumption implies that the term communication emphasizes interaction between nurse and patient and the phrase "interpersonal communication" becomes appropriate. Interpersonal communication means personal interaction, and includes sharing information, posing and answering questions, explaining and demonstrating procedures and giving feedback (Quinn, 2000, p. 444).

Consequently, sharing information is vital in the early intervention by nurses to ensure that patients receive the care and services they require.

Interpersonal communication is an *art* that should infuse warmth and meaning into the practice of nursing. The manner in which a nurse's image and actions are communicated to a patient determines the degree to which the patient will trust the nurse. In turn, this trust will influence the measure of wellbeing that a patient derives from a nurse's ministrations (Searle, 2004, p. 25), and may be said that an underlying element of success in interpersonal communication is a trusting relationship between patients and nursing staff. If trust prevails, sharing information, posing and answering questions, explaining and demonstrating procedures and giving feedback can be accomplished with ease.

Rapport is the basis of the nurse-patient relationship and this implies a two-way process between them, making the patient an active partner in his or her health care. Patients are admitted to health care in a variety of conditions, one of which may be to undergo surgery. Surgical patients enter the hospital in different degrees or states of health. A patient may be admitted for elective surgery, to correct a condition that is currently not life threatening, or emergence surgery that must be performed immediately to save his life or preserve a body part. Regardless of the type of surgery scheduled, it is preferable for the patient to be appropriately prepared both physically and mentally. A registered nurse will be responsible for this preparation (Cole, 1996, p. 91).

Most surgical procedures are major and are therefore performed under general anesthesia. The procedures are subject to many risks and patients need to be well informed about what

may be encountered before and after an operation. Patients also need an opportunity to express their feelings and opinions.

Furthermore, a patient faces physiological and psychological stress when facing the prospect of surgery, and therefore require close monitoring and skilled intervention by the nurse and the physician. Anticipation of surgery creates fear and anxiety in many patients, who may associate surgery with pain, possible disfigurement, dependence and perhaps even loss of life (Perry & Potter, 1996, p. 1079). For these reasons patients scheduled for surgery were selected for the study.

In surgical wards, patients should be provided with certain kinds of information by nurses on admission. This includes information about the environment, the procedure, nursing care, rights of the patient and medico-legal hazards. Furthermore, the patient needs to receive this information, in a form which is comprehensible to him.

Information that should get special attention includes patient consent for the operation as well as information on pre- and post-operative nursing care. Information provided by a surgeon should be validated by the registered nurse concerning the procedure, and general aspects like orientation on the physical environment and the rights of the patient. A patient can only make informed decisions concerning prospective surgery after clearly understood information has been supplied.

Because patients who have been admitted for surgery are usually anxious, it is important that nurses are skilled in the art interpersonal communication. These skills include being

able to encourage patients to communicate by posing questions, responding to the replies and giving information. Patients need to provide information about their health status to enable nurses to plan the nursing care required. The patient is the focal point for all health services and health care; he or she is, after all, the reason that nursing exists. Consequently a patient's interests and needs are a nurse's first priority. A patient has a right to know his diagnosis, his prognosis and about procedures relating to his disease, as well as about any policy procedures and available health services relevant to his condition (Young, van Niekerk & Mogotlane, 2003, p. 67).

Interpersonal communication also requires the skill of being able to listen to, and understand, a patient's concerns, fears and questions. According to Quinn (2000, p. 473), the ability to listen to people is an important social skill in any setting, but in nursing it is particularly vital to the effectiveness of interpersonal communication. Encouraging patients to talk about their concerns and anxieties is a key responsibility for any nurse. However, a person will be easily discouraged if he feels that his listener is not truly paying attention.

1.2 PROBLEM STATEMENT

A communications problem exists despite the existence of the patient charter and admission policies. How interpersonal communication between nurses and prospective surgery patients operates is not clearly understood. Neither is there agreement about what information should be imparted to patients on admission or later during their treatment. Because complaints have been voiced by the community indicating either that patients do

not know what is expected of them or that they are not properly prepared for a medical procedure (situations which this researcher has experienced in practice), it can be assumed that nurses sometimes fail to share information important to patients who are admitted to surgical wards. It has also been witnessed that nurses sometimes deal impatiently with patients, especially when they ask questions or do not comprehend the information that is provided to them.

Furthermore, admission procedures in many health facilities are conducted in a manner that disregards either human dignity or the feelings of patients. Also the attitude of nurses frequently displays that they feel there is not sufficient time to answer patients' questions, either because they are overworked or because of staff shortages. Display of impatience on the part of nurses is often not intended, but arises from their working conditions.

According to Searle (2000, p. 256), the time when a patient was merely a passive recipient of care, though not completely in the past, is rapidly drawing to a close. In the emerging image of nurse-patient interpersonal communication and relationships it is the particular duty of the nurse to discover a patient's latent capacities and assist him to utilize them so that he may make a contribution to his or her recovery.

A nurse must be able to recognise the unique individuality of each patient and then be willing to treat him in a personal manner which will neither depersonalise his person nor his condition. This approach to nursing care will provide a firm foundation for a satisfactory nurse-patient relationship.

The implication of the emerging view is, if proper interpersonal communication is not established, necessary information can not be transferred to patients on their admission to the ward. As a result, patients will not be able to participate in setting up their nursing care plan and their right to information will likewise have been disregarded. Should complications occur after a surgical procedure and a reliable communication link has not been established, the patient will choose to return to a traditional healer who he perceives will understand his needs and will communicate with him in terms he can understand - ultimately a person with whom he has established a relationship of trust.

Inappropriate explanations given to a patient can result in delayed recovery, the increased need for analgesics, and an increased possibility of complications, any of which could result in a longer hospital stay and general discomfort for the patient. On the other hand, improved interpersonal communication holds great potential to improve patient satisfaction and also the quality of care provided.

1.3 KEY QUESTION AND SIGNIFICANCE

1.3.1 **The key question**

The question that this study attempted to answer is: "What information should be shared by registered nurses through interpersonal communication with patients after their admission to a surgical ward?"

1.3.2 **The significance of the study**

This study is important because it will identify aspects of interpersonal communication between registered nurses and patients that need to be strengthened, in general and specifically upon admission to surgical wards. There are numerous challenges that registered nurses face concerning interpersonal communication. The first challenge for nurses is to update their knowledge of the subject. The second challenge is to consistently practice enhanced skill in interpersonal communication despite the pressures associated with heavy workloads. Effective interpersonal communication promotes a culture of professionalism within an organization and aligns patients and nurses with shared goals in the recovery process.

1.4 PURPOSE AND OBJECTIVES

1.4.1 Purpose of the study

The purpose of the study was to explore and describe interpersonal communication between nurses and patients who have been admitted to a surgical ward, with specific reference to the kind of information that is conveyed to them.

1.4.2 Objectives of the study

The objectives of the study are to:

- identify the personal particulars of respondents;
- determine what information is provided by nurses to surgical patients on admission;
- determine whether patients participate in their nursing care through being encouraged to pose questions or make suggestions;
- determine whether patients are informed about pre- and post-operative aspects of the procedure they are to undergo; and
- determine the strategies that could be employed to improve interpersonal communication between nurses and surgical patients on admission.

1.5 DEFINITION OF CONCEPTS

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

Ward: A room in a hospital with beds for several patients (Blackwell, 1997, p. 729).

Admission: Receive into a hospital for treatment (Pearsal, 1999, p. 17). By implication it means to be allowed to enter a ward, or the admittance of a patient to the ward.

Surgery: The branch of medicine that treats disease, deformities, and injuries, wholly or in part, by manual or operative procedures. Surgery usually involves making an opening in the body to remove, replace, or repair a part in order to cure or correct a pathological condition or damage caused by trauma, or to give the patient a period of remission from a disease (Blackwell, 1997, p. 649). By implication it means the treatment of injuries, deformities or disease by operation.

Information: Facts or details that tell you something about a situation, person or event. By implication it means anything that is conveyed or represented by a particular sequence of symbols or impulses (Pearsall, 1999, p. 727).

Communication: Communication is the process of creating meaning between two or more people through the expression and interpretation of messages. Communication is therefore an endeavor to reach the minds of others. By "expression" is meant a public demonstration or utterance of an idea or feeling initially within the mind of the communicator. By way of interpretation, "communication" is the meaning the receiver of information gives to a message (Cleary, Harran, Potgieter, Scheckle, Van der Merwe & Heerden, 2004, p. vii). Communication also means the process of exchanging thoughts or information in a reciprocal fashion.

Interpersonal Communication: Refers to communication that takes place between two persons who have established a communicative relationship. Forms of

interpersonal communication include conversations, interviews and small group-discussions. Human communication is dynamic because the process is constantly in a stage of change (Cragan, Wright & Kasch, 2004, p. 6). By implication it means the process by which information, meanings and feelings are shared by persons through messages. In health care settings it takes place between service providers and their clients and members of the community and is a key element in maximizing access to quality care.

Patient: A person who is physically or mentally ill or one who is undergoing treatment for physical or mental illness (Blackwell, 1997, p. 500). By implication it means a person receiving, or registered to receive medical treatment or a person who is in the hospital for medical treatment.

1.6 SUMMARY

Problems in providing effective health care to surgical patients have indicated the need for interpersonal communication between registered nurses and patients on admission to the surgical ward. Interpersonal communication will increase awareness of how important it is to provide information to surgical patients on their admission, and will thus contribute to the improvement in standards of nursing.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of a review of research literature is to assemble published knowledge and views on a topic (Pilot, Deck & Hungler, 2001).

The basis of all human relationships is communication. Indeed, communication is the basis of all relationships between living things. Only human communication enjoys a rich diversity of sounds, symbols, actions, attitudes and thoughts which has enabled humanity to obtain mastery of the known world and to open the gateways of the universe to explanation (Searle, 2000, p. 254).

The communication between a patient and a nurse is of the utmost importance to the effective rendering of quality nursing care. By implication, quality nursing care depends on a two-way process of communication between nurse and patient, and rapport is the basis of this communicative relationship. Communication is an interpersonal activity, one that involves people sending and receiving information. The effectiveness of communication between individuals depends on the way they feel about themselves, and on their values, attitudes and goals, as well as on their knowledge about what is being communicated and the factors that influence interpersonal communication (Young, Van Nieckerk & Mogolane, 2003, p. 291).

In this chapter factors influencing interpersonal communication, as well as a model for interpersonal communication, will be discussed.

2.2 INTERPERSONAL COMMUNICATION

When we communicate we "encode" ideas (meaning we put them into message form), we send the encoded message through our primary signal system (the senses of sight, hearing, taste, smell and touch) to someone who receives it via their primary signal system, who in turn decodes (translates) the message (Cragan, Wright & Kasch, 2004, p. 12).

Human beings influence each other primarily through communication. In the nursing process the patient and the nurse both undergo emotional experiences that are the result of the communication between them. The nursing process provides the foundation for nursing practice. The process involves a step-by-step method of selecting an action, or actions, to reach a desired goal. The common thread which runs through the nursing process is interpersonal communication; it is also the primary tool through which the nursing process is applied (Bradley & Edinberg, 2004, p. 15). The professional nurse must therefore clearly understand the power of communication in shaping a relationship. The quality of communication between a nurse and patient is an essential determinant of success in the professional relationship and in this context is referred to as "interpersonal" communication. This nurse-patient interaction is also a vehicle by which information on the subject of health is imparted to a patient. For these reasons, nurses should be able to

communicate effectively and interact with their patients on a high level of empathy and genuineness (Young et. al., 2003, p. 284). Nurses must be empathetic listeners. Empathy is an important capacity which a nurse must have in order to establish competent communication with a patient on admission (Bradley & Edinburgh, 2004, p. 68).

The starting point for any interpersonal communication is "self concept" or self disclosure: the way we perceive ourselves determines what we will say and to whom we are willing to say it. Self-disclosure is not simply providing information to another person, rather it may be defined as the sharing of personal information with another person that they would normally not know or discover about us (Wolvin, 1995, p. 199).

Self-disclosure is a way of gaining information about another person. It is also one way to learn how another person thinks and feels. As a nurse engages in self-disclosure, it is implied that the patient will also disclose personal information. Mutual disclosure deepens trust in the communicative relationship and helps both nurse and patient understand one another better (Brochers, 1999, http://www.abacon.com/commstudies/interpersonal/indisclosure.html).

The question we should ask is, "Why is the concept of interpersonal communication is so important in nursing?". According to Fitzpatrick (2002, p. 407), interpersonal communication relies on a number of processes that are important to communication in general, such as attracting, gaining compliance, informing, persuading and

comforting. Interpersonal communication is essential for delivering accurate and effective nursing care (Leahy & Kizilay, 1998, p. 236).

2.3 FUNCTIONS OF INTERPERSONAL COMMUNICATION

Interpersonal communication is important because of the end it achieves. According to Borchers (1999, p. 9), its primary function is to gain information, and by way of information the nurse gains knowledge about another individual, in this case a patient. According to the Social Penetration Theory (Borchers, 1999) we strive to gain information about others so that we can interact with them effectively.

Furthermore, we engage in interpersonal communication in order to build a context for mutual understanding. The process helps a person understand what another person says in a given context. In the hospital, an expression of anxiety by the patient awaiting an operation is a classic example.

Another function of interpersonal communication is to establish "identity". People play various roles in interactive relationships, and these roles affect the communication process. An individual's choice of words, sentence structure and tone of voice can vary considerably from role to role.

We engage in interpersonal communication because we need to express and share information about our personal needs. A theorist by the name of Schutz (1958) indicated that there are three personal needs that most people bring to interpersonal

relationships, namely the need for inclusion, control and affection. He maintained that people begin relationships in order to satisfy one or more of these needs.

2.4 FACTORS INFLUENCING THE INTERPERSONAL COMMUNICATION PROCESS

2.4.1 Interpersonal relationship

The first factor that influences interpersonal communication is interpersonal relationship. Interpersonal relationships are those on which people base predictions concerning psychological data, explanatory knowledge, and personally established rules. Interpersonal relationships help alleviate loneliness, enable people to secure stimulation, help them to gain self-knowledge, enhance their self-esteem, self-concept and enable them to maximize pleasure and minimize pain (Quinn, 2007).

Interpersonal relationships have been identified as more important than anything else in making our lives meaningful. For a relationship to exist between two people, they must be aware of each other and take each other into account. There must be some degree of influence between them and some agreement about the social form and expectations that govern their interaction (Adler, Rosenfeld & Proctor, 2001).

The self-concept of each participant in the communication process determines this relationship. Relationships which are formed during the process of health care possess certain characteristics. These are:

- Each person feels whole without the other, even though the two people enjoy each other's company.
- Each partner communicates effectively and honestly.
- Each partner accepts the other as he or she is.
- No unrealistic expectations or attempts to control the other person exist in the relationship.
- Both partners recognize and appreciate change.
- Each partner has different ways of perceiving the condition we refer to as "health".
- A balance exists between enjoyment in being together and leading separate lives for each partner. (Leddy & Pepper, 1993).

The named characteristics apply equally to interpersonal relationships between nurses and patients. Also, there are three factors that enhance the effectiveness of nursing care which place responsibility on the nurse. These may be identified as respond with sympathy, provide confirmation and share information. These factors are interrelated and collectively address both the content and the relationship dimension of interpersonal communication (Oerman, 1991, p. 50).

2.4.2 Listening Skills

Listening is a behavioral skill which goes beyond the mere act of hearing, which is simply a physiological event. Being able to listen well is perhaps the single most

important skill in effective communication. Both patient and nurse are continuously engaged in some form of listening. The act of listening may sometimes be ineffective if a person has not learned how to listen well. Active listening, which involves the ability to reflect back to the speaker a meaningful understanding of the message which he or she has imparted, is one of the most important listening (Devito, 1995, p. 60).

Equally important as the ability to listen, is to possess empathy for the speaker. Empathy is a sign of sensitivity to another person and significantly enhances the development of interpersonal relationships between health care professionals and their clients. Effective listeners are able to martial empathy to help them appreciate the other person's point of view (Kagan & Evans, 1995, p. 80).

Being able to listen well is just as important as being able to speak effectively. Effective communication occurs when the listener understands a message accurately and responds in thoughtful manner. In effective communication, the listener is aware of the thoughts and feelings being expressed by the other person and reflects them back to the speaker to confirm or clarify their understanding of the message communicated. Effective listening is necessary for forming and maintaining healthy relationships.

It is important for nurses to have consideration for their patients, and they demonstrate this consideration by paying attention to them when they express themselves. When attention is given, a nurse will be able to make comments that are

relevant to the conversation and input of this sort makes conversation interesting. Nurses who maintain eye contact and face the patient when he or she is speaking, demonstrate two of the most significant signs of attentive behaviour.

Good listeners exhibit the following behaviour:

- ***Eye contact***: The registered nurse shows he/she is paying attention by looking directly at the speaker.
- ***Body language***: The listener's body indicates attention through nodding, facial expressions, shrugging, and maintain an open posture.
- ***Encouragement***: Interjected words and phrases encourage the speaker to continue.
- ***Reflection***: Restate the speaker's thought or feelings to confirm accuracy of understanding.
- ***Questions***: Ask questions to clarify what the speaker is saying.
- ***Remain relatively relaxed***. (Erb, Kozier & Bufalino, 1998)

2.4.3 Roadblocks

Another factor that influences interpersonal communication is the existence of "roadblocks". According to Hauck and Hussey (2002, p. 3) a roadblock is any behaviour that has the effect of stopping or temporarily halting a meaningful dialogue. Typically, roadblocks are manifested in a two-way communication situation when one person is not really listening. A person who is not listening

during a conversation responds to the speaker in ways that elicit a negative feeling from him, rather than reflecting the positive feelings of that person which he would experience when he feels the other is listening.

In health care settings road blocking is not uncommon, and when they occur may elicit a range of the feelings in clients, such as dissatisfaction, confusion, isolation, even feeling that they are being put down. Roadblocks can deprive a patient of control and dignity (Ibid, 2002, p. 3).

2.4.4 Territoriality

Territoriality can be thought of as the need to obtain, or the processes connected with obtaining, "territory", which can be defined as resources, responsibilities, power, or ability to control others (Bradley & Edinburgh, 2004, p. 140). Territoriality is relevant to all the relationships nurses have, with patients as well as with others within the health care setting, including doctors. Territoriality has been defined as the behavior used to defend "turf" and is classified as an innate drive. The use of assertive or aggressive behaviour often helps a nurse to handle stress or even prevent conflict in the health care setting (Bradley & Edinburgh, 2004, p. 144).

Territoriality is the need to gain, maintain, and defend one's exclusive right to individual space, and is always with a person. Nurses must frequently move into a patient's territory, or personal space, simply due to the nature of care giving. The nurse must convey confidence, gentleness, and respect for privacy, especially when

actions require intimate contact. To foster trust a nurse must communicate warmth and caring and demonstrate consistency, reliability, honesty, and competence when giving information to the patient. Without trust, a nurse-patient relationship rarely progresses beyond superficial social interaction and superficial care giving (Perry & Potter, 1999, p. 209).

When a nurse observes that a patient is exercising their territoriality he/she must consider the patient's cultural background and must be aware of sensitivities in that context. Cultural sensitivity in communication entails understanding that people of different cultures have different standards in the use of eye contact, personal space, gestures, loudness of voice, pace of speech, touch and silence. Also nuance in the use of language has a cultural dimension. Cultural sensitivity also demands that the nurse must make a conscious effort not to interpret messages through his/her own personal cultural perspective, trying instead to understand communication within the context of the patient's background (Potter & Perry, 1999, p. 214).

2.4.5 Personal Space

Personal space is defined as an area with invisible boundaries into which another person, in this case a nurse, is not welcome (Bradley & Edinburgh, 2004, p. 192). Personal space has also been described as a bubble that surrounds an individual. Personal space determines the minimum distance people prefer to maintain between themselves and others (standing or sitting) when interacting with them. Or it may be described as the separating distance one feels comfortable with when interacting with

others. Physical space can directly influence the pattern and level of communication interaction. Nurses who are effective in nurse-patient communication have developed a sense of respect for the boundaries of their patients' personal space. Knocking before entering a patient's room, standing at the foot of the bed while talking to the patient and calling the patient by name are ways of respecting their need for territory and more physical space (Bradley & Edinburgh, 2004, p. 192).

An individual's personal space boundaries are usually reflected in the distance they attempt to maintain to another person. Personal space is violated repeatedly in cases of acute illness due to the requirements for nursing interventions such as giving injections, insertion of intravenous lines, and the use of monitoring devices. These numerous violations of personal space by nurses and other coworkers, especially in instances when they fail to introduce themselves or explain their purpose, often lead to heightened anxiety on the part of the patient. However, both nurses and patients are territorial and each needs to maintain personal space in order to feel secure (Bradley & Edinburg, 2002, p. 192).

Personal space is also important in the dynamic flux of conversation and close encounters. When a nurse invades a patient's space by touching him, this act can be perceived as a statement of intimacy, as can moving closer to the patient to ease communication. Intimacy may reduce both physical and psychological barriers and support a context for a less formal, more relaxed relationship (Duck, 1999, p. 13).

Nurses should assess the personal space needs of each individual patient, acknowledge their zones of comfort and attempt to respect their preferences as much as is feasible when providing care.

2.4.6 Emotions and self-esteem

Our sense of self-worth is a major influence on all communication we engage in. It can be our greatest asset in human interactions. An appreciation of one's own self-worth is essential in being able to communicate effectively with others. As human beings we depend to a large extent on the reactions of others to determine who we really are. These reactions provide a reflection of our self which becomes incorporated into our view of self. Each of us would like to regard ourselves positively and as a mature person. At the same time, we frequently depend on the reactions of others to us to determine who we are. In this light, our level of self-esteem, particularly if it is low, may prevent us from evaluating appropriately, praise, blame or criticism directed toward us. After all, a message sender may not be evaluating or judging us as a person, but only commenting on our behaviour (Wolvin, 1995, p. 59).

Self-esteem also influences communication patterns. People whose self-esteem is high, communicate honestly, with confidence and with congruence between verbal and nonverbal messages.

Emotions also affect a person's ability to interpret messages. Large parts of a message may not even be heard, or the message may be misinterpreted when the receiver is experiencing strong emotions.

Any message a nurse may send to a patient is comprised of both logical and emotional content. Emotions may arise from strong feelings about a particular subject and may result in an internal physical reaction to what has been said by the nurse. Emotional states include fear, anger, disgust, grief, joy, surprise and yearning (Wovin, 1995, p. 14). A nurse must assume a responsibility for a patient's feelings that arise from reactions to what the nurse has said during interpersonal communication.

2.4.7 Perceptions

Our perceptions - the way we view the world - affect our interpretation of a communication stimulus (Wolvin, 1995, p. 15). Because every person has unique personality traits, values and life experiences, each one perceives and interprets messages differently. According to Wolvin (1995, p. 15-16) there exist three factors that influence our perceptions, namely:

Perceptual filter: We process the messages we receive, evaluating them based on the concepts we hold. During the perceptual process, we see and hear what we want to see and hear. We often reveal our personal views and attitudes through language.

Channel capacity: Is the amount of information we can process at any one time, a factor that also affects our ability to perceive things. Neurological damage, fatigue or information overload can cause patients to miss or misperceive language and other stimuli (Wolvin, 1995, p. 15).

Cognitive style: The way in which we become aware of concepts, how we comprehend them, as well as how we organize and store information, affect how we learn and how we use language. Some people learn more easily by hearing information, others by reading. Because we all have different cognitive learning styles, the way we sort and organize the information we receive may be different from the way it is presented (Wolvin 1995, p. 16).

2.4.8 Socio-cultural background

Communication and culture have a direct link. The way we communicate is directly influenced by our cultural background. Culture may be described as a system of interpretations shared by a group of individuals.

Intra-cultural communication refers to communication based on the interactions of people who share a cultural bond, while intercultural communication refers to communication between individuals who do not share a cultural bond (Wolvin, 1995, p. 192). Nurses need to recognise that they too are cultural beings, and should be aware that the things they say also reveal their cultural background, as well as other

aspects of the self, and are important in the learning process of becoming competent communicators.

A person's ability to speak, hear, see and comprehend stimuli influences the communication process. A patient who is hard of hearing may require messages that are short, but spoken loudly and clearly. Those who are unable to read obviously cannot comprehend written information. Even if a patient is free of physical impairment, a nurse needs to determine how many stimuli a patient is capable of receiving and understanding within a given time frame.

It is very important that the nurse respects the values and beliefs of the patient, but at the same time must address misconceptions, prejudices or fixed ideas which are relevant to the care giving situation.

2.4.9 The role, relationship and purpose

Besides the relationship that exists between a medical practitioner and a patient, the particular role of the former affects the communication process. The diverse roles of nursing student, registered nurse and doctor, as well as that of patient, affect the communication process. Choice of words, sentence structure and tone of voice vary considerably from role to role. For this reason, the specific relationship between communicators is significant. The matrix of thought and existing relationships between people sum up the meaning of communication (Jooste, 2003, p. 201).

Therefore, intended purpose of a communication also alters interaction we have with others.

Referring once more to Schutz (1958) (see section 2.3 above) the three basic needs of inclusion, control and affection become important factors in the nurse-patient relationship. Inclusion refers to a patient's need to be recognized as a respected participant in his/her interaction with nurses. The feeling of being included is fundamental to a healthy human condition. Control refers to a peoples' need to make a difference in their social environment and to have some say about what occurs in that environment. Out of their need for affection, patients seek a sense of interpersonal warmth or a feeling of being liked or loved. The lack of fulfillment of these needs in relationships, is a source of much of the alienation that people experience in their lives (Anderson & Ross, 1998, p. 162; West & Turner, 2000).

During interaction with a patient, a nurse must always seek to communicate in a purposeful manner for that interaction to be meaningful. Nurses become competent communicators when they are able to choose a behavior that is both appropriate and effective for the communication process in any given situation that might present itself on admission of a patient. Understanding what is appropriate and effective will be based on knowledge, skill and motivation. Knowledge simply refers to awareness of what behavior is best suited in a given situation. A nurse must be able to recognize what communication practice is appropriate for a patient upon admission by taking into consideration the patient's condition. Skill refers to the ability to apply the appropriate behavior in the given context. Motivation refers to a nurse's

desire to communicate competently, meaning. He/she must want to communicate in an effective and appropriate manner with due consideration for the condition of the patient on admission (Beach & Metzger, 1997, p. 23; Cooper, 1997, p. 75).

2.4.10 Time and setting

The factor of time in the communication process also includes what events precede and follow the interaction. A patient who has been obliged to wait for some time to express his needs may respond quite differently to one who has not been forced to wait.

The setting also influences communication. The process can break down if there is a lack of privacy during a conversation. A nurse's organization of her time may either facilitate or inhibit a patient's willingness to communicate.

2.4.11 Attitudes

Attitudes people hold also convey information about their beliefs, thoughts and feelings about other people and events. Attitudes such as caring, warmth, respect and acceptance facilitate communication whereas condescension, lack of interest and coldness inhibit communication.

A nurse needs to be credible. Possessing credibility means a person is worthy of belief and is trustworthy and reliable. Credibility may be the most important

criterion of effective communication. To become credible a nurse needs to be knowledgeable about the subject matter being discussed and must possess accurate information about the situation. A nurse also needs to convey confidence and be certain about what she or he is saying. By the same token, it is important that a nurse avoids appearing overconfident or authoritarian (Kozier, Erb, Berman & Snyder, 2004, p. 25).

Nurses must portray a positive attitude for communication to flow smoothly and to ensure that the patient will participate fully in the process, as mentioned by Bennis (2002) in his definition of communication as an exchange, and not just an action. All parties must participate fully for the exchange of information to be complete (Bennis, 2002, p. 2).

A nurse must be able to listen with empathy. Empathy is a personal capacity that will facilitate effective communication when a nurse speaks to a patient on admission. Empathy is generally defined as the ability to imagine oneself in another's place and to understand another's feelings, desires, ideas and actions (Cragan et. al., 2004, p. 68).

A strategy likely to enhance the level of empathy in an encounter is paraphrasing. The technique of paraphrasing is repeating back for a patient what they have said to you, using other words, in order to indicate that you have understood the sender's intent. The process should occur at both the emotional and the ideational level of a conversation (Cragan et. al., 2004, p. 68).

2.4.12 Language

Given the Namibian historical context, in which people were accustomed to dividing groups or classes of people as a means of controlling them, it sometimes comes as a shock for an individual to be reminded that, by design and in practice, the medium of control has been language (Cobley, 2006, p. 42).

The use of technical language and professional jargon inhibits the communication process. Nurses, being accustomed to the clinical setting, often forget that most patients do not understand the medical terminology they use. A key issue in all communication models is linkage between the message and the receiver (Bradley & Edinburg, 2004, p. 9). In the case of spoken messages, words may have multiple meanings for patients. Furthermore, each patient is unique. In all situations, a correct interpretation of a message is of prime importance. Problems naturally arise when a person's intended message is not understood and the actual outcome of communication differs from the desired one (Bradley & Edinburg, 2004, p. 9).

2.5 COMMON WAYS OF HINDERING COMMUNICATION

According to Bradley & Edinburg (2004, p. 108**)** if a nurse exhibits any of the following behaviours, communication will be hindered:

- Placing blame on the patient.
- Changing the topic of conversation inappropriately.

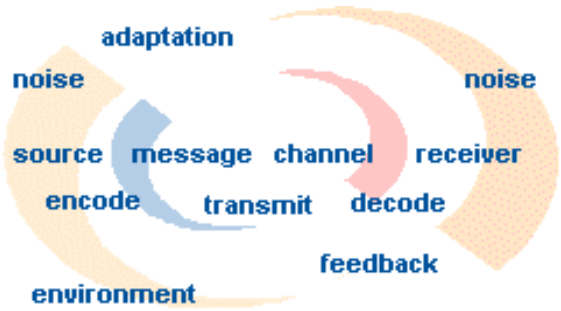
- Reacting defensively, in a hostile manner, with aggression, or by responding as if she/he had been attacked.
- Giving false reassurance, that is, promising something that may not be forthcoming or saying something that is untrue (even if done with the intention of relieving a patient's distress).
- Judging the patient: any evaluation a nurse makes of a patient can potentially have a negative effect and may be communicated to the patient either in subtle or obvious ways - by a raised eyebrow, a stern look, a raised voice or by way of accusation.
- Making leading statements, that is, by putting words in the patient's mouth.
- Posing multiple questions: if a nurse asks the patient several questions before waiting for a reply, the patient may become confused (likewise, messages are difficult to understand if they are loaded with a lot of information).
- Parroting the patient, which refers to overly frequent repetition of phrases or words in a patient's conversation in the attempt to reflect or paraphrase.
- Displaying stumped silence - a situation in an incomplete conversation when neither patient nor nurse knows what to say next (an uncomfortable or embarrassed pause which may give the impression that the nurse is confused).

2.6 INTERPERSONAL COMMUNICATION MODEL

There are many interpersonal communication models. For the purpose of this study, the transmission model was used as a conceptual framework.

DIAGRAM 2.1

The Transmission View of Communication



(Doyle, 2005, p. 3)

The model is comprised of seven elements:

2.6.1 Information source (the sender)

The sender, a person who wishes to convey a message to another, can be named the source, or encoder. he term implies that the person sending the message must have an idea or a feeling that is capable of being transmitted (Kozier et. al., 2004, p. 420). In this case, the information source that produces a message is a nurse. The quality of nursing practice is dependent on a variety of factors. One of the most important of these factors is the way in which communication takes place between the patient and the nurse. Through appropriate interpersonal communication, the nurse must establish a comfortable and trusting nurse-patient relationship (Searle, 2000, p. 254).

The nurse-patient interaction is a vehicle by which information concerning his/her health is imparted to a patient in order to establish a relationship based on trust. The nurse (sender) must adhere to certain principles, or qualities, to ensure effective interpersonal communication. These qualities are genuineness, respect, availability, honesty, the ability to listen and empathy (Ivurita, 1996, p. 80).

It is also important that the nurse (sender) determines the needs for information of the patient (receiver). According to Arie (2000, p. 1) it is important for the information source (sender) to identify the specific need and then to design the message accordingly. The author goes on to classify needs, with regard to communication, in three categories: universal needs, general needs and specific needs.

Universal needs

Universal needs are those needs that all people have and which direct or motivate both our general and also our communication behavior (Ibid, 2002). The information source (sender), in this case the nurse, may employ any one of several motivational theories to define universal needs. If one utilises Maslow's theory of motivation, which is based on basic needs, the nurse must take into consideration certain kinds of information that should be included in the messages to the patient. From this reference point, patients want information about the intake of food (meal times,

special diets, fluid diet), about excretion (toilets, urine, faeces) and about personal hygiene (facilities, bathrooms).

Patients also have a need for rest and sleep. Physical comfort refers not only to the absence of pain, but includes factors such as position of the body, absence of annoying distractions and stressful occurrences as well. They also have a need for security. Patients need to feel safe in the ward. If they are to undergo a medical procedure they should know about all the security measures that will ensure a safe operation. They also need the assurance that their belongings will be secured.

Concerning social needs they need information about visiting hours. They also need to feel welcome in the ward and to be respected by staff. Needs bearing on self-image create a desire for privacy and confidentiality, as well as to be admired and respected as a human being. Patients' actualization needs will evoke questions about how their treatment or procedure will enable them reach their fullest potential.

General communication needs

According to Arie (2000, p. 4) general communication needs refer to those needs that can be satisfied exclusively through communication. The author identified the following as general communication needs (ones that refer to the need for factual information). Patients need to know their diagnoses, what will be done during the operation, what is involved in pre- and post-operational situations, what are the medical or nursing procedures applicable to their case, what medication will be administered and how will pain be managed. They also want to know how their

basic human needs will be met after the operation, since they are aware that they will be totally or partially dependent on a nurse to fulfill these needs.

Specific Communication needs

Because each patient is a unique individual and will undergo a specific operation, specific communication needs will arise. The information source (sender), in this case the nurse, should make efforts to ascertain the specific communication needs of each patient. Furthermore, before the information source (sender) proceeds with a planned communication, he or she should analyze his/her own motivations to determine what personal needs will affect that communication (Fourie, 2000, p. 8).

2.6.2 Encoding (transmitting) the signal

The next step in the communication process is the encoding of a message. The information source (sender) accomplishes this step. This means that the message must be rendered into some kind of coded system that can be understood by the receiver. The message is encoded into written or spoken words that will have the best chance of influencing the patient, who is the receiver (Fourie, 2000, p. 4). Encoding includes the selection of specific signs or symbols (codes) in the form of language, the arrangement of words and tone of voice, as well as any gestures that might be appropriate (Kozier et. al., 2004, p. 420). For example, if a receiver speaks only Damara-Nama (a language not commonly spoken by nurses in the north), a nurse must select accompanying gestures and tone of voice, in order to communicate

his or her meaning, if she cannot speak that language, so that the patient will be able to understand.

Encoding is extremely critical because the environment of a health care facility is radically different from a patient's familiar surroundings. Unfamiliarity may create fear, loss of a identity, separation anxiety and loneliness in the patient (Cole, 1996, p. 25 and Bolander, 1993, p. 388). Any of these reactions to unfamiliar surroundings can influence the way a patient will react to information (the message). Remaining aware of this aspect of the patient's situation is particularly important if the message will be transmitted through the spoken word. The nurse should use a patient's name and avoid using expressions of endearment when talking with patients and their families. The nurse should face the person being addressed, maintain eye contact and use tone of voice, rhythm, volume, and inflection appropriately. The manner in which you say something is just as important as what is said (Cole, 1996, p. 40).

2.6.3 The message

The message is the primary focal point of communication. It never originates in a vacuum, nor is it received and interpreted in a vacuum. A message is formulated by the source of information (the sender) because there a need to share information exists. According to Fourie (2000, p. 12) a message is a single thought, idea, concept, truth or meaning the sender wishes to share with or communicate to his receiver (destination). The message should be clear, brief, simple and presented in a way that will keep the opinions and values of the sender in perspective (Cole, 1996,

p. 40). A message that is direct and simple will be more effective. Nurses should use widely understood words, speak with brevity and completeness, and in a manner that is appropriate to the age, knowledge, culture and education of the client (Kozier et. al., 2004, p. 423). A lot of information (many messages) should be shared with patients when they are admitted to a surgical ward.

The kinds of information (messages) can be categorised under the following headings:

- Information concerning the environment and the ward
- Information about the operation
- Information about policies of the ward
- Information about a patient's rights

2.6.3.1 Information concerning the environment and the ward

A definite plan on how to inform patients about the hospital and the ward should be in place. One method is to hold health education sessions with patients shortly after admission. According to Perry and Potter (1999) and Cole (1996), patients become more at ease after an orientation to the hospital and their ward, and will adjust more easily to the environment.

Information about a hospital and the ward should include the following:

- **Introductions between patient and staff**

First impressions are always very important and therefore patients should be greeted in a friendly and respectful manner. In any hospital environment, and especially in a surgical ward, the identity of the patient is important. Therefore, staff should know each patient's name. It is equally important for the patient to know the names of the nursing staff. If patients share a room, they should be introduced to one another.

- **Accessible areas**

It is important to identify other areas in the hospital that patients or support persons may use, such as lounges, cafeteria, chapel, canteen or snack area and public restrooms.

- **Equipment**

Next, a patient should be accompanied to his or her bed and receive both an explanation and a demonstration of the equipment in the room. Knowledge of the location and appropriate use of equipment will ensure a client's safety. Knowing how to obtain assistance if they need it will enhance their sense of well being.

- Explain how the call system (intercommunication system) works.

- Explain equipment in the bedside table and point out the client's locker.
- Indicate the location of the bathroom and showers.
- Demonstrate the room's overhead lighting and night lighting.
- Demonstrate the operation of the television if the room has one.
- Explain how the hospital's telephone system operates.
- Discuss restrictions, requirements, and liability related to any electrical equipment, either supplied by the hospital or brought in by the client. Most facilities require that equipment brought in from outside must be inspected and approved by the hospital engineering department. Explain how the client may obtain a television or radio.

2.6.3.2 Information concerning the medical procedure

A patient's anticipation of surgery frequently leads to fear and anxiety. The patient may associate surgery with pain, disfigurement, a potential change in body image, dependence on others, disruption of life-style, cancer, or even death. It is therefore vital that patients are given appropriate explanations about the procedure they are about to undergo (Cole, 1996, p. 429; Perry & Potter, 1999, p. 1079).

A nurse will explain hospital admission procedures and then inform the patient about preparation for his or her operation. Aspects that should be covered are the physical examination, and urine and blood tests. The client should also be informed about any treatment that might be necessary during the next shift or the next day. Clients who are about to undergo surgery need to know what preoperative preparations will

be necessary, such as surgical shave or pre-operative fasting. When a patient has knowledge of what they can expect, their level of anxiety is reduced. A caring nurse can relieve some of the anxiety by explaining to the patient and his family how equipment works.

According to Ulrich, Canale and Wendell (1998, p. 9) a patient, prior to surgery, will most likely:

- share thoughts and feelings about the impending surgery and its anticipated effects; and
- verbalize an understanding of the surgical procedure, preoperative care, and postoperative sensations and care.

Cole (1996, p. 429), Faulkner (1996, p. 360) and Ignatavicius, Workman and Mishler (1999, p. 318) identified the following information that needs to be communicated to a surgical patient before an operation:

- Prohibition against taking anything by mouth (NPO) after midnight or as ordered
- Pre-operative medication
- Informed consent through signing a surgery consent form
- Dentures or partial plate removal
- Preparation and shaving of the surgical site
- Removing and securing jewelry

- Removing glasses, contact lenses, prostheses, wigs, false eyelashes, hairpins, clips, nail polish and make-up
- Wearing a surgical gown and surgical cap
- Providing diminution or the insertion of a Foley catheter
- Pain management

Kozier et. al. (2004, p. 900) outline four dimensions of pre-operative instruction to patients:

- ***Information*** - including things that will occur during and after the procedure and when; what the patient will probably experience, including expected sensations and discomfort. In this context, a nurse needs to listen attentively to the client to be able to respond to specific concerns and fears he or she expresses.
- ***Psychosocial support*** - to reduce anxiety. The nurse provides support by actively listening to the client and providing accurate information. Demonstrations of a caring attitude towards the patient can increase feelings of trust on his or her part and reduce anxiety (Perry Potter, 2002, p. 959).
- ***The role of the client*** in pre-operative preparation and in the post-operative period. When a patient knows in advance what they will experience and how they should behave in the post-operative period, their sense of control will be increased and their anxiety reduced. In the post-operative period, their participation will include what behavior and self-care activities will be expected from them, as well as what they can do to facilitate recovery.

- ***Skills training for the patient*** - The patient must be instructed about moving, deep breathing, coughing, splinting incisions (manual relief of tension) with the hands or a pillow, and using an incentive Spiro meter.

Further insight is offered by Cole (1996, p. 429) who says that appropriate pre-operative instruction should help the patient develop a more positive attitude, which would in turn facilitate more rapid recovery. Other beneficial results may be reduced need for pain treatment, as well as a reduced possibility of post-operative complications, all of which could shorten the patient's stay in the hospital.

Perry and Potter (2002, p. 4) and Altman (2004, p. 491) added that a nurse should provide surgical patients basic information regarding the purpose of the surgery, preparatory procedures and post surgical care. Admission forms, consent forms, diagnostic tests and instructions need to be completed before the day of surgery is to be performed. Furthermore, Perry and Potter (2002, p. 959) and Beare and Myers (1997, p. 204) point out that preparing a patient for surgery involves activities and procedures that help decrease anxiety, ensure patient safety, and minimise the risk of complications. Anxiety can interfere with the effectiveness of anesthesia and the ability of a patient to actively participate in his or her care. For these reasons, a nurse should provide information about what will occur during the operation, as well as what sensations a patient is likely to have as a result of the procedure. The knowledge that medication for nausea and pain will be prescribed, if needed, will help decrease a patient's anxiety. Likewise, if a nurse demonstrates a caring attitude

towards the patient, trust is engendered, also reducing anxiety (Perry & Potter, 2002, p. 959). Finally, patients are entitled to receive a thorough explanation of the nature and consequences of the proposed surgery before they are asked to sign the consent form (Young, van Niekerk & Mogotlane, 2003, p. 652).

In the post-operative situation, the following information is considered important for the patient:

- Examinations that will be carried out to inspect vital signs or bleeding from the operation wound.
- Interventions, such as intravenous infusion or follow-up catheter.
- Procedures concerning personal hygiene, wound care and pain management.

To conclude, Cole (1996, p. 25) makes the following points regarding personal attitude and procedure which nurses should keep in mind when admitting patients to the ward:

- The patient should be viewed as a consumer in the health care system and as a human being who disserves to be treated with dignity, courtesy, and respect.
- The nurse's attitude often forms the basis for a patient's feelings about the care received.
- A plan for discharge should be initiated on the day of admission.

Finally, Young (2005, p. 8-2) urges nurses to observe the highest standards of care and professional behavior at all times, standards that can only be maintained when a nurse's knowledge and competency keep abreast of developments in the health care industry over the course of his/her entire career.

2.6.3.3 Information about the policies of the ward

Information on hospital policies regarding the following subjects should be given to a patient on admission:

- Visiting hours
- Use of alcohol and tobacco
- Medication not administered or prescribed at the hospital
- Patient's belongings

Tobacco: At the time of admission, nurses must inform patients about the adverse effects of tobacco on their condition. These include increased difficulty clearing respiratory secretions after surgery, as well as increased risk of post-operative complications such as pneumonia and atepectasis (Kozier et. al., 2004, p. 900). In fact, patients who are scheduled for surgery should receive information about the effects of tobacco by their doctor well before they are admitted. A patient should be encouraged to stop the use of tobacco at least 30 days before surgery, since nicotine delays healing of the surgical wound and increases the risk of infection by constricting blood flow (Perry & Potter, 2002, p. 960).

Alcohol: Patients should be well informed about the effects alcohol will have on their response to anesthesia, surgery and post operative recovery. (Kozier, Erb, Berman & Snyder, 2004, p. 900).

2.6.3.4 Information about a patient's rights

Basic human rights are a fundamental feature of all democratic nations. Human rights are enshrined in the constitutions of their governments and are also enshrined in the United Nations Convention on Human Rights. The Republic of Namibia is a signatory to this convention, and her constitution guarantees basic human rights in keeping with democratic culture and values (MOHSS, 1998, p. I). The Patient Charter of Namibia accords to all patients the right of access to their personal file, stipulating conditions of access, i.e., the presence of relevant staff, the file remains property of the Ministry (MOHSS, 1998, p. 8). The Patient Charter was created in order to inform and create awareness among both users and service providers about issues that will facilitate steady improvement in the services rendered (MOHSS, 1998, p. I).

Hospital staff carries a responsibility to inform patients about their rights. The fact that a nurse enters into a tacit agreement with a patient implies that he or she becomes the patient's agent. Ergo, an ethnical obligation rests on the nurse to protect a patient against any violation or disregard of his rights (Pera & Van Tonder, 1996, p. 173).

The right to considerate and respectful treatment implies that the client has a right to explanations from hospital staff about all aspects of their treatment, including what will occur during their stay, at what time and for what reason. The client also has the right to participate in the planning of his or her medical care (Kozier, Erb & Bufalino, 1998, p. 71).

Young, et. al. (2003, p. 68) document the following list of patients' rights:

- The right to full information relating to available health services, rules and regulations of the hospital as well as information regarding their diagnosis, prognosis, treatment and nursing care plan.
- The right to be examined and treated by a qualified medical practitioner and/or nurse.
- The right to informed consent (this implies that a patient will receive a detailed explanation about every diagnostic test, treatment, procedure, operation and the consequences thereof before being asked to consent to them).
- The right to informed refusal to grant permission for treatment or examination and to receive explanation about the possible consequences of this refusal.
- The inalienable right to respect and human dignity (irrespective of who or what a person is).
- The right to privacy and confidentiality, i.e. to complete secrecy, privacy and confidentially of all personal information, including information on medical records.

- The right to complete information on research.
- The right to assert personally claimed rights.
- The right to receive visitors in the hospital.

2.6.4. The channel and noise

The medium used to convey a message is called the "channel". The channel may be the spoken word, physical gestures, or written communication. It is important that the channel be appropriate in the immediate situation and should help clarify the intent of the message (Kozier et. al., 2004, p. 422 and Young et. al., 2003, p. 287).

In our case, usually direct communication takes place between the nurse and the patient, and it can be verbal or nonverbal (in the form of gestures). The circumstances under which communication takes place may have a profound influence on the process. A disturbance in this process can be noise. Noise is a disturbing factor because it interferes with a message traveling along a channel of communication, such as conversation between people. For example, a ringing telephone in the vicinity can be very disrupting. Such a disturbance can create a situation in which the patient may not hear properly what is being said. People who are ill are usually sensitive to any kind of noise, and in the context of the hospital environment, this may include anything from the sound of metal equipment being moved, to loud talking and laughter. Nurses should make an effort to keep the noise level in health care settings to an absolute minimum (Kozier et. al., 2004, p. 745).

What occurs in the physical setting in which communication takes place is important because external factors influence the fidelity, or accurate transmission, of messages. It has been estimated that even under optimal conditions, communication is only eighty percent (80 %) effective. A contributing factor to ineffective communication is noise (Closky, 2000, p. 4).

2.6.5 Receiver (decoder)

The receiver, according to Kozier, et. al. (2004, p. 745), is the listener, the person for whom a message is intended. But more than just listen, the receiver must observe and attend as well. This person is a "decoder", i.e. he must understand the intention of the sender in transmitting a message for the message to be effective.

In the case of this study, the receiver is a patient. Upon hearing a message, the receiver must interpret or decode it. Decoding means to relate the message perceived to the receiver's storehouse of knowledge and experience, and in this context to sort out its meaning (Kozier et. al., 2004, p. 745). Receivers decode or understand messages only in the context of presuppositions and assumptions that shape their personal view of the world. The information source (nurse) must encode and transmit information with this limitation in mind. It is the responsibility of the communicator to ensure that the message is received and understood with the highest degree of accuracy possible (http//guide gospel com.net/resources/sellitoofsen.Php.).

By implication this means that the nurse must consider a patient's mental and physical capacity, culture, socioeconomic background, class, interests, educational level, language skills and knowledge of technical terms.

The art of communication is therefore a vital skill, and its mastery will infuse warmth and meaning into nursing practice. The way in which a nurse's image and actions are communicated to a patient will determine the degree of trust the patient places in the nurse. In turn, that trust will affect the measure of wellbeing that the patient will derive from the nurse's ministrations. (Searle & Pera, 1995, p. 311).

2.6.6 Destination (feedback)

Assuming that a message has arrived, "destination" refers to the response, i.e. the message that the receiver returns to the sender after having received his message (Young, et. al., 2003, p. 288). How can the communicator know if his message has broken through the noise, has been decoded correctly and ultimately has been successfully incorporated into the receiver's awareness? The only way to accurately assess these factors of communication is through the feedback sent by the receiver himself.

According to Closkey (2000, p. 6) feedback is the process by which the receiver becomes an information resource, decoding the information he has received from you, then encoding a new message which he sends back. The new, or returned message, will reflect the degree to which he understood the original message.

Feedback is important because it sustains dialogue, that is, a two way process of interaction. Feedback will help you improve the quality of your conversation with another person, by showing you how to keep it personally relevant to the listener (Ibid, 2000, p. 7).

Nurses should create as many opportunities as possible for patients to give feedback and ask questions. Maintaining an atmosphere in which patients feel free to communicate is also an important part of the process.

2.6.7 Adaptation

Spoken messages need to be altered in accordance with behavioral patterns of the patient. The content of what a nurse says and the manner in which he or she says it must be carefully considered and individualized for each receiver. (Kozier, et. al., 2004, p. 424). Nurses need to be aware of the relevance of their message, the rate at which it is spoken and the timing when it is shared, when they speak to a patient at the time of their admission. Speaking slowly, softly and with enthusiasm will assuage the patient's fear of the unknown. Using these mannerisms or methods in speaking are simple ways of adapting messages to the listener.

Communication is one of the critical skills through which the caring attitude of a nurse is conveyed to a patient. Communication brings comfort to the patient. By the same token, effective communication is an essential element in the nurse-patient

relationship. In the course of their work, nurses become attuned to all kinds of communication, recognizing that gestures, expressions and other kinds of body language often convey messages more powerfully and accurately than words. Helping clients to feel that they are truly understood and supported by their nurse during this vulnerable time should be perceived as a vital aspect of nursing care (Kozier, et. al., 2004).

In the Namibian Public Service Charter it is stated that, if Namibia is to prosper, public servants must demonstrate their commitment to improving the quality of services delivered to everyone in the country. Imparting information is a principle promulgated by the Namibian Public Service Charter. To put this principle into practice, nurses need to provide information to all surgical patients without prejudice or distinction and in an open manner that is both straight forward and easily understandable.

2.7 SUMMARY

Interpersonal communication between patients and nurses is extremely important. Patients who are admitted to surgical wards for medical procedures are naturally anxious and suffer from stress. To function as effective care givers in such a situation, nurses need to be skilled communicators and able to apply all aspects and subtleties inherent in the communication process in the daily exercise of their profession. In this chapter the functions of interpersonal communication, its influencing factors, as well as a model for communication, were discussed.

CHAPTER 3

RESEARCH METHOD

3.1 INTRODUCTION

This chapter explains how the study was conducted. It also describes the design and method used in the study, which include a description of the population sample, data collection and the measures employed to ensure validity and reliability. Polit and Hungler (1999, p. 36; and Mateo & Kirchhoff, 1999, p. 269) define research method as steps, procedures and strategies used for gathering and analyzing data in the context of investigative research. The method also outlines basic strategies that the researcher adopts to process information so that it is accurate and interpretable (De Vos, 2002, p. 138). The purpose of the methodology is to describe precisely and accurately what the researcher did to answer the study question (Polit & Hungler, 1999, p. 155).

3.2 RESEARCH DESIGN AND METHOD

3.2.1 Research design

A research design entails the systematic planning of research so that it will produce valid conclusions (Reis & Judd, 2000, p. 17 and Clare & Hamilton, 2004, p. 12). A quantitative, exploratory and non-experimental design was used for this study. This

design was chosen because it will provide a more complete picture of the interpersonal communication that takes place between registered nurses and their patients who are admitted to hospital for surgery.

The study is explorative. Its purpose is to provide insight and generate meaning on the subject of interpersonal communication between registered nurses and surgical patients on admission (Sinleton Jr. & Straits, 2005, p. 223).

The study is also descriptive of the phenomenon, since it presents statistically quantitative data based on a sample representing the population (Mouton, 1993, p. 434; and Cresswell, 1998, p. 62).

3.2.2 Research Method

A research method can be defined as a systematically organised set of techniques and procedures that a researcher follows in collecting data. In this study a descriptive survey was used to gather information on interpersonal communication between registered nurses and surgical patients admitted to a surgical ward of the hospital (Polit, Deck & Hungler, 2001, p. 186; Burns & Grove, 2005, p. 239).

3.3 POPULATION AND SAMPLING

3.3.1 Population description

Burns and Grove (2005, p. 342), Schneider, Elliot, LoBiondo-Wood and Haber, (2003, p. 256) and Bless and Smith (2000, p. 85) defined a "population" as the entire group of persons or objects that is of interest to the researcher and is the subject of his research.

The target population for this study consisted of two groups:

- All adult patients hospitalized exclusively to undergo surgery in Oshakati Hospital, excluding those who were either unconscious or mentally ill. The number of patients who were operated on between January 2006 and December 2006, was 567 (five hundred sixty seven).
- All ten (10) registered nurses working in surgical wards at Oshakati Hospital.

Oshakati Hospital is a referral hospital in the North West Health Directorate. It is the facility to which surgical patients are admitted and where their operations are performed.

Surgical wards were selected for the study because:

- surgical procedures, performed under general anesthesia, expose patients to many risks;
- admission to a hospital for surgery creates in patients physiological and psychological stress that cause fear and anxiety; and
- impending surgery places patients in a complex, delicate situation whose details they should be well informed about, the surgery itself requiring their consent which should be informed consent (Perry & Potter, 2002, p. 959).

3.3.2 Sample and Sampling

3.3.2.1 Sampling

Two methods can be used to sample a population, namely, probability and non-probability sampling. According to Singleton Jr and Straits (2005, p. 119) and Rubsin and Earl (1997) a probability sampling is one in which each person or object in the population has the same opportunity of being selected for the sample. In the case of non-probability sampling, not every member of the population has an opportunity for selection in the sample. Probability sampling increases the likelihood that the sample will be representative of an entire target population (Newman, 1997). The researcher used probability sampling in this study:

- so that each surgical patient would have an equal chance of selection; and

- since it enabled the researcher to estimate sample errors and to reduce bias in the sample (Brink, 2001, p. 134 and Singleton Jr & Straits, 2005, p. 118).

3.3.2.2 Sample

The sample was taken from both groups that composed the population, namely surgical patients and registered nurses (Burn & Groove, 2005, p. 342). The researcher sampled patients first. Surgical patients are admitted at Oshakati Hospital five days a week, Monday through Friday. The researcher wrote the names of the days, Monday to Friday, on separate pieces of paper and all were placed in a box. After the box was shaken to scramble the pieces of paper, one sheet was drawn, on which the name Wednesday had been written. Every second patient admitted to a surgical ward on a Wednesday was interviewed until a total of one hundred patients were interviewed. One hundred respondents, a statistically controlled figure, were selected to ensure a confidence interval level of a 95 %. It should also be noted that interviews were intensive because not all respondents could speak English.

The second group in the population, registered nurses working in adult surgical wards, numbered 10 individuals. All the registered nurses working in the surgical wards of Oshakati Hospital have extensive experience dealing with patients admitted for surgery. Because the number was small, it was decided to interview the entire population of 10 nurses, rather than a sample. All ten nurses expressed willingness to participate in the study and were interviewed.

3.3.3 Instrument for Data Collection

Two structured questionnaires were developed and used to gather information from patients and registered nurses. The questionnaires consisted of open-ended and closed-ended questions. The questionnaires were designed to achieve the following objectives:

- to identify the personal particulars of respondents;
- to determine what information is provided to surgical patients by nurses when the former are admitted to the hospital;
- to determine whether patients participate in their nursing care through being encouraged to pose questions or make suggestions;
- to determine whether patients are informed about the pre- and post-operative aspects of their surgery; and
- to determine the strategies that could be employed to improve interpersonal communication between nurses and surgical patients on admission.

The questionnaires consisted of A and B sections. Section A consisted of questions of a personal nature, while section B consisted of questions concerning interpersonal communication between surgical patients and registered nurses. The questionnaires for both nurses and patients were the same, except in section A, regarding the wording used to solicit personal qualifications, marital status, years of nursing

experience and the number of years of nursing experience in surgical wards by registered nurses.

The questionnaires provided the following advantages that rendered them appropriate for gathering the information needed for the survey: they identified and explored meanings in occurrences of interpersonal communication, and corroborated information collected from both nurses and surgical patients about that communication.

3.4 MEASURES TO ENSURE VALIDITY AND RELIABILITY

3.4.1 Validity

The validity of an instrument is a determination of the extent to which the instrument actually reflects the abstract construct being examined (Burns & Groove, 2005, p. 376; and Black, 2003, p. 243).

The degree of validity of the instruments used in the study was determined by judging their content validity. Content-related validity examines the extent to which criteria contained in the instrument measurement include all the major elements relevant to the construct being measured (Burns & Groove, 2005, p. 377).

Evidence that all major elements of the construct were contained in the instruments, thus ensuring content validity, was obtained from the literature, from representatives of the population and from experts in the field of nursing. An extensive review of

literature on the subjects of interpersonal communication and information sharing was carried out. Meetings and interviews were conducted with people in surrounding communities and with hospital staff. After the questionnaires had been developed on this foundation, they were given to content experts, namely senior registered nurses and their supervisors, to scrutinize and to give comments on the instruments. No corrections were made or items added.

3.4.2 Reliability

Reliability of an instrument is the degree of consistency with which the instrument measures the attribute it is designed to measure (Burns & Grove, 2005, p. 379). Reliability increases when the researcher is familiar with the research environment (De Vos, 2002, p. 168).

The researcher conducted a pilot test of the instruments on ten registered nurses and patients who were not part of the study. The information obtained from the pilot testing was used to improve the instruments (Polit & Hungler, 1999, p. 44). Pitfalls and errors that could have proven costly in the study were identified in the pilot testing and were eliminated from the instruments. Some questions relating to interpersonal communication that previously had been omitted were added. Moreover, some questions appeared to have been included in the wrong sections of the instruments and were moved. Questions were also cross-checked for ambiguities

and repetition. All problems identified by the pilot testing and the formulation of the questions were refined.

3.5 PILOT STUDY

The reason for testing the instruments were to assess the feasibility of a research project, the practical possibilities to carry it out, the correctness of some concepts, and the adequacy of the method (Polit & Hungler, 1999, p. 320).

The instruments were tested with registered nurses and patients before the actual data collection. Ten registered nurses with knowledge about nursing procedures were selected randomly from other wards and given the questionnaires to complete. These ten registered nurses were excluded from the final study.

The structured questionnaires for patients were tested on ten patients who were selected randomly from other wards and were excluded from the final study. These patients were interviewed by the researcher herself using the structured questionnaires.

No problem was encountered during the testing of the instruments.

3.6 DATA COLLECTION

Data collection is the process of selecting subjects and gathering data from these subjects (Burns & Grove, 2005, p. 733). Data was collected using questionnaires. Questionnaires for registered nurses were distributed by the researcher to ten (10) nurses; all ten questionnaires were completed and returned.

Data from patients was collected by the researcher and a research assistant through interviews with the patients using structured questionnaires. The research assistant was a registered nurse who is familiar with the procedures of admission to wards but who is not part of the surgical staff. She also received training on how to conduct interviews with patients using the structured questionnaire.

3.7 DATA ANALYSIS

Data analysis is the systematic organisation and synthesis of research data (Polit & Hungler, 1999, p. 699). During this phase, answers to the key questions the study poses, those generated from the central concern of the research, are collected and evaluated (Burns & Groove, 2005, p. 733). Data analysis brings logical and observational factors together in the search for patterns in the responses that have been collected (Baxter & Babie, 2004, p. 9). The purpose of data analysis is to organise and elicit meaning from the data collected, and to provide structure for it (Polit et. al., 2001, p. 383).

In this study the data was analysed according to an ordinal scale that ranked responses on a scale of one to four (1 - 4). Respondents were requested to select one of four possible responses, ranked according to the frequency of occurrence that corresponded with their personal choice, for example:

1 = never

2 = sometimes

3 = often

4 = always

The average frequency of an occurrence, i.e. the value of each item, was calculated by adding the numerical value of all responses to a question, and dividing the sum by the number of responses, for example:

N = 20 (20 respondents)

		Total
5 (respondents)	= 3	15 (5x3)
10 (respondents)	= 2	20 (10x2)
5 (respondents)	= 4	20 (5x4)
		= 55
		$= \frac{55}{80} x4 = 2.75$

In this study, graphs, percentages and tables have been prepared to present the findings of the study. These visual tools assist us to identify patterns in the data and to interpret exploratory findings (Burns & Groove, 2005, p. 733).

Analysis of the data was completed using a computer and with assistance from a statistician.

3.8 ETHICAL CONSIDERATIONS

Maintaining ethical standards is a vital part of any research, and during this study the necessary consideration was given to ethics. The principles of informed consent, freedom of choice, anonymity and confidentiality were observed.

- ***Informed Consent*** was given both verbally and in writing. Informed consent was obtained in (illegible word) from the Ministry of Health and Social Services as well as the Oshakati medical superintendent. Verbal consent was obtained from all respondents, patients and registered nurses involved in the study.

- ***Respondents' freedom of choice***: No respondent or registered nurse was coerced or manipulated in any way to take part. Each was informed that participation in the study was in no way compulsory and that they could

withdraw their participation at any time. This information was also imparted at the time the questionnaires were administered.

- ***Anonymity and confidentiality***: The anonymity of every respondent was guarded and preserved and all data collected was treated with confidentiality. Data was kept secret and confidential until data coding was carried out.

3.9 SUMMARY

The research methodology was discussed in depth in this chapter. After identifying the population and the sampling methods, the means for developing and validating the instruments was presented and a description of how data was collected and analysed was given.

A quantitative approach was used to carry out the study. Structured questionnaires were prepared to gather the data. Quantitative results of the study will be presented in the next chapter.

CHAPTER 4

ANALYSIS AND DISCUSSION OF RESEARCH DATA

4.1 INTRODUCTION

This chapter focuses on the analysis and discussion of data obtained from the interviews of patients and registered nurses. The aim of research lies in the discussion and interpretation of data once it has been collected (LoBiondo-Wood & Haber, 2006, p. 393).

Polit and Hungler (1999, p. 699) identify the purpose of analysis as the organization of data, providing a structure for data and extracting meaning from data. Expressed another way, it can be said that the purpose of data analysis is to impose order on a large body of information so that it can be synthesized, interpreted and shared with others in a coherent manner.

The study sample consisted of 100 patients and 17 registered nurses. All the patients surveyed were able to respond to all questions. The questionnaires were translated into Oshiwambo, Afrikaans and Portuguese to accommodate respondents in the sample who did not understand English. Of the 17 registered nurses surveyed, only 10 completed the questionnaires.

Data collected from both groups of respondents in the population are presented in this chapter. Section A of each instrument was analyzed and discussed separately, while section B of each instrument was analysed and presented together.

4.2 DEMOGRAPHIC DATA

SECTION A

The demographic data of the respondents is as follows: N=100.

Instrument A (Section A)

Patients

Gender (N = 100)

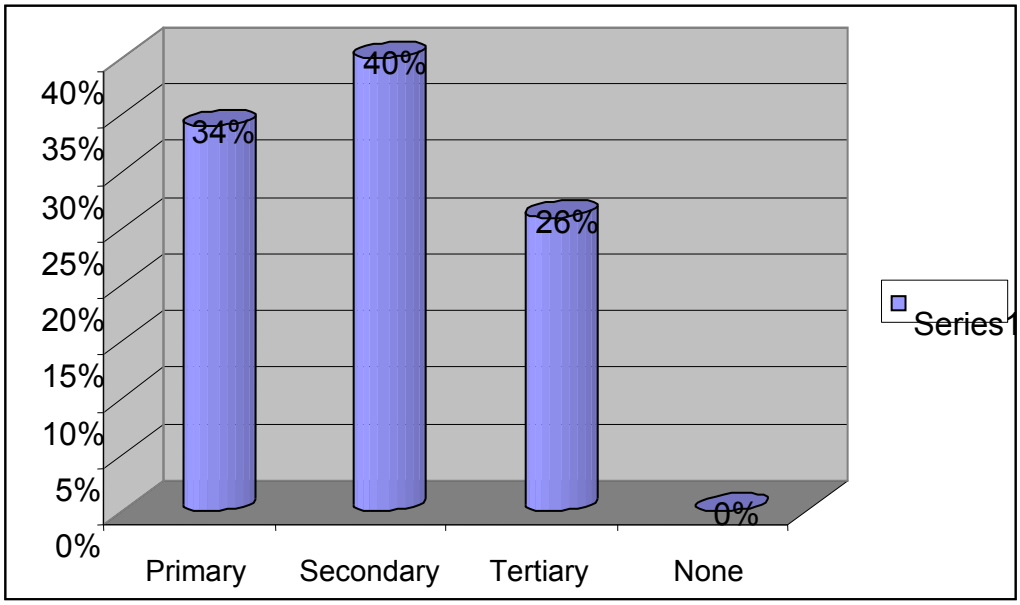
The data shows that the majority of respondents (patients) were males.

Demographic for age (N = 100)

The patients surveyed were organized into age groupings, the first group starting at age 18, the last group ending with ages 50 years and above. Of the sample N=100, 32 (32 %) were between 18 and 29 years, 32 (32 %) were between 30 and 39, 20 (20 %) were between 40 and 49 years, while 16 (16 %) were 50 years or older. The age range of the respondents implies that, because they are all adults, it may be assumed

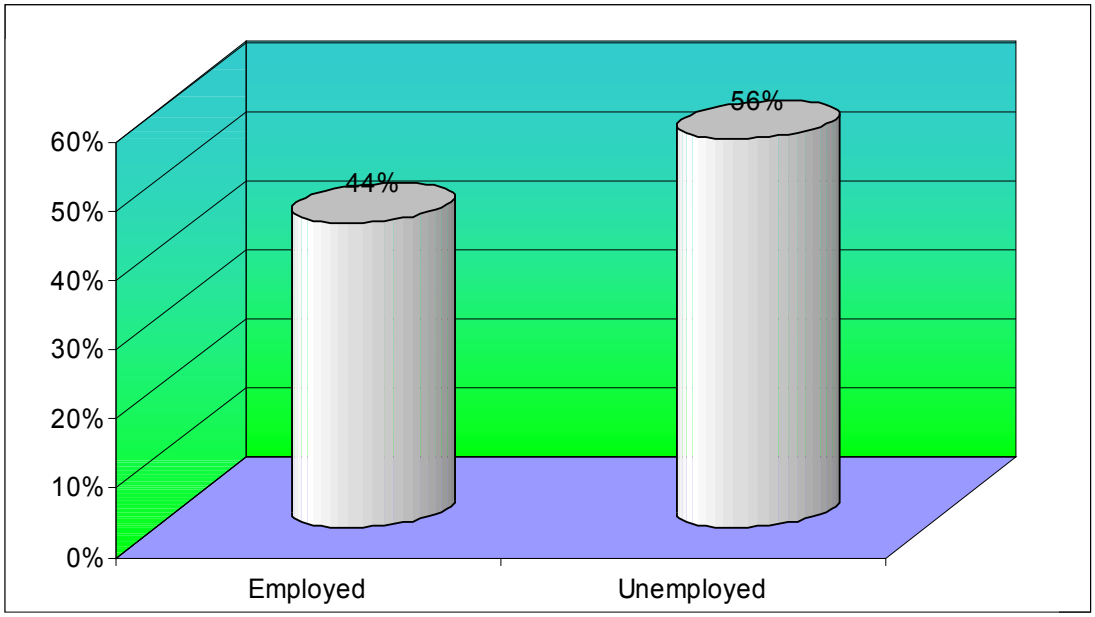
that they are mature enough to understand and respond appropriately to the information given them by nurses on admission to the surgical ward.

Figure 4.2.1 Demographic for level of education (N = 100)



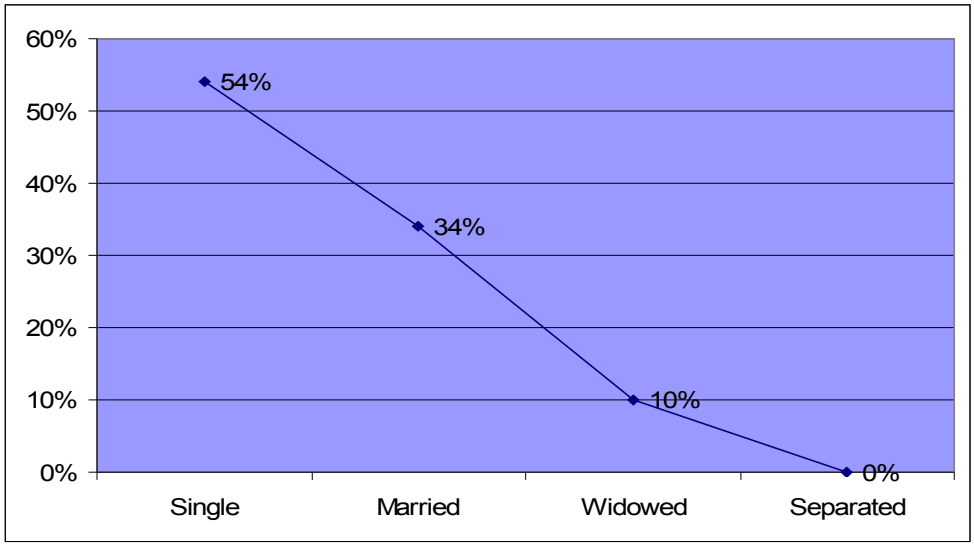
The data shows that all respondents had some education. This fact would make it easier to disseminate information on admission, particularly in written form. Of the total sample N=100, 34 (34 %) respondents had primary education, 40 (40 %) had secondary education and 26 (26 %) had tertiary education.

Figure 4.2.2 Demographic for employment status (N = 100)



Of the sample N=100, only 44 (44 %) were employed while 56 (56 %) were unemployed. This demographic had no impact on the study findings, and is recorded for the purpose of presenting a more complete profile of the respondents.

Figure 4.2.3 Demographic for marital status (N = 100)



The findings reflect that, of the sample N=100, 54 (54 %) were single, 34 (34 %) were married, 10 (10 %) were widowed and none separated. This demographic also had no impact on the study findings, and is recorded for the purpose of presenting a more complete profile of the respondents.

Instrument B (Section A)

Nurses

Analysis of demographic data of all respondents (nurses) is as follows N=10.

Gender (N = 10)

Only one nurse (10 %) from the sample N=10, was a male and 9 (90 %) were female. Traditionally in Namibia, nursing has been regarded as a woman's profession, not appropriate or suitable for men. This demographic may simply be a reflection of that cultural prejudice.

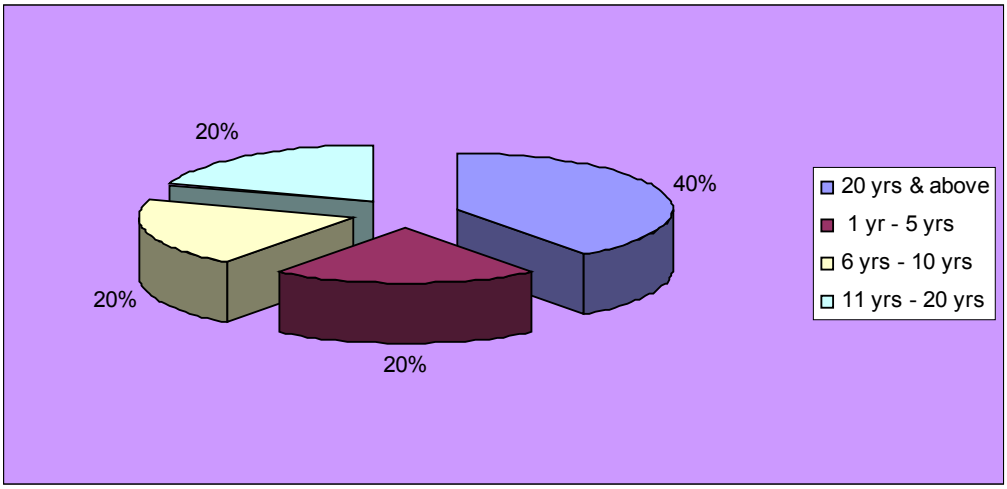
Demographic for age (N = 10)

Data analysis shows that, of the sample N=10, 1 (10 %) was between 23 and 29 years, 6 (60 %) were between 30 and 39, 1 (10 %) was between 40 and 49, whereas 2 (20 %) were 50 or older. The span of ages for the nurses reflects maturity. It is reasonable to expect this group to be responsible enough to disseminate information to patients under their care on admission.

Rank of participants (N = 10)

The findings reflect that, 1 (10 %) was a principal registered nurse, 2 (20 %) were senior registered nurses and 17 (70 %) were registered nurses. This simply indicates that these respondents are responsible people who, as leaders, should ensure that patients are well-informed at all times.

Figure 4.2.4 Years of nursing experience (N = 10)



The nursing experience of the registered nurses surveyed ranged from one to 20 years and above. Of the total sample N=10, 2 (20 %) of the registered nurses have between 1 and 5 years of nursing experience, 2 (20 %) nurses have 6-10 years of nursing experience, 2 (20 %) nurses have 11-20 years of nursing experience and 4 (40 %) nurses have 20 years or more nursing experience. The findings show that the majority of the registered nurses surveyed have 20 or more years' experience. These nurses certainly possess the knowledge and have extensive experience imparting information to patients on admission.

Table 4.2.1 Number of years nursing experience in surgical ward

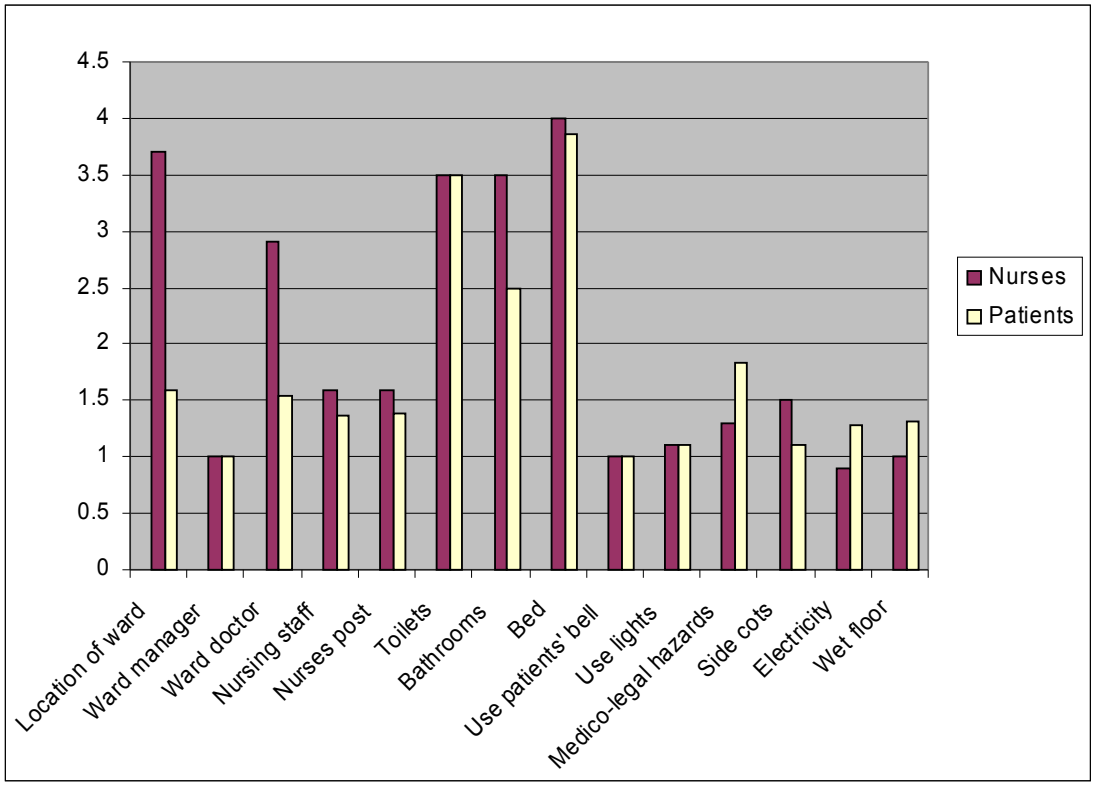
NUMBER OF YEARS IN SURGICAL WARD	NUMBER OF NURSES	PERCENTAGES (%)
Less than 1 year	2	20
1-5 years	3	30
6-10 years	2	20
11-20 years	2	20
20 years and above	1	10

The registered nurses surveyed had nursing experience in surgical wards for periods of time between less than one year to 20 years and above. The data indicates that 3 (30 %) nurses had 1-5 years of nursing experience in surgical wards, 2 (20 %) had 6-10 years of experience, 2 (20 %) had 11-20 years of experience, and only 1 (10 %) nurse had 20 years experience in surgical wards. The findings show that only 2 (20%) registered nurses had less than one year nursing experience in surgical wards and this lack of experience could have an impact on their ability, or on the quality of information they would provide to surgical patients on admission. The majority of registered nurses have between 1 and 20 nursing experience in surgical wards. Having worked in surgical wards for a long period of time could mean that a registered nurse has more knowledge of and more experience in communicating with all kinds of patients admitted in surgical wards.

SECTION B

Data was analysed according to the formula explained in Chapter 3.

Figure 4.2.5 Orientation of patients in surgical wards



Item (i) orientation in the ward

The questions that were posed to patients, 100 (100 %), about information received, and to nurses, 10 (100 %), about information imparted, regarding orientation in the ward on admission captured 14 items. The first item asked whether patients were shown the location of the ward. On a scale rating responses from 1 to 4 (never to very often) a rating of 1.6 was obtained from patients and a rating of 3.7 from registered nurses. This result implies that while patients believe they were not shown the location of the ward, registered nurses believe that they do impart this information to the patients. Cole (1996, p. 25) indicates that admission to a hospital is an experience that creates anxiety in most patients. For this reason, measures should be taken by nurses to eliminate elements that cause anxiety in their patients

unnecessarily and to make effort to establish a natural and trusting nurse-patient relationship. According to Perry and Potter (1999) and Cole (1996) patients are more at ease after orientation to the ward. Being more relaxed, they will adjust better to their new environment.

On the question whether patients are introduced to the ward manager, the same response was received from both groups of respondents, indicating that the nurse manager was never introduced to patients (on a scale of 1-4, a rating of 1.0 was obtained). According to Kozier, Erb, Blais, Johnson and Tample (1993, p. 106), on admission a patient should be told the name of the nurse-in-charge of the ward, and also should be told the nurse-in-charge's role. Knowing the name of the nurse-in-charge and his/her problem-solving role helps the patient feel more secure and introduces another person to whom the patient can communicate their problems.

On the question whether patients are introduced to the ward doctor, it was found that patients are not always introduced to a ward doctor. A rating of 1.54 was obtained from patients (almost never) and 2.9 for registered nurses (sometimes to often), both on a scale of 1- 4.

From responses of both groups, it was evident that patients are shown the location of toilets and bathrooms. A rating of 3.16 from patients and 3.5 from registered nurses were calculated for "showing location of the toilets", while a rating of 2.5 for patients and 3.5 for nurses were calculated for "showing location of bathrooms", on a

scale of 1-4. The environment of a hospital is very different from a patient's home. Unfamiliar sights, sounds and odors may make patient feel uncomfortable (Cole, 1996, p. 26).

To the question whether patients are introduced to the nursing staff and shown the nursing post, the following ratings, on a scale of 1-4, were obtained:

Introduction to nursing staff – 1.36 (patients), 1.6 (nurses)

Showing the nursing post – 1.39 (patients), 1.6 (nurses).

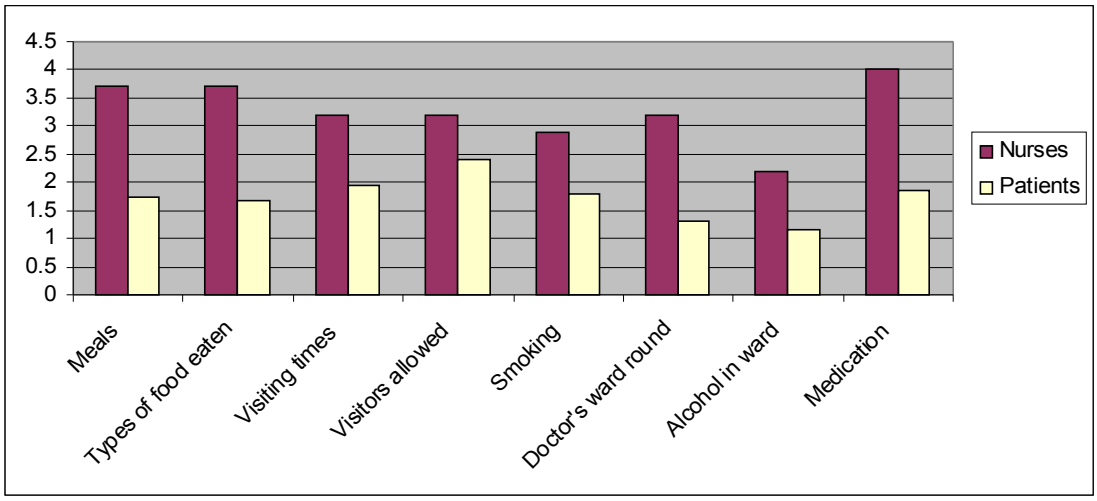
Introducing staff members to patients facilitates their adjustment to the hospital and also helps the patient to recognize caregivers. Cole (1996, p. 85) added that the newly admitted patient should know where the nurses' station is relative to his/her own room and should know how to call a nurse from either his bed or the bathroom. Bolander (1994, p. 38) also agrees that on admission, the patient should be orientated and fully informed about his/her own room, the nursing station, or the individual care unit, as applicable.

Patients indicated that they are shown their beds (rating 3.86) and side cots (1.2), while nurses indicated they always show patients their beds (rating 4.0) but almost never the side cots (rating 1.5). Although patients are shown their beds and informed about side cots by nurses, the use of a patient's bell is not communicated, because the facility is simply not provided at Oshakati Hospital. Concerning instructions on

how to operate room lighting facilities, patients indicated they were almost never instructed, (rating of 1.2), while nurses rated themselves even lower (1.1), on a scale of 1-4. According to Cole (1996, p. 85) and Pottery and Perry (1999) admission procedures should always include orientation to hospital bed, call light system and intercom use. It is very important for a nurse to orientate a patient on the operation of equipment in the room, including hospital bed, call light and emergency button. If the orientation is thorough, the patient will feel confident to use that equipment.

On a scale of 1-4, patients gave the following ratings regarding the information they received from nurses: 1.7 on medico-legal hazards, 1.3 regarding electrical outlets and 1.3 on wet floors. The nurses gave themselves even lower scores than the patients: 1.3 on medico-legal hazards, 0.9 on electricity and only 1 on wet floors! A nurse should provide all this information to patients on admission. Possessing this knowledge will help to decrease a patient's anxiety, ensure their safety, and decrease the risk of complications (Perry & Potter, 2002, p. 959).

Figure 4.2.6 Information on policies and procedures of the surgical ward



Item (ii) Policies and procedures of the surgical ward

Questions that were posed to patients, 100 (100 %), about information received, and to nurses, 10 (100 %), about information imparted, regarding policies and procedures of the surgical ward on admission covered eight items. On a scale of 1-4 (never to almost always), the following were indicated:

Meals in the ward – 1.72 (patients), 3.7 (nurses)

Types of food served – 1.66 (patients), 3.7 (nurses)

Regarding visiting times and when visitors are allowed in the ward:

Visiting times – 1.94 (patients), 3.2 (nurses)

When visitors are allowed to visit – 2.4 (patients), 3.2 (nurses)

Regarding when doctors make ward rounds, as indicated in Figure 4.2.6:

1.32 (patients), 3.2 (nurses)

Information about hospital policies and procedures is so important to patients because the significant emotional and physical stress they experience on admission can be alleviated by knowing how the running of the hospital affects them personally (Kozier, Erb, Blais, Johnson & Tample, 1993, p. 106).

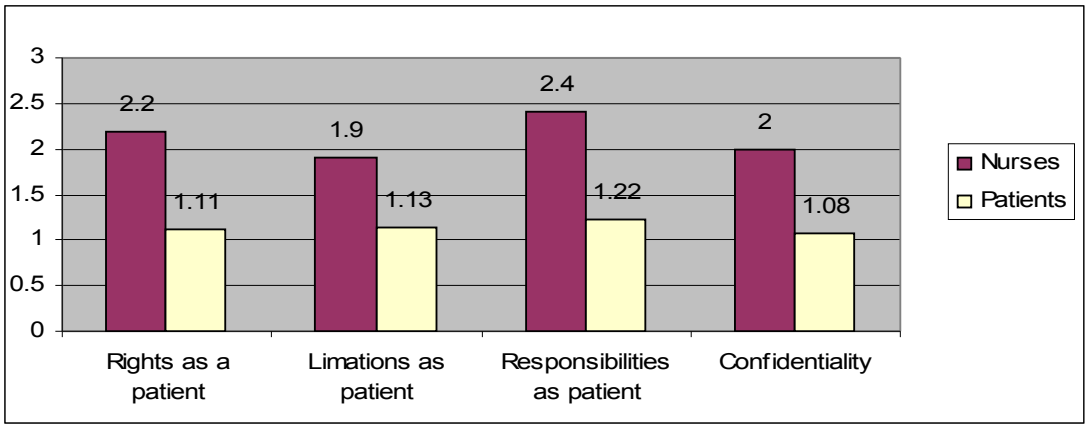
As indicated in Figure 4.2.6, policies regarding the use of alcohol in the ward as well as information regarding any and all medication, patients indicated they are given information on admission and nurses indicated they supplied that information as follows:

Alcohol in the ward – 1.2 (patients), 2.2 (nurses)
Medication (brought from outside) – 1.9 (patients), 4.0 (nurses)

Patients admitted to a hospital to undergo surgery usually are given extensive pre-operative care before their procedure (Perry & Potter, 1999, p. 1147). It is therefore important that information given the patient should include the type of treatment or medications they will receive in the hospital (such as enemas or laxatives), as well as

any restrictions on medication brought in from outside, if any are permitted on the morning of surgery (Perry & Potter, 1999, p. 960).

Figure 4.2.7 Information on patients' rights



Item (iii) Information on surgical patients' rights

As is clearly indicated in table 4.3, patients are very poorly informed about their rights as patients, about their responsibilities as patients, about limitations imposed upon them and about the right of confidentiality. On a scale ranging from 1-4 (not informed to well informed), the following levels of awareness were registered by patients themselves:

Rights of a patient – 1.11

Limitations as a patient – 1.13

Responsibilities of a patient – 1.22

Right of confidentiality – 1.08

In contrast, the nurses believed they had given information to patients on these subjects when they were admitted as follows:

Rights of a patient – 2.2

Limitations as a patient – 1.9

Responsibilities of a patient – 2.4

Right of confidentiality – 2.0

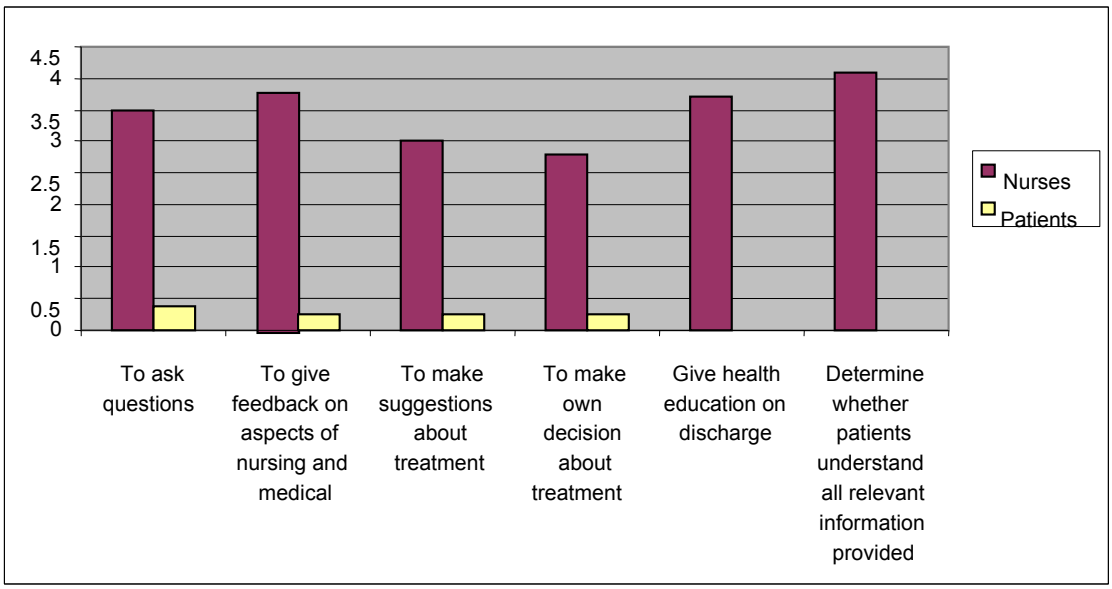
Perry and Potter (1999, p. 124) say that a caring nurse can relieve some of a patient's anxiety by explaining to them what rights they enjoy. Such explanation helps a patient feel more comfortable and in control. Therefore, a patient should receive information regarding the patient's bill of rights, describing the right to be well informed and to receive respectful, competent, continuous, and confidential health care (Pottery & Perry, 1999, p. 124). The education of nurses regarding ethnics, professional practice, methodology and standards of nursing focuses on the rights of patients (Pera & Van Tonder, 1996, p. 180).

Besides the right to health as a human being, a patient has the right to health care. The nurse continues to be the most important protector of patients' rights. (Young, Van Niekerk & Mogotlane, 2003, p. 68). Pottery and Perry (1995, p. 44) have made it clear that a hospital is responsible for informing patients of their legal rights at admission. Every patient who visits facilities under the Ministry of Health and Social Services in Namibia has the right of access to information. Providing

information to patients is part of the primary heath care strategy, and is an ethical obligation of all health care practitioners.

The Ministry of Health and Social Services has developed the patient charter of Namibia to inform and create awareness among both users and service providers on issues that will ensure a steady improvement of services rendered by the health care industry (MOHSS, 1998, p. I). According to the patient charter of Namibia all patients have rights to access to information and to be given detailed information on the health and social welfare services.

Figure 4.2.8 Encouragement given by nurses to surgical patients



Item (iv) Encouragement to participate in health care

Patients indicated that they were inadequately encouraged to participate in their own treatment because they were not informed about the following aspects of participation, based on a rating scale of 1-4 (not informed to well informed):

To ask questions – 0.38

To give feedback on aspects of nursing and medical care – 1.0

To make suggestions about treatment – 0.25

To take own risk (make own decision) about treatment – 0.25

Also referring to Figure 4.2.8, the registered nurses, in contrast to the patients, believed they had done well to encourage patients on admission about those and two additional aspects:

To ask questions – 3.5

To give feedback on aspects of nursing and medical care – 3.6

To make suggestions about treatment – 3.0

To take own risk (make own decision) about treatment – 2.8

In addition to items patients were asked to rate, nurses also indicated that they gave health education to patients on discharge, (a rating of 3.7) and asked patients whether they understood all relevant information that had been provided to them (a rating of

4.1). For nurses to be capable of encouraging patients to participate in their own treatment by asking questions, giving feedback on aspects of nursing and medical care, making suggestions about treatment and taking risks themselves, nurses need to be skilled listeners. Beyond being able to listen, nurses need to be adept in the art of conversation with patients. This skill involves encouraging patients to communicate, knowing how to question a patient, being able to respond appropriately to patient comments and questions, and being able to impart information. For nurses to prepare an appropriate nursing care plan, they must know how to elicit information from their patients about the status of their health (Quinn, 2000, p. 174). Beyond this, encouraging patients to talk about their concerns and anxieties is a key function of every nurse.

Figure 4.2.9 (a) Pre-operative information

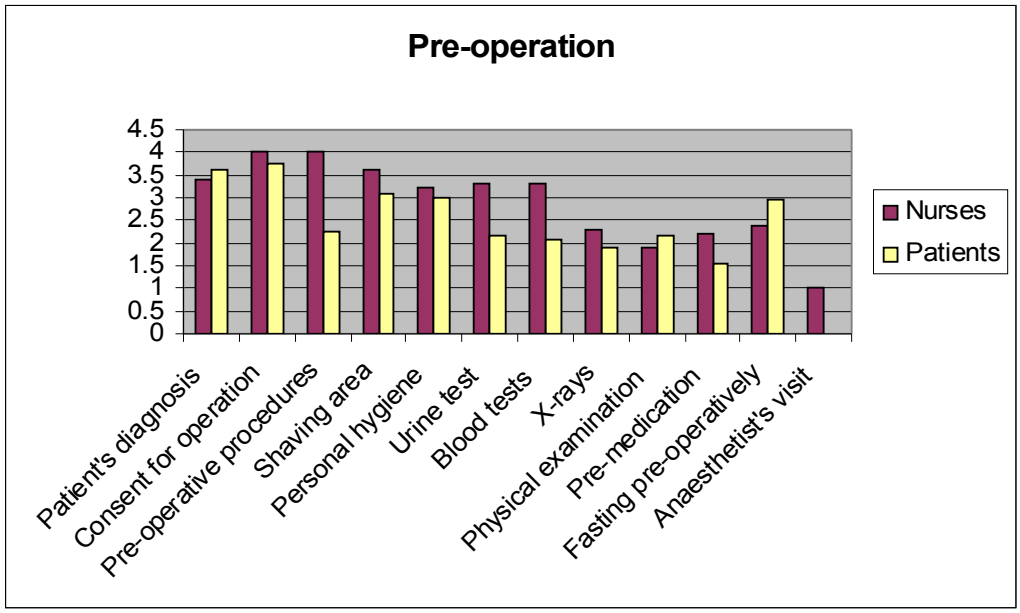
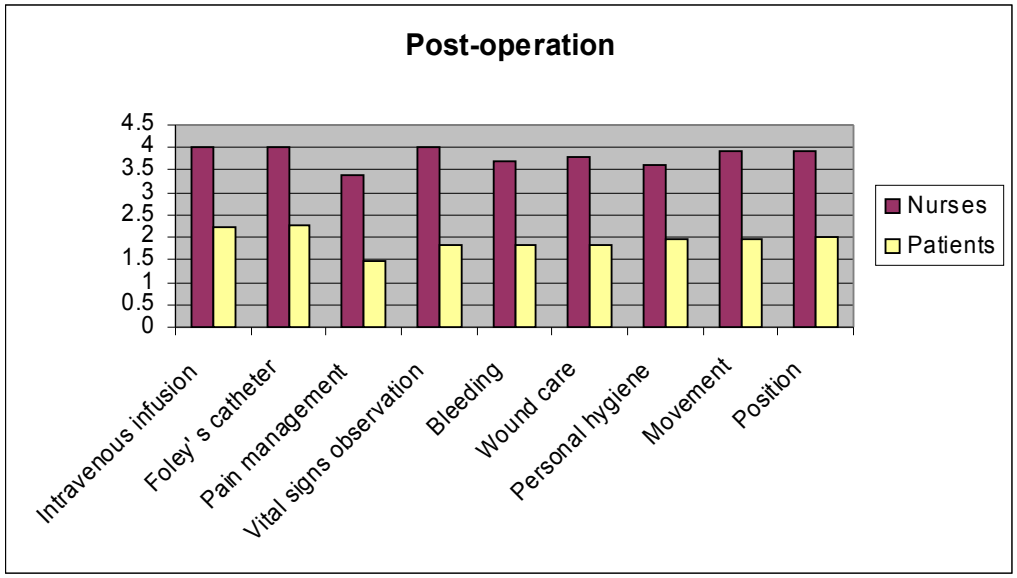


Figure 4.2.9 (b) Post-operative information



Item (v) Pre-operative and post-operative Information

Questions that were posed to patients, 100 (100 %), about information received, and to nurses, 10 (100 %), about information imparted, regarding the pre-operative and post-operative periods, at the time of admission, captured 21 items.

Figure 4.2.9 (a) indicates that none of the responding patients were given information by nurses about the visit of the anaesthetist (a rating of 1.0), while some nurses indicated they had given this information (rate 1.X).

Also referring to Figure 4.2.9 (a), the following items of information were indicated by patients and nurses:

Consent for operation – 3.74 (patients), 4.0 (nurses)

Shaving area of incision – 3.1 (patients), 3.6 (nurses)

Personal hygiene – 2.98 (patients), 3.2 (nurses).

According to patients, only a moderate amount of information on the following topics was given to them on admission, rated on a scale of 1-4:

Urine test – 2.16

Blood tests – 2.06

X-rays – 1.88

Pre-operative fasting – 2.94

Pre-operative medication – 1.56

Nurses rated themselves, imparting information to patients, on the same topics:

Urine test – 3.3

Blood tests – 3.3

X-rays – 2.3

Pre-operative fasting – 2.4

Pre-operative medication – 2.2

As displayed in Figure 4.2.9 (b), surgical patients indicated that they received even less information concerning the post-operative period. Nurses' ratings regarding the

same post-operative conditions contradicted the patients' assessments considerably, as shown below (on a scale of 1-4):

Bleeding – 1.82 (patients), 3.7 (nurses)

Wound care – 1.82 (patients), 3.8 (nurses)

Vital signs observation – 1.82 (patients), 4.0 (nurses)

Pain management – 1.46 (patients)

Movement and position – 3.9 (nurses)

Being admitted to a surgical ward to undergo surgery is a time of anxiety for patients. They are naturally very concerned about their health problems, or potential problems, and the outcome of their treatment. The patient's first contact with nurses and other health care workers is critical because at that time anxiety and fear can be assuaged and progress toward instilling a positive attitude regarding their care can be initiated (Cole, 1996, p. 25). Kozier, Erb, and Bufalino (1998, p.71) say that patients have the right to be treated with consideration and respect, which rights include that they are entitled to receive information about what will happen to them, why and when. Understanding will increase their willingness to comply and strengthen their faith that staff are treating as an intelligent individual (Faulkner, 1996, p. 360). The nursing objective during pre-operative interpersonal communication is to eliminate or minimize anxiety related to the impending procedure and to the post-operative period (Tompson, McFarland, Hirsch & Tucker, 2002, p.338). Thus, adequate

explanation concerning their condition before surgery and what they can expect after surgery will help prevent distress (Faulkner, 1996, p. 361).

Young, Van Niekerk and Motgale (2003, p. 663) list the following information that should be given to patients about the pre- and post-operative periods:

- Information regarding diagnosis, prognosis, treatment and nursing care.
- Detailed explanations of every diagnostic test, treatment, procedure, operation and possible consequences, so that the patient's informed consent is possible.
- Information regarding the possible consequences of refusing to grant permission for treatment/examination.

Alexander, Fawcett and Runciman (2002) state that nurses must give patients information about care of the surgical wound and about analgesics for pain, in order to decrease the patient's anxiety. By providing thorough pre- and post-operative information to patients on admission, their anxiety will be ameliorated and a sense of security will be enhanced (Cole, 1996, p. 25).

On the matter of strategies that could be employed to improve interpersonal communication between nurses and surgical patients on admission, the following recommendations were made by patients. The majority of patients (66 %) suggested that information should be provided in writing and be displayed on the wall or door of their rooms. Other patients (34 %) suggested that nurses could give them some

information, like a general orientation on the ward at the time of admission and to impart other important information on the following day.

Nurses made the following suggestions:

- Increase nursing staff.
- Employ a ward clerk to assist with paper work.
- Initiate the communication of information in the consulting rooms and continue in the ward.
- Provide rooms for privacy.
- Provide a separate area for admissions.
- Prepare booklets, that contain all the information that should be shared, and provide them to each and every patient on admission.
- Prepare informational sheets that can be posted on the wall in each room.
- Nurses are urged to give patients information on admission.

4.3 **SUMMARY**

In this chapter, the collected research data was analysed and discussed in depth. Data was organised in groups and figures and tables were used to present findings.

CHAPTER 5

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

5.1 INTRODUCTION

The previous chapter analysed and discussed the collected data of the study. This chapter focuses on the conclusions, recommendations and limitations inherent in this study.

The aim of the study was to explore and describe the interpersonal communication that takes place between nurses and surgical patients on admission. Based on the findings of the study, conclusions and recommendations will be made. Limitations of the study will also be identified.

5.2 CONCLUSIONS

Based on the findings, the following conclusions were drawn relative to the objectives of the study.

OBJECTIVE 1

5.2.1 To record personal information of respondents (demographic data)

The surgical patients surveyed included both men and women who differed widely in regards to age, level of education, employment status and marital status. Concerning the registered nurses who participated in the survey, it was noted that they also differed in age, gender, rank, years of general nursing experience and years of nursing experience specifically in surgical wards.

OBJECTIVE 2

5.2.2 To determine what information is provided by nurses to surgical patients on admission (Orientation, policies in the ward and rights of patients)

The information that patients should receive was grouped in the following categories:

- Orientation to the ward
- Policies and procedures of the surgical ward
- Rights of the patient

It was noted that, although registered nurses claimed that they provided orientation for patients to the ward environment, patients' responses indicate that orientation was lacking or insufficient. An exception was noted in some items of orientation, namely: introduction to the ward manager, and instruction on how to use room lighting. It is very important for patients to be introduced to the ward manager and to know what his or her role is. Kozier, Erb, Blais, Johnson and Tample (1993, p. 110) also indicate that a patient must be told the name of the nurse in charge of the ward when admitted, and know his/her problem solving role. Possessing this information helps a patient feel more secure and introduces another staff member to whom the patient can communicate problems.

Information on the use of a patient bell is not relevant at Oshakati Hospital because this facility is not provided. Cole (1997) states that new patients should be given orientation on how to adjust the bed and room lights. This orientation is important because the ward environment, being very different from a patient's familiar surroundings, can be a threatening place to the patient. Kozier, et. al. (1993, p. 110) also indicate that nurses should explain and demonstrate the use of equipment in the room, specifically overhead room lighting and night light.

Findings of the study also revealed that, from the patients' perspective, nurses do not provide surgical patients enough general information on admission. Nurses are aware of the importance and necessity of doing this and they also know what kinds of information should be provided on admission (see data analysis of Figures 4.2.5 to 4.2.9 (b)).

In nurses' training, instruction concerning ethics, professionalism, methodology and standards focuses on the rights of patients (Pera & Van Tonder, 1996, p. 180). Nurses, therefore have no excuse for failing to impart important information to patients on admission.

Cole (1996) also states that nurses must orientate patients to the hospital in order to put them at ease, since they are usually anxious. Faulkner (1996, 353) confirms this by pointing out that nurses are part of patients' new and unfamiliar experience and therefore their interaction on admission is most important. When a patient enters a ward for the first time, he/she has a natural need for social interaction, i.e. the exchange of greetings and introductions to staff, who are strangers to them. Patients often complain that they are abruptly taken to a bed and left without the exchange of greetings or explanations, and such treatment is certainly bound to raise their anxiety levels (Faulkner, 1996, p. 353).

OBJECTIVE 3

5.2.3 To determine whether patients participate in their nursing care through being encouraged to pose questions or make suggestions

If it is important that patients participate in their own health care, they need to understand the information that is communicated to them. It was concluded from an analysis of the survey that patients felt they were poorly encouraged to participate in their care. This finding is indicated in Figure 4.2.8 nurses, on the other hand,

indicated that they do encourage patients to ask questions, to give suggestions about their treatment, and to take their own decisions about treatment. This discrepancy simply indicates that a gap or breakdown in, interpersonal communication exists. Successful interpersonal communication depends on a nurse listening to patients' questions, suggestions, concerns and fears. A nurse needs to keep in mind that patients have the right to participate in decisions that influence their life and health (Dickson, Hargie & Morrow, 1997, p. 220).

OBJECTIVE 4

5.2.4 To determine whether patients are informed about pre-operative and post-operative aspects of the procedure they are to undergo

An analysis of Figure 4.2.9, revealed that, although registered nurses indicated that they do inform patients about the pre- and post-operative aspects of their treatment, patients feel they are not given enough information about the pre- and post-operative aspects. According to Mitshel's uncertainty illness theory (1988), people develop subjective appraisals of meaning in order to interpret the experience of illness and treatment. In surgical wards, feeling insecure causes patients to associate surgery with pain, disfigurement, dependence and perhaps even loss of life (Potter & Perry, 1999, p. 1079). In light of Mitshel's theory, at the time of admission, patients experience feelings of powerless, anxiety and fear of the unknown due to personal uncertainty, which in turn is caused by having too little information at this time. Measures should be taken by nurses to ensure patients' comfort and to reduce their

feeling of uncertainty by providing appropriate and through information on pre- and post-operative aspects of treatment.

In order to influence a patient's natural, health-seeking behaviors, sufficient pre- and post-operative information must be given fully at the time of admission. The well-informed patient knows what they should expect throughout the preoperative period and will consequently participate more fully in the interventions designed to speed postoperative recovery (Bolander, 1994, p. 1421). Ignatavicius, Workman and Mishler (1999, p. 318) and Smeltzer and Bare (2000, p. 323) further state that effective pre-operative instruction improves an individual's coping skills by enhancing a sense of personal control and helps to reduce post-operative anxiety and discomfort. Furthermore Faulkner (1996, p. 359) adds that no assumptions should be made about a patient's understanding of his or her operation. Therefore, patients should be informed about the time they are going to theatre, the details of necessary preparations and what they can expect after coming out of anaesthesia.

Pearse's (1992) theory of "human becoming" views a human being as an open system, free to choose from among a series of options that give meaning to a situation (George, 1995, p. 336). In light of this theory, nurses have to encourage patients to share their thoughts and feelings about the operation they are about to undergo.

OBJECTIVE 5

5.2.5 Strategies that could be employed to improve the communication of information to surgical patients on admission

To improve interpersonal communication between nurses and surgical patients at the time of admission, the following suggestions were offered by registered nurses who participated in the study:

- Increase the size of the nursing staff.
- Employ a ward clerk to assist with paper work.
- Provide a privacy room for staff.
- Set aside a separate area for admissions at the hospital.
- Provide booklets, that contain all the information that should be shared, to every patient on admission.
- Post printed information on the wall or door of each room.
- Initiate the communication of information in consulting rooms and continue the process in the ward.

These recommendations are supported in the following references:

Cole (1996) mention that the admission procedure generally begins in the admitting department were a clerk gathers information to open a patient's record.

Perry and Potter (1999, p. 123) write about admitting officers, secretaries and technicians, personnel who are involved with the preliminary procedures for admitting clients into an agency.

Perry and Potter (2002, p. 4) add that the role of the admitting clerk or secretary includes specific activities such as initiating and maintaining a professional relationship with the patient, providing for the patient's safety and the patient's rights. Each of these activities is an essential and important part of the admission process (Perry & Potter, 2002, p. 3).

Furthermore, Potter and Perry (1999, p. 123) and Ignatavicius, Workman and Mishler (1999, p. 317) state that a hospital, according to state law, must give clients written information about their rights to make personal decisions regarding their medical care, including the rights to accept or refuse treatment.

Potter and Perry (1999, p. 123) and Ignatavicius, Workman and Mishler (1999, p. 317) also state that the client or family should receive a brochure explaining available services, visiting hours, meal schedule, smoking policies and other policies or rules that affect a client.

5.3 RECOMMENDATIONS

The following recommendations are made based on analysed and discussed data:

5.3.1 Employment of a ward clerk at Oshakati Hospital

It is hereby recommended that the Ministry of Health and Social Services be approached to employ a ward clerk or assistant to help patients complete the necessary forms at admission at Oshakati Hospital. The ward clerk should type the information and print a copy for patients to read afterwards.

To submit this recommendation, hospital management of Oshakati hospital need to write a motivation to the Ministry of Health and Social Services to have a ward clerk included in the staff establishment section of their annual plan and budget.

5.3.2 Information booklets or information sheets

It is hereby recommended that the Ministry of Health and Social Services be approached to prepare booklets containing important information patients need at the time of admission to the hospital.

- Information should be typed and printed in booklet form, or as leaflets or posters, that can be given to patients on admission.
- Booklets, leaflets and posters should be translated into other languages to make the information accessible to as many people as possible.
- Patients should be encouraged to ask nurses and other health workers to explain printed information they receive, and to request any information they feel they are lacking.

Nurses and doctors from surgical wards should be enlisted to assist in the preparation of information to be included in booklets or printed sheets. The Information, Education and Communication unit (IEC) could be given the task to enter the information electronically and to organize printing of the materials. Before printing, however, these materials should be seen and reviewed by a number of patients and nurses to determine how effective they are in communicating the information therein.

5.3.3 Strictly observed ward orientation

Nurses are urged to orientate patients to the ward on admission, if their condition will allow it. When ward supervisors do their daily rounds, they should check whether new patients have received a ward orientation.

It is essential that nurses orient patients to the hospital in order to relieve their natural anxiety and to put them at ease (Cole 1996). Furthermore, a system of room bells should be installed at the hospital so that patients can alert staff if they are in need.

Kozier, et. al. (1993, p. 110) indicate that the following information should be provided to patients on their admission to the ward:

- Greet the client in a manner that conveys interest and concern.
- Orient the client to the unit.
- Inform the client about admission procedures, and begin the procedure.

- Instruct the client about any specimens required and tests or treatment ordered by the physician.

By providing adequate and thorough information on admission to surgical patients, their anxiety can be alleviated and a sense of security begin to form (Cole, 1996).

5.3.4 In-service education sessions for nurses

It is hereby recommended that in-service education sessions for nurses be provided on a regular basis on the following subjects:

i) Information that should be shared with patients on admission, to include the following features:

- Physical orientation to the ward
- Procedures of the ward

  The patient needs to be informed about meal times and his/her special nourishment requirements. If a patient is placed on a special diet, the nurse must stress the importance of diet restrictions, set either by the hospital or otherwise ordered by the physician. Policies regarding visiting hours as well as regulations limiting smoking in the ward have to be explained to a patient on admission (Kozier et. al., 1993, p. 106).
- Rights of patients

ii) The communication process, with emphasis on interpersonal communication with patients concerning all aspects of the pre- and post - operative periods.

Being able to listen to a person is an important social skill in any setting, and in nursing it is particularly vital to the effectiveness of communication. Encouraging patients to talk about their concerns and anxieties is a key function that every nurse should embrace. However, a nurse must keep in mind that patients can be easily discouraged if they feel a listener is not truly paying attention. Besides being good listeners, nurses need to be skilled in the art of conversation with patients. Such skill involves encouraging patients to communicate, to ask questions, to respond to and give information. It is important that patients share information about their health status for a nurse to be enable to plan the nursing care that is required by that particular patient (Quinn, 2000, p. 174).

Perry and Potter (1999, p. 960) added that written instructions are useful supplementary material to verbally given information because the patient or family can refer to points that are unclear or have been forgotten. For this reason, informational material relevant to a patient's treatment should be available to them well in advance of their surgery (Perry & Potter, 2002, p. 4).

5.3.5 Creating an area specifically for hospital admission

It is hereby recommended that the Ministry of Health and Social Services be approached to commission building extension or a reorganization of space at Oshakati Hospital to create an area for exclusive use for hospital admission. A separate admission area would help nurses focus more attention on the needs of patients at the time of admission and would thus facilitate better interpersonal communication with them. Such a facility would also improve the situation regarding patients' right to privacy.

5.4 LIMITATIONS OF THE STUDY

Limitations are defined as restrictions in the study that may decrease generalization of the findings (Uys & Basson 1991; Burns & Groove 2001). The fact that this study was conducted using only patients from a selected hospital in Namibia, could be regarded as a limitation, if it were argued that the sampling is not representative enough of the country's population that has undergone surgery.

Generalisation to patients in the whole of Namibia would be impossible. The study findings can only be generalized in the context of the selected hospital in which the study has been conducted. Time and financial constraints contributed to this limitation. The small sample size might be considered a limitation, though the researcher has referred to standards set by published researchers whose literature validate the sample size.

The reliability of the findings might be questioned but the researcher maintains that reliability is ensured due to the fact that the instrument was developed especially for this case by the researcher herself. Certain measures were taken to ensure reliability, namely:

- The concepts were derived from existing literature.
- The content validity was confirmed by expert nurses in the field.
- A pilot study was conducted and similar results were produced throughout the research process.
- The instrument was original and developed by the researcher.

If it were true that the respondents did not respond honestly when completing the questionnaires, then justification to doubt the findings would be established, thus creating a serious limitation. However, this researcher is of the opinion that the measures taken, a) to assure respondents that anonymity would be preserved, and b) the fact that no information from the survey could be used to identify individual respondents, are both grounds for the assumption that responses were honest. Finally, it may be maintained that, because the researcher is a well respected member of the community, a trusting relationship existed between her and the respondents, and therefore there is no reason to believe that they would falsify their responses.

5.5 SUMMARY OF THE STUDY

One of the challenges in health care today is providing patients with appropriate services. In the industry, the nurse plays a key role in helping patients adjust to the environment and conditions surrounding their care and helping them understand what can be expected from different health care providers. The nurse should guide the patient through the hospital admission process, so that he or she will be more aware of health care services and will be prepared to cope with them.

Admission to a hospital is a time of anxiety for most patients, and therefore measures should be taken to ensure their comfort and to reduce their anxiety. These are important step in establishing a natural and trusting nurse-patient relationship. By providing appropriate and thorough information to patients on admission, their anxiety will be decreased, a sense of safety and security will be engendered, and psychological well-being will be promoted.

Patients should be treated with professionalism, in a caring manner and should be addressed appropriately, to ensure that effective interpersonal communication occurs between them and their nurses. Sound interpersonal communication plays a vital role in both the promotion and the maintenance of good health. Providing thorough information to patients regarding their treatment results in more rapid recovery, may reduce their need for pain medication, as well as reduce the possibility of post-operative complications. Any of these benefits can shorten a patient's stay in hospital

and increase nurses' effectiveness through better cooperation from a patient who feels more comfortable in the unfamiliar environment.

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ANNEXURE 1

ANNEXURE 2

QUESTIONNAIRE ON INTERPERSONAL COMMUNICATION BETWEEN REGISTERED NURSES AND SURGICAL PATIENTS ON ADMISSION.

SECTION A

Personal details

Tick off the correct box:

1. Gender

Male	Female
1.	2.

2. Age

23 -29	1
30 -39	2
40 -49	3
50 and above	4

3. Rank

Principal Registered Nurse	1
Senior Registered Nurse	2
Registered Nurse	3
Senior Enrolled Nurse	4
Enrolled Nurse	5
Auxiliary Nurse	6

4. How many years of nursing experience do you have?

1 -5	1
6 -10	2
11 -20	3
20 and above	4

5. How many years of nursing experience in surgical ward?

1 year	1
1 -5	2
6 -10	3
11 -20	4
20 and above	5

SECTION B

ANSWER ALL THE QUESTIONS BY TICKING OFF IN THE CORRECT BOX. THE SCALE RANGING 1-4 IS AS FOLLOWS:

1- never
2 - sometimes
3 - often
4 - always

1. ORIENTATION TO THE WARD

1. To what extend do you give information to the surgical patient on admission on the following?

	1	2	3	4
Location of the ward				
Ward manager				
Ward doctor				
Nursing staff				
Nurses post				
Toilets				
Bathrooms				
Toilets				
Bathrooms				
Patient's bed				
Patient's bell				
Use of lights				
Medicolegal hazards				
Side cots				
Electricity				
Wet floor				

2. POLICIES AND PROCEDURES OF THE WARD

2. To what extend do you inform the patient on admission on the following?

	1	2	3	4
Meals				
Type of food eaten in the ward				
Visiting times				
Visitors allowed				
Smoking				
Doctor's ward round				
Medication in the ward				

Alcohol in the ward				

3. <u>ENCOURAGING OF PATIENTS</u>

3. To what extend do you encourage the patient on admission on the following?

	1	2	3	4
Questions from patients				
General feedback				
Suggestions about treatment				
Own decision making on treatment				

4. <u>PATIENTS' RIGHTS</u>

4. To what extend do you inform the patient on admission on their rights?

	1	2	3	4
Patient's rights as a patient				
Limitations as a patient				
Responsibilities as a patient				
Confidentiality				

5. <u>PRE-OPERATION AND POST-OPERATION INFORMATION.</u>

5. To what extend do you give information to the patient on admission on the following pre- and post-operation aspects?

Pre-operation	1	2	3	4
Consent for operation				
Pre-operation procedures				
Shaving specific area				
Personal hygiene				
Urine testing				
Blood tests				
X-rays				
Physical examination				
Pre-medication				
Fasting pre-operation				
Anesthetist's visit				
Diagnosis				

Post-operation	1	2	3	4
Intravenous infusion				
Foleys catheter				
Pain management				
Vital signs observation				
Bleeding				
Wound care				
Personal hygiene				
Movement				
Positions				

WHAT STRATEGIES CAN BE EMPLOYED TO IMPROVE THE INTERPERSONAL COMMUNICATION BETWEEN NURSES AND SURGICAL PATIENTS ON ADMISSION?

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QUESTIONNAIRE ON INTERPERSONAL COMMUNICATION BETWEEN REGISTERED NURSES AND SURGICAL PATIENTS ON ADMISSION.

SECTION A

Personal details

Tick off in the correct box:

1. Gender

Male	Female
1.	2.

2. Age

18 – 29	1.
30 – 39	2.
40 – 49	3.
50 and above	4.

3. Level of education

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

4. Employment status

Employed	1.
Unemployed	2.

5. Marital status

Single	1.
Married	2.
Widowed	3.
Separated	4.

SECTION B

ANSWER ALL THE QUESTIONS BY TICKING OFF IN THE CORRECT BOX. THE SCALE RANGING 1-4 IS AS FOLLOWS:
1- never
2 - sometimes
3 - often
4 - always

1. ORIENTATION TO THE WARD

1. To what extend were you orientated by nurses on admission on the following?

	1	2	3	4
Location of the ward				
Ward manager				
Nursing staff				
Nurses post				
Toilets				
Bathrooms				
Toilets				
Bathrooms				
Patient's bed				
Patient's bell				
Use of lights				
Medicolegal hazards				
Side cots				
Electricity				
Wet floor				

2. POLICIES AND PROCEDURES OF THE WARD

2. To what extend were you given information by nurses on admission on the following?

	1	2	3	4
Meals				
Type of food eaten in the ward				
Visiting times				
Visitors allowed				
Smoking				
Doctor's ward round				
Medication in the ward				
Alcohol in the ward				

3. ENCOURAGING OF PATIENTS

3. To what extend were you encouraged by nurses to:

	1	2	3	4
ask questions				
give feedback on aspects of nursing and medical care				
make suggestions about treatment				
take own decisions on treatment				

4. PATIENTS' RIGHTS

4. To what extend were you informed by nurses on admission about your rights?

	1	2	3	4
Your rights as a patient				
Limitations as a patient				
Responsibilities as a patient				
Confidentiality				

5. PRE-OPERATION AND POST-OPERATION INFORMATION.

5. To what extend were you prepared on regarding your pre- & post operative care?

Pre-operation	1	2	3	4
Informed consent				
Pre-operation procedures				
Shaving specific area				
Personal hygiene				
Urine testing				
Blood tests				
X-rays				
Physical examination				
Pre-medication				
Fasting pre-operation				
Anesthetist's visit				
Diagnosis				

Post-operation	1	2	3	4
Intravenous infusion				
Foleys catheter				
Pain management				
Vital signs observation				
Bleeding				
Wound care				
Personal hygiene				
Movement				
Positions				

6. WHAT STRATEGIES CAN BE EMPLOYED TO IMPROVE THE INTERPERSONAL COMMUNICATION BETWEEN NURSES AND SURGICAL PATIENTS ON ADMISSION?

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