

THE COMMUNICATION CHALLENGES BETWEEN NURSES AND PATIENTS IN AN URBAN EMERGENCY CENTRE IN THE WESTERN CAPE

Katriena Wilhelmina Ruiters

Student number: 3378817

Thesis submitted in fulfilment of the requirements for the Degree of Master in Nursing,
School of Nursing, Faculty of Community and Health Sciences,
University of the Western Cape

Supervisor: Professor F Daniels

Date: November 2017

ABSTRACT

Background: The perceptions of the communication, between patients and nurses in an urban emergency centre of a district hospital, were explored to identify the challenges.

Purpose: The aim of the study was to explore the challenges hindering effective communication between patients and nurses, as well as propose possible improvement strategies for effective communication.

Methodology: A qualitative, exploratory and descriptive design was applied in this study. Data was collected through in-depth interviews with patients and nurses. The analysis of the data was performed, using the inductive thematic analysis, which aligned the emerging themes, with the four principles of the Patient-Centred Communication Model (PCCM).

Findings: The research observed that patients and nurses perceived various challenges to affect the manner in which professional nurses communicated with patients in the emergency centre and overnight ward. These challenges, such as increased patient numbers and skills shortages, under which the professional nurses have to perform their patient-care duties, had a negative effect on communication.

Practice Implications: The research revealed an overwhelming need for further research of all the challenges, resource limitations, as well as staff capacity and skills that influence the communication between patients and nurses. The strengthening of the work place model PCCM, to promote a friendly, accepting and warm environment, which will contribute to the positive health outcome of the organisation, was recommended.

CONCEPTS

Access	
Choice	
Communication	
Emergency centre	
Empowerment	
Information sharing	
Patient care	
Patient satisfaction	
Respect	
Support	<u></u>
	UNIVERSITY of the
	WESTERN CAPE

LIST OF ABBREVIATIONS

EBSCO host: Elton B Stephens Company research database

EC: Emergency centre

HRM PCCM: Human Resource Management People Centred Communication Model

PCCM: People Centred Communication Model

PN: Professional nurse

TA: Transactional analysis

UWC Search: University of Western Cape Library and Information Service and

UNIVERSITY of the WESTERN CAPE

WHO: World Health Organization

iii

DECLARATION

I declare that "The communication challenges between nurses and patients in an urban emergency centre in the Western Cape" is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used, or quoted, have been indicated and acknowledged

Name: Katriena Wilhelmina Ruiters

Date: November 2017

KRintero ERSITY of the

ACKNOWLEDGEMENTS

I want to express my sincere appreciation to the following persons for their respective contributions to this dissertation:

- To my Master be the glory and honour, for granting me the opportunity, strength and courage to complete my studies.
- To Prof. F Daniels, my supervisor, who provided me with the guidance and direction to complete this thesis - I appreciate the learning experiences and the opportunities to explore my inner self.
- To Senate Research Committee of the University of the Western Cape, for granting me permission to undertake this research study.
- To the participants, for their willingness to participate in the study.
- To my colleagues and friends for their patience in listening thank you.
- To Prof. P Truter, my guardian angel, who motivated me, and through whose example, allowed me to envision the end of this journey.

UNIVERSITY of the

- To Eddi Londt for editing the manuscript.
- I would like to thank my family at large for their on-going encouragement and support. With you, I am able to live my dreams to its fullest.

DEDICATION

This dissertation is dedicated to my Master, for His passionate and unconditional love, unwavering guidance and assistance in my life.



TABLE OF CONTENTS

ABSIKACI		1
CONCEPTS		ii
LIST OF ABBREVIATIONS		iii
DECLARATION		iv
ACKNOWLEDGEMENTS		v
DEDICATION		vi
TABLE OF CONTENTS		vii
	TO THE STUDY	1
1.1. Introduction and background.		
	UNIVERSITY of the	3
	WESTERN CAPE	3
1.4. Research Purpose		3
1.5. Research objectives		3
1.6. Clarification of concepts		4
1.7. Significance of the study		5
1.8. Methodology		5
1.8.1. Research approach a	and design	6
1.8.2. Study population		6
1.8.3. Sampling		6
1.8.4. Data collection		7

1.8.4.1. Data collection instrument	
1.8.4.2. Data collection process	
1.8.5. Data analysis	
1.8.6. Rigor	
1.9. Ethics	8
1.10. Overview of the study	8
1.11. Summary	9
CHAPTER 2: LITERATURE REVIEW	10
2.1. Introduction	10
2.2. Selecting and reviewing of the literature	
2.3 Presentation of the literature	11
2.3.1. Communication in healthcare	11
2.3.2. Communication and patient satisfaction	15
2.3.3. Communication and staff satisfaction	19
2.3.4. Conceptual framework	21
2.3.5. Patient-centeredness	21
2.3.6. Model of Communication	25
2.4. Summary	27
CHAPTER 3: RESEARCH METHODOLOGY	28
3.1. Introduction	28
2.2. Descared approach and design	20

3.3. Research setting
3.4 Study population30
3.4.1. Professional nurses30
3.4.2. Patients30
3.5. Sampling30
3.5.1. Professional nurses31
3.5.2. Patients31
3.5.3. Inclusion criteria32
3.5.4. Exclusion criteria
3.6. Data collection32
3.6.1. Data collection method
3.6.2. Data collection instrument
3.6.3. Data collection process
3.7. Data Analysis and Interpretation
3.7.1. Process of data analysis36
3.8. Rigor36
3.8.1. Trustworthiness
3.8.1.1. Credibility
3.8.1.2. Transferability37
3.8.1.3. Confirmability
3.8.1.4. Dependability

3.8.2. Reflexivity
3.9. Ethics
3.10. Summary40
CHAPTER 4: RESULTS AND DISCUSSION4
4.1. Introduction
4.2. Results from the interviews with patients
4.3. Results from the interviews with professional nurses
4.4. Discussion
4.4.1. Principle 1: Respect44
4.4.1.1. Theme 1: Nurses' attitude was viewed as positive by both patients and professional nurses
4.4.2. Principle 2: Choice and Empowerment
4.4.2.1. Theme 2: Both patients and professional nurses felt that patients were allowed to make informed decisions about their health and health care55
4.4.3. Principle 3: Access and Support62
4.4.3.1. Theme 3: Both patients and professional nurses viewed nurse-patient relationships as positive and reported that patients were satisfied with the waiting time and the care they received
4.4.4. Principle 4: Information sharing69
4.4.4.1. Theme 4: Nurses were viewed as having good communication skills and a positive level of communication with patients
4.5. Summary80
CHAPTER 5: SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION81
5.1. Introduction

5.2. Summary	81
5.3. Limitations of the study	82
5.4. Recommendations	83
5.4.1. Recommendations for nursing practice	83
5.4.2. Recommendations for education	83
5.4.3. Recommendations for policy development	84
5.4.4. Recommendations for further research	84
5.5. Conclusion	84
REFERENCES	85
A-Z	
ANNEXURES	108
Annexure A: Patient centred care: ILMC Task Team Initiative	108
WESTERN CAPE Annexure B: In-depth interview guide for professional nurses and patients	111
Annexure C: Permission letter: consent to conduct research	112
Annexure D: Permission letter: consent to conduct research	115
Annexure E: Participant information sheet	118
Annexure F: Informed consent	122
Annexure G: Approval by Provincial Health Research Committee	123
Annexure H: The transcript of participant	124
Annexure I: Ethics clearance letter	138
Annexure J: Editorial certificate	139

LIST OF TABLES

Table 4.1: Patients themes and categories	42
Table 4.2: Professional nurses themes and categories	43
Table 4.3 : Horizontal themes that cut across patient and professional nurses vertice themes44	al



CHAPTER ONE

ORIENTATION TO THE STUDY

1.1. Introduction and background

Nurses are confronted daily with high workloads, due to high patient numbers and the nature of the health care environment (MacPhee, Dahinten & Havaei, 2017). Nurses are expected to meet the demands, concerns and expectations of patients, by delivering an exceptional service in emergency centres (Republic of South Africa [RSA], Western Cape Government, Department of Health, 2013). To assist in the delivery of quality healthcare in the emergency centres, the Western Cape Department of Health developed a document entitled, Circular H44 (Republic of South Africa [RSA], Western Cape Government, Department of Health, 2014), to standardise the processes of the emergency centres in the Western Cape, in order to improve the access to care, as well as the quality of care.

Slade, Manidis, McGregor, Scheeres, Chandler, Stein-Parbury, Dunston, Herke & Matthiessen (2015) refer to mounting evidence of pressures, regarding communication in high-stress areas, such as hospital emergency centres. In addition, emergency centres have a high volume of patients on a daily basis (RSA, Western Cape Government, Department of Health, 2013), and nurses on the frontline are confronted with patients, who have high levels of expectations for patient care delivery. Besides these demands to deal with the needs of patients at all levels, nurses have to face, and deal with their own needs, as well as the demands of their profession, which may cause stress and burnout, and, ultimately, affect the delivery of patient care.

The public concerns that are raised daily, as well as the subsequent investigations into incidents, and reports about patient care delivery and communication in the hospital emergency centres, motivated Human Resource Management (HRM) to develop a People Centred Communication Model (PCCM) that would promote a people-centred approach, increase the professionalism of the organisation, and improve the communication between staff and patients (Annexure A).

The researcher is of the opinion that nurses should be motivated to impact the patients' experience of using the service, through communication, as well as creating a friendly environment, where they can take pride in the services that are offered. The challenges, regarding patient care in the complex and highly pressurised service sector as the emergency centre, are becoming increasingly difficult, and has developed into a contested public outcry (Korsha, 2011). The nature of the interpersonal relationships between nurses and patients, as well as its effect on patient care, is critical in health care service delivery, to ensure that the patients' expectations are met, or exceeded (Koukourta & Papathanasiou, 2014).

Effective communication also improves the delivery of services and promotes patient satisfaction, treatment, recovery and well-being (Australian Commission on Safety and Quality in Healthcare [ACHSQH], 2010). The significance of communication, therefore, whatever the context and nature, is critical, and might be reflected in better patient care, better health outcomes, and better results for patients overall (Bekkum & Hilton, 2013).

The researcher's daily professional duties include, being responsible for the quality of the clinical practice of a team of nurses, working in the urban emergency centre. In this emergency centre, special attention is given to effective communication, to ensure excellence in patient care, which is one of the key roles of nurses, and should be introduced as one of the core pillars of emergency care. To provide high-quality communication in emergency care is a complex task. Nurses are expected to promote excellence in nursing practice, but it was clear to the researcher that the emergency care environment was challenging, and that communication between the nurses and patients was placed under a great deal of stress. The lack of effective communication could negatively influence the nurse-patient relationship, as well as patient care delivery. The crisis in communication remains a serious problem in the Western Cape, which is compounded by staff shortages. The statement of Korsha (2011), regarding the public outcry about the behaviour of nurses, while interacting with patients, is supported by the researcher's experience in the workplace. Against this background, the researcher decided to explore the challenges of, as well as improvement strategies for, effective communication in an urban emergency centre, in the Western Cape. This current study,

therefore, endeavours to establish how communication could be improved, promoted more effectively, and supported to enhance the quality of healthcare.

1.2. Problem statement

Based on anecdotal evidence such as public outcry about the behaviour of nurses while interacting with patients, as described by Korsha (2011), the researcher is of the opinion that there are problems with communication between nurses and patients in the emergency centre identified for this study. Furthermore, based on public concerns that are raised daily, and subsequent investigations into incidents, and reports about patient care delivery and communication in the hospital emergency centres, the researcher decided to explore the challenges of communication between nurses and patients in the emergency centre (RSA, Western Cape Government, Department of Health, 2013). Moreover, the notion that nurses do not communicate as well as they should in healthcare settings seems a challenge reported globally in the literature. Similarly, the results from studies undertaken in two hospitals affiliated to Alborz University of Medical Sciences in 2012, showed that despite the attempts of nurses and patients to communication, there are some barriers, which can be removed through raising the awareness of nurses and patients along with creating a desirable environment (Norouzinia, Aghabarari, Shiri, Karimi & Samami, 2016). Research has also identified similar concerns with communication issues and problems in emergency centres in Hong Kong (Pun, Matthiessen, Murray & Slade, 2015). Therefore, the crisis of nurse/patient interactions remains a serious problem in the Western Cape, despite criticism and concern expressed by the public. Given this background, it is still unknown what the specific challenges are for communication to be effective between nurses and patients in this urban emergency centre in the Western Cape. It was also unknown what the nurses and patients would propose to improve communication between them, towards improved patient care. This current study, therefore, explored what these challenges in communication are, as well as what could be done to improve communication between nurses and patients in the emergency centre.

1.3. Research question

The central research question is: "What are the challenges facing effective communication between nurses and patients in the emergency centre; and how could communication be improved?"

1.4. Research Purpose

The purpose of the study is to explore the challenges of effective communication between nurses and patients, during the delivery of healthcare in an urban emergency centre, as well as to explore the possible improvement strategies for effective communication.

1.5. Research objectives

- To explore the nurses' and patients' views on communication between them in the emergency centre, against the HRM PCCM.
- To determine the challenges of effective communication at the emergency centre, as experienced by nurses and patients.
- To establish the views of nurses and patients on how communication between them could be improved.

1.6. Clarification of concepts VERSITY of the

- Access: For the purpose of this study, the definition of access to healthcare, as perceived by the patients, represents everything that affects a patient's ability to receive the right care, at the right time, in the right place (The Advisory Board Company, 2017).
- Choice: As per the patient-centred principles, choice is a valuable commodity ascribed to patients and their families, from the time the patient enters the hospital, until discharged. The information disclosed to the patient must allow him/her to exercise his/her choice in the treatment process (Planetree, 2009).
- **Communication:** For the purpose of this study, communication is recognised as fundamental to the delivery of care. Effective communication concerns the positive exchange of information and empathy, to develop a relationship between the patient and the health care providers (James & Miza, 2015).

- Emergency centre: The emergency centre, as defined by the Western Cape Department of Health (RSA, 2013), is a dedicated area in a health care facility that is organised and administrated to provide a high standard of emergency care to those in the community, in need of acute, or urgent care. It forms the direct port of entry for patients requiring emergency services. For the purpose of this current study, the emergency centre includes the overnight ward for patients of the emergency centre.
- **Empowerment:** Planetree (2009) subscribes to empowering the patient with the following principles:
 - * Respect for the patients' values, preferences and expressed needs;
 - Information and education;
 - Emotional support and alleviation of fear and anxiety;
 - Involvement of family and friends.
- **Information sharing:** In the context of this study, it refers to the process of the sending and receiving of information, from the patient to the health care provider, or vice versa (Bacchini, 2012).

WESTERN CAPE

- Patient care: Is defined as care that meets acceptable technical standards, for example, improving the processes of care (such as reducing waiting times), patient satisfaction, as well as the needs of patients and communities (National Research Corporation Canada, 2015).
- Patient satisfaction: Is a recognised and widely used measure of the
 effectiveness of the health care provider-patient communication and the
 outcome of care (National Research Corporation Canada, 2015).
- **Respect:** The dictionary definition of respect is as follows: a feeling or understanding that someone or something is important, serious, etc., and should be treated in an appropriate way (Bacchini, 2012).

• **Support:** In the context of this study, the framework support is limited to the health care provider's emotional support, as experienced by the patient, during the treatment process (King & Hoppe, 2013).

1.7. Significance of the study

Improved communication contributes to improved nurse/patient relationships, and, ultimately, the image of nursing. Through communication, nurses could create a friendly environment, which improves the patients' health care experience and improves patient satisfaction. Improved communication contributes to improved patient care outcomes, nurse and patient responsiveness, and the level of nurses' job satisfaction.

1.8. Methodology

A brief overview of the research methodology is provided in the current chapter while a full report follows in Chapter 3. This section focuses on the research approach, design, sampling, data collection and data analysis.

1.8.1. Research approach and design

A descriptive design with a qualitative approach, utilizing in-depth interviews, was applied to explore the challenges of, and the improvement strategies for, effective communication in an urban emergency centre in the Western Cape.

1.8.2. Study population

Krueger & Casey (2009) defines a study population as, all the individuals who meet the criteria for inclusion in a research study, and is also referred to as the target population.

 Professional nurses: The study population of this current study included all 25 nurses working at the selected urban emergency centre and overnight ward in Western Cape. • **Patients:** The population included all the patients, who were discharged from the urban emergency centre and overnight ward.

1.8.3. Sampling

- Professional nurses: Purposively sampling, a non- probability sampling method was followed in this study. This method is used when the researcher's judgement is applied to decide which participants should be included in the study (Mouton, 2013).
- **Patients:** Adult patients, who were discharged from the emergency centre and overnight ward, were purposively sampled.

1.8.4. Data collection

According to Brink, Van Rensburg & Van der Walt (2012), data collection is the process of gathering data from the participants selected for the research study.

1.8.4.1. Data collection instrument

Individual in-depth interviews were used to collect data. An interview guide (Annexure B), with one open-ended question related to the study objectives, was employed. The question was posed to the participants and probes were used to gain the necessary depth of the discussion.

1.8.4.2. Data collection process

To avoid the possibility of bias, the data collection was conducted by the researcher and a fieldworker, who had received training on how to take notes, and how to observe important incidents during the interviews. The researcher was affiliated with the institution under study, but the field worker was not. Permission was also obtained from the participants for the interviews to be audiotape recorded. The interviews were conducted at a time, a date and a venue that was convenient to the participants.

1.8.5. Data analysis

The inductive process (Observation, pattern, tentative hypothesis, theory) was used for thematic analysis of the data from the in-depth interviews; listening to audio recordings and transcribing them verbatim, which allowed the researcher to

obtain a comprehensive view and broader understanding of the phenomenon under study (Mouton, 2013).

1.8.6. Rigor

Trustworthiness

Trustworthiness of qualitative data was ensured throughout the process as described by Jooste (2010b), namely credibility, transferability, confirmability, and dependability.

• Reflexivity

Reflexivity was used to further enhance trustworthiness. Babbie & Mouton (2014) state that "reflexivity refers to the active acknowledgement by the researcher that her/his own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation". Because the researcher is employed at the district hospital, she remained aware of the purpose of this study and ensured that her presence, participation and personality did not prejudice the data collection process. The researcher also took into consideration that all the participants were known to her and, therefore, maintained a professional relationship with them, focussing on the research objective and purpose.

1.9. Ethics

The ethical considerations are discussed in further detail in Chapter 3 (Research Methodology). Consent to conduct the study was obtained from the Senate Research Committee of the University of the Western Cape (Reg. No. 14/10/45:), as well the institution under study. As recommended by Brink *et al.* (2012), protection of human rights was maintained by ensuring confidentiality, anonymity, privacy and the right to self-determination. Informed written consent was obtained for participation in the interviews, as well as the recording thereof. There were no participants who experienced emotional distress during the in-depth interviews. Therapeutic counseling was available for participants, who might have experienced emotional distress, during or after the data collection process.

1.10. Overview of the study

Chapter 1 incorporates the researcher's portrayal of the background and motivation of the study, as well as a brief overview of the problem statement, research question, research purpose, study objectives, clarification of concepts, significance of the study, research methodology and the study layout.

Chapter 2 contains a review of various literature related to the topic of the communication challenges between nurses and patients in the emergency centre, as well as the conceptual framework of the study.

Chapter 3 comprises of a detailed description of the research methodology that was applied in this study.

Chapter 4 incorporates the researcher's presentation of the results of the study, as well as the discussion thereof.

Chapter 5 contains the summary, limitations, recommendations and conclusion of the study objectives and discussed in chapter 5. The recommendations are based on scientific evidence obtained in this study, and the conclusion is aligned with the purpose and objectives of this study.

UNIVERSITY of the

WESTERN CAPE

1.11. Summary

A background description of the communication challenges between nurses and patients in an urban emergency centre in the Western Cape was provided. The underlying reasons that motivated the researcher to explore the challenges of effective communication between nurses and patients, during the delivery of healthcare in an urban emergency centre, as well as possible improvement strategies for effective communication, are explained in the rationale. An overview of the research methodology that was applied in the study was also presented. The chapter is concluded with an outline for the remainder of the thesis. The next chapter contains a presentation of the literature related to the concept of the communication challenges between nurses and patients in an urban emergency centre, in the Western Cape.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

A literature review, according to Mouton (2013), is an assessment of a body of research that addresses the research question/s, and is a description of the literature relevant to a particular field or topic under study. It is not primary research, but rather reports on findings of studies conducted by researchers, globally. The intention of a literature review is to explore similar or related studies that could serve as the foundation for the intended study. Therefore, this chapter contains a review of literature that relates to communication in an emergency centre, in relation to what has already been published on the subject, as well as the current nursing practice.

2.2. Selecting and reviewing of the literature

A significant amount of literature was accessed over a period of 15 to 24 months. The review commenced before the proposal for the study was completed. On completion of the analysis of the data, it was clear that the findings of the study relate to aspects, such as professionalism, attitude and respect between nurses and patients. These concerns were not thoroughly addressed in the initial review. Therefore, after data analysis was completed, the review was strengthened and adapted to provide information that was aligned with the findings of the study.

Search engines, such as UWC Search (University of Western Cape Library and Information Service) and EBSCO host (Elton B Stephens Company research database)

were employed, as well as the on-going support and assistance of the supervisor. The majority of the materials selected for the review, from multiple electronic databases, were published within the last ten years. The databases of the University of Western Cape library, and Pub med. Periodicals, journals and various monographs (pamphlets and books) were reviewed. The keywords included communication, emergency centre, healthcare, staff and patient satisfaction. Both South African and international publications were accessed.

2.3. Presentation of the literature

The findings from the literature are presented in the following order:

- Communication in healthcare
- Communication and patient satisfaction
- Communication and staff satisfaction
- Conceptual framework
 Patient- centeredness
 Model of communication
 Summary
 - 2.3.1. Communication in healthcare

The emergency centre is one of the most critical departments in healthcare settings. Effective communication is an important element that facilitates the smooth flow of operations and processes in the emergency centre (Jenkins, Calabria, Edelheim, Hodges, Markwell, Walo, Weeks & Witsel, 2011). Therefore, communication among patients and healthcare professionals in the emergency centre is very important (Hakami & Hamdi, 2013). Nurses as professionals in the health care field, work to provide the best care for patients. Due to the team-based nature of their work, communication is an important and essential component of care for patients. It is vital to many professionals, especially health professionals; therefore, communication, as a basic competence, is the foundation to all nursing interaction, and central to all human interaction (Pun et al., 2015; Hakami & Hamdi, 2013). Communication is a multi-dimensional, multi-factorial phenomenon and a dynamic, complex process,

WESTERN CAPE

closely related to the environment in which patients and healthcare professionals share their experiences (Hakami & Hamdi, 2013).

The word 'communicate' stems from the Latin *communicare* and means to share, impart, participate, convey, or inform (Bach & Grant, 2009). The importance of communication and interaction for nursing has been highlighted by nurses and nursing scientists, since Florence Nightingale in the 19th century, and continues to this day (Fleischer, Berg, Zimmermann, Wüste & Behrens, 2009). Goethals, Gastmans & Dierckx de Casterle' (2010) assert that nurses play a role of care ethics to promote moral care about the patient's health and welfare. However, they are confronted with organizational and legal restrictions in their reasoning and decision-making, which may affect, prevent, and change the moral reasoning development of nurses, as well as effective communication.

During communication there must be sufficient information communicated in the emergency centre; however, communication in the emergency centre is a complex process, where failure could lead to poor patient care, loss of information, delays and efficiency (Redfern, Brown & Vincent, 2009). Effective ccommunication is a key element and an important aspect of patient care, as it improves the nurse-patient relationship and has a profound effect on the patient's perceptions of health care quality and treatment outcomes (Li, Ang & Hegney, 2012). Therefore, to develop a positive nurse-patient relationship, the effective communication skills of health professionals in health care settings, is vital to ensure effective health care provision, and could lead to positive outcomes, including decreased anxiety, guilt, pain, and disease symptoms in patients. In addition, nurses can increase patient satisfaction, acceptance, compliance, and cooperation with the medical team, thereby improving the physiological and functional status of the patient (Aghabarari, Mohammadi, & Varvani- Farahani, 2009). In the opinion of the researcher, a positive nurse-patient relationship would have a great impact on the training, which should include better communication between nurses, patients and family members, as well as how to maintain the patient's physical and mental functioning to promote quality of life, better medication management and improved disease symptoms.

There is ample literature available to suggest that nurses do not communicate as well as they might in healthcare settings (Jangland, Gunningberg & Carlsson, 2009). The results of previous studies have revealed that nurses are trained to establish effective communication; however, they do not use these skills to interact with their patients in clinical environments (Bridges, Nicholson, Maben, Pope, Flatley, Wilkinson & Tziggili, 2013).

Unfortunately, this is because nurses are not aware of the meaning and significance of the nurse-patient relationship (Fleischer et al., 2009). The World Health Organisation (WHO), however, emphasized the importance of patient focused communication between health professionals and patients (Bach & Grant, 2009).

Effective communication is essential to deliver quality healthcare in hospital settings, including emergency centres (ECs) and waiting rooms (Slade et al., 2015). Similarly, the results of other studies reveal that nurses, in general, have not made an effort to establish positive interactions with patients. Most of the reported problems are related to the decreased sense of altruism among hospital staff, including nurses (Bridges et al., 2013).

According to Sheldon (2015), communication pitfalls are 5-10% in general population, and more than 15% in hospital admissions. The results are consistent with the findings of Downey and Happ (2013), with hospitalized patients of all ages, often experiencing complex communication needs, including mobility, sensory, and cognitive needs, as well as language barriers during their stay. A relationship of trust should be developed, through good communication between the nurse and the patient; however, very few studies have examined the patients' experiences of how nurses communicate (Legg, 2011). The following can occur in the EC, for example, ambient noise, anxiety and confusion that accompany these events, which could make interactions between the nurse and patient very challenging. In some cases communication could be a challenge due to language barriers and cultural backgrounds (Pun et al., 2015).

Prosen (2015) concurs that patients are entitled to culturally competent care; nurses must be prepared to recognize patients' needs that derive from their culture and develop skills that will facilitate their achievement. Unfortunately, there is a lack of communication skills, as well as training in the healthcare professions, which also play a major role (Augmentative Communication News [ACN], 2009). Nurses should be able to judge the best way to communicate with patients, although, studies in nursing frequently describe that nurses are poor communicators (Jenkins et al., 2011). Nurses are in a perfect position to judge; during assessments, recording of treatment and care, handling of sensitive information confidentially, as well as dealing with complaints effectively, and are conscientious in reporting the issues that concern them (Casey & Wallis, 2011).

During patient care, patients should experience effective communication. The scope of practice for nurses is to enhance a positive nurse-patient relationship, which refers to cooperation between the health professionals and their clients, in order to encourage the client to make the best health care choices (Li et al., 2012). The patient interview is the most commonly used procedure that nurses will employ as a healthcare procedure (Republic of South Africa [RSA], Department of Health [DoH], 2010). There is evidence to suggest that the complex, high stress, unpredictable and dynamic environment of the emergency centre constructs particular challenges for effective communication, with the potential for communication and actions to be chaotic and interrupted (Pun et al., 2015). In addition, nurses identified distractions and time pressure as the two main factors that compromised the effectiveness of communication with their patients (Fleischer et al., 2009).

Several studies of emergency centres report that patients considered themselves as outsiders or had no idea what was going on around them, suggesting a lack of information, or poor communication between the staff and the patients about processes, waiting times, and other matters (Garling, 2008; New South Wales [NSW], Health, 2010). The emphasis is on the environment, which is a very important factor in shaping communication, for example, the health care environment produces both opportunities and constraints between staff and patients/clients (Norouzinia et al., 2016). According to Slade, Manidis,

McGregor, Scheeres, Chandler, Stein-Parbury, Dunston, Herke and Matthiessen (2015), there has not been any research conducted to date that examines the dynamic complexity of the interactions unfolding, in real time, in high-risk environments, such as emergency centres. The findings of their study are supported by the University of Southern California (USC, 2017) that deliberates a form of research, which reviews, critiques, and synthesizes representative literature on a topic, in an integrated way, resulting in the generation of new frameworks and perspectives on the topic. The body of literature would include all studies that address related or identical theories. A well-executed integrative review meets the same values as primary research, in terms of clarity, rigor, and replication.

2.3.2. Communication and patient satisfaction

Patient satisfaction is the core of patient-centred care (Korda, 2012). There is no consensus in literature on how to define the concept of patient satisfaction in healthcare, although, it is identified as an important quality outcome indicator to measure success of the services delivery system (Bhartendra & Triza, 2016). Patient satisfaction is defined according to the Donabedian's quality measurement model, as a patient-reported outcome measure, while the structures and processes of care can be measured by patient-reported experiences (Oyvind, Ingeborg & Hilde, 2011). It appears that many authors have different perceptions and definitions of patient satisfaction. Jayaprakash, O'Sullivan, Bey, Ahmed and Lotfipour (2009) highlight, in their study, that patient satisfaction seems mostly to represent attitudes about care, or aspects of care. The results of a study referred to patient satisfaction as patients' emotions, feelings and their perception of delivered healthcare services (Rama & Kanagaluru, 2011). Other authors however, defined patient satisfaction as a degree of congruency between patient expectations of ideal care and their perceptions of real care received (Iftikhar, Allah, Shadiullah, Habibullah, Muhammad & Muhammad, 2011).

The emergency centre is the gate-keeper for patient care and treatment; however, it is not always possible to ensure that patients receive quality patient care, and are well satisfied. Factors like overcrowding, lengthy waiting times, lack of an established provider-patient relationship, or lack of privacy could cause the

patient to be less than pleased with his/her experience (Hassan, Changiz, Shaker, Payam, Reza, Amirhossein, Rouzbeh & Mary, 2011). Business of Healthcare (2016) asserts that poor patient satisfaction comes with a few less-than-desirable consequences. For every one patient, who complains; twenty do not, but are unhappy; leading to missed opportunities. Seventy per cent of patients, who receive "perceived deficient care" will not visit that particular facility again, which is a breakdown in care. Seventy-five per cent of unsatisfied health care consumers, talk about it, and will tell nine family members, or friends.

The researcher is of the opinion that health care professionals, at health care facilities in the Western Cape, should promote continuity of patient care, by monitoring and evaluating patient satisfaction. The Patients Right Charter, The patients Right Charter-Ideal Clinic and Batho Pele Principles are displayed in health care facilities to ensure that each patient is well informed; no individual shall be abandoned by a health care professional worker, or a health facility, which initially took responsibility for the individual's health (RSA, Western Cape, Department of Health, 2013). Currently, in the researcher's experience, it is common in healthcare practice, to use patient information about complaints or compliments, as a measure of determining patient satisfaction. However, it has been established that, according to the booking list in the health information system at the health care facility, a high number of patients do not return for follow up visits (Western Cape Department of Health, 2013).

Patient satisfaction is a recognised and widely used measure, as well as an important indicator to nurses, of the effectiveness of provider-patient communication and the outcome of care in the emergency centre (Health Canada, 2010; Peprah, 2014). The reviewed literature concur that measuring patient satisfaction impacts quality improvement of care. The research studies conducted by Oyvind et al., (2011), as well as Iftikhar et al., (2011) reveal that patients' evaluation of care is a realistic tool to stimulate improvement, enhance strategic decision-making, reduce cost, meet patients' expectations, frame strategies for effective management, monitor healthcare performance of health plans and provide benchmarking across the healthcare institutions.

In addition, due to the tendency of healthcare facilities to concentrate on patient-centred care, patient satisfaction reflects the patients' involvement in decision-making and their role as partners in improving the quality of healthcare services (Hakami & Hamdi, 2013; Iftikhar et al., 2011). In addition the results of another study deemed the correlation between measuring patient satisfaction and the continuity of care as significant, where the satisfied patients tended to comply with the treatment, and adhered to the same healthcare providers (Rama & Kanagaluru, 2011). Patient satisfaction represents a key marker of communication and health-related behaviour (Tonio, Joerg, Joachim, 2011). In contrast, some of the literature dismissed patients' views as a wholly subjective evaluation and an unreliable judgment of the quality of care (Oyvind et al., 2011; Rama & Kanagaluru, 2011).

There are basically two approaches for evaluating patient satisfaction in the health care setting – qualitative and quantitative (RSA, Western Cape Department of Health, 2014). The statistics of patients' complaints and compliments, as a quantitative approach, provide accurate methods to measure patient satisfaction. A study conducted by Otani, Hermann and Kurz (2011) revealed that standardized questionnaires (either self-reported, or interviewer-administrated, or by telephone) has been the most common assessment tool for conducting patient satisfaction studies. The Standard IT Services Client Satisfaction Team (2012) used The Information Technology Services 2012 Client Survey as their method of assessing whether clients were satisfied, or dissatisfied, as well as to identify which gaps caused any disappointment in the clients' experience (IT Services 2012 Customer Satisfaction Survey, 2012). The remarkable outcome of four studies, conducted in tertiary hospitals, in different countries revealed that the nurses' courtesy, respect, careful listening and easy access of care were particularly the strongest drivers of overall patient satisfaction (Al-Abrid & Al-Balushi, 2014). These aspects of nursing care are highly ranked by patients, compared to other independent factors, such as physician care, admission process, physical environment and cleanliness (Forough, Mohammed & Hamid, 2007; Tonio et al., 2011). In addition, a study conducted in 430 hospitals in the USA, by Kutney-Lee, McHugh, Sloane, Cimiotti, Flynn, Neff & Aiken, (2009), observed

that the nurses' work environment, as well as patient-nurse staffing ratio had statistically significant effects on patient satisfaction and recommendations.

Many studies have indicated positive implications for patient retention and loyalty; patient satisfaction influences the rate of patient compliance with physician advice, as well as the healing process of patients (Peprah, 2014). There are limited healthcare resources to allocate and manage effectively; therefore, it is crucial for healthcare providers to access and identify the patients' priorities in various service quality dimensions, and to improve these dimensions for patient satisfaction (Peprah, 2013). A number of studies report that patients' satisfaction is influenced by the following factors, which play a critical role in the satisfaction of patients: the attitudes of nurses towards patients; the nurses' capacity to deliver prompt service without wasting time; their ability to disseminate information to patients; and the availability of updated equipment (Peprah, 2014). Various studies indicate that younger patients are less satisfied than older patients (patients with higher education and income), and those who are sicker, tend to be more satisfied than patients who regard themselves as healthier (Rothrock, 2012; Gruman, 2012; O'Reilly, 2012).

WESTERN CAPE

Patient satisfaction in the emergency centre was increasingly influenced by the staff members' inability to communicate, as a priority area for improving patient satisfaction includes, keeping the patient and his/her family informed about the patient's condition and the reasons for delays (Peltier, Dahl & Mulbern, 2009). Similar studies in Australia have revealed similar results, indicating that the relationship between staff and patient is central to a patient's overall views and experiences of the emergency centre (Piper, Iedema, Merrick & Perrott, 2010). It was observed that patient satisfaction in the emergency centre was not based on the length of the waiting time, but was affected negatively by the nurses' attitudes and treatment of patients. In cases of acute and sudden complications, combined with the stress and high anxiety levels in the emergency centre, the patient relies on the nurse for empathy, to meet their needs, as well as expectations, in order to improve patient satisfaction (Peltier et al, 2009).

Business of Healthcare (2016) revealed the following core elements that contribute to improved patient satisfaction:

- Expectations: providing an opportunity for the patients to tell their story;
- *Communication:* explained information clearly;
- *Control*: to express their ideas, concerns and expectations;
- Decision-making: social, mental and physical functioning was acknowledged;
- *Time spend:* patient satisfaction rates improved as the length of the healthcare visit increased;
- Clinical team: the patient values the clinician and his/her team;
- *Continuity of care:* Patient satisfaction is increased by seeing the same healthcare provider/s; and
- *Dignity:* treated with dignity and respect by the healthcare professions.

There is considerable room for improvement in emergency centres, regarding patient care and communication, as highlighted in the NSW Health Caring Together document, recommending that communication with patients and issues relating to patient care could be improved (NSW Health, 2010). The literature regarding patient satisfaction in emergency centres have increased rapidly (Welch, 2010). In the increasingly competitive market of healthcare institutions, healthcare managers should focus on achieving high, or excellent, ratings of patient satisfaction, to improve the quality of service delivery. Therefore, healthcare managers need to identify the factors influencing patient satisfaction, which are used as a means to assess the quality of healthcare delivery. The focus should be to continue the improvement of patient care, as well as the value of healthcare for patients in emergency centres (Lateef, 2011).

2.3.3. Communication and staff satisfaction

Employee satisfaction, also known as job satisfaction, is the extent to which the employees display happiness, when they are satisfied with their job, working conditions, as well as the role it plays in their job, as it is used as one way of

measuring a company's success. Employees play the most important role in a company, and their satisfaction of business practices, influences the success of the company (Carroll & Shabana, 2010). The satisfaction among health-care professionals has a direct impact on patient satisfaction, and is significant for the maximization of human resource potential (Bhatnagar & Srivastava, 2012). Nurses are the backbone of healthcare facilities and their satisfaction of healthcare practices does influence service delivery. Therefore, it is essential for nurses in the healthcare industry to be passionate about delivering service of excellence (Wilson, 2013).

Staff satisfaction among nurses, however, is a great challenge in healthcare institutions (Ziapour, Kazemi, Kiani Pour & Ziapour, 2013). Currently, the world is facing a workforce crisis, and one of the most striking examples is the shortage of nurses. Within the hospital sector in South Africa there are alarming staff shortages in the healthcare profession, which results in poor quality of, and less efficient patient care (Pillay, 2008). In several countries, employers place great importance on the well-being of their employees and its impact on their jobs (Robison, 2010). In Denmark, several surveys have been conducted to measure the satisfaction of the employees and according to the survey, the following results were highlighted: Management cares about nurses by listening, reducing of stress; conducting fair evaluations of staff work performance; and patients are treated with respect (Slade, Jordan, Clarke, Williams, Kaliniecka, Arnold, Fiorillo, Giacco, Luciano, Égerházi, Nagy, Krogsgaard, Østermark, Rössler, Kawohl, Puschner & CEDAR Study Group, 2014).

From the researcher's perspective, a developmental programme should be identified for each staff member, according to their needs, as well as the appointment of a mentor to facilitate, support and assist the staff member throughout the programme (Kossivi, Xu & Kalgora, 2016). Satisfied nurses reflect higher levels of patient safety, and less medication errors, which helps to increase patient satisfaction (MacPhee et al., 2017). Satisfied nurses contribute to shortened lengths of stay for patients and lower variables (Kavanagh, Cimiotti, Abusalem & Coty, 2012). Nurses, who are satisfied with their jobs, build a

rapport and express care, as well as warmth towards the patients (Wettergren & Blix, 2016). Highly motivated nurses take pride in their work; as a result, they feel good about the organization and its values, and provide high quality care to patients (Peltier et al., 2009).

Previous studies have revealed that unsatisfied health care employees negatively affect the quality of care, which adversely affects patient satisfaction and loyalty to the hospital (Janicijevic, Seke, Djokovic & Filipovic, 2013; Peltier et al., 2009). This could create the possibility of patients receiving sub-standard treatment, or even being placed in danger (Kekana, Du Rand & Van Wyk, 2007). The challenging environment, however, places a great deal of stress on the nurses that could influence effective communication and staff satisfaction in the emergency centre (Pun et al., 2015). One of the most significant ways, in which staff performance is affected, surfaces in their interaction with patients (De Silva, 2013).

Therefore, it is evident that health care organizations that provide a good working environment, which enhances the service capability of staff, through empowered decision-making, will lead to more satisfied nurses, who are more likely to remain loyal to the organization, and provide a higher patient satisfaction (Peltier et al., 2009). It is vital that health institutions understand concepts such as, staff engagement and satisfaction, as well as how their levels of engagement and satisfaction relate to patient satisfaction and overall customer experiences (Peltier et al., 2009). Organizations that desire to improve patient satisfaction, therefore, must be concerned about internal issues related to employee satisfaction, and should view their employees as clients, too (Bhatnagar & Srivastava, 2012).

2.3.4. Conceptual framework

A combination of the patient-centred care (patient centeredness) approach and a model of effective communication will provide a conceptual framework for this study, based on the premise that for the rendering of patient-centred care, communication must be effective (Starfield, 2012). Wilkins (2017: p. 637) suggests that "good communication is both an ethical imperative, necessary for

informed consent and effective patient engagement, and a means to avoid errors, improve quality, save money and achieve better health outcomes".

2.3.5. Patient-centeredness

The essence of Patient-Centred Care (PCC) is that patients are the centre of the healthcare system and, therefore, the system is designed around them (International Alliance of Patients' Organizations [IAPO], 2007). Patient-centred care improves the quality and effectiveness of communication (National Institute of Health, 2015). Patient- centred care is a modern healthcare trend and is recommended as the first principle to guide health care delivery (National Health and Hospitals Reform Commission, 2008). It is also recommended that pathways of care should be easy to navigate, and care should be provided in the most favourable environment (Australian Commission on Safety Quality in Health Care [ACSQHC], 2011). The Ontario Medical Association (OMA, 2010: p. 34) defines patient-centred care as follows: "A patient-centred care system where patients can move freely along a journey of patient care regardless to which physician, other health-care provider, institution or community resource they need at that moment in time." Patient-centeredness is described as a standard of practice that considers the individual needs of patients, and treats them accordingly (Ontario Health Quality Council, 2012).

The concept of PCC is receiving more attention internationally, as a dimension of the broader concept of high-quality health care, and is explained as a New Health System for the 21st Century, for good-quality care that is safe, effective, patient-centred, timely, efficient and equitable (Australian Commission on Safety and Quality in Healthcare, 2011). This concept of health care is responsive to the individual differences, cultural diversity and the preferences of people receiving care, and is achieved partly, through providing choice in health care (Piper et al., 2010). However, there is no consensus on the definition of patient-centred care and there is a need for theory development (Holmström & Röing, 2010). Harvey Picker, founder of the Picker Institute, established in 1994, is the champion and founder of patient-centred care (Frampton, Guastello, Brady, Hale, Horowitz, Smith & Stone, 2008).

A recent literature review observed the possibility that patient-centred practice could make a positive difference to health outcomes, patient and client satisfaction, as well as improve an individual's sense of professional worth (Commonwealth of Australia, 2017). The theoretical point of departure for that study of patient-centeredness is the theory and philosophy of the patient-centred approach. It has also been identified that patient-centred communication is a prerequisite to evoke person-centred care (Scholl, Zill, Härter & Dirmaier, 2014). Essential to this and other theories on person-centred care, is the quality of interactions between nurses and patients in a person-centred way (International Alliance of Patients' Organizations [IAOP], 2007). For the achievement of patient-centred health, the IAPO declaration on Patient-Centred Healthcare (PCH) declares that healthcare should be based on the following five principles, respect, choice and empowerment, patient involvement in health policy, access and support, and information. These principles are being used as the basis for the evaluation of current practice, and to develop new patient-centred indicators. (International Alliance of Patients' Organizations (IAPO), 2012).

This current study is guided by four of the five above-mentioned principles, including respect, choice and empowerment, access and support and information sharing. The concept of person-centred communication is stated as a set of skills for nurses, demonstrated through verbal, para-verbal and non-verbal communication, which facilitates patient-centred care (Hafskjold, Sundler, Holmström, Sundling, Van Dulmen & Eide, 2015). The attributes of nurses, such as empathy, mindfulness and emotional intelligence, may influence both, the delivery of care, and communication behaviour, and, therefore, need to be taken into account (Hafskjold et al., 2015). Nurses should be encouraged to use patient-centred communication, to promote patient wellness, as well as quality nursing care, which is related to the patient's overall satisfaction with care (Korsha, 2011).

Most of the investigations for patient-centeredness focus primarily on the encounter between physicians and patients, ignoring *the important role of nurses*, particularly in hospital EC units (Kemmis, Wilkinson, Edwards-Groves, Hardy, Grootenboer & Bristol, 2014). For nurses to communicate in a patient-centred

way, the concept of person-centred communication is defined as a skills-set of the health provider, demonstrated through verbal, para-verbal and non-verbal communication, which facilitates person-centred care (Kourkouta & Papathanasiou, 2014). Nurses should portray the following attributes, namely, empathy, mindfulness and emotional intelligence, to influence the care delivered (Entwistle & Watt, 2013). The specific aim of person-centred communication is to ensure the nurses' attention to the whole person, and involves sharing of information and decisions, providing compassionate and empowering care, and being sensitive to patient needs (Constand, MacDermid, Dal Bello-Haas & Law, 2014). The limited evidence presented in the literature is largely supportive of person-centred approaches to care (Victoria State Government, 2011).

The literature on strategies to improve patient-centred care is overwhelming, and a review, prepared by the Cochrane Collaboration, highlighted that "patient-centred care is a widely used phrase, but a complex and contested concept" (Groene, 2011: p. 535). Therefore, three simple arguments are provided for a patient-centred approach, from a quality improvement perspective, namely, improving patients' rights, improving health gain and contributing to organizational learning (Gorawara-Bhat, Dethmers & Cook, 2013); however, there are difficulties with the concept, especially at the level of implementation (Davies, 2007). The implementation of patient-centeredness has been hampered by the lack of clear definition and a method of measurement (Robinson, Callister, Berry & Dearing, 2008).

Nurses should be equipped with the following skills to deliver patient-centered care (Pelzang, 2010).

- The demonstration of effective communication, good relationship development with patients, their families and other professionals;
- The demonstration of good knowledge of clinical practice, clinical reporting/documentation, procedures, as well as skills in data collection; and
- The ability to focus on significant events, conditions or situations.

The positive outcome of patient-centered care, according to Planetree (2009), ensures the improvement of quality patient care, reduces the cost of care, and increases satisfaction among nurses, physicians and patients, by strengthening professional practice and maintaining the values of the patient and healthcare providers. However, there is a paucity of literature that includes direct client, carer or family perspectives on patient-centred health care. There is also limited empirical evidence on the effectiveness of these approaches (Victoria State Government, 2011).

Patient-centred care is essentially a holistic concept, and to be effective, it must become embedded in all hospital processes and functions, from leadership strategies to staff development (Audit Scotland, 2012). An organisation that is truly patient-centred, would consider the direct input of patients and their families, concerning what is most important to them about their care, and how the nurses could satisfy those needs, preferences and expectations best (Planetree, 2009). Patient-centred quality of care is one of the principles guiding the Western Cape Department of Health's strategy for healthcare 2030, which is in line with the World Health Organization [WHO] (RSA Western Cape DoH, 2014).

UNIVERSITY of the

2.3.6. Model of Communication N CAPE

Models of communication are conceptual models used to explain the human communication process (Al-Fedaghi, Alsaqa & Fadel, 2009). This process is a combination of people, messages, meaning, practices and purposes, and the foundation of good patient care, to strengthen patient-centeredness (ACHSQH, 2010). Effective relationships emerge from communication that enhances staff and patient satisfaction, improved patient care, builds trust and provides a way for patients to express emotions (Berger, 2011).

The transactional model of communication, used in this current study, acknowledges that communication is a dynamic process that changes over time (University of Minnesota, 2016). In this model, as described by Wood (2013), the elements in communication, namely the speaker and the listener, are interdependent in the communication process. By virtue of the communication

process, both the speaker and the listener may be sending and receiving messages simultaneously. Wood (2013) describes the transactional model as follows:

- "Transactional" refers to communication being a process that is on-going and continuously changing;
- The changing situation refers to those involved in the communication process, as well as the environment;
- In the transactional process, each element is interdependent, and exists in relation to all the other elements, for example, there is no source without a receiver, and no message without a source;
- The reaction of those involved in the communication process depends on factors such as, their background, prior experiences, attitudes, cultural beliefs and esteem;
- The transactional model takes into account "noise" or interference in communication, such as maintenance of the building, disorientated patients, staff members communicating loudly with each other, traffic within and outside the emergency center.

UNIVERSITY of the

The norms and standards for noise reduction are described by the Department of Health (Republic of South Africa [RSA], Department of Health [DoH], 2013), as follows: "There is a need to decrease sound transmission in the emergency centre due to the high noise levels in emergency centre. Due to the nature of emergency medicine there will be a need for patients to disclose intimate information at most points in their journey, therefore it is essential to create an conducive environment for patients to feel comfortable doing so. High noise levels adversely affect both patients and staff and can influence staff ability to function, leading to increased fatigue, increased perceived work pressure, stress, emotional exhaustion and error due to distraction and poor communication. While much of the noise in an emergency centre is unavoidable some can be mitigated by paying attention to acoustic architecture: It will be beneficial to rather plan specifically for the accommodation and management of staff, anxious patients and relatives by designing a calming environment as well as sound proof rooms".

Dr Eric Bern developed the "transactional analysis" theory in the 1960s, as a useful model, based on states of mind, and how these influence transactions between people (Centre for Pharmacy Postgraduate Education (CPPE), 2014). Transactional analysis (TA) is a scientific unit that analyses people's behaviour in the three categories of 'child', 'parent' and 'adult' (Pataki, 2009). Transactional Analysis (TA) plays an important role in nursing, which has gone unnoticed. It is fundamental in nurse-patient communication and managing emotions during difficult dialogue with patients (Whitley-Hunter, 2014). By using "transactional analysis", the nurses are aided to increase their communicative skills, to improve patient satisfaction (Pataki, 2009). Nurses must understand how to detect this transference and become properly trained, to manage the patient's conversations in a time of illness. With a lack of understanding, the various levels of communication, as well as the ability to adjust to fit the mind-set of the patient's signals, can become crossed, and miscommunication can occur. Without the capability to recognize a person's ego, state of mind and body language, there is always a chance of compromising patient care. The expectation is to advance empathy and communication skills for student and veteran nurses, which in turn can create progress with patient outcomes and personal satisfaction (Whitley-Hunter, 2014). WESTERN CAPE

Acknowledging the effectiveness of the TA on the improvement of relationships, this current research is an attempt to evaluate the effect of the TA education on nurses regarding patients' satisfaction (Pataki, 2009). The best interactions occur when both parties are acting in adult mode, using factual, non-emotional dialogue and showing respect towards each other (Centre for Pharmacy Postgraduate Education [CPPE], 2014).

2.4. Summary

This chapter presented a discussion on aspects related to communication in the emergency centre, regarding the current nursing practice. An overview of communication in the emergency centre, globally and locally, was also provided. Communication was defined and a discussion on strategies that relate to communication in emergency centres was conducted. In addition, an explanation of the factors that influence communication in emergency centres was presented.

The next chapter focuses on the research methodology adopted to conduct this current study. A description of the research design, methodology, data collection, data analysis, efforts to ensure trustworthiness and ethical considerations are presented in Chapter 3.



3.1. Introduction

In this chapter, the researcher provides an account of the research design and methodology used in this current study. The purpose of the study was to explore the challenges of effective communication between nurses and patients, during the delivery of healthcare in an urban emergency centre, as well as to explore possible improvement strategies for effective communication. Through a qualitative research methodology, the researcher explores the problem, or issue, pertaining to a particular group, or population, of which the variables cannot be easily measured (Creswell, 2014).

Kothari (2011) defines research methodology as a way to solve the research problem methodically. It includes the research methods, but also the logic behind the methods used in the context of a research study. The researcher seeks to describe the

methodology used in this study, and provides a detailed account of process followed to study and answer the research question, as well as the methods used during data collection and analysis.

It is envisaged that the data yielded by this current study would develop strategies to improve communication between nurses and patients, during the delivery of healthcare in an urban emergency centre. In order to meet the study purpose, the researcher applied a qualitative, exploratory and descriptive research design.

3.2. Research approach and design

A descriptive design, with a qualitative approach, utilizing in-depth interviews, was applied to explore the challenges of, and improvement strategies for, effective communication in an urban emergency centre, in the Western Cape. The purpose of a research design is to provide a plan for answering the research question (Wood & Kerr, 2011). De Vos, Strydom, Fouche and Delport (2011) describe a design as, all those decisions contained in the plan, or blueprint of the intended study. A descriptive design is used to determine current problems in practice and to identify what others, in similar situations, are doing (Burns & Grove, 2009). Additionally, the descriptive design is used, when more information is required (Brink et al., 2012). The descriptive design was considered to be the most appropriate for the purpose of this current study, as advised by Boswell and Cannon (2015), as it provides in-depth information about the characteristics of the participants in the field of study, in this current case, communication in an urban emergency centre. Brink et al. (2012) states that qualitative designs explore the meaning and describe, as well as promote the understanding of human experiences, such as pain, grief, hope or caring. Accordingly, a qualitative approach was employed, as it allowed participation with the nurses and patients through in-depth interviews, to obtain information on communication in an urban emergency centre. Qualitative researchers study issues in their natural setting, by trying to make sense of the phenomenon, in terms of the meanings people attach to them. In this current study, the researcher interviewed the participants at an urban emergency centre in the Western Cape.

Exploratory research is conducted to acquire an understanding of a situation, phenomenon, and persons, for example, communication between nurses and patients in an urban emergency centre, in the Western Cape (De Vos et al., 2011). It is also applied to "satisfy the researcher's curiosity and desire for a better understanding" of communication between nurses and patients in an urban emergency centre (Bless, Higson-Smith & Sithole, 2013). An advantage of exploratory research is that it allows the participants to respond in their own words. The responses from participants are rich and explanatory in nature (Creswell, 2014). An exploratory design was relevant to this current study, since the researcher was focused on exploring the challenges of effective communication between nurses and patients, during the delivery of healthcare in an urban emergency centre, as well as possible improvement strategies for effective communication.

3.3 Research setting

The study was conducted in an urban emergency centre in a district hospital in the Western Cape. Approximately 3000 and 3500 patients visit the emergency centre per month. The emergency centre has an overnight ward which is staffed by professional and other nurses. The patients, both adults and children, usually present with medical, surgical, trauma, mental illness and paediatric conditions. Patients are discharged from the overnight ward.

3.4. Study population

Krueger and Casey (2009) defines a study population as all the individuals, who meet the sample criteria for inclusion in a study, sometimes also referred to as the target population. Jooste (2010a) states that the study population is the whole group of individuals, who are of interest to the researcher. De Vos et al. (2011) further define it as setting boundaries regarding the participants.

3.4.1. Professional nurses

The study population included all 25 nurses (n=25) working in the urban emergency centre and overnight ward in Western Cape. To ensure 24 hours coverage of the emergency centre and overnight ward, 7 days a week, nurses at

the emergency centre are divided into 2 day teams and 2 night teams working opposite each other.

3.4.2. Patients

The population included all patients, who would have been discharged from the urban emergency centre and overnight ward on any given day. Currently, approximately 30 patients (n=30), including children under the age of 18 years, were discharged from the emergency centre and overnight ward on any given day.

3.5. Sampling

According to Jooste (2010a), a sample is a group of people, objects, items, or units selected from the larger population. Researchers only select a portion of the population to represent the entire population. Qualitative research is conducted to gather information from participants, who are likely to answer the research questions (Skinner, 2011). According to De Vos et al. (2011), a qualitative study is concerned with non-statistical methods and small samples that are often purposely selected. Purposive sampling, however, is the deliberate selection of all key informants to be included in the study. The participants of this current study were deliberately selected based on their knowledge of the topic the researcher considered they had (Burns & Grove, 2009). All the participants were working at an urban emergency centre, in conjunction with those discharged from an overnight ward and an urban emergency centre.

3.5.1. Professional nurses

Following ethical approval (see Annexure I) to conduct the study, purposively sampling, a non-probability sampling method, was used in this current study. This method is used when the researcher's judgement is applied to decide which participants to include in the study sample (Babbie & Mouton, 2014). However, for this current study, a total of 8 professional nurses were purposefully sampled. The sample included 4 professional nurses (n=4) working on night duty and 4 professional nurses (n=4) working on day duty. Eight individual interviews were conducted until data saturation was reached. Data saturation is a stage reached in the study when the researcher does not gain any new knowledge about the

phenomenon under study (De Vos et al., 2011). Data collection ended when data saturation was reached.

3.5.2. Patients

Following ethical approval (see Annexure I) to conduct the study, purposive sampling, a non-probability sampling method, was used in this study. As mentioned previously, this method is used when the researcher's judgement is applied to decide which participants to include in the study sample (Babbie & Mouton, 2014). Adult patients, who were discharged from the emergency centre and overnight ward, were purposively sampled. For this current study, 10 adult patients (n=10) were sampled. Data collection ended when data saturation was reached. Ten interviews were conducted until data saturation was reached. As mentioned previously, data saturation is a stage reached in the study, when the researcher does not gain any new knowledge about the phenomenon under study (De Vos et al., 2011).

3.5.3. Inclusion criteria were:

- All male and female professional nurses working in the emergency centre and overnight ward; and
- All adult patients that would have been discharged from the emergency centre and overnight ward.

3.5.4. Exclusion criteria were:

- All children under the age of 18 years; and
- All patients who showed evidence of intoxication or confusion.

3.6. Data collection

According to Babbie and Mouton (2014), data collection is the process of gathering data from the selected participants. The process of data collection is important for the successful completion of a study.

3.6.1. Data collection method

Data were collected using in-depth interviews. During the process of in-depth interviews, the researcher engages the participants directly in a conversation, in order to generate deeply contextual, nuanced and authentic accounts of participants' outer and inner worlds, specifically, their experiences and how they interpret them (Babbie & Mouton, 2014).

3.6.2. Data collection instrument

The researcher collected the data, during May to June 2015, by conducting indepth interviews and capturing field notes. This instrument was chosen to allow the participants to express their opinions, in their own words (De Vos et al., 2011). An interview guide (see Annexure B) for professional nurses and patients was used as an aid during the interviews. One research question, "What are the challenges to effective communication between nurses and patients in an urban emergency centre and how could it be improved?" was asked of the two participant samples, the professional nurses and the patients. Subsequently, the researcher used probes, such as the following; describe, think back/reflect, give examples, explain, why, by whom, when, as well as how, to gain the necessary depth of discussion regarding the participants' beliefs, views, and perspectives about the topic under investigation. It also allowed the researcher more flexibility to pursue interesting, related ideas that emerged (De Vos et al., 2011).

In-depth interviews allowed the researcher to conduct an in-depth exploration of the issue under investigation, for the purpose of gaining a better understanding of, and attaching the meaning of what was discussed. This information included, body language, tone of voice, and the interpretation of non-verbal cues, such as facial expressions, and body gestures (Burns & Grove, 2009). In this current study, the interviews generated rich data, since the participants could express their views without being influenced by the researcher.

3.6.3. Data collection process

The Provincial Research Team was requested to grant permission (see Annexure G) to conduct the research study at the selected facility in the Western Cape.

Having been granted permission (see Annexure D), the researcher contacted the Executive Director of the selected sub-structure and selected facility. To avoid the possibility of bias, the in-depth interviews for both professional nurses and patients were conducted by the researcher, as well as one fieldworker, who held a Master's Degree in Public Health. The researcher ensured that the fieldworker was trained on how to take notes of important incidents, observed during the interviews. The researcher prepared a writing pad, pen, and an audio recorder, in advance, for the interviews. The participants were contacted by the researcher to arrange available times for the interviews, at their convenience. The Chief Executive Officer was informed of the scheduled interviews, as arranged with the staff members (the professional nurses working in the emergency centre and overnight ward) and patients (discharged from the emergency centre and overnight ward).

Each in-depth interview lasted approximately 45 minutes. The in-depth interviews with the professional nurses were conducted at a convenient time, on day or night duty, so as not to disrupt patient care, or the operation of the emergency centre. The patients were requested to participate in an in-depth interview on discharge from the emergency centre or overnight ward. These interviews were held in a quiet room at the district hospital, and recorded with the permission of the participants. At the beginning of the actual interview, the purpose was explained once more (see Annexure E), written consent was obtained (see Annexure F) from each participant before continuing, while privacy and confidentiality were ensured.

All the participants were asked one initial open-ended question as follows: "What are the challenges to effective communication between nurses and patients in an urban emergency centre and how could it improved?" Subsequently, the researcher asked probing questions for the purpose of gaining more information and clarity about the phenomenon under study. Probing was used by the researcher to obtain more detail from the participants and to clarify certain aspects of the study. Probing was employed by using a word that encouraged participants to explain more about the phenomenon under discussion (Hennink, Hutter & Bailey, 2011). When a participant disclosed that to communicate

effectively was a challenge, the researcher would probe that statement by asking, "Why was it challenging?" Communication skills like maintaining eye contact, nodding, as well as clarification were applied to encourage the participants to share their opinions. Field notes were captured during the interviews, which were audio recorded with permission from the participants. The researcher's personal impressions, feelings, concerns and observations about the data obtained from the participants, were also recorded to avoid bias. The interviews were transcribed verbatim and clarity was sought for statements made by participants. The participants were free to discuss issues they deemed important (Creswell, 2014).

Audio recorder

In qualitative research, interviews are usually audio recorded (Turner, 2010). This process of audio recording and verbatim transcription is important for detailed analysis, to ensure that the interviewees' responses are captured in the precise manner in which they were expressed. By only relying on the capturing of field notes, important terms, phrases, and language that were used during the interviews, could be lost. Before the interviews, the researcher ensured that the audio recorder was of good quality and in working order. These precautions were necessary to assure good sound quality. The researcher also ensured that the setting was a quiet place, without disruptions, to ensure limited or no noise that might have affected the quality of the audio recordings. Privacy was ensured to allow the participants the opportunity to speak freely without fear of being overheard. The researcher transcribed each interview immediately after the interview to gain a sense of the emerging themes. By making use of an audio recorder, the researcher could capture notes, while simultaneously observing the participants during the interviews.

3.7. Data Analysis and Interpretation

Data analysis is a process during which the collected data are reduced, organised and ascribed significance (Turner, 2010). The findings of the data were guided by the conceptual framework for this current study that was based on the patient-centred care (patient centeredness) approach and a model of effective communication. A combination of the patient-centred care approach and a model of effective

communication provided the framework for this current study, based on the premise that for the rendering of patient-centred care, communication must be effective. The inductive process was used with thematic analysis of the data from the in-depth interviews, which implied, listening to audio recordings and transcribing them verbatim (by the researcher). This allowed the researcher to gain a comprehensive view and broader understanding of the phenomenon under study (Babbie & Mouton, 2014). The raw data were read thoroughly for the researcher to gain an understanding of the themes of the text. Thereafter, data were reduced into brief summary format, coded, and categories, patterns, as well as themes were identified. Field notes (recorded during interviews) were simultaneously analysed (Sutton & Austin, 2015).

The transcripts and notes, generally, comprised the main issues that the participants viewed and challenged, either positively or negatively, as well as the indicators that related to specific issues. The researcher, who works as a nursing manager at the institution under study, made a concerted effort to bracket, or set aside personal beliefs and did not judge what was reported by the participants. The researcher remained amenable to the data, as advised by (Sutton & Austin, 2015). The researcher, therefore, endeavoured to remain neutral and set aside previous knowledge about the phenomenon under study. The researcher organized the data in an orderly, coherent fashion to distinguish patterns and relationships (Sutton & Austin, 2015). Data analysis was executed by following the general inductive approach of Thomas (2006).

3.7.1. Process of data analysis

The analysis of the data from the interviews and field notes were conducted by using a general inductive approach (Thomas, 2006).

- The data from the interviews were filed in a common format; meaning that everything that was recorded in the interviews (see Annexure F) were transcribed [written out in hard copy format] (see Annexure H).
- After all the data from the interviews were transcribed, the text was read, in detail, by the researcher, to gain a clearer understanding of the text.

- The theoretical framework, the principle of patient-centred care, was identified. Multiple readings of the text (in vivo coding) entailed that most of the data were copied and pasted after categories had been identified.
 The segments of information were labelled to form or create categories.
- The number of themes and categories were defined and reduced in cases where the information were overlapping, or when the information was not relevant to the topic of the research.
- In each category, sub-topics were identified that included points of view and insights of the patients and the professional nurses.
- Transcriptions of the data were sent to an independent coder to be analysed. The researcher had a consensus discussion with the coder, who had experience in qualitative data analysis.

3.8. Rigor

3.8.1. Trustworthiness

According to Lincoln and Guba (1985, cited in Babbie & Mouton, 2014), the key criterion, or principle, of good qualitative research, is located in the notion of trustworthiness: the neutrality of its findings and decisions. Quantitative studies cannot be considered valid, unless it is reliable; similarly, qualitative studies cannot be called transferable, or deemed credible, unless it is dependable (Babbie & Mouton, 2014). Trustworthiness in this current study involved credibility, transferability, dependability and confirmability.

3.8.1.1. Credibility

When checking for credibility, the researcher asks the following question, "Is there compatibility between the constructed realities that exist in the minds of the participants and those that are attributed to them" (Babbie & Mouton, 2014). Self-awareness is important for the researcher to understand his/her history and situation. The researcher kept a journal of self-reflection, as a cross reference, during the data analysis process, to minimise personal biases. The researcher engaged in the exploration of the patients' and

professional nurses' experiences of communication in an emergency centre, while personally enduring similar experiences, as a nurse manager at the institution under study. At the time of this current study, the researcher was familiar with most of the professional nurses, and, therefore, had to be consistently aware to pursue interpretations in different ways, in conjunction with a process of constant and tentative analysis (Babbie & Mouton, 2014). Credibility was established through triangulation, as the researcher made use of different data collection techniques (interview, audio-recording, documentation, as well as observation) during the data collection process.

3.8.1.2. Transferability

Transferability is the extent to which the findings of this current study could be applied in other contexts, or with other respondents (Babbie & Mouton, 2014). In this research study, a qualitative, exploratory and descriptive, research design was the method of inquiry into the lived experiences of patients admitted at an urban emergency centre and an overnight ward, as well as the professional nurses, who performed their duties in an urban emergency centre and overnight ward. The findings of this study could be experienced differently by another set of subjects, at another emergency centre and overnight ward. The researcher established transferability by providing the reader with a description of the research study and what it entailed. A detailed description of the study was given to ensure that the reader is familiar with the context of the study. *Transferability* will be ensured by describing the research context, thoroughly.

3.8.1.3. Confirmability

Confirmability was established through triangulation, keeping an audit trail, as well as self-reflexivity.

3.8.1.4. Dependability

According to Sutton and Austin (2015), dependability will be ensured by means of a thick description of the research methods by the researcher. For a study to be accurate, Lincoln and Guba (1985, cited in Babbie & Mouton,

2014) suggest that an audit trail be kept. An inquiry must also provide its audiences with evidence that if it were to be repeated with the same, or similar respondents (subjects), in the same (or a similar) context, its findings would be similar (Babbie & Mouton, 2014). In this study, the researcher made use of field notes during the interview process, and specifically recorded entries, based on the interviews. The transcriptions of the data were sent to an independent coder to be analysed, in order to minimise bias during the data analysis process. Subsequently, the researcher had a consensus discussion with the coder, who had experience in qualitative data analysis.

3.8.2. Reflexivity

Reflexivity was used to further enhance trustworthiness. According to Green and Thorogood (2009), reflexivity refers to the researcher's admission that her/his actions and decisions will inextricably affect the significance and perspective of the experience under study. Because of being employed at the district hospital, the researcher remained aware of the purpose of this study, and ensured that her presence, participation and personality did not prejudice the data collection process.

3.9. Ethics

Ethics approval was obtained from the University of the Western Cape (UWC) Research Ethics Committee (See Annexure I; Ref No 14/10/45). Permission for the professional nurses and patients to participate in this current research study was obtained from the Provincial Health Research Committee (See Annexures C, D and G). In this current study the researcher respected the rights and protection of the participants, by adhering to the following:

• Confidentiality and Anonymity: The researcher ensured that the information pertaining to this study, discussed with the participants, was not disclosed to anyone else (except with the study supervisor). To further ensure confidentiality, all audio tape recordings, transcripts, all written notes from the researcher pertaining to this research study, were locked in a cupboard for the duration of the study, and will be securely stored for five years, after which it

will be destroyed. The researcher made use of study codes for each participant, to ensure the anonymity of the participants. The study codes were also used as identification tools on the audio recording tapes, as well as the transcripts. In addition, the researcher ensured that all identifiable information was removed from the transcripts.

- Autonomy: The participants were thoroughly informed by the researcher of their right to withdraw at any time from participating in the research study, without prejudice.
- **Justice:** The participants, who participated in this current study, all met the criteria for inclusion.
- Consent: Adequate information about the research was shared with the participants by the researcher, allowing them to comprehend that they had the right to consent or decline participation, voluntarily (See Annexures E and F). No one was coerced in any manner.
- **Privacy:** The researcher advised the participants that they could determine when and where the interviews could be conducted.
- Risk: In this current study, there were potential risks for the participants, although these risks were minimal. Since the research explored personal experiences during the in-depth interview sessions, some experiences might have affected the participants, emotionally. The researcher, therefore, informed the participants that, should they experience the need for counselling, as a result of the in-depth interviews, they should inform the researcher, and a suitably qualified counsellor would be engaged. The participants could also experience fear, which could affect them emotionally, due to factors, such as being victimised at the health facility, as a result of the information revealed during the in-depth interview sessions. The researcher ensured the participants that the value of confidentiality and anonymity was a personal matter. No reward was offered, or paid to the participants, for participation in this research study.

3.10. Summary

In this chapter, the research methodology was presented to uncover the communication challenges between nurses and patients in an urban emergency centre, in the Western Cape. An exploratory, descriptive, design was employed to describe these experiences.

In the next chapter, the results of the data analysis of this study will be presented, which include the themes and categories, along with anecdotes from the participants, as well as a discussion on the interpretation of the research results.



CHAPTER FOUR

RESULTS AND DISCUSSION

41

4.1. Introduction

In this chapter, the researcher presents the results of the data analysis conducted on the data gathered from the in-depth interviews with the patients and professional nurses, as well as an integrated discussion, using existing literature on the topic as a control. The results of the study fulfil the study's aim, which was to explore the challenges of effective communication between nurses and patients, during the delivery of healthcare in an urban emergency centre, as well as possible improvement strategies for effective communication. The results relate to the study objectives, which were:

- To explore the nurses' and patients' views about communication between themselves in the emergency centre against the HRM PCCM.
- To determine the challenges to effective communication within the emergency centre as experienced by nurses and patients.
- To establish the views of nurses and patients on how communication between them can be improved

It is anticipated that the results of this current study will positively influence the six principles on which health policy is based, namely, safety, effectiveness, patient-centeredness, timorousness, efficiency, and equity. The presentation of the results is guided by the four principles of patient-centred care, which is the theoretical framework of this study, namely, respect; choice and empowerment; access and support; and information sharing. The categories and themes from the patients and professional nurses are illustrated in Table 4.1 and 4.2. Thereafter, the horizontal themes that cut across the vertical themes of the patients and professional nurses are illustrated in Table 4.3. The discussion section in this chapter is focused on the horizontal themes only, as these are the core results of this research.

4.2. Results from the interviews with patients

Four themes emerged from the patient data and are presented in Table 4.1. A total of 9 categories were clustered to form the four themes.

Table 4.1: Patients themes and categories

Theoretical Framework - Principles of patient-centred care	Theme	Categories	
1. Respect	Nurses were viewed as having a positive attitude.	 1.1. Nurses were experienced as being friendly, kind, patient, sincere, caring and helpful. 	
		Nurses behaved professionally and were viewed as competent in their tasks.	
		Patients were treated with dignity and their rights and privacy were respected.	
2. Choice and empowerment	Patients were allowed to make informed decisions about their health.	2.1. Patient's conditions were explained, they were counselled and encouraged to make the best choice and to make informed decisions.	
3. Access and support	Participants developed positive	3.1. A safe health care environment was created.	
	relationships with the nurses and were satisfied with the waiting time and care received.	Nurses provided good patient care, by improving comfort, treatment and quickly respond to patients' needs.	
	4. Nurse had a positive level of communication with patients.	4.1. Nurses displayed good listening skills.	
3. Information sharing		4.2. Patients felt free to speak to the nurses.	
WI		A.3. Patient's questions were adequately answered.	

4.3. Results from the interviews with professional nurses

Four themes emerged from the interviews with professional nurses and are presented in Table 4.2. A total of 10 categories were clustered to form the four themes.

Table 4.2: Professional nurses themes and categories

Theoretical Framework - Principles of patient-centred care	Theme	Categories
1. Respect	Nurses attitudes towards the	Nurses acted in a friendly, kind, patient, sincere, caring and helpful manner.

	patients were positive.	Nurses behaved professionally and were competent in their tasks.	
		Patients were treated with dignity and their rights and privacy were respected.	
	2. Patients were allowed to make informed decisions about their health and health care.	2.1. Patients' condition and treatment were explained to them.	
2. Choice and empowerment		Patients were counselled and encouraged to make informed decisions about their care.	
3. Access and support	3. Good nurse patient relationships were developed and patients were satisfied with the waiting time and care received.	3.1. A safe health care environment was created.	
		3.2. Nurses provided good patient care, by improving comfort, treatment and quickly respond to patients' needs.	
4. Information sharing	Nurse's displayed good communication skills.	4.1. Nurses displayed good listening skills	
		4.2. Patients were free to speak to the nurses.	
		4.3. Patient's questions were adequately answered.	

4.4. Discussion

The four principles of the theoretical framework are used to guide the discussion. The horizontal themes that capture both the patients' and professional nurses' themes are discussed, as they relate to each principle. This allows for the triangulation of the patients' and professional nurses' data and an integrated discussion, which includes a literature control.

UNIVERSITY of the WESTERN CAPE

Table 4.3: Horizontal themes that cut across patient and professional nurses vertical themes

Principles of Theoretical Framework	Patient Themes	Professional Nurse Themes	Horizontal Theme
1. Respect	Nurses were viewed as having a positive attitude	Nurses attitudes towards the patients were positive	Nurses' attitude was viewed as positive by both patients and professional nurses

2. Choice and Empowerment	Patients were allowed to make informed decisions about their health	Patients were allowed to make informed decisions about their health and health care	2. Both patients and professional nurses felt that patients were allowed to make informed decisions about their health and health care.
3. Access and support	3. Patients developed positive relationships with the nurses and were satisfied with the waiting time and care received	Good nurse patient relationships were developed and patients were satisfied with the waiting time and care	3. Both patients and professional nurses viewed nurse patient relationships as positive and reported that patients were satisfied with the waiting time and the care they received
4. Information sharing	Nurses had a positive level of communication with patients	Nurse's displayed good communication skills	4. Nurses were viewed as having good communication skills and displayed a positive level of communication with patients

4.4.1. Principle 1: Respect

The patients' and the professional nurses' perceptions of respect, as defined in this current study, refers to the manner in which the healthcare provider, for example, the professional nurse, shows how they value the patient. The way in which the professional nurse talks, behaves and approaches a patient, influences the patients' perceptions of the nurse. The literature does not provide a clear and narrow definition of respect in the health care environment. However, respect towards individuals, including patients, their families, and the community has been mentioned as an important nursing ethical value (College of Nurses of Ontario, 2009). Pang, Senaratana, Kunaviktikul, Klunklin & McElmurry (2009) argue that nurses should treat patients with the respect and dignity in action, which they deserve. According to Fry, Veatch & Taylor (2010), the value systems of individuals, differences in their backgrounds, as well as different personalities, influence how they will behave towards each other during health care delivery. However, their research study does not attempt to define respect. Therefore, the Batho Pele Principles, as well as the Patient Rights Charter should be upheld, according to the Constitution of the Republic of South Africa (Republic of South Africa [RSA], 1996; RSA Western Cape DoH, 2013).

A major contribution towards a positive health outcome would be ensured, when patients perceived that they are treated with respect during the delivery of care in the emergency centre and overnight ward. Patients should be treated with respect by health care professionals; in a way that maintains their dignity and demonstrates sensitivity to their cultural values (National Research Corporation Canada, 2015). Literature supports healthcare professionals, who show respect, provide more information, and whose approach is more positive towards patients (Beach, Saha, Branyon, Ehanire & Mathews, 2016). Subsequently, consensus was reached that patients are at the centre of care, have the greatest stake in their care, and should be respected as equal partners in their care (The Joint Commission on Accreditation of Healthcare Organization, 2008; Bucknall, Hutchinson, Botti, McTier, Rawson, Hewitt, McMurray, Marshall, Gillespie & Chaboyer, 2016).

.

4.4.1.1. Theme 1: Nurses' attitude was viewed as positive by both patients and professional nurses

The attitude of the heath care professional is vital and how the patient perceives the care that is provided is a particularly important aspect. The worldview of the nurses is portrayed in how they behave towards patients. Fry et al. (2010), as well as Wood (2013) argue that personal values, such as respect, responsibility, and obligation, are dependent on the worldview of the nurse. Professional attitudes in nursing comprise inclinations, feelings and emotions that conform to the principles of their profession, and serve as the basis for that behaviour (UK Essays, 2015). Planetree (2009) highlights what patient input confirms; it is often the simple acts of caring, such as friendliness, kindness, patience, sincerity, as well as a caring and helpful manner that are most meaningful. Conversely, the absence of caring attitudes and caring gestures can leave a lasting negative impression. If nurses are not satisfied and happy in their work environment, it could influence their attitude (Batnagar & Srivastava, 2012).

From the categories in Table 4.1, most of the patients experienced the behaviour, as described above, which is evident in the following response: from participant:

"For me personally I felt the nurses' friendliness was a huge help during my stay in hospital especially during my first admission in hospital" (Patient 003).

A similar report was received from another participant:

"During my stay in hospital, nurses expressed kindness and sincerity... they were always smiling and were friendly" (Patient 007).

A participant felt that, even though nurses were busy, they were not "offputting" and had a positive attitude, as per the following anecdote:

"...the nurses were always busy during my stay in hospital, their attitude to me were always kind and friendly" (Patient 002).

One participant reported how nurses alleviated his fears about being in hospital, as follows:

"Nurses were friendly and showed signs of patience...because you know...as we go to hospital, you have that fear of it's not going good in the hospitals, but with the nurses assisting us and being there for us...it helped a lot" (Patient 004).

Knowledge of what may influence patients' participation, from the patient's perspective, is of great importance, and could be used to remedy negative experiences (Larsson, Sahlsten, Segesten & Plos, 2011). One "coloured participant disclosed his prejudice regarding black nurses, as follows:

"I always thought black nurses are unfriendly, but they were always friendly... they had a caring attitude and were helpful" (Patient 005).

The nurses' behaviour towards the patients, as per the reflected categories in Table 4.2, emphasizes the value of positive relationships with patients. Papadantonaki (2012) described good personal relationships as the ability

of the nurse to ask questions with kindness, and provide information in a manner that does not scare, demonstrates interest, and creates feelings of acceptance, trust, as well as a harmonious relationship, especially in a modern multicultural society. This was evident from what the professional nurses remarked during their interviews. One participant reported:

"I think it's really vital as a nurse to show friendliness on her face every time dealing with the patient, because it gives hope to the patient" (PN008).

Another participant expressed the following:

"I showed sincere concern by smiling at my patient...to establish a trust relationship with my patient; I asked questions in a friendly tone. It helps a lot... already the healing process has started" (PN003).

The participants expressed a strong belief in the value of acting in a friendly, kind, patient, sincere, caring and helpful manner, and considered it essential for the enhancement of effective communication between nurses and patients. One participant mentioned the following:

"It is important to orientate the patients in the emergency centre and overnight ward...care is a complex interaction between the nurses and patients. The staff has to deal with whatever comes their way, and remain focused, friendly, helpful and caring... the patient should know at the end that he/she did receive the proper care" (PN006).

Another participating nurse reported on positive attempts to create an acceptable environment for patients:

"We give them smiles so that they can feel the kindness and warmth of the people, who are working in the area. Although there's not always enough time, we still want the patient to know we care" (PN004).

Another participating nurse expressed:

"We try our best to provide optimal care to our patients. Sometimes it might appear as if we are neglecting them...it is just that we do not have that much time" (PN002).

The patients' perceptions of the nurses' behaviour, as reflected in the categories in Table 4.1, demonstrate the professional behaviour and competence of the nurses. The patients' impressions, during the study revealed that healthcare professionals were behaving in a professional manner. The importance of integrating their competencies, such as knowledge, skills, experience and communication abilities, is essential to meet patient expectations and provide safe and effective patient care (Jooste, 2010a; Lateef, 2011; Lorber & Savič, 2011). One participating patient expressed the following:

"Even though the working environment was challenging... this did not influence their behaviour in a negative way. The nurses were always professional and demonstrated competency in their work" (Patient 008).

A similar report was received from another participating patient:

"Emergency centre was stressful because of the high volume of patients and the work load of nurses, but still... you could clearly see nurses are trained and they were very professional" (Patient 010).

Smith, Dixon, Trevena, Nutbeam & McCaffery (2009), as well as Sukrin, Bakkar, El-Damen & Ahmed (2013) assert that nurses care about patients, value them and display a genuine interest. In addition, they are mindful not to put their preferences, beliefs and values first, while emphasising the positive effects of their qualification and clinical experience. A participating patient disclosed the following:

"They treated me professionally...I think they do not put their own values and beliefs first". Another participant (PT004) said: "Nurses treated all patients professionally... nurses have the knowledge and skills...I could clearly see nurses are experienced and competent when they perform their job" (Patient 003).

Nurses have a professional duty to serve the interests and needs of patients efficiently, while most of the participants acknowledged the importance of health care professionals adhering to a professional code of conduct (Zahedi *et al.*, 2013), as expressed by a participating patient:

"Nurses practiced according to their ethical code...the nurses treated me professionally and nurses showed evidence of competency and that they were trained" (Patient 006).

The cognitive and professional characteristics exhibited by the professional nurses towards their patients are reflected in the categories in Table 4.2. The participants proposed that critical creative thinking and clinical judgement are viewed as essential competencies for every health professional, to provide safe and effective nursing care, in an increasingly complex health care environment (Potgieter, 2012; Van Graan, Williams & Koen, 2016).

There were, however, some responses, which indicated that nurses were challenged in the emergency centre and overnight ward, as reflected in the following quotation:

"We are being helpful since day one when the patient is admitted in emergency centre and overnight ward... we even try to attend to them immediately those who need immediate care... but I still feel we don't give the patients enough help" (PN005).

Another participating nurse reported:

"Although the emergency centre can become very busy and patients put some strain on nurses... we remain professional" (PN006).

There were however negative experiences with regards to the lack of experience and skills of professional nurses as well as agency staff. One professional nurse stated:

"Doctors expressed their unhappiness in cases where they experienced the new professional nurses were not fast enough" (PN007).

A similar report was received from one participant, who said:

"It is very difficult to work with agency staff who are not familiar with the environment and do not always know the correct procedures... we do not have time to train them" (PN001).

Another professional nurse also reported:

"We don't have enough professional nurses who are trained. That can be sometimes a risk for the patients, as well as for the organisation" (PN007).

The limited resources to develop junior and relief health care professionals, adds an extra burden to train and support the aforementioned categories (Kieft, De Brouwer, Francke & Delnoij, 2014). Schroeter (2008) and Kieft et al. (2014) revealed that task orientation of the junior professional nurses in the organization, made effective work functioning, with established performance standards, very challenging in the working environment. Therefore, it appears that the professional working relationship between the health care professionals and the junior professional nurses is at risk.

Russell (2012) asserts that it is required of health care professionals to practice within the scope of their designated role and setting to protect

patients from unprofessional and unsafe nursing practice. One participating nurse expressed the following:

"Nurses did many things which were out of their scope... we do have competent nurses... it is expected that nurses should work according the ethical code, nurses should be professional at all times" (PN006).

Another participant also responded as follows:

"I have no problem to work with my colleagues...my colleagues are experienced and are competent to do their job" (PN004).

Patients' perceptions of nurses' behaviour, regarding respect, as reflected in the categories in Table 4.1, emphasized how they were treated with dignity and their rights, as well as privacy respected. Adib-Hajbaghery and Aghajani (2015) suggest that the attribute of respect includes self-respect, respect for others, respect for peoples' privacy and confidentiality, as well as self-belief and belief in others. Self-respect, as well as respect between patients and healthcare providers, are some of the elements noted in the Patient Rights Charter, according to The Constitution of the Republic of South Africa (Republic of South Africa [RSA], 1996; RSA Western Cape DoH, 2013). One participating patient reported as follows:

"Patients should acknowledge the fact that there should be dual respect and understanding between nurses and patients ... yes...they considered my rights" (Patient 001).

Another participant reported the following:

"I could see there was dual respect and understanding between the nurses and patients... there was privacy in the hospital...nurses treated me with dignity and respect" (Patient 006).

Bacchini (2012), as well as Brodnik, Rinehart-Thompson and Reynolds (2012) describe the concept of privacy as distinct from confidentiality, and

view it as an individual client's right, to make decisions about how personal information is shared between professionals, in order to manage the patient, as well as the physical space, to ensure that the private conversations remain so, and that the patient's dignity is preserved. One participant commented on the issue of privacy to sleep alone, as follows:

"Nurses respected my privacy...it was nice to close the curtains when you wanted to sleep" (Patient 001).

The participants also referred to the increased number of patients, which was not used as an excuse by nurses to treat patients with disrespect and contempt, as is reflected in a participant's statement:

"There were a lot of patients admitted in in the overnight ward...but this situation did not prevent the nurses treating us with respect and dignity" (Patient 008).

One participant added:

"There was limitation of bed space... however; nurses respected my privacy during my stay in hospital" (Patient 003).

Another participant related:

"Yes... confidentiality was maintained at all times ...we were treated with dignity and respect" (Patient 004).

A similar report was received, as follows:

"The nurses created an environment of such a nature... they considered my privacy... they also treated me with respect and dignity" (Patient 0010).

Continuous engagement was also noted by the participants, as one informed:

"There was continuous engagement between the nurses and patients during my admission in emergency centre... the nurses considered my privacy, treated me with confidentiality, respect and dignity" (Patient 007).

Brodnik et al. (2012); Education Career Articles (2013); as well as Tabler, Scammon, Kim, Farrell, Tomoaia-Cotisel and Magill (2014) reveal that continuous interaction is recognized as essential for nurse-patient communication, as it builds confidence in patients. This continuous interaction is viewed as important, as well as beneficial for the health and satisfaction of patients.

Most participants in the reflected categories in Table 4.2 indicated that the patients were treated with dignity, while their rights and privacy were respected. However, one participating nurse reported the following:

"Although we endeavour to maintain privacy, unfortunately... it doesn't happen in our trauma unit. There isn't enough space for all the patients... patients do have their rights and we have to treat patients with dignity and their privacy should be respected" (PN002).

A similar report was received from another participant who stated:

"We had less patients previously compared to today...patients were treated with dignity and their rights and privacy were respected, because you could draw curtains between patients... today there is no space for patients in casualty" (PN001).

Studies conducted by Diamantopoulou (2009), as well as Papagiannis (2010), support the professional nurses' perception of effective nursepatient communication, which is conducted under the appropriate conditions.

The participants in this current study also revealed other contributing factors that undermine patients' respect, dignity, confidentiality and

privacy, such as overcrowding, limited space and inadequate resources (Nayeri & Aghajani, 2010). One participating nurse reported:

"I think the whole situation has changed, which I believe is because of space...and still the patients should be treated with dignity and their privacy should be respected...we don't actually have enough privacy" (PN003).

Another participant added:

"Due to the high volume of patient influx, space is limited that impacts on the privacy and rights of the patient that should be respected...this is a major challenge to treating patients with dignity" (PN004).

A similar report was received from yet another participating nurse:

"I feel very unhappy with the setup at the moment... as it is because the males and females are not even separated which has a negative influence to treat them with dignity and to respect their rights" (PN006).

A further comment was received from one other participant:

"We try by all means to treat the patients with dignity and to respect their rights and privacy... we are not always able to interact in privacy with a patient when needed to do so" (PN007).

To reiterate, Wood (2013) suggests that the worldview of the nurses is portrayed in how they behave towards patients. Planetree (2009) highlights that patient consider the simple acts of caring as the most meaningful, for example, friendliness, kindness, patience, sincerity, as well as a caring and helpful manner, while the absence of caring attitudes and gestures could create a negative impression.

4.4.2. Principle 2: Choice and Empowerment

The concept of choice, as per the patient-centred principles, according to Planetree (2009), is a valuable prerogative ascribed to patients and their families, from the time that the patient enters the hospital, up to his/her discharge. The concept of empowerment is a dynamic process that can be shared, taken or given to others. It is also defined as the granting of ability; the delegation of power or authority; enablement; or permission; and should be recognised as both an individual, as well as a community process (WHO, 2009; UK Essays, 2015). The Picker's model subscribes to empowering the patient with the following principles: respect for patient's values, preferences and expressed needs; information and education; emotional support, as well as alleviation of fear and anxiety; and the involvement of family and friends (Planetree, 2009). Konishi, Yahiro, Nakajima and Ono (2009) assert that conscious adult patients should make their own decisions. Similarly, in this current study, regarding the nursing profession, nurses should empower patients with information, explain suggested interventions, and allow them to either accept or reject impending procedures, so that they and their families could make informed decisions about their health care.

4.4.2.1. Theme 2: Both patients and professional nurses felt that patients were allowed to make informed decisions about their health and health care

The participants in this current study, both the patients and the professional nurses, were of the opinion that patients had the freedom to make informed decisions about their health and health care. The Australian Centre for Healthcare Improvement [CHI] (Commonwealth of Australia, State of Queensland Government, 2011) highlights that informed decision-making is fundamental, as well as a two-way communication process between patients and their health practitioners, regarding the benefits, risks and alternative treatment regimes, while considering the patient's personal circumstances, beliefs and priorities, which is central to patient-centred healthcare. It is also described as a decision by a patient, regarding a diagnostic or therapeutic procedure, based on choice, which requires that the decision should be voluntary and the patient has the capacity for choice. This capacity depends on 3 elements, namely, the possession of a set of

values and goals; the ability to understand information and communicate decisions; and the ability to reason and deliberate (Segen's Medical Dictionary, n.d). The improvement of the patients' experiences, as well as enabling patients to maintain their independence, has been described as a moral virtue, bringing an ethical dimension to choice, which nurses are expected to do (South African Nurses Council [SANC], 2013). However, the study conducted by Shayo, Norheim, Mboera, Byskov, Maluka, Kamuzora and Blystad, 2012) indicate extensive limitations, in terms of fair participation in health care decision-making processes, in the study's district of Tanzania; the influence of gender, wealth, ethnicity and education presents substantial challenges in practice.

The perceptions of the patients, as reflected by the categories in Table 4.1, highlight active involvement, when nurses explain their conditions and treatment. Research conducted by Lateef (2011), the Commonwealth of Australia, State of Queensland Government (2011), as well as Queensland Health (2017) observed that patients, who are actively involved in decision-making regarding their care, better understand the likely, or potential, outcomes of their treatment. This process builds trust, prevents harm, and reduces surprise, as well as distress, when complications or adverse events do occur during consultation with the health care professionals, taking into account the context of the clinical situation, as experienced by the patients. One participant reported:

"When I asked them something that I was not sure of, they responded to me in a correct way... they explained my condition and treatment in such a way that I could understand" (Patient 001).

Similar reports were received from other participating patients:

"Nurses had sometimes more than one tasks to complete... however, they did explain my condition and treatment well enough that I could understand" (Patient 003).

"Nurses were always busy attending to a lot of patients' needs... although they were busy... they created the time in their busy schedule to explain my condition and treatment to me" (Patient 004).

The research study conducted by Li et al. (2012) support the importance of establishing appropriate verbal communication with patients, to understand explanations about their condition and treatment better. One participant reported:

"When the nurses explained my condition and treatment to me... they explained it in my own language... it was clear to me" (Patient 006).

Another participating patient expressed:

"I never experienced difficulties during my stay in hospital regarding communication... they did explain my condition and treatment clearly to me" (Patient 008).

Research conducted by the Commonwealth of Australia, State of Queensland Government (2011) found that health care professionals should provide information to patients; in a language they are fluent in, or by any other means, so that the patient will be able to understand the information clearly.

The nurses' behaviour towards patients, as reflected by the categories in Table 4.2, demonstrates the manner in which they explain the patients' condition and treatment to them. It was observed in this current study that health care professionals explained the patients' rights and obligations to them, during care delivery, including their right to pose questions about the prescribed course of treatment. In addition, communication was open and transparent during interaction with the patients, allowing them to make informed decisions (Aghabarari et al., 2009; Commonwealth of Australia, State of Queensland Government, 2011). One participating nurse reported:

"Patients need to be informed what is going to happen to them... what is going on... what is their diagnosis...what is the patient being treated for" (PN002).

Another participant reported:

"The nurse has to have a level of firmness to the patient... in order to ensure patients' condition and treatment was clearly explained" (PN006).

A similar report was received from yet another participant:

"We have to explain the patients' condition and treatment in a calm manner" (PN002).

Although the participants in this current study did not refer directly to responsiveness, the participants expressed that nurses are considered the direct care provider, and the smallest delay in care provision, could be perceived as medical negligence, specifically during the explanation of the patients' condition and treatment (Aghabarari et al., 2009). One participating nurse reported:

"It makes it very difficult to sit with one patient to thoroughly explain the patient's condition and treatment...our patients do not always understand what we're trying explain to them... to explain the patient's condition and treatment can become time consuming" (PN004).

Ammentorp, Sabroe, Kofoed and Mainz (2007), as well as Porter and Teisberg (2007), refer to additional contributing factors, such as yelling, constant nagging and misunderstandings in the setting, which directly influence the effective nurse-patient communication in a healthcare setting. A participating nurse expressed:

"The patients are yelling, constantly nagging or enquiring about the doctor...and the nurse is getting upset while trying to explain the patient's condition and treatment ...the nurse also raising his or her voice and it has an effect on your persona" (PN002).

Ammentorp et al. (2007) suggest that health care professionals should also consider the patient's family members, who are simultaneously experiencing a difficult time, and have different needs and demands. Additionally, Dixon, Robertson, Appleby, Burge, Devlin and Magee (2010), highlight that providing information and education, improves patient, family and carer capacity for involvement, understanding, participation and partnership in an individual's care. A participating nurse reported:

"If we are enough staff, we will try to make *time to explain the* patient's condition and treatment... we found that it is very important when you can include a family member of the patient... because sometimes... if the patient is alone he will not always understand" (PN007).

Regarding nurses' behaviour towards patients, as reflected by the categories in Table 4.1, patients were counselled and encouraged to make the best choice, as well as informed decisions, which are key components of patient-centred care. However, Pyl and Menard (2012) suggest that daily nursing practice should reflect effective nurse/patient communication and shared decision-making, as key components of patient-centred care. One participating patient reported:

"I understand English... the nurses counselled and encourage me to make informed decisions and they spoke in English to me... communication was not an obstacle between nurses and patients... yes...we were counselled and encouraged to make informed decisions" (Patient 001).

A similar report was received from another participant:

"The nurses counselled and encouraged me to make informed decisions during my stay in hospital...I could do that, because there was no breakdowns in communication" (Patient 003).

According to Al-Khathami, Kojan, Aljumah, Alqahtani and Alrwail (2010), the patients experienced that health care professionals considered different cultural backgrounds in the study, by taking steps to address linguistic and cultural barriers, to bridge the communication gap. A participant's response indicated general feelings of satisfaction on how they were counselled and encouraged to make informed decisions, as expressed in the following quotation:

"There were no language barriers and cultural differences when nurses counselled and encouraged me to make informed decision" (Patient 004).

Another participating patient stated that nurses even made eye contact, in an effort to improve communication between nurses and patients, as per the following excerpt:

UNIVERSITY of the

"When nurses counselled and encouraged me to make informed decisions, the nurses made eye contact when they talked to me" (Patient 006).

One participant shared positive experiences about nurses, who were continuously communicating, as follows:

"There were good interaction between the nurses and patients when they counselled and encouraged the patients to make informed decisions" (Patient 010).

It would appear that the nurses were focused on the positive implications of helping the patient to make informed and supported decisions, throughout the patient's decision-making process. The reflected categories in Table 4.2 illustrate the importance of nurses counselling and encouraging patients to make informed decisions about their care. Effective counselling requires an understanding of the patient, as well as the experiences they express. It requires skills and, simultaneously, the sincere intention of the nurse to understand what concerns the patient, to ensure the best informed decision (Kourkouta & Papathanasiou, 2014). There were, however, some responses, which indicated that nurses were challenged in the emergency centre and overnight ward, as is reflected in the following excerpt:

"We're just trying to explain the routine procedure of admission... we try our best to counsel and encourage the patients in order to make informed decisions...but it can sometimes cause conflict in the case of misunderstanding" (PN006).

A similar report was received from another participating nurse:

"Our patients do not understand what we're trying to tell them during our counselling session to encourage them to make informed decisions...then you find the family also interfering...this interference leads to unnecessary frustration between patients and nurses" (PN004).

The participants highlighted the importance of counselling, which should be clear for them to understand, as is reflected in one professional nurse's report:

"It is quite important to counsel patients... and it must be clear for the patients to understand... in order to encourage them to make informed decisions" (PN007).

According to Bekkum and Hilton (2013), the nurses articulated novel insights into how the health care professionals could negotiate some of the challenges, in terms of the environment that could impede them from

effectively communicating. One participating nurse indicated the benefit of a therapeutic environment, to promote efficient communication:

"We try to create an conducive environment by for example putting a screen between patients... and we must make time to go and give counselling...you know for them to make informed decisions... there should be good communication between the nurse and the patient" (PN003).

According to Vahdat, Hamzehgardeshi, Hessam and Hamzehgardeshi (2014), an effective nurse-patient relationship is an important contributing factor of patient involvement in decision-making. The findings of a study conducted by Dixon et al. (2010) highlighted that the patients perceived the professional nurses as health care workers, who ensured clear explanations for patients to make the correct choice of treatment that resulted in positive outcomes. These outcomes stimulated an increase of efficiency, responsiveness, and reduced inequities in access to care and quality of services.

4.4.3. Principle 3: Access and Support

Patient access is surely one of the most important issues for health care providers in the future. The Advisory Board Company (2017) emphasizes that access is a multi-dimensional concept and, currently, there is not one universally accepted definition. To them, "patient access" represents everything that affects a patient's ability to get the right care, at the right time, in the right place. According to the European Patients Forum [EPF] (2016), patients need to have access to health care in their country of origin, as the primary responsibility for access is national. It is also noted that the necessary care for all should be easily and timeously accessible, as well as fair, and patients should have the opportunity to exercise their options of treatment. However, for many countries, the rationalization of the healthcare system means the closure of small regional hospitals, which becomes a politically-charged issue, globally, and hinders access to, and support from, the health facilities (CGI Group INC, 2014).

4.4.3.1. Theme 3: Both patients and professional nurses viewed nurse-patient relationships as positive and reported that patients were satisfied with the waiting time and the care they received

Both patients and professional nurses viewed nurse-patient relationships as positive and reported that patients were satisfied with the waiting time, as well as the care they received. The patients' feedback in a research study is useful to evaluate the service and care, as well as influence the overall perceptions of health care and the health system (Ontario Hospital Association, 2010/2011). For patients, caring denotes positive connectedness, being instructed and taught, and having a nurse spending time and being patient with them (Palese & Papastavrou, 2011).

According to the categories in Table 4.1, most of the patients experienced that nurses created a safe healthcare environment. The study conducted by the Royal College of Nursing (2015) analysed the patient environment as the interface between the patient and the organisation that provides a practical and safe area, in which to provide patient care. This concept is evident in the response of a participating patient, as follows:

"Although there was a lot of patients admitted in emergency centre and overnight ward, I felt the presence of a safe healthcare environment was created by the nurses... I felt comfortable and safe" (Patient 002).

Another participant complimented the service and environment as follows:

"Nurses tried their best to provide a safe nursing care practice...The service and environment is up to standard" (Patient 006).

A similar report was received from a different participant:

WESTERN CAPE

"Nurses always tried to protect the patients... the healthcare environment was fine, the nurses were always there" (Patient 003.

The participants' responses indicated that the nurses ensured that there were no unnecessary disturbances that could affect good patient care. One participant reported:

"The nurses created a safe and comfortable healthcare environment. They even made sure that there was no disruption or any noise" (Patient 004).

A participating patient shared a positive experience:

"It was my first experience in emergency centre and overnight ward... however... I never felt threatened in hospital during my stay" (Patient 008).

Regarding the categories in Table 4.2, most of the professional nurses acknowledged creating of a safe health care environment. According to Lateef (2011); Bekkum and Hilton (2013), as well as Parker and Marco (2014), nurses work in an emergency environment of acute and time-dependent care. Nurses, who work in such an environment, are encouraged to maintain high standards, be timely, and efficient, while simultaneously providing satisfactory service, including a safe patient care environment, as well as effective communication. There were, however, some responses, which indicated that the nurses were challenged in the emergency centre and overnight ward, as is reflected in what one participant reported:

"Sometimes it becomes hectic and we are not always able to create a safe health care environment..." (PN005).

The participants indicated that nurses were challenged by the diversity of patients, especially mentally ill patients, to ensure safe patient care, as the following participant articulated:

"We have a vast diversity of patients especially...the psychiatric patients, which is a challenge to ensure a safe environment" (PN002).

Another participant responded and stated that it was incumbent on the nurses to put the patients at ease, although the emergency care environment can be a significant source of safety problems (Zani, Marcon, Tonete, De Lima & Parada, 2014). A similar report was received from a different participant:

"It is incumbent on the nurse to create safe health care environment... and to put the patient at ease... we've had violent psychiatric patients coming in that is very, very straining on the staff... what about creating a safe healthcare environment" (PN006).

Nurses could suggest how to make their work environment more comfortable, in order to contribute to positive patient experiences, irrespective of the challenges they faced. In addition, they can initiate the creation of a meaningful, effective nurse-patient relationship, as direct contact with patients is crucial to building and maintaining a relationship of trust (Becker's Healthcare, 2012; Kieft et al., 2014). One participant highlighted the importance of good communication, to promote an effective nurse patient relationship:

"We can still manage to create a safe environment...which leads to good communication between nurse and patients" (PN003).

Another participant referred to preventative measures that should be in place, as well as the correct procedures to follow:

"We have to take precautionary measures and follow the correct procedure to ensure the patients are managed in a safe health care environment" (PN007).

The responses from the participants indicated how difficult it was to create a safe environment, due to the increasing numbers of patients, as the following quotation highlights:

"It's difficult to create a safe environment... we've seen previous years 40 to 50 patients a day... now we see more than 100 patients per day" (PN001).

The patients' perceptions of nursing care, as reflected by the categories in Table 4.1, emphasizes that nurses provided good patient care, by improving comfort, treatment and quickly responding to patients' needs. Kvale and Bondevik (2008), as well as Ayyub, Kanji, Dias and Roshan (2015) assert that patients could be considered vital sources of information, for the evaluation of existing care, as they could inform on important incidents, noted during patient-care. Understandably, patients feel vulnerable when they are faced with illnesses, and welcome good patient-care that makes them feel like they had been treated, and accepted by the nurses as unique individuals. Most of the patients indicated that the nurses provided good patient care and treatment, by quickly responding to patients' needs. The following are some quotations of participating patients' responses:

"The nurses provided good care to me ... they improved my comfort by showing me the bathroom and ablution facilities... I did not wait too long for my folder or to see the doctor... after I saw the doctor, the nurse started immediately with my treatment" (Patient 002).

"I experienced a good journey... the nurse offered me a bed immediately... I did not experience any negligence or lack of attention from the nurses...they showed interest in my well-being and understood my condition...she started with my treatment immediately" (Patient 003).

"I felt happy the way they attended to me...there was no difference in service delivery between day and night staff... they tried their best to improve my comfort... they responded promptly on my needs" (Patient 005).

"There were a lot of nurses looking at my well-being and showed interest in me... they provided good patient-care to me" (Patient 004).

"We as patients were comfortable in the emergency centre... the nurses didn't only treat me...they also taught me...the nurses acknowledged me as a human being... everything was perfect in the emergency centre... the nurses gave immediate attention to me" (Patient 010).

Rodak (2012) concurs that nurses have the opportunity to work with patients, who are ill, and can help them to feel better. The nurse has to demonstrate compassion and strive to be successful in such a field. A participating patient indicated that the patients received excellent treatment and the nurses displayed a passion for their job:

"I could see nurses love their job... the standard of the service is equal to the private sector... the service improved over the years" (Patient 006).

A similar report was received from another participating patient:

UNIVERSITY of the

"I had a positive experience... I had a good experience... I was happy with my treatment... the nurses valued me as a patient... I was helped soon after arrival at the emergency centre" (Patient 008).

One participant referred to the nurses' responsiveness, their presence and their demonstration of compassion towards the patients:

"I was happy with the time I was waiting for assistance...I had a good experience I emergency centre... I was happy with my treatment...the nurses attended to my needs and concerns" (Patient 007).

Yet another participant was of the opinion that the nurses were knowledgeable and skilled:

"I felt comfortable and at ease when I saw a nurse... because I knew they did their job" (Patient 001).

One participant shared positive experiences about waiting times and treatment, as follows:

"I was happy with the time I was waiting for assistance... I was helped immediately after arrival at the emergency centre... I had a positive experience...I was treated well" (Patient 009).

According to the nurses, the essence of service quality is to ensure that health care providers attend to the patients' needs promptly, exhibiting caring and comforting behaviours that play a significant role in creating patient and family satisfaction in the emergency department (Ontario Hospital Association, 2010/2011). However, research suggests that the blurring of professional boundaries and job roles, which these reforms generate, could cause confusion about what is expected of them, for both patients and practitioners, and often patients perceive that hospital staff are too busy to help or answer their questions properly, as experienced by the participants in the study conducted by Machin, Machin and Pearson (2012).

According to the reflected categories in Table 4.2, most of the nurses claimed to provide good patient-care, by improving comfort, treatment and quickly responding to patients' needs, as described above. The participants' responses indicated that the staff members had to be increasingly aware of good patient-care, although patients are not always admitted into beds. One of these responses was as follows:

"While patients are waiting for beds in the emergency centre...
nurses still need to provide good patient care" (PN001).

A participant held the opinion that a specific nurse, with interpersonal skills to communicate effectively with patients, should be dedicated to the duty of ensuring good patient-care:

"The nurse should have good interpersonal skills... be able to communicate effectively with patients and in that way the patient might be more at ease... patients that are helped promptly shows satisfaction and has a good experience... they will thank you for the good patient care" (PN002).

Similar reports were received from other participating nurses:

"You as a nurse should really need to understand that the patient is sick... we really need to make them comfortable... to provide good patient care and to administer the treatment immediately" (PN008).

"There's not always enough time... but we do try our best to improve the patients' comfort and even good patient care" (PN004).

"We attend or respond immediately to patients' needs" (PN005)

"In the case where the patient is known asthmatic, for example, we have to respond to that patient immediately" (PN007).

However, one participant expressed that patients are not always aware of the quality care and treatment they received as provided by the nurses:

"The patient did not always know at the end that s/he did receive good patient care and treatment" (PN006).

According to The National Research Corporation Canada (2015), access and support was achieved by enhancing individuals' physical comfort during care, especially support with the activities of daily living, and maintaining a focus on the hospital environment (for example, privacy, cleanliness, comfort, accessibility of visits), to form the basis of a positive nurse-patient relationship, as well as patient satisfaction with the waiting time and care received.

4.4.4. Principle 4: Information sharing

The findings of a research study conducted by Pajnkihar, Štiglic and Vrbnjak, 2017) reveal that effective information sharing and uptake, across providers and care settings, was perceived as an essential step in tailoring information to suit patients' needs, vulnerabilities, and capacities. These results are consistent with the findings of a study conducted by Constand et al. (2014), which highlight that accountability for the accuracy of the information shared, is paramount to ensuring a high quality of care for all patients. James and Miza (2015) assert that, besides consultation, access and courtesy, the Batho Pele Principles also refer to the provision of fully accurate information to citizens about the public health services to which they are entitled. The literature review concurs with the Batho Pele Principles, as the public have faith that the health care professionals will provide them with accurate information regarding health issues; therefore, the nurse has the responsibility of ensuring that s/he is fully informed about all changes and new developments in the healthcare sector. Drenkard (2013) compares the importance of sharing desired information with the patients and families, to active partnering with them, to determine care priorities and a plan, tailoring their level of involvement, according to their preferences, not those of the care providers, and re-formulating the plan as the situation changes.

4.4.4.1. Theme 4: Nurses were viewed as having good communication skills and a positive level of communication with patients

According to Levinson, Lesser and Epstein (2010), communication skills are fundamental to patient-centred care, as effective communication requires an understanding of the patient and the experiences they disclose. In addition, good communication between nurses and patients is described as essential for the successful outcome of individualized nursing care of each patient. From the literature review, it is apparent that, in the current health care environment, a great deal of effort is being invested in improving communication between patients, families and members of the health care team. Kourkouta and Papathanasiou (2014), as well as Fakhr-Movahedi, Negarandeh and Salsali (2012), concur that nurses, who want to form the desired relationship with the patients, must gain their trust and support from the first moment. This will happen if the communication

occurs under the appropriate conditions, and it should be noted that the nurses' courtesy and kindness are definite requirements.

According to the reflected categories in Table 4.1, most of the patients experienced that the nurses displayed good listening skills. Patients have developed higher expectations; they want to be listened to (or heard), respected, supported emotionally, and told the truth at all times, as experienced by the participants during this current study. Active listening, however, is a non-intrusive way of sharing a patient's thoughts and feelings, and is particularly relevant in a hospital setting; it engages the speaker and listener in true communication, making a difference in rebuilding a patient's sense of self, and also be rewarding for the nurses (Health Facilities Scotland, 2012). Most of the participants shared their positive experiences with the nurses, whom they considered to have displayed good listening skills. The following are some quotations from the participants' responses:

"They always listened to me... the nurses listened to my fears and concerns... I think nurses do not put their own values and beliefs first" (Patient 003).

"The nurses would listen to me and they would even solve any problem that I might have" (Patient 006).

"The nurses listened to me... the nurses showed their understanding and concern" (Patient 009).

"The nurse's body language showed me that she was listening" (Patient 007).

"The nurses showed that she supported by listening to what I was telling them" (Patient 010).

The reflected categories in Table 4.2 indicate that the professional nurses displayed good listening skills. The research studies conducted by Kapoor (2016); Bramley and Matiti (2014); as well as Neese (2015), suggest that listening is a vital part of communication for healthcare professionals in

emergency centres. Nurses should be able to identify the need that requires attention, as well as mobilize all their senses to perceive any verbal and non-verbal messages, emitting from the patients. Therefore, the nurses' experience of work overload, lack of time and other priorities counteracts good listening (Moskop, Sklar, Geiderman, Schears & Bookman, 2009). There were, however, some responses, which indicated that nurses were challenged in the emergency centre and overnight ward, regarding time management, as reflected on by a participating nurse:

"It is not easy for us to listen to the patient and to explain everything to a patient... I think some of us do have those listening qualities, but time is of the essence" (PN005).

Another participant commented:

"We should take a specific nurse that has more interpersonal skills... someone who is able to communicate effectively with other people... and in that way people tend to listen to that nurse" (PN002).

One participant highlighted the importance of professionalism, to promote an effective nurse-patient relationship, as reflected in the following extract:

"We maintain professionalism by listening to the patients". (PN003).

The use of speech refers to the informal exchange of views, ideas or information, to consult or confer with someone. Communication occurs, when one person speaks and another listens, referred to as verbal communication (Bacchini, 2012; Boissy, Windover, Bokar, Karafa, Neuendorf, Frankel, Merlino & Rothberg, 2016). The patients' experiences, as reflected by the categories in Table 4.1, emphasized freedom to speak to the nurses, as described above. Many patients shared their positive experiences with the nurses they were able to speak to. The following are some quotations from participants' responses:

"The nurses did not show negative body language that they don't want to communicate with us... I think there was a good interpersonal relationship between the nurses and patients... the nurses showed empathy...I really felt free to talk" (Patient 003)

"We had the opportunity to disclose our fears... we were free to talk with nurses... the nurses communicated all the time well with me... even though the nurse was under pressure... she managed to talk to me... and I felt comfortable the way they talked to me" (Patient 001).

"I felt free to speak to the nurses... none of the nurses showed negative behaviour to me".

"When I speak to the nurses... the nurses did not show negative body language, abruptness or haste" (Patient 008).

"I was free to talk to nurses... I could raise my concerns and fears" (Patient 010).

"The nurses showed interest in me as a patient, that's why I felt free to speak to them" (Patient 008).

Most of the professional nurses considered that the patients were free to address the nurses, as reflected in the categories of Table 4.2. Additionally, most of the participants in the study continuously stressed the importance of communicating, while delivering care to patients (Slade *et al.*, 2015; Fletcher, 2013), as indicated by the following quotations:

"Patients are coming to the nurses, because they are free to talk and we should know how to present ourselves" (PN003).

"Patients felt free to talk... so it is important to tell him/her in a nice and polite way and you don't get angry with him... sometimes there's a lack of communication between the patient and other health care professionals" (PN008).

Some of the participants in the study, however, were of the opinion that there were challenges that hindered effective communication. These challenges resulted in patients being uncooperative, hostile, demanding, disruptive, and unpleasant (Davies, 2013). However, the converse is probably also relevant, as the patients may have perceived the doctors to display similar characteristics. The following quotations of the participants reflected their perspectives:

"The patients felt free to talk... but we experience patients are constantly nagging or enquiring about the doctor" (PN002).

"Patients felt free to speak in such a way that most of the patients do come with their own demands" (PN004).

The nurses disclosed that some patients may hold unrealistic expectations, or be unwilling to take responsibility for their health. There is a shifting in the communication relationship, between patients and professional nurses, which results in arguing, talking over the patient, or interrupting the patient, possibly leading to a downward spiral in the interaction. This could cause the professional nurses to feel stress, anxiety, anger, or helplessness, and could even lead to a disliking of the patient, as well as the use of avoidance strategies, as experienced by the participants in this current study. This view is supported by McClain (2012); Bekkum and Hilton (2013); as well as Davies (2013). However, there were some responses, which indicated that nurses were challenged with rude and difficult patients in the emergency centre and overnight ward, as is reflected in what one professional nurse reported:

"Patients felt free to talk... that they are rude sometimes... they can become very, very difficult... with high demands of you or high expectations" (PN005).

Another participating nurse sated that patients were not willing to wait for healthcare:

"Patients felt free to speak... but patients have their own expectations and the expectation is to be helped as soon as possible" (PN006).

Nurses spend a lot of time with patients, and their most important duty is to create an environment that may influence the patients' participation, and have a major impact on their experience (which is crucial), as well as foster an atmosphere in which questions are welcomed (Lateef, 2011; Larsson et al., 2011).

The results of a study conducted by Graham and Brookey (2008) reveal that patients are empowered, when they are invited to ask questions, and encouraged by health care professions, who want them to understand their own health care. In addition, the participants felt reassured, when the nurses answered their questions, and provided adequate explanations in this current study (Ncube, Barlow & Mayers, 2016).

The patients' experiences, as the categories reflect in Table 4.1, indicate their questions were adequately answered, as described above. Many participants shared their positive experiences with the professional nurses, as they considered that the patient's questions were adequately answered. The following are some quotations from the participants' responses:

"I had the opportunity to ask questions to the nurses... and the part I did not understand... they replied in a correct way and explain to me in a way which I could understand" (Patient 001).

"I sometimes struggled with questions regarding my concerns and fears... the nurses answered my questions adequately by explained everything... they also counselled and encouraged me" (Patient 010).

"The communication was good...when I asked any questions I noticed my questions were adequately answered" (Patient 002).

"When I asked questions to the nurses... my questions were always adequately answered...I understood them at all times" (Patient 003).

"When I asked nurses questions... the nurses explained to me... it was clear" (Patient 006).

"I had the opportunity to ask questions and I never experienced where nurses did not adequately answered my questions".

The reflected categories in Table 4.2 indicate that the professional nurses answered the patients' questions adequately. The promotion of good communication is important to explain the patient's treatment and condition, which is essential for the successful outcome of individualized nursing care of each patient. Good communication, however, is not only based on the physical abilities of nurses, but also on their education and experience, while adequately answering patients' questions (Kieft et al., 2014; Kourkouta & Papthanasiou, 2014). One participant highlighted the importance of communication to adequately answer patients' questions:

JIVI EKSIII oj me

"Patients' questions should be answered adequately... and I think communication is very important" (PN005).

Besides, nurses spend a lot of time with patients and influence their patient care experiences, as it has been observed that the nursing work environment is crucial, when the patient's treatment and condition has to be explained, and their questions adequately answered. The participants emphasized, in this current study, that nursing is a demanding job, and often the professional nurse could feel as though they do not have enough time to complete all their tasks (Kieft et al., 2014; Qteat & Sayej, 2014) as indicated in the following statements:

"It is very difficult to answer the patients' questions adequately, because it takes a lot of time to explain the patient's treatment and condition and to answer questions" (PN001).

"In order to answer patients' questions adequately... we must make time to go to the patients and give feedback" (PN003).

"Although it is expected to answer patients' questions adequately... sometimes you work alone as a registered nurse, and it can become very hectic" (PN005).

In addition, the participant continues to describe how difficult it is to answer patients' questions, adequately. Effective communication cannot always be established; there is the difference of the spoken language and, even non-verbal communication, in different cultures, may have different interpretations (Norouzinia et al., 2016). The participants' responses indicated that the nurses experienced challenges of diversity, as well as language barriers, when attempting to communicate effectively. The following quotations of the participants reflected their perceptions:

"It is sometimes very difficult to answer patients' questions adequately... because patients are coming from diverse community where... sometimes they usually have a language barrier" (PN007).

"Doctors do not always understand patients' language to answer patients' questions adequately... then we as nurses sometimes have a lot of work to do... and then the doctors call us to come and interpret for the patients as well" (PN008).

Other contributing reasons why the participating nurses were not able to answer patients' questions adequately, are, the issue of overcrowding, as well as the excessive demands of patients, which leads to physical and emotional burden on the health professionals (Kieft et al., 2014). A few participating nurses mentioned the increased number of patients that added to their workload, as per the following quotations:

"The overcrowding of patients in emergency centre and overnight ward... also put some strain on nurses... that impacts on answering patients' adequately" (PN004).

"You rarely interact with the other patients... although you should be adequately answered the patients' questions... you rather refer to your colleague should you experience problems with patients" (PN002).

The participants' responses indicated that nurses experienced challenges regarding the cooperation of patients, during communication between the nurse and the patient. One professional nurse expressed:

"Patients expect from us to answer their questions adequately... but do not try to understand or comprehend... while we are supposed to be more understanding ...we only try to explain to a patient certain things just to get rid of the patient... rather to answer patients' questions adequately" (PN002)

Norouzinia et al. (2016) also noted that hospitalization is potentially stressful, and involves unpleasant experiences, as the patients considered interaction between the healthcare professionals and the patients, as well as their families, a key element of their treatment in this current study. A participating professional nurse mentioned the complaints and arguments between nurses and patients, which impacts effective communication:

"In cases where patients' questions not adequately answered...that's why most of the time we will get all this complaints and you get arguments between nurses and patients most of the time fail to communicate openly with them" (PN003).

In a study conducted by Lateef (2011), healthcare professionals found that patients' stress and anxiety levels are usually high, due to the acute and sudden nature of their problems. These reactions, due to unmet expectations, could range from disappointment to anger; in this current case, complaints and arguments. One of the participants highlighted the importance of an inter-mediator, to improve effective communication between nurses and patients, as per the following extract:

"We as nurses try our best to answer patients' questions adequately... and wherever conflict arose between patients and staff... there was always somebody else to intervene" (PN006).

The results of this current study reveals that in both groups, nurses and patients, a great deal of effort is being invested in improving communication in the current health care emergency environment between patients, families and members of the health care team. These results are consistent with the results of studies conducted by Handzo, 2012, as well as Kourkouta and Papathanasiou (2014). The participants' responses also indicated the promotion of "patient access", to ensure patients get the right care, at the right time, in the right place, as supported by European Patients Forum (EPF, 2016). Regarding the patients' experience in this current study, they were treated with respect by the health care professionals, in a way that maintained their dignity and demonstrated sensitivity to their cultural values (National Research Corporation Canada, 2015). The professional nurses, in this current study, expressed that, at the present time, health professionals require continuous communication with patients, as a fundamental component of patient-centred care. The professional nurses described effective communication as an understanding of the patient, as well as the experiences they expressed, while receiving health care in the emergency center and the overnight ward. Both groups believed communication is the basis on which to build the relationship between nurses and patients, and is described as essential for the successful outcome of individualized nursing care of each patient (Levinson, Lesser & Epstein, 2010). As previous mentioned, Papagiannis, 2010, as well as Fakhr-Movahedi et al. (2012) concur that nurses, who want to create the right relationship the patients, must win them over from the first moment; this will happen if the conversation is held in appropriate conditions and it should be noted that courtesy and kindness on part of the nurse is required.

Constand et al. (2014), as well as James and Miza (2015) provide novel insights into how healthcare professionals, while sharing information with patients, should observe the culture of openness and transparency to

improve effective communication. The main goal of communication is to create a relationship between nurses and patients, to provide effective patient information and, simultaneously, for the nurse to understand what concerns the patient, as experienced in this current study. The participants in this current study were conscious adult patients, who made their own decisions (Konishi, Yahiro, Nakajima & Ono, 2009). The study results also emphasized that in the nursing profession, nurses should empower patients with information, explain suggested interventions, and allow them to, either, accept or reject future procedures, until they, along with their families, could make a decision about their condition.

Kourkouta and Papathanasiou (2014) suggest that effective communication is not only based on the physical abilities of nurses, but also on their education and experience. Understanding the patient only, is not sufficient; the nurse must also convey the message that s/he is understood and accepted, as it is a reflection of the knowledge of the participants, the way they think and feel, as well as their capabilities. However, during this current study, it was noted that hospitalization is potentially stressful for patients, as it involves unpleasant experiences, and the patients consider interaction with the healthcare professionals, patients and their families as a key to their treatment (Norouzinia et al., 2016). The evaluation of the viewpoints of professional nurses revealed barriers that hindered effective communication. Being overworked, shortage of nurses, and the lack of time were the most important barriers for the nurse group.

From personal experience and the literature review, the researcher concludes that communication is a vital instrument for the development of personal interaction between nurses and patients, and to improve communication skills.

4.5. Summary

In this fourth chapter, the research findings were explored in detail, and supported by findings from other studies that were conducted along similar lines. The research findings were also conceptualised into the theoretical framework that was used to guide the discussion from the review of literature. In the final part of the chapter, the researcher

explored some of the shortcomings of the study, as well as what was done to to minimise the way these shortcomings affected the research findings.

The next and final chapter comprises the summary, limitations, recommendations and conclusion of this current research project.

CHAPTER FIVE SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION UNIVERSITY of the

5.1. Introduction

This final chapter is divided into four main sections: summary, limitations, recommendations and conclusion. The summary provides a general idea of what the thesis was all about, and the findings obtained from the study. The limitations provide those characteristics of methodology that impacted the interpretation of the findings of the research. The recommendations provide suggestions that the researcher proposes to the various stakeholders, based on the findings of the study, and finally, the conclusion, containing the final remarks by the researcher, which are aligned with the purpose and objectives of the research study. It is also intended to assist the reader to understand why the research should matter to him/her after reading this thesis.

5.2. Summary

The purpose of the study was to explore the perceptions of patients and professional nurses on their communication during the delivery of healthcare, in an urban

emergency centre. The Patient Centred Framework, combined with the Model for Effective Communication, has proven to be an effective framework to identify the challenges that were perceived by all the participants.

A qualitative descriptive research design, to explore the perceptions of patients and professional nurses, was the method of choice. To ensure the validity and trustworthiness of the research findings, measures were taken to ensure credibility, dependability, confirmability, and transferability of the study and the results. For the study, all similar research was used as guiding principles. Data were collected through in-depth interviews, employing an interview guide with one open-ended question that was posed to the study participants. Probes were used to gain the necessary depth of discussion. A total of 8 professional nurses and ten patients were purposefully sampled. Data collection ended when data saturation was reached. The interview data were transcribed and analysed.

The analysis of the data was conducted, using the inductive process that followed the stages of developing themes, in line with the four principles of PCCM, which was the theoretical framework of this current study. These four principles include respect; choice and empowerment; access and support; and information sharing. From these principles, emerging from the data, horizontal themes were developed in an integrated manner, to represent both the findings of the interviews with patients and professional nurses. Subsequently, these findings were compared, contrasted and weighed against the existing body of literature.

5.3. Limitations of the study

This research study was only conducted at an urban emergency centre (EC) and overnight ward. The population comprised of all patients that had been admitted to, and discharged from the EC and overnight ward, and all the professional nurses employed at the EC. Ten (10) patients and eight (8) professional nurses were purposefully selected, according to the inclusion and exclusion criteria. The study, therefore, was limited to a small study sample of patients discharged from the EC and the overnight ward, as well as the professional nurses employed at the EC and the overnight ward, in the Western Cape. The researcher, however, ensured that data saturation was reached.

The findings, therefore, cannot be generalised and is limited and applicable to the context of this current study. Additional limitations relate to the researcher, who also conducted the interviews, being employed as a nurse manager at the institution under study. This may have an influenced the professional nurse's responses, as they might have revealed what they thought the researcher wanted to hear. Therefore, despite the researcher's attempt at bracketing, it must be acknowledged that, however minimal, the researcher's presence might have influenced this current study.

The study was not conducted as originally planned due to difficulties in interviewing the patients and professional nurses. Some patients, who were asked to participate, did not show much interest in sharing their personal experiences, and others did not want to wait to be interviewed, after being discharged. Despite the researcher's assurances that all research ethics had been adhered to, the participants might still have been reluctant to share more explicitly, for fear of being identified and exposed by the institution, which might also have influenced this current study.

It was also very challenging to interview the professional nurses on the four shifts, due to a complex and very busy emergency center, being short staffed, with inexperienced agency staff, which needed assistance and support.

WESTERN CAPE

5.4. Recommendations

The implications of the findings of this current study for nursing practice, policy development, nursing education, and nursing research for the improvement of communication are presented next.

5.4.1. Recommendations for nursing practice

- The research reveals that there is an overwhelming need to further research environmental challenges, resource limitations, staff capacity and skills that influence the staff's current and future needs, patient care experience and improvement of communication;
- Strengthening of the work place model PCCM, to promote a friendly, accepting and warm environment that would contribute to the positive health outcomes of the organisation;

 A mechanism to address the lack of information and communication for changes in critical patient movement should be explored.

5.4.2. Recommendations for education

- Appropriate programmes should be provided to the patients, family members, community and staff in their work environment for example educational television programmes, education packets, new employee orientation, rounding, online resources, etc.
- Effective communication skills should be taught to all healthcare workers at emergency care units.
- Orientation of newly appointed healthcare professionals should be provided, to communicate effectively, the procedures in the emergency environment.
- Ensure that the physical environment provides confidentially and privacy.

5.4.3. Recommendations for policy development

- Existing health communication models should include addressing the patients' communicated problems (such as waiting times) and concerns, in a satisfactory manner.
- The availability of a resource in the first language requires creativity and flexibility in the emergency areas, to assist the health workers in their communication with their patients.

5.4.4. Recommendations for further research

Quantitative studies, using validated instruments to measure the level of communication, are recommended as the current study did not focus on levels of communication. It is recommended that similar studies to be conducted in other emergency centres and overnight wards to establish the level of communication between nurses and patients, during patient care. It would be useful to repeat the study using larger groups of participants and a different setting, for example, in the wards.

5.5. Conclusion

Based on the findings, the researcher concluded that patients and nurses perceived the challenges to influence how professional nurses communicated with them in the emergency centre and overnight ward. These challenges, such as increased patient numbers and skills shortage, under which the professional nurses have to perform their patient care duties, had a negative effect on communication. Ultimately, the researcher trusts that the recommendations made will be acted on appropriately, as this could possibly help to resolve the challenges experienced by the patients and professional nurses.



Adib-Hajbaghery, M. & Aghajani, M. (2015). Nursing Midwifery Studies Patients dignity in Nursing *Nursing and Midwifery Studies*, *4*(1): e22809. [Online]. Available at: https://www.ncbi.nlm. nih.gov/pmc/articles/PMC4377527/ [Accessed: 16 October 2016].

Aghabarari, M., Mohammadi, I. & Varvani-Farahani, A. (2009). Barriers to application of communication skills by nurses in nurse-patient interaction. Nurses and patients' perspective. *Iranian Journal of Nursing*, 22(16), 19-31.

Al-Abrid, R. & Al-Balushi, A. (2014). Patient satisfaction survey as a tool towards quality improvement. *Oman Medical Journal*, 29(1), 3-7. [Online]. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3910415/ [Accessed: 28 October 2017].

Al-Fedaghi, S., Alsaqa, A. & Fadel, Z. (2009). Conceptual Model for Communication. *International Journal of Computer Science and Information Security*, 6(2). [Online]. Available at: http://sites.google.com./site/ijcsis/ [Accessed: 12 November 2017].

Al-Khathami, A.M., Kojan, S.W., Aljumah, M.A., Alqahtani, H. & Alrwail, H. (2010). The effect of nurse-patient language barrier on patients' satisfaction. *Saudi Med J. 31*, 1355-1358.

Ammentorp, J., Sabroe, S., Kofoed, P.E. & Mainz, J. (2007). The effect of training in communication skills on medical doctors' and nurses' self-efficacy: A randomized controlled trial. *Patient Education and Counseling*, 66(3), 270-277. [Online]. Available at: http://dx.doi.org/10.1016/j.pec [Accessed: 25 May 2017].

Audit Scotland (2012). NHS National Health Services Scotland. Annual Report on the 2011/2012 audit. Public Finance and Accountability (Scotland) Act 2000. Prepared for NHS National Services Scotland and the Auditor General for NHS financial Performance 2011/2012. [Online]. Available at: http://www.audit-scotland.gov.uk [Accessed: 19 September 2016].

Augmentative Communication News [ACN]. (2009). *Communication Access Across the healthcare Continuum patient satisfaction*. 21(2). This issue is part of an effort by an ad hoc group to increase awareness of patient-provider communication issues. [Online]. Available at: http://www.augcominc.com/newsletters/?fuseaction =newsletters&C=ACN [Accessed: 28 November 2017].

Australian Commission on Safety and Quality in Healthcare (ACHSQH) (2010). *Patient- centred care: Improving quality and safety by focusing care on patients and consumers*. Discussion paper. Draft for public consultation. [Online]. Available at: https://www.safetyand.quality.gov.au. [Accessed: 7 September 2016].

Australian Commission on Safety and Quality in Healthcare (2011). *Patient-centred care: Improving quality and safety through partnerships with patients and consumers.* [Online]. Available at: https://www.safetyand quality.gov.au. [Accessed: 7 September 2016].

Ayyub, R., Kanji, Z., Dias, J. & Roshan, R. (2015). Perceptions of patients regarding quality nursing care (QNC) at a Tertiary Care Hospital in Karachi, Pakistan. *Journal of Clinical Research & Bioethics*. The AGA Khan University.

Babbie, E. & Mouton, J. (2014). *The practice of social research*. Cape Town. Oxford Publishers.

Bach, S. & Grant, A. (2009). *Communication of interpersonal skills for nurses*. USA: Learning Matters. Original from Pennsylvania State University. [Online]. Available at: https://books.google.co.za/books/about/Communication_and_Interpersonal_Skills_f.ht ml?id=HocrAQAAMAAJ&redir_esc=y [Accessed: 27 October 2017].

Bacchini, S. (2012). Concise Oxford English Dictionary (12th edition), 26(5), 37-38. Available at: https://doi.org/10.1108/09504121211240620. [Accessed: 12 March 2018].

Beach, M.C., Saha, E., Branyon, I., Ehanire, Z. & Mathews, L.A. (2016). Communicating Respect for Patients as Persons: A Qualitative Study. *The International Journal of Person Centered Medicine*, 6(1), 32-41.

Becker's Healthcare. (2012). Clinical Leadership & Infection Control. 10 guiding principles for patient-centered care. [Online]. Available at: https://www.beckers hospitalreview.com/quality/10-guiding-principles-for-patient-centered-care.html [Accessed: 15 November 2017].

Bekkum, J.E. & Hilton, S. (2013). *The challenges of communicating research evidence in practice: Perspectives from UK health visitors and practice nurses*. [Online]. Available at: http://bmcnurs.biomedcentral.com/articles/10.1186/1472-6955-12-17 [Accessed: 5 January 2017].

Berger, B. (2011). *The Science beneath the art of Public Relations. Institute for Public Relations*. [Online]. Available at: http://www.instituteforpr.org/employee-organizational-communications/ [Accessed: 27 October 2014].

Bhartendra, S. & Triza, J. (2016). The impact of quality of hospital services on patient's satisfaction in selected hospitals of Punjab, India. *Research Journal of Recent Sciences*, 5(5), 24-28. [Online]. Available at: http://www.isca.in/rjrs/archive/v5/i5/5.ISCA-RJRS-2016-003.php [Accessed: 28 October 2017].

Bhatnagar, K. & Srivastava, K. (2012). Job satisfaction in healthcare organizations. *Industrial Psychiatry Journal*, 21(1), 75-78. Doi:10.4103/0972-6748.110958. [Online]. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3678186/ [Accessed: 4 November 2017].

Bless, C., Higson-Smith, C. & Kagee, A. (2013). 5th. ed. *Fundamentals of social research methods*. *An African perspective*. Cape Town: Juta.

Boissy, A., Windover, A.K., Bokar, D., Karafa, M., Neuendorf, K., Frankel, R.M., Merlino, J. & Rothberg, M.B. (2016). Communication skills training for physicians improve patient satisfaction. *Journal General Intern Medicine*, *31*(7), 755-761.

Boswell, C. & Cannon, S. (2015). *Introduction to Nursing Research: Incorporating Evidence-Based Practice*. [2nd ed.]. United States of America: Jones & Bartlett Publishers.

Bramley, L. & Matiti, M. (2014). How does it really feel to be in my shoes? Patients' experiences of compassion within nursing care and their perceptions of developing compassionate nurses. *Journal of Clinical Nursing*, 23(19-20), 2790-2799.

Bridges, J., Nicholson, C., Maben, J., Pope, C., Flatley, M., Wilkinson, C. & Tziggili, M. (2013). Capacity for care: Meta-ethnography of acute care nurses' experiences of the nurse-patient relationship. *Journal of Advanced Nursing*. 69(4), 760-772. http://dx.doi.org/10.1111/jan.12050 . [PMC free article] [PubMed]

Brink , H.I., Van Rensburg, G. & Van der Walt, C. (2012). *Fundamentals of research methodology for health care professionals*. [3rd ed.]. Cape Town: Juta.

Brodnik, M., Rinehart-Thompson, L. & Reynolds, R. (2012). Fundamentals of Law for Health Informatics and Information Management Professionals. Chicago: AHIMA Press.

Bucknall, T.K., Hutchinson, A.M., Botti, M., McTier, L., Rawson, H., Hewitt, N.A., McMurray, A., Marshall, A.P., Gillespie, B.M. & Chaboyer, W. (2016) Engaging patients and families in communication across transitions of care: an integrative review protocol. *Journal of Advanced Nursing*, 72(7), 1689-1700. *doi*: 10.1111/jan.12953.

Burns, N. & Grove, S.K. (2009). *The practice of nursing research. Appraisal, synthesis and generation of evidence*. [6th ed.]. St Louis: Saunders Elsevier Publishers.

Business of Healthcare. (2016). *The Role of Customer Satisfaction in Patient Care*. *Schumacher Clinical Partners Provider*. [Online]. Available at: https://www.schumacherclinical.com/providers/blog/the-role-of-customer-satisfaction-in-patient-care [Accessed: 23 September 2012].

Carroll, A.B. & Shabana, K.M. (2010). The Business Case for Corporate Social Responsibility: A Review of Concepts, Research and Practice. *International Journal of Management Reviews*, 12, 85-105. doi:10.1111/j.1468-2370.2009.00275.

Casey, A. & Wallis, A. (2011). Effective communication: Principle of Nursing Practice E *Nursing Standard*, 25(32), 25; 32; 35-37.

Centre for Pharmacy Postgraduate Education [CPPE]. (2014). *Consultation skills for pharmacy practice: taking a patient-centred approach.* A CPPE distance learning programme for pharmacy professionals. Educational solutions for NHS pharmacy workforce. Manchester: The University of Manchester [info@cppe.ac.uk].

CGI Group INC, (2014). *Healthcare Challenges and Trends. The Patient at the Heart of Care.* White Paper. [Online]. Available at: https://www.scribd.com/document/338112797/Cgi-Health-Challenges-White-Paper [Accessed: 15 November 2017]. CGI is a Canadian global information technology consulting, systems

integration, outsourcing, and solutions company, headquartered in Montreal, Quebec, Canada.

College of Nurses (CNO) of Ontario. (2009). *Practice Standards. Professional Standards*, Revised 2002. Toronto: College of Nurses of Ontario. [Online]. Available at: http://www.cno.org [Accessed: 13 November 2017].

Commonwealth of Australia. (2017). *Annual reports of Human Services 2015-16*. Australia: Department of Human Services.

Commonwealth of Australia, State of Queensland Government. (2011). *Queensland health guide to informed decision-making in healthcare* [1st ed.]. Australia: Centre for Healthcare Improvement [CHI].

Constand, M., MacDermid, J.C., Dal Bello-Haas, V. & Law, M. (2014). Scoping review of patient-centered care approaches in healthcare. *BMC Health Serv Res, 14*, 271.

Creswell, J. W. (2014). Research design: Qualitative, quantitative, and mixed methods approaches. Thousand Oaks: Sage.

UNIVERSITY of the

Davies, M. (2013). *Managing challenges interactions with patients*. BMJ Careers. [Online]. Available at: careers.bmj.com/careers/advice/view-article.html?id=20013822 [Accessed: 5 January 2017].

Davies, P.G. (2007). Patient Centredness. J Epidemiol Community Health, 61(1), 39.

De Silva, D. (2013). Organisation: The Evidence centre. Evidence scan: No. 18, Measuring patient experience. London, UK: The Health Foundation.

De Vos, A.C., Strydom, H., Fouche, C.B. & Delport, C.S.L. (2011). *Research at Grass roots: For the social sciences and human service professionals.* [4th ed.]. Pretoria: Van Schaik Publishers.

Diamantopoulou, E. (2009). Parents' Needs for Information about the Management of their Chronically Ill Children. *Nosileftiki*, 48(3), 317-324.

Dixon, A., Robertson, R., Appleby, J., Burge, P., Devlin, N. & Magee, H. (2010). *Patient Choice. How patients choose and how providers respond.* Europe: Picker Institute.

Downey, D. & Happ, M.B. (2013). The Need for Nurse Training to Promote Improved Patient-Provider Communication for Patients with Complex Communication Needs. *Perspectives on Augmentative and Alternative Communication*, 22(2), 112-119. [Online]. Available at: http://dx.doi.org/10.1044/aac22.2.112 [23 May 2017].

Drenkard, K. (2013). Transformational leadership: unleashing the potential. *The journal of Nursing Administration*, 43(2), 57-8. doi:10.1097/NNA.0b013e31827f1ea0

Education Career Articles. (2013). *Nursing Ethos: What is Confidentialty?* [Online]. Available at: http://educationcareerarticles.com/career-information/career-news/nursing-ethics-what-is-confidentiality/ [Accessed: 25 June 2016].

Entwistle, V.A. & Watt, I.S. (2013). Treating patients as persons: a capabilities approach to support delivery of person-centered care. *Am J Bioeth*, *13*, 29-39.

European Patients Forum [EPF]. (2016). *Defining and Measuring Access to Healthcare: the Patients' Perspective. Position Statement*. EPF 2015 Work Programme, with funding under an operating grant from the European Union's Health Programme (2014-2020). [Online]. Available at: www.eu-patient.eu.

Fakhr-Movahedi, A., Negarandeh, R. & Salsali, M. (2012). Exploring nurse-patient communication strategies. *Hayat Journal of Faculty of Nursing & Midwifery*, 18(4), 28-46.

Fleischer, S., Berg, A., Zimmermann, M., Wüste, K. & Behrens, J. (2009). Nursepatient interaction and communication: a systematic literature review. In: *Journal of Public Health*, 17(5), 339-353.

Fletcher, M. (2013). Are patients shaping healthcare across Europe? What is patient involvement and what are its benefits? *Breathe*, 9(5), 333-334. doi: 10.1183/2073 4735.007013.

Forough, R., Mohammad, E. & Hamid, H. (2007). Nurse caring in Iran and its relationship with patient satisfaction. *Australian Journal of Advanced Nursing*, 26(2), 75-84.

Frampton, S., Guastello, S., Brady, C., Hale, M., Horowitz, S., Smith, S.B. & Stone, S. (2008). *Patient- centered care improvement guide*. Planetree and Picker Institute. [Online]. Available at: https://www.capacityplus.org [Accessed: 19 September 2016].

Fry, S.T., Veatch, R.M. & Taylor, C. (2010). *Case studies in Nursing Ethics* [4th ed.]. Canada: Jones & Bartlett Learning.

Garling, P. (2008). Final report of the special commission of inquiry; Acute care services in NSW public hospitals. [Online]. Available at: http; //www.lawlink.nsw.gov.au.acsinquiry [Accessed: 28 August 2015].

Goethals, S., Gastmans, C. & Dierckx de Casterle', B.D. (2010). Nurses' ethical reasoning and behaviour: A literature review. *Int J Nurs Stud.* 47, 635-650.

Gorawara-Bhat, R., Dethmers, D.L. & Cook, M.A. (2013). Physician eye contact and elder patient perceptions of understanding and adherence. *Patient Educ Couns*, 92, 375-80.

Graham, S. & Brookey, J. (2008). Do Patients Understand? *The Permanente Journal*, 12(3), 67-69.

Green, J. & Thorogood, N. (2009) *Qualitative methods for health research* [2nd ed.]. Los Angeles: Sage.

Groene, O. (2011). Patient centredness and quality improvement efforts in hospital: rationale, measurement, implementation. *International Journal for Quality in Health Care*, 23(5), 531-537.

Gruman, J. (2012). *Patient Engagement!: Our skin is in the game*. [Web log post]. [Online]. Available at: http://blog.preparedpatientforum.org/blog/2012/02/patient-engagement-our-skin-is-in-the-game [Accessed: 5 November 2017]

Hafskjold, L., Sundler, A.J., Holmström, I.K., Sundling, V., Van Dulmen, S. & Eide, H. (2015). A cross-sectional study on person-centered communication in the care of older people: the COMHOME study protocol. *BMJ Open*, *5*, e007864. doi:10.1136/bmjopen-2015- 007864. [Online]. Available at: http://bmjopen.bmj.com/content/5/4/e007864 [Accessed: 9 September 2016].

Hakami, A. & Hamdi, O. (2013). *Influence of communication between nurses and physicians on patient outcome in hospital settings: A literature review*. European Centre for Research Training and Development UK. Sophiahemmet University.

Handzo, G. (2012). *Good communication in health care is about listening*. Patient. [Online]. Available at: http://www.kevinmd.com/blog/2012/01/good-communication-health care-listening.html [Accessed: 28 September 2017].

WESTERN CAPE

Hassan, S., Changiz, G., Shaker, S., Payam, R., Reza, G.V., Amirhossein, J.R., Rouzbeh, R.G. & Mary, S. (2011). Emergency department patient satisfaction survey in Imam Reza Hospital, Tabriz, Iran. *International Journal of Emergency Medicine*, 4(2). doi: 10.1186/1865-1380-1-2

Health Canada (2010). *Healthy Canadians - A federal Report on Comparable Health Indicators*. [Online]. Available at: http://publications.gc.ca/site/archivee-archived.html?url= http://publications.gc.ca/collections/collection_2011/sc-hc/H21-206-2010-eng.pdf [Accessed: 28 October 2017].

Health Facilities Scotland. (2012). *Patient-centred care*. National Services Scotland (NHS), a Division of NHS National Services Scotland. [Online]. Available at: http://www.audit-scotland.gov.uk. [Accessed: 19 November 2017].

Hennink, M., Hutter, I. & Bailey, A. (2011). *Qualitative Research Methods*. Los Angeles/London/New Delhi/Singapore/Washington DC: Sage Publications Ltd.

Holmström, I. & Röing, M. (2010). The relation between patient-centeredness and patient empowerment: a discussion on concepts. *Patient Educ Couns*, 79, 167–72.

Iftikhar, A., Allah, N., Shadiullah, K., Habibullah, K., Muhammad, A.R. & Muhammad, H.K. (2011). Predictors of patient satisfaction, *Gomal Journal of Medical Sciences*, 9(2), 183-188.

International Alliance of Patients' Organizations [IAPO]. (2007). What is patient-centred health care? A Review of Definitions and Principles. [2nd ed.].United Kingdom: International Alliance of Patients' Organizations [IAPO].

International Alliance of Patients' Organizations. (2012). A global voice for patients. Patient-centred healthcare indicators for consultation. United Kingdom: International Alliance of Patients' Organizations [IAPO].

IT Services 2012 Customer Satisfaction Survey. (2012). Stanford University. MOR Associates, Inc.

UNIVERSITY of the

James, S. & Miza, T.M. (2015). Perceptions of professional nurses, regarding introduction of the Batho Pele principles in State Hospitals, *Curationis*, *38*(1), Art. #1128. [Online]. Available at: http://dx.doi.org/10.4102/curationis.v38i1.1128. [Accessed: 22 October 2017].

Jangland, E., Gunningberg, L. & Carlsson, M. (2009). Patients' and relatives' complaints about encounters and communication in health care: Evidence for quality improvement. *Patient Education and Counseling*, 75(2), 199-204. [Online]. Available at: http://dx.doi.org/10.1016/j.pec.2008.10.007 . [PubMed]

Janicijevic, I., Seke, K., Djokovic, A. & Filipovic, T. (2013). Healthcare workers satisfaction and patient satisfaction – where is the linkage? *Hippokratia*, 17(2), 157-162.

Jayaprakash, N., O'Sullivan, R., Bey, T., Ahmed, S.S. & Lotfipour, S. (2009). Crowding and delivery of healthcare in emergency departments: The European perspective, *Western Journal of Emergency Medicine*, *10* (4), 233-239.

Jenkins, J., Calabria, E., Edelheim, J., Hodges, J., Markwell, K., Walo, M., Weeks, P. & Witsel, M. (2011). *Service Quality and Communication in Emergency Department Waiting Rooms: Case studies at Four New South Wales Hospitals*. Research and scholarly publications of South Cross University Report. EPublications @SCU

Jooste, K (2010a). The principles and practices of nursing and healthcare: ethos and professional practice, Management, Staff Development, and Research. Pretoria: Van Schaik Publishers.

Jooste, K. (2010b). A Framework for Recognition of Prior Learning within a Postgraduate Diploma of Nursing Management in South Africa. *Journal of Nursing Management*, *18*, 704-714. [Online]. Available at: http://onlinelibrary. wiley.com/doi/10.1111/j.1365-2834.2010.01160.x/abstract [Accessed: 17 July 2017].

Kapoor, S. (2016). *10 qualities that make a great nurse. Minority nurse*. [Online]. Available at: http://minoritynurse.com/10-qualities-that-make-a-great-nurse/ [Accessed: 1 March 2017].

Kavanagh, K.T., Cimiotti, J.P., Abusalem, S. & Coty, M-B. (2012). Moving healthcare quality forward with nursing-sensitive value-based purchasing. *Journal of Nursing Scholarship*, 44(4), 385-395. doi:10.1111/j.1547-5069.2012.01469.x.

Kekana, H.P., Du Rand, E.A. & Van Wyk, N.C. (2007). Job satisfaction of registered nurses in a community hospital in the Limpopo Province in South Africa. *Curationis*, 30(2), 24-35.

Kemmis, S., Wilkinson, J., Edwards-Groves, C., Hardy, I., Grootenboer, P. & Bristol, L. (2014). *Changing Practices. Changing Education*. (Chapter 2, p. 25). Singapore: Publisher Springer Science+Business Media.

Kieft, R.A.M.M., De Brouwer, B.B.J.M., Francke, A.L. & Delnoij, D.M.J. (2014). How nurses and their work environment affect patient experiences of the quality of care: A qualitative study. *BMC Health Services Research*, *14*, 249. doi:10.1186/1472-6963-14-249.

King, A. & Hoppe, R.B. (2013). "Best Practice" for Patient-Centered Communication: A Narrative Review. *Journal of Graduate Medical Education*, *5*(3), 385-393. [Online]. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3771166/ [Accessed: 22 October 2017].

Konishi, E., Yahiro, M., Nakajima, N. & Ono, M. (2009). The Japanese value of harmony and nursing ethics. *Nurs Ethics*. *16*, 625-36.

Korda, H. (2012). *Center for Advancing Health (CFAH)*. *Patient Satisfaction: Quality, Cost and the New Rules of Engagement*. [Online]. Available at: http://www.cfah.org/blog/2012/ patient-satisfaction-quality-cost-and-the-new-rules-of-Center for Advancing Health (CFAH) [Accessed: 28 August 2015].

Korsha, K.A. (2011). Nurses' stories about their interactions with patients at the Holy Family Hospital, Techiman, Ghana. *Open Journal of Nursing*, 2011(1), 1-9.

Kossivi, B., Xu, M. & Kalgora, B. (2016). Study on determining factors of employee retention. *Open Journal of Social Sciences*, *4*, 261-268. [Online]. Available at: http://dx.doi.org/10.4236/jss.2016.45029. [Accessed: 4 November 2017].

Kothari, C.R. (2011). *Research methodology: Methods and techniques*. New Delhi: New Age International.

Kourkouta, L. & Papathanasiou, V.I. (2014). Communication in Nursing Practice. *Materia Socio-Medica*, 26(1), 65-67. *Journal of the Academy of Medical Sciences of*

Bosnia and Herzegovina [Online]. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/ PMC3990376/ [Accessed: 15 November 2017].

Krueger, R.A. & Casey, M.A. (2009). Focus groups: A practical guide for applied research [4th ed.]. Thousand Oaks, CA: Sage Publications (Book). *Australian journal of advance nursing* 28(3), 61-67 (Journal article)

Kutney-Lee, A., McHugh, M.D., Sloane, D.M., Cimiotti. J.P., Flynn, L., Neff, D.F. & Aiken, L.H. (2009). Nursing: a key to patient satisfaction. *Health Aff (Millwood)*, 28(4), w669-77. doi: 10.1377/hlthaff.28.4.w669. [Online]. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2718727/ [Accessed: 4 November 2017].

Kvale, K. & Bondevik, M. (2008). What is important for patient-centred care? A qualitative study about the perceptions of patients with cancer. *Scandinavian Journal of Caring Science*, 22, 582-589.

Larsson, I.E., Sahlsten, J.M., Segesten, K. & Plos, K.A.E. (2011). Patients' perceptions of nurses' behaviour that influence patient participation in nursing care: A critical incident study. *Nursing Research and Practice*, 2011, 1-8. Article ID 534060. [Online]. Available at: http://dx.doi.org/10.1155/2011/534060 [Accessed: 24 May 2017].

Lateef, F. (2011). Patient expectations and the paradigm shift of care in emergency medicine. *Journal of Emergencies, Trauma and Shock, 4*(2), 163-167.

Legg, M.J. (2011). What is psychosocial care and how can nurses better provide it to adult oncology patients. *Australian Journal of Advanced Nursing* (Online). Australian Nursing Federation. *HighBeam Research*. 17 Nov. 2017 https://www.highbeam.com.

Levinson, W., Lesser, C. & Epstein, R. (2010). Developing physician communication skills for patient-centered care. *Health affairs*, 29(7), 1310-1318.

Li, H., Ang, E. & Hegney, D. (2012). Nurses' perceptions of the barriers in effective communication with impatient cancer adults in Singapore. *Journal of Clinical Nursing*,

21(17-18), 2647-2658. [Online]. Available at: http://dx.doi.org/10.1111/j.1365-2702.2011.03977.x [Accessed: 25 February 2016].

Lorber, M. & Savič, B.S. (2011). Perceptions of managerial competencies, style, and characteristics among professionals in nursing. Public Health. *Croation Medical Journal*, *52*(2), 198-204. [Online]. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3081218/ [Accessed: 12 November 2017].

Machin, A.I., Machin, T. & Pearson, P. (2012). Maintaining equilibrium in professional role identity: a grounded theory study of health visitors' perceptions of their changing professional practice context. *Journal of Advanced Nursing*, 68(7), 1526-1537. [Online]. Available at: http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2648.2011.05910.x/abstract [Accessed: 15 November 2017].

MacPhee, M., Dahinten, V.S. & Havaei, F. (2017). The impact of heavy perceived nurse workloads on patient and nurse outcomes. *Administrative Sciences*, 7(1), 7. doi:10.3390/admsci7010007

UNIVERSITY of the

McClain, G.R. (2012). *Healthcare Professionals: Acknowledging Emotional Reactions in Newly-Diagnosed Patients*. [Online]. Available at: justgotdiagnosed.com/resources/professionals-acknowledging-emotional-reactions-newly-diagnosed-patients/ [Accessed: 5 January 2017].

Mouton, J. (2013). How to succeed in your Master's & Doctoral Studies. A South African Guide and Resource book [18th ed.]. Pretoria: Van Schaik Publishers.

National Health and Hospitals Reform Commission. (2008). *A healthier future for all Australians – Interim Report*. [Online]. Available at: Hyyp://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/home-1 [Accessed: 14 November 2015].

National Institute of Health [NIH]. (2015). *The National Diabetes Education Program:* Guiding principles for the care of people with or at risk for diabetes. The U.S. Department of Health and Human Services' National Diabetes Education Program

(NDEP). [Online]. Available at: https://www.niddk.nih.gov [Accessed: 5 November 2017].

National Research Corporation Canada. (2015). *Eight Dimensions of Patient-Centered Care*. Registered Nurses' Association of Ontario (RNAO) [Online]. Available at: http://www.nationalresearch.com/products-and-solutions/patient-and-family experience /eight-dimensions-of-patient-centered-care [Accessed on 19/01/2017]

Nayeri, N.D. & Aghajani, M. (2010). Patients' privacy and satisfaction in the emergency department: A descriptive analytical study. *Nurs Ethics*, 17(2), 167-77.

Ncube, R.K., Barlow, H. & Mayers, P.M. (2016). A life uncertain – My baby's vulnerability: Mothers' lived experience of connection with their preterm infants in a Botswana neonatal intensive care unit. *Curationis*, 39(1), a1575. http://dx.doi.org/10.4102/curationis.v39i1.1575

Neese, B. (2015). *Effective communication in nursing: Theory and best practices*. [Online]. Available at: http://online.seu.edu/effective-communication-in-nursing/#sthash.p2slb0rL.dpuf [Accessed 4 February 2017].

New South Wales [NSW], Health. (2010). *Health Reform in NSW;* A discussion paper on implementing the federal government's 'A national health and hospital network for Australia's future' in NSW [Online]. Available at: www.health.nsw.gov.au/resources/.../ healthreform/.../lhn-disc-paper.pdf [Accessed: 28 August 2017].

Norouzinia, R., Aghabarari, M., Shiri, M., Karimi, M. & Samami, E. (2016). Communication barriers perceived by nurses and patients. *Glob J Health Sci.* 8(6), 65-74.

Ontario Hospital Association (2010/2011). *Leading Practices in Emergency Department Patient Experience*. Prepared for the Ontario Hospital Association by Finders 2010/2011. [Online]. Available at: http://www.hqontario.ca.[Accessed: 19 September 2016].

Ontario Health Quality Council. (2012). *Quality Monitor. 2012 Report on Ontario's Health Systems*. Institute for Clinical Evaluate Sciences (ICES). Health Quality Ontario. [Online]. Available at: www.hqontario.ca. [19 September 2016].

Ontario Medical Association (OMA). (2010). *Patient- Centered Care*. Policy Paper. Ontario Medical Review (OMR). [Online]. Available at: https://www.google.co.za/search? source=hp&ei=DuL-. [Accessed: 19 September 2016].

O'Reilly, K.B. (2012). Coming wave of Medicaid patients will test quality at safety net hospitals. *American Medical News*. [Online]. Available at: http://www.ama-assn.org/amednews/2012/08/06/prl20806.htm. [Accessed: 5 November 2017].

Otani, K., Herrmann, P.A. & Kurz, R.S. (2011). Improving patient satisfaction in hospital care settings. *Health Serv Manage Res*, 24(4), 163-169.

Qteat, M. & Sayej, S. (2014). Factors Affecting Time Management and Nurses' Performance in Hebron Hospitals. *Journal of Education and Practice*, 5(35), 41-58

Oyvind, A.B., Ingeborg, S.S. & Hilde, H.I. (2011). Overall patient satisfaction with hospitals: effects of patient-reported experiences and fulfilment of expectations. *British Medical Journal Quality Safety*. [Online]. Available at: http://qualitysafety.bmj.com [Accessed on August 2011].

Pajnkihar, M., Štiglic, G. & Vrbnjak, D. (2017). The concept of Watson's curative factors in nursing and their (dis)harmony with patient satisfaction. *Nursing Science and Medical Education*. *PeerJ* 5, e2940. [Online]. Available at: https://doi.org/10.7717/peerj.2940 [Accessed: 14 November 2017].

Palese, A. & Papastavrou, E. (2011). Surgical patient satisfaction as an outcome of nurses' caring behaviors: A descriptive and correlational study in six European countries. *Journal of Nursing Scholarship*, 43(4), 341-350.

Pang, D., Senaratana, W., Kunaviktikul, W., Klunklin, A. & McElmurry, B.J. (2009). Nursing values in China: The expectations of registered nurses. *Nursing & Health Sciences*, *11*, 312-317. doi:10.1111/j.1442-2018.2009.00468.x

Papadantonaki, A. (2012). Nursing Role. Nosileftiki, 51(1), 7-9.

Papagiannis, A. (2010). Talking with the patient: fundamental principles of clinical communication and announcement of bad news. *Medical Time Northwestern Greece*, 6(Supplement), 43-49.

Parker, B.T. & Marco, C. (2014). Emergency Department Length of Stay: Accuracy of Patient Estimates. *West J Emerg Med.*, 15(2), 170-175.

Pataki, C. (2009). Comprehensive Textbook of Psychiatry [vol. 2]. In: B.J. Sadock, V.A. Sadock & P. Ruiz [eds]. *Adolescent Development*. Philadelphia: Lippincott Williams & Wilkins.

Peltier, J., Dahl, A. & Mulbern, F. (2009). Forum for People Performance Management and Measurement. *The relationship between Employee satisfaction and Hospital Patient Experiences*. Whitewater: University of Wisconsin.

Pelzang, R. (2010) Time to Learn: Understanding Patient-Centred Care. *British Journal of Nursing*, 19(14), 912-917. [Online]. Available at: https://doi.org/10.12968/bjon. 2010.19.14.49050.

Peprah, A.A. (2013). Health Care Delivery in Sub; Saharan Africa; Patients' satisfaction and perceived service quality, A case study of Sunyani Regional Hospital in Ghana. Germany: LAP LAMBERT Academic Publication.

Peprah, A.A. (2014). Determinant of patients' satisfaction at Sunyani Regional Hospital, Ghana. *International Journal Business and Social Research IJBR*, 4(1), 96-108.

Pillay, R. (2008). Work satisfaction of professional nurses in South Africa: a comparative analysis of the public and private sectors, *Human Resources for Health*, 7, 7-15.

Piper, D., Iedema, R., Merrick, E. & Perrott, B. (2010). *Experience-based co-design program 2, Satge/evaluation report* - Final to Health Service Performance Improvement Branch, Centre for Health Communication and NSW Health, Sydney.

Planetree. (2009). *Patients as Experts, Patients as Partners: Integrating the Patient and Family into Hospital Operations*. White Paper. [Online] Available at: http://www.planetree.org. [Accessed: 5 January 2010].

Porter, M.E. & Teisberg, E.O. (2007). How physicians can change the future of health care. *JAMA*, 297, 1103-11

Potgieter, E. (2012). Clinical teaching: developing critical thinking in student nurses. *Professional Nurse Today, 16*(2), 4e8.

UNIVERSITY of the

Prosen, M. (2015). Introducing transcultural nursing education: Implementation of transcultural nursing in the postgraduate nursing curriculum. *Procedia - Social and Behavioral Sciences* 174,149 – 155. [Online] Available at: http://creativecommons.org/licenses/by-nc-nd/4.01. [Accessed: 12 March 2018].

Pun, J.K.H., Matthiessen, C.M.I.M., Murray, K.A. & Slade, D. (2015). Factors affecting communication in emergency departments: doctors and nurses' perceptions of communication in a trilingual ED in Hong Kong. Int J Emerg Med. 8, 48. Published online 2015 Dec 15. doi: 10.1186/s12245-015-0095-y

Pyl, N. & Menard, P. (2012). Evaluation of Nurses' Perceptions on Providing Patient Decision Support with Cardiopulmonary Resuscitation. *ISRN Nursing*. 2012, 591541. doi:10.5402/2012/591541. [Online]. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3529485/. [Accessed: 19 November 2017].

Qteat, M. & Sayej, S. (2014). Factors Affecting Time Management and Nurses' Performance in Hebron Hospitals. *Journal of Nursing Education and Practice*, 5(35), 41-58.

Rama, M. & Kanagaluru, S.K. (2011). A study on the satisfaction of patients with reference to hospital services. *Zenith International Journal of Business Economics & Management Research*, 1(3), 15-25 [Online]. Available at: http://zenithresearch.org.in/www.zenithresearch.org.in 15. [Accessed: 29 September 2017].

Redfern, E., Brown, R. & Vincent, C.A. (2009). Identifying Vulnerabilities in communication in the emergency department. *Emergency Medicine, Journal*, 26, 635-657.

Republic of South Africa [RSA]. (1996). *Constitution of the Republic of South Africa*. Act No. 108 of 1996. Second Amendment Act, No. 3 of 2003.

Republic of South Africa [RSA], Department of Health [DoH]. (2010). *Essence of care 2010: Benchmarks for communication*. Pretoria: Government Printer. [Online]. Available at: http://bit.ly/hloYI [Accessed: 22 August 2015].

Republic of South Africa [RSA], Department of Health [DoH]. (2013). *Infrastructure Unit Support Systems (IUSS) Project Health Facility Guides: Emergency Services*. Pretoria: Government Printer.

Republic of South Africa [RSA], Western Cape, Department of Health. (2013). *Sinjani Statistical Package for District Health System*. Pretoria: Government Printer.

Republic of South Africa [RSA], Western Cape, Department of Health [DoE]. (2014). *Departmental Standards for Emergency Centres: Circular H 44 of 2014*. Pretoria: Government Printer.

Robison, J. (2010). The Business Case for well-being. *Business Journal*. [Onlin]. Available at: http://news.gallup.com/businessjournal/139373/business-casewellbeing.aspx [Accessed: 4 November 2017].

Robinson, J.H., Callister, L.C., Berry, J.A. & Dearing, K.A. (2008). Patient-centered care and adherence: Definitions and applications to improve outcomes. *Journal of the American Academy of Nurse Practitioners*, 20, 600-607. doi:10.1111/j.1745-7599.2008.00360.x

Rothrock, S. (2012). Higher patient satisfaction associated with more cost, more treatments, and more deaths. *Health News Observer*. [Online]. Available at: http;//www.healthnewsobserver.com/articles/detail/patient-satisfaction-associated-withmore-cost-more-treatments-and-more-dea [Accessed: on 20 September 2012].

Scholl, I., Zill, J.M., Härter, M. & Dirmaier, J. (2014). An integrative model of patient-centeredness—a systematic review and concept analysis. *PLoS ONE 2014*, 9. e107828. doi:10.1371/journal.pone.0107828.

UNIVERSITY of the

Schroeter, K. (2008). *Competence literature review. Competency & Credentialing* Institute (CCI). [Online]. Available at: http://www.innovationlabs.com [Accessed: 12 November 2017].

Segen's Medical Dictionary. (n.d.). [Online]. Available at: reference [Accessed: 29 September 2017].

Shayo, E.H., Norheim, O.F., Mboera, L.E.G., Byskov, J., Maluka, S., Kamuzora, P. & Blystad, A. (2012). Challenges to fair decision-making processes in the context of health care services: a qualitative assessment from Tanzania. *International Journal for Equity in Health*, 11(30). doi:10.1186/1475-9276-11-30.

Sheldon, L.K. (2015). *Chapter Five. Establishing a Therapeutic Relationship*. Section Two. The Nurse-Patient Relationship @ Jones & Bartlett Learning, L.L.C. [Online].

Available at: http://samples.jbpub.com/9781449691/9781449691776on [Accessed: 11 September 2015].

Skinner, E. (2011). *Gender and Climate Change: Overview Report*, BRIDGE Cutting Edge Pack on Gender and Climate Change. Brighton: Institute of Development Studies.

Slade, M., Jordan, H., Clarke, E., Williams, P., Kaliniecka, H., Arnold, K., Fiorillo, A., Giacco, D., Luciano, M., Égerházi, A., Nagy, M., Krogsgaard Bording, M., Østermark Sørensen, H., Rössler, W., Kawohl, W., Puschner, B. & the CEDAR Study Group (2014).

Slade, D., Manidis, M., McGregor, J., Scheeres, H., Chandler, E., Stein-Parbury, J., Dunston, R., Herke, M. & Matthiessen, C.M. (2015). *Communicating in Hospital Emergency Departments*. London: Springer.

Smith, S.K., Dixon, A., Trevena, L., Nutbeam, D. & McCaffery, K.J. (2009). Exploring patient involvement in healthcare decision making across different education and functional health literacy groups. *Social Science and Medicine* 69(12), 1805-12. doi: 10.1016/j.socscimed.2009.09.056.

South African Nursing Council [SANC]. (2013). *Code of ethics for Nursing Practioners in South Africa. Excellence in professionalism and advocacy for health care users*. [Online]. Available at: http://rhap.org.za [Accessed: 13 November 2017].

Starfield, B. (2012). Is patient-centered care the same as person-focused care? *The Permanente Journal*, *15*(2), 63-69. [Online]. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140752/ [Accessed: 5 November 2017].

Sukrin, R.K., Bakkar, B.S., El-Damen, M.A. & Ahmed, S.M. (2013). Attitudes of Students at Sulta Qaboos University towards Nursing Profession. *Sulta Qaboos University Medical Journal(SQUMJ)*, 13(4), 539-544.

Sutton J. & Austin, Z. (2015). Qualitative Research: Data Collection, Analysis, and Management. *The Canadian Journal of Hospital Pharmacy*, 68(3), 226-231.

Tabler, J., Scammon, D.L, Kim, J., Farrell, T., Tomoaia-Cotisel, A. & Magill, M.K. (2014). Patient care experiences and perceptions of the patient-provider relationship: A mixed method study. *Patient Experience Journal*, *I*(1), Article 13. [Online]. Available at: http://pxjournal.org/journal/vol1/iss1/13. [Accessed: 1 March 2014].

The Advisory Board Company (2017). *Access to Care. Research Platform. Achieve Best Practice Performance*. [Online]. Available at: https://www.advisory.com/topics/performance-improvement/quality/access-to-care [Accessed: 15 November 2017].

The development and evaluation of a five-language multi-perspective standardised measure: clinical decision-making involvement and satisfaction (CDIS). *BMC Health Serv Res.*, *14*, 323. Published online 2014 Jul 28. doi: 10.1186/1472-6963-14-323

The Joint Commission on Accreditation of Healthcare Organisation. (2008). Accreditation Program: Ambulatory Healthcare. National Patient Safety Goals. [Online]. Available at: http://www.jointcommission.org/ [Accessed: 13 November 2017].

Thomas, D.R, (2006). A General Inductive Approach for Analysing Qualitative Evaluation Data. University of Auckland, School of Population Health. *American Journal of Evaluation*, 27(2), 237-246.

Tonio, S., Joerg, K. & Joachim, K. (2011). Determinants of patient satisfaction: a study among 39 hospitals in an in-patient setting in Germany. *International Journal for Quality in Health Care*, 23(5), 503-509.

Turner, D.W. (2010). Qualitative interview design: A practical guide for novice investigators. *The Qualitative Report*, 15(3), 754-760.

UK Essays (2015). *Professional values attitudes and behaviors of nurses*. Nursing Essay. [Online]. Available at: https://www.ukessays.com/essays/nursing/professional-

values-attitudes-and-behaviors-of-nurses-nursing-essay.phpowerment-nursing-essay.phpon. [Accessed: 27 November 2016].

University of California [USC]. (2017). *Research Guides. Organizing Your Social Sciences Research Paper*: 5. The literature Review. [Online]. Available at: http://libguides.usc.edu/c.php?g=234974&p=1559473 [Accessed: 27 October 2017].

University of Minnesota. (2016). *Communication in the Real World: An Introduction to Communication Studies*. University of Minnesota Libraries. [Online]. Available at: http://open.lib.umn.edu/communication/ [Accessed: 16 August 2016].

Vahdat, S., Hamzehgardeshi, L., Hessam, S. & Hamzehgardeshi, Z. (2014). Patient involvement in Health Care Decision Making. *A Review*, 16(7), e12454.

Van Graan, A.C., Williams, M.J.S. & Koen, M.P. (2016). *Professional nurses'* understanding of clinical judgement: A contextual inquiry. Publishing services by Elsevier B.V. on behalf of Johannesburg University.

UNIVERSITY of the

Victoria State Government. (2011). What is person-centred health care? A literature review. National Ageing Research Institute. A Victorian Government Initiative. Melbourne, Victoria, Australia: Victoria Government Department of Human Services. [Online]. Available at: https://www2.health.vic.gov.au/getfile//?sc_itemid=% 7BCC68AD22-6F31-42BE-87FA-287ACB0335FF%7D [Accessed: 19 September 2016].

Welch, S.J. (2010). Twenty years of patient satisfaction research applied to the emergency department: A qualitative review. *American journal of Medical Quality*, 25(1), 64-72.

Wettergren, A. & Blix, S.B. (2016). Empathy and objectivity in the legal procedure: the case of Swedish prosecutors, *Journal of Scandinavian Studies in Criminology and Crime Prevention*, 17(1), 19-35.

Whitley-Hunter, B.L. (2014). Validity of transactional analysis and emotional intelligence in training nursing students. *Jadv Med Educ Prof*, (4), 138-145.

Wilkins, J. (2017). Quality of Life in Dementia. *AMA Journal of Ethics*, *17*(9), 635-735. [Online]. Available at: http://journalofethics.ama-assn.org/2017/07/toc-1707.html [Accessed: 16 January 2017].

Wilson, C. (2013). *Comment: Nurses the backbone of our health-care system. Times Colonists*. [Online]. Available at: http://www.timescolonist.com/opinion/oped/comment-nurses-the-backbone-of-our-health-care-system-1.607724 [Accessed: 4 November 2017]. Article in Press

Wood, D. (2013). A Good Nurse Has the Right Attitude. *Journal of Professional Nursing* [Online]. Available at: http://www.nursetogether.com/good-nurse-has-right-attitude. [Accessed: 20 March 2017].

Wood, M.J. & Kerr, J.C. (2011). *Basic steps in planning nursing research: from question to proposal*. [7th ed.]. Sudbury: Jones and Bartlett Publishers.

Zahedi, F., Sanjari, M., Aala, M., Peymani, M., Aramesh, K., Parsapour, A., Bagher Maddah, S.S., Cheraghi, M.A., Mirzabeigi, G.H., Larijani, B. & Vahid Dastgerchi, M. (2013). The code of Ethics for Nurses. *Iran Journal of Public Health*, 42(supple 1), 1-8.

Zani, A.V., Marcon, S.S., Tonete, V.L.P., De Lima, C.M.G. & Parada, C.M. (2014). Communicative process in the emergency department between nursing staff and patients: Social representations. *Brazilian Journal of Nursing*, *13*(2). [Online]. Available at: http://www.objnursing.uff.br/index.php/nursing/article/view/4036/html_118 [Accessed: 15 November 2017].

Ziapour, A., Kazemi, N., Kiani pour, N. & Ziapour, M. (2013). Study the job satisfaction and its affected factors in Kermanshah hospitals nurses, *Nat & Sci*, *12*(4), 88. [Online]. Available at: http://www.sciencepub.net/nature [18 May 2017].

Annexure A: Patient centred care: ILMC Task Team Initiative



METRO DISTRICT HEALTH SERVICES

REFERENCE: 5/5/P

ENQUIRIES: Ms T Bashe

MDHS: HRM CIRCULAR 2 /2014

TO: ALL SUB-STRUCTURE DIRECTORS/SUB-STRUCTURE DEPUTY DIRECTORS: HUMAN RESOURCES/HEADS OF INSTITUTIONS/FACILITY MANAGERS / HEADS OF INSTITUTIONS/IMLC CHAIRPERSONS

PATIENT CENTRED CARE: MDHS: IMLC TASK TEAM INITIATIVE

- The attached document is the outcome of the deliberations in a task team mandated by the MDHS: IMLC to look at initiatives to improve patient care as well as careing for the carer and stems from a workshop held with representatives from all IMLC's within MDHS.
- 2. The initiatives proposed are attempts to ensure that simple measures are implemented at all institutions within MDHS with the objective of trying to improve the environment in which we work for the benefit of patients as well as staff.
- 3. These measures should be used to complement existing initiatives being implemented at institutions.
- 4. It is proposed that the document attached is tabled at your next IMLC meeting for discussion and the implementation strategy be agreed to at the IMLC.
- 5. All Heads of institutions must take cognisance of the contents of this circular and also bring it to the attention of all staff

CHIEF DIRECTOR: METRO DISTRICT HEALTH SERVICES

DATE:

2014 -03- 12

2nd Floor, 8 Riebeek Street, Cape Town, 8001

tel: +27 21 483 9370 fax: +27 21 483 9349

PO Box 2060, Cape Town, 8000 www.capegateway.gov.za



Dr M. Moodley

CEO: Eerste River Hospital

Tel: 021 902 8042

Melvin.moodley@westerncape.gov.za

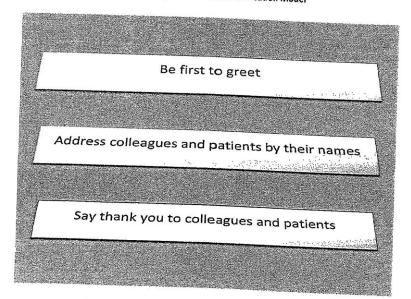
Patient Centred Care: IMLC Task Team Initiative

Mandate: Develop a Patient Centred initiative that can be implemented across the MDHS that supports staff and patients. The task team settled on 3 initiatives.

Initiative 1

The task team settled on 3 key behaviours that should be part of the standard communication model for MDHS staff. Importantly, this communication must be applied when staff communicate with each other and to patients.

The People Centred Communication Model



The task team settled on a 3 step communication model that would promote a people centred approach, increase the professionalism of the organisation and improve the communication between staff and between staff and patients. The task team debated other communication models

and felt that the following options should be made available to augment the People Centred Communication Model.

- 1. Smile
- 2. Display a friendly face
- 3. Maintain a friendly tone
- 4. Treat everyone professionally
- 5. Listen to the patients

Initiative 2

The task team felt that uniforms for staff was an important step towards improving staff morale and consequently staff engagement. This is however a long standing issue that the MDHS IMLC will take up with MDHS management.

Initiative 3

The task team felt strongly that all busy areas should have someone available to assist patients. We proposed that all facilities should have a help desk, where patients can be given advice and assistance. The help-desk can be staffed by: a clerk, an intern or a volunteer. The choice of staffing must be based on facility size and resources.

Annexure B: In-depth interview guide for professional nurses and patients



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2271, Fax: 27 21-959 2274

E-mail: kjooste@uwc.ac.za

IN-DEPTH INTERVIEW GUIDE FOR

PROFESSIONAL NURSES AND PATIENTS

TOPIC: The communication challenges between nurses and patients in an urban emergency centre in the Western Cape

Research question:

What are the challenges to effective communication between nurses and patients in an urban emergency centre and how can it improved?

Probes:

- Describe
- Think back / reflect
- Give examples
- Explain
- Why
- By whom
- When
- How

Annexure C: Permission letter: consent to conduct research



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2271, Fax: 27 21-959 2274

E-mail: kjooste@uwc.ac.za

PERMISSION LETTER

8 Bosch Street

Paarl

7646

UNIVERSITY of the WESTERN CAPE

Dr K Cloete

The Chief Director

Metro District Health Services

Northon Rose

Cape Town

8000

October 2014

Dear Dr Cloete

RE: CONSENT TO CONDUCT RESEARCH

I am a post- graduate student at the University of the Western Cape who is studying towards a Master's Degree in Nursing. My research topic is: The communication challenges between nurses and patients in an urban emergency centre in the Western Cape. The purpose of the study is to explore the challenges of effective communication between nurses and patients during the delivery of healthcare within an urban emergency centre and to explore possible improvement strategies for effective communication.

Permission to access the institution is crucial for the completion of the study. In order to conduct this study, in-depth interviews will be conducted with professional nurses working in the emergency centre and patients discharge from the emergency centre and overnight ward at a district hospital in the Eastern Substructure in the Western Cape. Informed consent will be obtained from them for participation in the study. The discussions will be conducted in a private room. Participants will participate voluntarily and may withdraw, without fear, from the study and at any time. All information of the participants and your institution will be handled confidentially and will be transcribed and by the researcher. The participants will remain anonymous and codes will be used to protect participants' identity.

I therefore request permission to conduct my research investigation at your facility. Attached are the research proposal and copies of the participant information sheet and informed consent that will be provided to participants. Information acquired during this research project will be shared with all participants and organisations. Results of the study will be published in an accredited journal or a peer review journal.

115

Yours sincerely,

.....

Ms K Ruiters

Student No: 3378817

Cell no: 072 835 8448

Email: Kruiters@westerncape.gov.za

.....

Prof Felicity Daniels

Supervisor

School of Nursing

University of the Western Cape IVERSITY of the WESTERN CAPE

Bellville, 7530

Western Cape

South Africa

Tel: 9592271

Email: fdaniels@uwc.ac.za

Annexure D: Permission letter: consent to conduct research



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2271, Fax: 27 21-959 2274

E-mail: kjooste@uwc.ac.za

PERMISSION LETTER:

8 Bosch Street

Paarl

7646



Dr E Erasmus

Chief Executive Officer

Helderberg Hospital

Private bag x2

Somerset West

7129

Dear Dr Erasmus

RE: CONSENT TO CONDUCT RESEARCH

I am a post- graduate student at the University of the Western Cape who is studying towards a Master's Degree in Nursing. My research topic is: The communication challenges between nurses and patients in an urban emergency centre in the Western Cape. The purpose of the study is to explore the challenges of effective communication between nurses and patients during the delivery of healthcare within an urban emergency centre and to explore possible improvement strategies for effective communication.

Permission to access the institution is crucial for the completion of the study. In order to conduct this study, in-depth interviews will be conducted with professional nurses working in the emergency centre and patients discharge from the emergency centre and overnight ward at a district hospital in the Eastern Substructure in the Western Cape. Informed consent will be obtained from them for participation in the study. The discussions will be conducted in a private room. Participants will participate voluntarily and may withdraw, without fear, from the study and at any time. All information of the participants and your institution will be handled confidentially and will be transcribed and by the researcher. The participants will remain anonymous and codes will be used to protect participants' identity.

Permission has been granted by the Chief Director Metro District Health Services, Western Cape to conduct this research. I therefore request your further permission to conduct this research study. Attached are the research proposal and copies of the participant information sheet and informed consent that will be provided to participants. Information acquired during this research project will be shared with all participants

118

and organisations. Results of the study will be published in an accredited journal or a
peer review journal.
Yours sincerely,

Ms K Ruiters

Student No: 3378817

Cell no: 072 835 8448

Email: Kruiters@westerncape.gov.za

UNIVERSITY of the
WESTERN CAPE

Prof F Daniels

Supervisor

School of Nursing

University of the Western Cape

Bellville, 7530

Western Cape

South Africa

Tel: 9592271

Email: fdaniels@uwc.ac.za

Annexure E: Participant information sheet

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2271, Fax: 27 21-959 2274

E-mail: kjooste@uwc.ac.za

PARTICIPANT INFORMATION SHEET

Project title: The communication challenges between nurses and patients in an urban

emergency centre in the Western Cape

What is the study about?

This research project is conducted by Katriena Ruiters from University of the Western

Cape. You are being invited to participate in this research project because you currently

working in emergency centre and overnight department or you are a patient using this

facility. The purpose of this study is to describe your views with regards to challenges

of communication between yourself (as professional nurse or patient) and the patients /

professional nurse in emergency centre and overnight ward at a district hospital in

Western Cape.

What will I be asked to do if I agree to participate?

You will be asked to answer a few questions on your views about communication

between patients and the professional nurse in the emergency centre. The interview will

take approximately 45 minutes and will be conducted at the district hospital. You will

120

http://etd.uwc.ac.za/

be required to sign informed consent to indicate your willingness to participate in the study and for the use of a voice recorder.

Would my participation in the study be kept confidential?

Your participation and personal information will be kept confidential. To help protect your confidentiality, transcripts will be coded and your name will not appear on the transcript. Only the researcher and her supervisor will have access to the data. Your identity will remain anonymous throughout the research study and after completion of the study the transcripts and voice recordings will be destroyed after 3 years.

What is the risk of this research?

There may be some risks associated with participating in this research study. All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

There is no financial gain or other benefits to you personally, but the results may assist the researcher to understand challenges with communication in an urban emergency centre and overnight ward and identify ways to overcome the communication challenges. It will be of significant value to the Department of Health and the emergency centres as the results may assist with the development of a communication policy to provide clear guidelines to improve communication.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to

take part at all. If you decide to participate in this research, you may stop participating

at any time. If you decide not to participate in this study or if you stop participating at

any time, it will be without penalty..

What if I have questions?

This research is being conducted by Katriena Ruiters from the University of the

Western Cape. If you have any question about the research study, please contact me at

072 835 8448 or e-mail: Kruiters@westerncape.gov.za

Should you have any questions about this study and your rights as a research participant

or if you wish to report any problems you will be experiencing in relation to the study,

please contact:

UNIVERSITY of the

WESTERN CAPE

Director: Prof K. Jooste

School of Nursing

University of the Western Cape

Private Bag X17, Bellville, 7535

Telephone: 021 959 2271

kjooste@uwc.ac.za

Research Supervisor: Prof F. Daniels

School of Nursing

University of the Western Cape

122

Private Bag X17, Bellville, 7535

Telephone: 021 959 2271

fdaniesl@uwc.ac.za

Dean of the Faculty of Community and Health Sciences: Prof J. Frantz

University of the Western Cape

Private Bag X17

Bellville 7535

Tel: +27 (0) 21 959 2631/2746

Fax: +27 (0) 21 959 2755

Email: jfrantz@uwc.ac.za



Annexure F: Informed consent

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2271, Fax: 27 21-959 2274

E-mail: kjooste@uwc.ac.za

INFORMED CONSENT

Title of Research Project: The communication challenges between nurses and patients

in an urban emergency centre in the Western Cape

The study has been described to me in language that I understand. My questions about

the study have been answered. I understand what my participation will involve and I

agree to participate of my own choice and free will. I understand that my identity will

not be disclosed to anyone. I understand that I may withdraw from the study at any time

without giving a reason and without fear of negative consequences or loss of benefits. I

consent to the use of a voice recorder.

PARTICIPANT'S NAME:

PARTICIPANT'S SIGNATURE:....

DATE:....

124

Annexure G: Approval by Provincial Health Research Committee



STRATEGY & HEALTH SUPPORT

Health.Research@westerncape.gov.za tel: +27 21 483 6857; fax: +27 21 483 9895 5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001 www.capegateway.gov.za)

REFERENCE: WC_2015RP5 935 **ENQUIRIES: Ms Charlene Roderick**

University of the Western Cape Private Bag X17 Bellville 7535

For attention: Katriena Ruiters

Re: THE COMMUNICATION CHALLENGES BETWEEN NURSES AND PATIENTS IN AN URBAN EMERGENCY CENTRE IN THE WESTERN CAPE.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following people to assist you with any further enquiries in accessing the

Helderberg Hospital

following sites:

D Heyns

Contact No: 021 850 4700

Kindly ensure that the following are adhered to:

- 1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
- 2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of This can be submitted to the provincial Research Co-ordinator research. (Health.Research@westerncape.gov.za).
- 3. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR A HAWKRIDGE

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 24/4/2015. CC

G PEREZ

ACTING DIRECTOR: KHAYELITSHA/ EASTERN

Annexure H: The transcript of a participant

46:03

REC 008

PN006

INTERVIEWER Good evening, Sister. I'm Ms Ruiters. I'm going to have an indepth interview with you. My topic is the 'Communication challenges between nurses and patients in an urban emergency centre in the Western Cape'. The research question: What are the challenges to affect the communication between nurses and patients in an urban emergency centre and how can it improve? We are supposed to smile at the patient at all times; to display a friendly face; to maintain a friendly tone; to treat every patient professionally and also to listen to patients. Do you agree or do you think...describe what your view is. A patient entering an emergency centre, if you look at this, do you think that we can always display this or not? Do you think that is also one of the challenges that affect communication?

PARTICIPANT I think it is not always possible but we must always keep in mind that it is incumbent on the nurse to put the patient at ease, to reassure the patient that help can be found in a hospital setting.

INTERVIEWER So do you think that you listen to the patient all the time and remember, the patient numbers have increased. You do have your families that assist who are coming with the patient, et cetera.

PARTICIPANT That is a challenge because if the patient is escorted, if the patient can speak for himself, the patient has their own expectations and the expectation is to be helped as soon as possible. And the nurse has to be firm in the instances where the patients are triaged and colour coded and then the nurse

has to have a level of firmness and explain to the patient. The patient has a different expectation and think that they will be helped immediately. They may not understand the different grades of the acuteness of a problem. And it also depends on the age of the patient. When a patient is escorted for example, a child, there's higher expectations on the mother's side. And that is sometimes a problem because that is where we have conflict between the nurses because the patient, if for example, a toddler or a baby is brought in the middle of the night for a minor problem, which we consider just something that can be treated at home and then the child may in fact really be so ill but the nurse might respond, why didn't you come earlier or didn't you go to the day hospital? And that is a challenge. Nurses have to be professional and not question the mother's or the caregiver's sense of urgency, although it is very difficult. In the case of the elderly we have the same problem where it's very often not even a family member that's escorting somebody whose just a caretaker bringing .the elderly and they want to be released of the patient because they have to go back to their duties. And they don't really recognise the timeframe where often our doctors are called out of the casualty department and then they really have to wait. By the time that the doctor has arrived the patient is already stabilised. Or the patient might be stable on arrival because the ambulance staff might have stabilised the patient already. And then the view of the nurse is that she must withhold her observations and not say anything to put nurses in a negative light, which very often happens. If you get to the relevant expertise of the nurse, which is also a challenge due to understaffing, so the sister might react differently and the staff nurse might react differently. And now we also have nursing assistants working in the triage and that is their first point of contact. We don't know what information the patient received outside of the hospital, for example, referrals. People who are referring a patient to the hospital. The doctor on the outside, the GP or maybe a doctor from another hospital or the clinic might say, you will receive help immediately. And then it causes the nurse to be the one in the wrong and I always say, why do you shout at the nurse? Why do you not use this tone of voice towards the doctor? Because when you go into the doctor you will never speak like that. And where the nurse is just trying to explain the routine procedure of admission and it can cause conflict. I don't know if I've said enough in this regard.

INTERVIEWER Sister, if you think back, you worked in casualty. There was like a timeframe, you were not in casualty and when you came back, can you clearly see there is a difference in casualty with regard what can have a challenge on effective communication between nurses and patients? What do you see if you think back, how did you communicate? How did you approach the patients? How did the patients approach you comparing with today?

PARTICIPANT

When I came back, that was my first time of working in casualty, I'm not aware that we had a triage scoring system before I left. That made a difference and I think that nurses that worked in casualty before I left, they were very experienced. They were people of a calibre of nursing that you don't find now. But we don't know also where the level of knowledge was based in because it wasn't scientifically based. It was scientifically based but they didn't have the various questions to fill in at that time. They could basically just assess a patient on the parlour of the skin or the signs of shock or bleeding or what injury. So there was a difference in that. The nurses before I left, the nurses were I would say very harsh on the patients. They were very strict but the patient did know at the end that he did receive the proper care. We did have expert nurses. I remember one nurse who could do facial stitching better than a plastic surgeon. So the nurses did many things which were out of their scope; totally out of their scope. And when I arrived we had more doctors and the nurses had a different attitude. It was a new generation of nurses who worked in casualty. It was a different ... they had a different approach. I think they were focused on writing more than helping the patient. And wherever conflict arose between patients and staff there was somebody else to intervene. They could refer to the Matron. There was a Matron...quality assurance Matrons. So that was also there, which was a change. We also had this, I think I changed when I came back. I think the difference in me was that I've seen the first world country, how they operated and I did understand when I came back about the certain levels that would change when no is no and red is red and things were more definite and where Batho Pele came in. Overseas it was required of me also, we were told smile, smile, smile. So I came back with that information and that helped me. So I could easily slot in with very young nurses and it was a delight to work in casualty. Being of a psychiatric background that also assisted me because to me it was we are going to start this. If I have to talk about my personal reasons why I left was because I felt that the patients who were positive, especially the children, that they weren't getting from the government that they needed. And I was totally, totally disgusted by the level of deaths in the paediatrics. I couldn't stand working in the paediatric setting. I couldn't stand the fact of the Aids epidemic. I couldn't stand it. It really upset me so much and the politics involved and the non-supply of ARVs to the children and that upset me. So that was part... But when I came back I felt that I needed to ... I think I ran away from the situation. I came back and I was ready to give my best with the youngsters and to learn and adapt to the new setup. The public had a different approach but some of the expectations of the public was also very politically inspired. They felt that we were the majority of the patients were not given rights. They felt that they now could insist on having rights and then there was the old apartheid regime. We had people marching to the Medical Superintendent because they felt that they were too light of colour and the others felt again that we have struggled too hard and...

INTERVIEWER Sorry, is that the patients or the staff?

PARTICIPANT That was the public but included the patients. It included the patients. The staff had to deal with the change in regime, the apartheid system and the new Batho Pele. The staff had to deal with it and remain focused and remain friendly and that is where I came in. I felt that I was going to do at all times to support whatever needed to be done and that is not, I mean, this research is not about my but that was just my take on it.

INTERVIEWER Sister, can you explain to me why you say with regard to examples you mentioned, why there are challenges in effective communication, if we look, remember, when you came back with our emergency centre, there's a lot of patients; a high number of patients coming into your setting; patients with the burden of disease, different diseases; patients with your mental health challenges, your emergency patients like your stab wounds and if you look at your staff numbers comparing patients and staff numbers; if you look at your casualty self, your space, your occupation because the patients are admitted or

are supposed to be admitted, what will you say all that other ... does that have a challenge to effective communication?

PARTICIPANT It must have a challenge to effective communication.

Everything is over and above, the expectation, the load that we have to deal with and still remain focused and the setting has also been changed. That has been difficult. It has been difficult. But once you get to know the outlay of the place I think Sister Khumalo had the idea in that nursing cubicle to put that cupboard there and it wasn't a long time that there were no handles on the The whole thing was destroyed because the nurses were too busy running in and out there. The nurses were just trying to survive on their shifts and to stay on their toes and to do their work. But where I would say maintaining of equipment was concerned, I mean we had to share a .[DEX. Meter] with a ward. We had to share the [HGT meter], even today. The [dynamos] gave in. The monitors gave in. The leads gave in. It was a problem because the patients need to remain at a high level and you have to run in between giving, you know, we also have a problem with the clerks, because they didn't order what we needed. And we were very frustrated in that because, for example, the one [Ivac] takes a certain kind of line. Now say for example, the one patient is using two [Ivacs] and we have run out of those lines. It causes a problem. And then you have to run to do the ECG. Some of the doctors also started with unnecessary strange requests from the staff. We spoke about it in this week. The one doctor wanted half-hourly ECGs on a patient and that is why the entire space is being filled with children that are having gastro, we don't have space for the infectious diseases, people, the dead, the dying, the walking, the wounded, they are all in there and she wants half-hourly ECGs.

And then we have one ECG monitor and then we don't have the leads or the leads are broken. All that has been very frustrating, it has been. We still share. [DEX meters] and. [meters] with casualty ... the ward. Because I'm in the overnight ward now. We still have to run there to fetch what we need. There's also been a lot of theft and what do you call it, vandalism. We also never had security staff in casualty because of the level of danger. We had even patients who come in to assault staff, throwing bricks and smashing windows. We've had violent psychiatric patients coming in. The doctors have wanted the nursing staff to face the violent patients and that's where I have been on the forefront saying, you don't have to use violence and try to bring the patient down, talk the patient down. You don't have to be violent in this setting. We're going to help you. We talk to the family. We will chat and we will talk in private. All those things it has suddenly come upon us. It was there in the past but it just increased so much. And I'm also very glad that we don't receive the rape victims in casualty. That would have been very devastating to the staff, which even now, the patients having miscarriages in casualty, it is very, very straining on the staff. It is very hard to deal with because there's very little privacy. You are always thinking how you can ... what service you can give to the patient, how you can protect and reassure the patient but the resources are very poor. There are no curtains there to draw. The one day you come on duty the curtains are removed. And the next day ... we have to be aware... we are not always aware that we have other ways and means of doing things because also we are not always informed, the agency staff who are working there, they don't feel the need to communicate like the own staff of the hospital. So there's also that... we never had the agency staff. I can't even remember that I ever worked with agency staff but it just increased in leaps and bounds. So that we are working more with people that you won't see tomorrow. You don't know them. We also have to build trust with each other to be able to provide a service. That is difficult. And when the equipment breaks down and when the space is changed it is difficult. I don't know why I'm sounding so negative.

INTERVIEWER Remember, I'm doing an in-depth interview and I need to determine what is the challenges. So you just give the information, is that okay? . Sister, the patients, when they enter the emergency centre, the procedure is that they have to collect their file. Do you think that there is the challenge of communication because the filing system is also a challenge here at the hospital? I am not sure.

PARTICIPANT It is a big problem.

INTERVIEWER Remember, the patients, they come to raise their concerns with regard to waiting time, et cetera, family members who come and approach you to raise their concerns with regards to the file, the waiting time, whatsoever?

PARTICIPANT Yes, there is a problem. The filing system has been a challenge but we as nurses we basically are dependent on the clerk, on the admin staff to fetch the file from where they're filed. And there are now various other areas where the files are kept. We haven't overcome that. We have for example, apart from the fact that the file has to be fetched, we don't have the porters that will fetch files. So the clerk has to leave their station. I don't understand why. I think they should have messengers to fetch the files. And the first port of call is at the clerk. The clerk shouldn't be absent from a station especially when a patient arrives there and the people are anxious. They don't know who to ask and the security will block them at the gate, which is

unfair. And then for example, the patient with the very thick folders, I've noticed that the folders have shrunk and they have made so many duplicate folders where so much information is lost. And I think that is also taxing on the finances of the hospital. It all boils down... it all has a... it's like a circular effect where the patient care will suffer, the nursing care will suffer because of the fact that so many extra folders are open and tests have to be repeated. I don't understand why the doctors keep on doing TB tests when they can phone into a lab. I worked a clinic, the details, all the information is there. They don't do that. They repeat the tests. They open a new folder every time. The patient can have three/four new folders and all the information gets lost. The patient gets treated on symptomatic basis every time. A very good friend of mine has been treated in this manner on symptomatic...and then she actually had a chronic problem developing from that and the information is lost somewhere. So she had to end up at Tygerberg and that is where they found a long-term solution to WESTERN CAPE the problem.

INTERVIEWER Sister, the triage you mentioned, when you came back to the emergency centre, you noticed the triage system. The triage system for you was like, not foreign, was like foreign. So what do you think, how do the patients experience, can that also be a challenge to effective communication? The triage system, are all the patients aware of what the triage system... do they know about the colour coding? Do you think they also get frustrated? Do you think we give them enough information in order to understand the triage system?

PARTICIPANT I think the nurses try their utmost to give the information.

It might help if there are bigger signs where the patients can also read in the waiting room what these things mean or if they had handouts or just signs where

they could point towards this is a stitch area, this is where the doctor ... just to give more information to the patient, but the nurses try their utmost, I must say.

INTERVIEWER So do you think, if you look at your triage area and we have to apply our ethical code all the time. We need to be professional. We need to be confidential because patients give confidential information. Do you think that you can apply like privacy, confidentiality, treat the patient with dignity?

PARTICIPANT That is very, very difficult. That is difficult. The questions that the patient has to answer according to the form really, it is not... it harms their dignity I think. Like, are you using ARVs? Are you using medication? Things like that. It is very difficult. I don't think that I would be able to answer a question and when the patient's guard is up misinformation is given. Sometimes the patient is in the ward before the real problem comes out. So it's not ... if they had an area where they could sit down and do it professionally. Let the patient feel at ease in privacy, which would be a much better system.

INTERVIEWER If you look at your casualty, we're supposed to have patient friendly environment and we're supposed to treat patients, because the priority is now patient-centred care. But because we have when we deal we have to deal with this high patient number it creates that there is not always space for patients specific for admissions et cetera. Do you think that that is a challenge to effective communication? We need to ensure that the patient get the quality, the excellent patient care. We need to ensure that the patient experience patient satisfaction. We need to ensure that the patient experience a good patient journey in casualty. What will you say with regard to effective communication?

PARTICIPANT It is very hard to link this now because I don't think the patients have much of a choice. So they will accept the situation which is not conducive to their dignity and their privacy. I feel very unhappy with the setup at the moment as it is because the males and females are not even separated. There is no division between the patients. The very, very acutely sick, the chronic sick patients, the dying patients, they are all mixed because of lack of space in the hospital. That is very unsatisfactory. And the patients are not complaining. At the moment I feel that there is just a passive acceptance of service delivery in South Africa is what it is and we are sick, so we just hope that we get help. So they are satisfied with the barest minimum. It is very sad to think that health care has come to this point. There is not much health care. There's just actually skimming the surface.

INTERVIEWER Sister, remember we are also working with our own colleagues.

Do you think your colleagues are happy and satisfied with these conditions, the working conditions in this point of time in casualty? Do you think some of them are burnt out? They are highly stressed?

PARTICIPANT I've come across very, very young sisters, very young ones saying that they are experiencing high level of stress. I can say that I worked, I think I worked more than thirty years before I started really to say that I've had enough now or this is too much. Nursing has not been a pleasant experience lately because ... maybe in the wards it is different but in casualty and overnight it is just a matter of dealing with totals and stats. It's different. But you also get the different kind of staff attitude from the permanent staff and the agency staff whereas the feelings are not discussed. So the staff, I wouldn't say all agency staff, but some agency staff come to do a session. And they

come and they go. It is just a matter of doing the work. But I feel that there is a difference in nursing where the young nursing staff are already feeling the strain.

Interviewer I need to ask you, do you think there is a difference or there is also a challenge with regard to skills, experience with your fellow colleagues?

If the sister who is working in casualty you think the professional nurses, all the staff actually, are they fully skilled or do you think they still need more skills?

PARTICIPANT The people who are working in casualty have to become as skilled as they possibly can be very quickly because they don't always have the expertise amongst them. So they have to learn very, very quickly. There is a very great need for ongoing in-service training by the whites that are skilled, which is a shortage. It is a problem. The nurses have given over a lot of their previous work to the doctors. But I think maybe it is also a good thing where the doctors do doctors' work and the nurses do the nurses' work. Nurses were so out of their scope but now you don't ... something has changed in casualty and how quickly the patients gets sorted out. It is so fast-tracked that you can hardly say that there was much skill needed because the doctor will say, do this, do that, do that, do that and then when the catheters are in, the drips are in, the first thing that they do, is put the drip in after observations of course, put the drip on, put the catheter in. The patients are ventilated one after the other. It happens so quickly now. The nurses learn on their feet and it is surprising how quickly the nurses learn. But the new generations of nurses are very brave. I must say that. When they feel that they want to take on the challenge of learning these things and that is why I have enjoyed the difficult times because they are young and

they want to learn and they... sometimes they know more about things than I do.

But medications have changed. Techniques have changed. So they do it.

INTERVIEWER You raised a lot of challenges in casualty. If you get the opportunity to improve the circumstances in casualty, in order to improve effective communication, what will you do there?

PARTICIPANT I will start by putting the staff there that really want to work there and to ask them to commit to working a certain time. And that they also get monitored before they get burned out that they can be at [INAUDIBLE]... where they can go so that they can get help and support from senior management or from the hospital departments. I would also like to change the waiting area, that hard benches are terrible. I would ask to put signs up that direct the patients. And to put at least to leave one porter in casualty to assist with heavy patients and pushing trolleys and to have, I wouldn't say the gate system removed, I would really like that gate system to be removed. And what? I would like to have a doctor at the triage with at least a professional nurse at triage. I would like to have a permanent clerk that will do the correct ordering and fill out and have the equipment serviced. Because if there is one link in the chain broken, if there is one weak link it makes it difficult for everybody. The doctors expect things to be there. The nurses have to provide the environment. So the doctors will walk in and start. And they wouldn't think why this temperature wasn't not taken. The thermometers have all been broken, stolen so the nurses have now got electronic thermometers and they will just expect things to be there. The doctors don't ask questions. The nurses have to work with each other. So we need senior, at least one senior nursing staff per shift and a qualified trained trauma nurse and am I asking too much?

INTERVIEWER Nee, jy kan maar praat.

PARTICIPANT I would like to have that discharge system changed. If they could have one or two maybe a pharmacist or an assistant pharmacist there to issue the medication, it takes a lot of load off the nurses. Why the nurses still have to deal with medication in that way is beyond me. What else? I would like to have at least two permanent doctors in casualty per shift and a senior doctor. I would like to have the matrons or the management to have insight into the rotation of the doctors and not to put all junior doctors in on weekends. To have at least one senior doctor.

(End of audio)



Annexure I: Ethics clearance letter



OFFICE OF THE DEAN DEPARTMENT OF RESEARCH DEVELOPMENT



17 March 2015

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by: Ms KW Ruiters (School of Nursing)

Research Project: The communication challenges between nurses

and patients in an urban emergency centre in

the Western Cape.

Registration no: 14/10/45

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

pies

Ms Patricia Josias Research Ethics Committee Officer University of the Western Cape

Private Bag X17, Bellville 7535, South Africa T: +27 21 959 2988/2948 . F: +27 21 959 3170 E: pjosias@uwc.ac.za www.uwc.ac.za

Annexure J: Editorial certificate



11 November 2017

To whom it may concern

Dear Sir/Madam

RE: Editorial Certificate

This letter serves to prove that the thesis listed below was language edited for proper English, grammar, punctuation, spelling, as well as overall layout and style by myself, publisher/proprietor of Aquarian Publications, a native English speaking editor.

Thesis title

The communication challenges between nurses and patients in an urban emergency centre in the Western Cape

Author

Katriena Wilhelmina Ruiters

The research content, or the author's intentions, were not altered in any way during the editing process, however, the author has the authority to accept or reject my suggestions and changes.

Should you have any questions or concerns about this edited document, I can be contacted at the listed telephone and fax numbers or e-mail addresses.

Yours truly

Publisher/Proprietor

STREET ADDRESS

Idea Corporation t/a

AQUARIAN PUBLICATIONS

9 Dartmouth Road Muizenberg 7945

POSTAL ADDRESS

P O Box 00000 Muizenberg 7946

TELEPHONE

021 788 1577

FAX

021 788 1577

MOBILE

076 152 3853

E-MAIL

eddi.aquarian@gmail.com eddi.londt@gmail.com

WEBSITE

www.aquarianpublications.com

PUBLISHER/PROPRIETOR E H Londt