COMMUNICATION SATISFACTION OF PROFESSIONAL NURSES WORKING IN SELECTED PUBLIC HEALTH CARE SERVICES IN THE CITY OF JOHANNESBURG

by

J-D WAGNER

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submitted in accordance with the requirements for
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SUPERVISOR: PROF. M.C. BEZUIDENHOUT

CO-SUPERVISOR: PROF. J.H. ROOS

FEBRUARY 2013

DEDICATION

To Prof. M.C. Bezuidenhout for your unwavering belief in me that enabled me to complete this dissertation

Student number: **3096-473-3**

DECLARATION

I declare that **COMMUNICATION SATISFACTION OF PROFESSIONAL NURSES WORKING IN SELECTED PUBLIC HEALTH CARE SERVICES IN THE CITY OF JOHANNESBURG** is my own work and that all sources used or cited have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

February 2013

_____ _____

J-D WAGNER **DATE**

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COMMUNICATION SATISFACTION OF PROFESSIONAL NURSES WORKING IN SELECTED PUBLIC HEALTH CARE SERVICES IN THE CITY OF JOHANNESBURG

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ABSTRACT

The purpose of this study was to explore and describe communication effectiveness and communication satisfaction experienced by professional nurses in selected public health care services. Quantitative, explorative and descriptive research was conducted to determine the communication effectiveness and levels of communication satisfaction.

The Downs and Adrian (2004) structured questionnaire was adapted and used to collect the data. The study population consisted of three groups of professional nurses, namely nurse managers (*n*=18), operational managers (*n*=22) and professional nurses (*n*=90).

The study highlighted areas of effective and ineffective communication, as well as areas of communication satisfaction and dissatisfaction, among professional nurses. The findings revealed that although professional nurses are satisfied with their supervisor-subordinate communication, they are dissatisfied with personal feedback between all categories of professional nurses. Recommendations for the improvement of the communication effectiveness and communication satisfaction of professional nurses are aimed at creating an organisational atmosphere conducive to two-way communication.

KEY CONCEPTS

Communication satisfaction; communication audit; interpersonal communication; group communication; health care service; nurse manager; organisational communication; operational manager; professional nurse

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List of abbreviations and acronyms

AD	Assistant Director
ANOVA	Analysis of Variance
AP	Actual Population
CPN	Chief Professional Nurse
CSSD	Central Sterilising and Storage Department
CSQ	Communication Satisfaction Questionnaire
DD	Deputy Director
DENOSA	Democratic Nursing Organisation of South Africa
GDHSD	Gauteng Department of Health and Social Development
GPG	Gauteng Provincial Government
GSSC	Gauteng Shared Services Centre
ICU	Intensive Care Unit
KPA	Key Performance Area
NDOH	National Department of Health
NM	Nurse Manager
OM	Operational Manager
PMDS	Performance Management and Development System
PN	Professional Nurse
SANC	South African Nursing Council
SAS	Statistical Analysis System
SPN	Senior Professional Nurse
SWOT	Strengths, Weaknesses, Opportunities and Threats
TP	Target Population

Chapter 1
ORIENTATION AND BACKGROUND TO THE STUDY

1.1 INTRODUCTION

Communication is probably the single entity we do most. We teach people things like operating catheterisation laboratories, working in highly specialised ICUs, programming intensely intricate computer programmes and much more. Yet we never teach people to communicate effectively and lovingly. Apart from generally not having the necessary skills, our verbalisation also leaves much to be desired: we talk in riddles and expect everyone to understand and act upon them! Lastly, we tend to be so 'diplomatic' that the true meanings of our words are diluted to the point of shallowness and being distorted (Blom 2000).

Communication is an essential element for the success of any organisation. For an organisation to perceive itself as effective, it has to have a thorough understanding and knowledge of its communication system (Muller, Bezuidenhout & Jooste 2006:299; Trenholm 2011:202). Health services function as organisations and therefore need to assess their communication systems from time to time, (by means of communication audits), to assess the effectiveness of these systems and to alter the existing communication structures to stay in line with the dynamic business of health care delivery.

In addition to assessing the effectiveness of the organisational communication system, communication audits can also produce information on the strengths and weaknesses of an organisation's' communication channels, and how communication practices relate to employee job satisfaction (Jones 2006:i).

Another aspect of communication that can be assessed by utilising a communication audit is the level of employee satisfaction with the overall communication in the organisation. Communication satisfaction is the level of satisfaction employees in an organisation experience during interactions between themselves and their superiors and between themselves and their fellow employees.

Professional nurses (PNs) and registered midwives, according to figures released by the South African Nursing Council (SANC) in 2012 for 2011, numbered 30 770 in Gauteng province. Of these, the largest number, are employed by hospitals in the public health sector, and they form some of the most important role players in these health care organisations (SANC, 2012). Professional nurses spend on average around 40 hours per week at work, are required to communicate effectively on an on-going basis and want to experience a high level of communication satisfaction, which could enhance their job satisfaction.

Research by Jones (2006:11) has shown in the past that the easiest way for employees (in this case nurses) to find job satisfaction is to ensure that they are satisfied with organisational communication. It must be stated, however, that communication in the health care organisations can only be effective if all the dimensions (factors) that influence the communication process are applied by all role players in such a way as to ensure communication satisfaction among professional nurses.

This chapter will describe the background to the research, the problem statement, the purpose and objectives of the study and briefly introduce the research design. It will define the conceptual framework and the operational definitions, and explain the organisation of the research report.

1.2 BACKGROUND TO THE RESEARCH

Inadequate communication (or the lack of communication) is often to blame for the failure of the functioning of an organisation. The lack of “effective communication and information exchange exacerbates uncertainty [and can] increase the alienation of employees amongst one another” (Hargie & Tourish 2000:7).

Communication with subordinates in health services often takes the form of top-down communication and the messages are received, according to Downs and Adrian (2004:54), “in the form of orders, company publications, performance judgements, job instructions, company orientations, and training for the job”. These messages are created by organisations in such a way as to “travel down the chain of command from managers to subordinates” (Downs & Adrian 2004:54).

According to Downs and Adrian (2004:84), the persistent problem with messages travelling down the chain of command is the uncertainty about the "accuracy and adequacy of information reaching lower levels of the organisation" and this information "is most often distorted, filtered or arrives too late to be of significant benefit to lower-level employees". In agreement with this statement, and due to the extremely complex transactional nature of the communication process, Nel, Swanepoel, Kirsten, Erasmus and Tsabadi (2005:329) state that the process is "subject to a great deal of interference, filtering and distortion [and that communication] should therefore be carefully managed". Nel et al (2005:329) add that "communication is a two-way process [and that] systems that focus largely on downward communication will be ineffective in most cases".

Enslin (2005:31) highlights communication as one of the most important problems in the National Department of Health (NDOH) and states that "communication from many sources has been attempted in the past, but in general we (nurses), the backbone of the health sector, are ignored". This lack of communication efficacy seems to influence a wide health care delivery spectrum. "There is no effective communication on an interdepartmental level and there is only one direction of communication at a time. We (nurses) either try to talk to them [NDOH] with no response or they [NDOH] tell us what we will do regarding a situation" (Enslin 2005:31).

Although Professional nurse S.M. Zuma (2007:52) views the Gauteng province as the largest employer of nurses in the country, for both public and private sectors, it is faced with service challenges that contribute to a negative practice environment. The lack of communication means is highlighted as one of these service challenges and needs to be addressed, with other challenges, in order to create and sustain a positive practice environment. Some situations occurring in the NDOH, where a lack of communication satisfaction is evident, pertain to administrative matters, the performance appraisal system, nurse-manager communication and interpersonal relationship challenges – to name a few (Zuma 2007:52).

Despite all the positive aspects of Gauteng as a province, Zuma (2007:52) still sees the inadequacy of formal and informal channels of communication in health services as one of the greatest challenges for the province; she feels that this lack of communication channels contributes largely to a negative practice environment.

An example of a negative practice environment is evident from an ethics audit completed by the Ethics Institute of South Africa in 2001 in one of the largest health care services in the City of Johannesburg, the Chris Hani Baragwanath hospital (Landman, Mouton & Nevhutalu 2001). This audit included communication as one of its major ethical pillars. Results from this survey underlined the need for this study.

According to Landman et al (2001:xvi), three-quarters (76%) of the staff indicated that there was too little transparency in the hospital, evidenced by rumour (the grapevine) being an important source of information, too little communication between management and staff, and too much secrecy. A substantial proportion of staff (45%) did not believe that employees were allowed to say what they really thought. Communication between employees and their supervisors was less than optimal and 50% of staff said their complaints had not been acted upon, while nearly two-thirds (65%) said they had not received regular feedback from their supervisors. Fifty-four percent of staff also did not believe that there was a system in place for reporting instances of misconduct. According to 62% of staff, rumour was a common source of information in the hospital, which is another indicator that existing channels of and procedures for communication were regarded as inadequate.

Landman et al (2001:xiv) are of the impression, after having analysed the data on management and communication in the audit, that an organisation will be unsuccessful if it does not value participation and consultation in decision making, if views of ordinary staff members do not matter, and if opportunities for constructive communication are limited or non-existent.

A follow-up study conducted by Von Holdt and Maseramule (2005) reported that this hospital still had no internal communications capacity, implying that it did not make provision for formal or informal communication channels. This was one of its many managerial problems, creating justifiable frustration and disempowerment among staff; no health care transformation was evident.

Administrative situations where communication silence is observed often include situations where managers open new sections and accept additional beds without creating additional posts for adequate patient care; or when organograms are reviewed and the number of chief professional nurse (CPN) posts are reduced, to the extent that

their responsibilities are filled by ward unit managers who are junior professional nurses (Zuma 2007:52). This scenario clearly constitutes a closed-door and communication-channel approach in which the opinion of the junior professional nurse is not valued.

A study conducted by Kekana, Du Rand and Van Wyk (2007:32) on job satisfaction at a community hospital in Limpopo reflected a poor interpersonal relationship between supervisors and employees at the specific community hospital. The respondents in this study indicated their dissatisfaction with the guidance provided by their supervisors and expressed dissatisfaction with the lack of performance appraisals. However, they were satisfied with the opportunity to get to know other people at work and the chance to socialise and communicate with colleagues.

The NDOH admitted in 2007 that it was not blind to its own shortcomings. Due to persistence of poor service delivery and patient care, the NDOH performed introspection in 2007 on its internal affairs, identifying “poor quality information (among other challenges) as a problem in both public and private health care services in South Africa that require immediate addressing and redressing” (NDOH 2007:3).

1.3 RESEARCH PROBLEM

In the capacity of professional nurse, the researcher observed that some satisfaction dimensions (such as feedback and proper communication channels) are absent in some of the health care facilities of the NDOH, contributing to communication dissatisfaction amongst the professional nurses in public health care services. Such a situation can lead to miscommunication on important work-related issues, a lack of feedback about performance, poor team spirit and a general sense of non-cohesion.

1.4 RESEARCH QUESTIONS

A research question is a concise, interrogative statement that is worded in the present tense and includes one or more variables. The foci of the research questions are to describe a variable or variables, determine the differences between two or more groups regarding selected variables, examine relationships among variables (relational), and to use independent variables to predict a dependent variable (Burns & Grove 2009:167). The research questions that stemmed from the research problem were:

- What constitutes effective organisational communication?

- To what extent are the professional nurses in public health care services satisfied with the existing formal communication processes?

1.5 AIM OF THE STUDY

1.5.1 Research purpose

The aim of this study was to determine what constitutes effective organisational communication and to establish the extent of communication satisfaction among professional nurses in selected public hospitals in the City of Johannesburg. The ultimate aim was to make recommendations to improve communication in the public health care setting.

1.5.2 Research objectives

According to Burns and Grove (2009:165), the objectives in a research study form a bridge between the more abstract problem and the selected research design, data collection and analysis. The objectives of the study were to:

- establish what constitutes effective organisational communication

- explore the extent of communication satisfaction of professional nurses in public health care services

- make recommendations to improve communication channels in the public health care setting.

1.6 SIGNIFICANCE OF THE STUDY

Effective organisational communication is pivotal in a highly demanding nursing service environment. Therefore it is the responsibility of all categories of nursing personnel to create a therapeutic nursing environment, beneficial to patient care, through effective interpersonal, group and organisational communication.

This study explored the question of what constitutes effective organisational communication and determined the level of communication satisfaction of professional nurses working in selected public hospitals in the City of Johannesburg.

The significance of this study was embedded in the fact that once the communication aspects with which professional nurses are dissatisfied have been clearly identified, recommendations can be developed to improve overall formal communication in public hospitals. Improved communication could have several advantages for operational functioning, productivity, interpersonal relations and managerial functioning.

1.7 DEFINITION OF TERMS

For the purposes of this study the following terms were defined:

1.7.1 Communication

Communication is a process whereby messages are transferred between senders and receivers via a number of formats (types), such as verbal and non-verbal formats (*Concise Oxford Dictionary* 2009:289). For the purposes of this study, communication will refer to all types of communication that travel vertically or horizontally in both directions between nurse managers, the NDOH and professional nurses.

1.7.2 Communication satisfaction

Communication satisfaction can be described as an affective feeling, dependent on the level of effectiveness of communication interaction between stakeholders in an organisation (Morele 2005:20-21).

Communication satisfaction in this study referred to the professional nurses' state of being satisfied and the meeting of their communication expectations, needs and desires in public health services during all types of formal communication interactions (vertically or horizontally in both directions).

1.7.3 Communication contexts

Communication contexts refer to different types of communication situations, according to Steinberg (2007:61-62), and are classified according to the number of people involved in the interaction as well as the degree to which they are able to interact. In this study the three communication contexts, namely the interpersonal, group and organisational communication contexts are of significance.

1.7.4 Dimensions

According to the *Concise Oxford Dictionary* (2009:402) the concept of dimension refers to *an aspect or feature* of something. In the context of this study, dimensions refer to the aspects or features of formal communication processes and channels.

1.7.5 Effective communication

Effective communication is described as the flow of material information, perceptions and understandings between individuals and between different groups. It is a means of exchanging behaviours, perceptions and values, of getting others to behave and feel differently and of creating understanding (Muller 2009:202; Cleary 2008:7-8).

1.7.6 Nurse Manager (NM)

The term nurse manager (NM) refers to a person who is registered under section 31 of the Nursing Act (Act No.33 of 2005) as a registered nurse. For the purposes of this study the term *nurse manager* will refer to nurses registered, functioning at middle and top managerial levels within public hospitals in the City of Johannesburg.

1.7.7 Operational Manager (OM)

The term operational manager (OM) refers to a person who is registered under section 31 of the Nursing Act (Act No. 33 of 2005) as a registered nurse. For the purposes of this study the term *operational manager* will refer to registered nurses functioning at operational (first-level) management levels in public hospitals in the City of Johannesburg.

1.7.8 Organisation

An organisation can be defined as an organised group of people with a particular purpose, such as a business or government department. It further implies the organising and systematic arrangement of elements (*Concise Oxford Dictionary* 2009:1008).

Jooste (2009:52) states that the word “organisation” can refer to several contexts, and suggests that any health care organisation should structure its functions and tasks in an orderly fashion. The tasks referred to in this statement are for all the levels, divisions, units and individuals in the organisation and therefore an organogram (clear description of the plan) is necessary to explain the lines of authority, span of control and assignment of responsibilities.

In this study, organisations refer to the public hospitals resorting under the Department of Health; the concept pertains to all levels, divisions and units therein, where professional nurses are working within the lines of authority, span of control and assigned responsibilities as stipulated by the micro organogram of the specific public hospital or the macro organogram of the NDOH.

1.7.9 Organisational communication

Jones (2006:4) describes the study of organisational communication as “a study of how organisation in social collectives is produced and affected by communication; and a system identified by purpose, operational procedures and structure”. Organisational communication in this study refers to all types of formal communication travelling horizontally or vertically through all structures, levels, divisions and units of public health services, for different purposes, through operational procedures and structures. This concept is discussed in context and in more detail in Chapter 2 of this study.

1.7.10 Professional Nurse (PN)

The term professional nurse (PN) refers to a person who is registered under section 31 of the Nursing Act (Act No. 33 of 2005), and pertains to “a person registered as such”. For the purposes of this study the term “professional nurse” will refer to nurses

registered under the specific section of the Act as mentioned above, functioning at operational and managerial levels within public hospitals in the City of Johannesburg.

1.7.11 Public health care services

Public health care services are health care services governed and financed by the South African government (Ruff, Mzimba, Hendrie & Broomberg 2011:S184). For the purposes of this study the concept of “public health care service” refers to all non-private, governmentally subsidised hospitals such as community, district and academic hospitals in the City of Johannesburg.

1.8 THEORETICAL FRAMEWORK

A theoretical framework, according to Burns and Grove (2009:39), is the abstract, logical structure of meaning that guides the development of a study and enables the researcher to link the findings to the body of knowledge in the discipline. The framework should be well integrated with the methodology, carefully structured, and clearly presented.

1.8.1 Downs and Hazen communication satisfaction model

The theoretical framework utilised for the purpose of this study was the Downs and Hazen model (1977) of Communication Satisfaction, consisting of three dimensions of communication satisfaction. The three communication satisfaction dimensions as described by Downs and Hazen (1977) are interpersonal communication, communication in group context and communication in organisational context.

The applicability of this model for this study was rooted in the conclusion drawn by the creators of the model, Downs and Hazen (1977:72), who state that “it is possible that the various dimensions of communication satisfaction can provide a barometer of organisational functioning, and the concept of communication satisfaction can be a useful tool in an audit of organisational communication”. The model can therefore also act as a barometer to measure the functioning of communication networks in health care services. This model will be discussed in more detail in Chapter 2 of the study.

1.9 RESEARCH DESIGN AND METHODOLOGY

Polit and Beck (2008:21) define a research design as the researcher's overall plan for obtaining answers to the research question, including specifications for enhancing the study's integrity. It spells out, in advance, the strategies the researcher plans to adopt in order to develop information that is accurate and interpretable.

A quantitative approach utilising an explorative and descriptive design was used for this study. Research methodology refers to the process or plan for conducting the specific steps of the study (Polit & Beck 2008:719). The steps may include the population, sampling and sampling method, data collection, validity and reliability of the instrument, and the data analysis.

The research design and methodology of the study were discussed under the following headings:

1.9.1 Quantitative approach

According to Burns and Grove (2009:717), quantitative research is a formal, objective, systematic process to describe and examine cause and effect interactions amongst variables. A quantitative approach was selected for this study as this study aims to explore and describe interactions among the variables of communication satisfaction.

1.9.2 Exploratory design

An exploratory research design will conduct research into an area or phenomenon that has not been studied (Botma, Greeff, Mulaudzi & Wright 2010:50), and in which a researcher wants to develop initial ideas and a more focused research question (Neuman 2003:535). Furthermore, according to Adler and Clark (2003:12), studies with an *"exploratory purpose is aimed at developing a plausible explanation of the variables in the study phenomenon".* Thus an exploratory study is the first stage of research and gives the researcher new knowledge on the study phenomenon in order to design a more in depth study.The aims of this study were exploratory in nature and it attempted to explore to what extent the professional nurses in public hospitals are satisfied with the existing formal communication processes.

1.9.3 Descriptive design

A descriptive research design refers to an accurate portrayal or account of the characteristics of a person, situation or group in real life, and/or the frequency with which certain phenomena occur, and implies the categorising of information (Burns & Grove 2009:696). This research sought to describe what constitutes effective formal organisational communication.

1.10 POPULATION AND SAMPLE SELECTION

According to Burns and Grove (2009:714), the population of a study refers to all the elements, including individuals, objects or substances that meet the criteria for inclusion in a given universe. The sample refers to a subset of the population that is selected for a study (Polit & Beck 2008:721).

1.10.1 Population

The population for this study consisted of professional nurses (from professional nurse to nurse manager level) functioning in all departments within the three selected public hospitals in the City of Johannesburg.

1.10.2 Target population

According to Burns and Grove (2009:724), the target population consists of a group of individuals who meet the sampling criteria and to which the study findings will be generalised. In order for a respondent to be included in this study, the respondent had to be a professional nurse with at least one year's work experience (in the capacity of professional nurse) in one of the three selected public hospitals.

1.10.3 Sample

A sample of 265 professional nurses, working in selected public hospitals was included, and a disproportionate stratified sampling method was used (Polit & Beck 2008:345-346) for the purposes of this study.

1.11 DATA-COLLECTION METHOD

Data was collected by means of a survey utilising a structured questionnaire. Survey techniques are often used in exploratory or descriptive research because they allow the researcher to ask questions in a written form and utilise a short period of time, and the answers can be summarised in percentages, tables and graphs (Botma et al 2010:135).

1.11.1 Instrument

A structured questionnaire was developed to measure the communication satisfaction of participants using a five-point Likert scale. This questionnaire was based on the dimensions of the *Communication Satisfaction Questionnaire (CSQ)* of Downs and Adrian (2004), which was in turn based on the Downs and Hazen (1977) model of communication satisfaction, and adapted for the purposes of this study.

1.11.2 Validity and reliability of the instrument

According to Baxter and Babbie (2004:168), it is the validity and reliability of the questions asked that ensure the quality of survey research. In this study the questions for the survey were derived from a validated *Communication Satisfaction Questionnaire (CSQ)*, previously developed by Downs and Adrian (2004).

According to Burns and Grove (2009:727), validity refers to the extent to which an instrument "actually reflects the abstract construct being examined". Validity in this study was determined by means of face and content validity. Face validity requires that the instrument appears to measure the content desired for the study (Burns & Grove 2009:700), thus in this study face validity was determined by periodic submission of the instrument to content experts. Content validity refers to the extent to which the method of measurement includes all the major elements relevant to the construct being measured (Burns & Grove 2009:693). Evidence for content-related validity for this study was obtained by conducting a literature review.

Reliability, according to Neuman (2003:534), refers to "dependability of a measurement instrument, thus, the extent to which the instrument yields the same results on repeated trials" and, according to Polit and Beck (2008:730), to "the degree of consistency or

dependability with which an instrument measures the attribute it is designed to measure".

The reliability of the Downs and Adrian CSQ (2004) lies in the fact that this instrument has been tested several times in the past. According to Downs and Adrian (2004:139-140), "this CSQ has been the basis for more than 30 PhD dissertations and MA theses" to date, and has been used in a variety of organisations, "including banks, hotels, mental health centres, airlines, hospitals, and police departments".

1.11.3 Pre-test

De Vos, Strydom, Fouchė and Delport (2005:206) state that the pre-testing of a measuring instrument implies trying out the instrument on a small number of persons displaying characteristics similar to those of the target group. A pre-test was conducted on 10 professional nurses in a fourth public hospital, inclusive of the three target population strata and sampling criteria, to assess the time required to complete the questionnaire, as well as the clarity of the questions.

1.12 DATA ANALYSIS

Data analysis refers to the categorising, ordering and summarising of data to obtain answers to research questions (De Vos et al 2005:218). The statistical analysis of the data obtained in this survey was performed with the assistance of an independent statistician; the data were analysed by utilising the Statistical Analysis System (SAS JMP version 10.0) statistical software.

Descriptive analysis and frequency calculations were computed first, to report on the distribution of the respondent demographics (Jones 2006:26). Item analysis was then performed to explain variances observed in the eight communication satisfaction dimensions. Cronbach's alpha was computed to test internal reliability and to test whether the communication satisfaction dimensions had been measured in a useful way. Furthermore, a one-way analysis of variance (ANOVA) test was performed in case of statistically significant differences between the three different strata of the study population with regard to communication satisfaction dimensions.

1.13 ETHICAL CONSIDERATIONS

Ethical clearance was sought from the Higher Degree Committee of the Department of Health Studies, University of South Africa. Permission was requested from the Director of the Department of Health and Social Development of the Gauteng province, the Chief Executive Officers of the hospitals in which the research was conducted, and from the respondents participating in the study.

Ethical considerations were followed to enhance the protection of respondents in accordance with the DENOSA ethical research criteria (1998:1-4). Permission was also sought from the original creators of the CSQ to adapt and use their instrument for the purposes of this study (Annexure D).

To verify his integrity, the researcher hereby declares that he has acknowledged in full all sources and reference material utilised for the compilation of this research, to avoid the possibility of plagiarism.

1.13.1 Right to self-determination or autonomy

The researcher addressed issues including the freedom of respondents to withdraw from the research at any time. Informed consent was acquired from the respondents after they had been clearly and fully informed about what the research entailed.

1.13.2 Anonymity and confidentiality

According to Bell (2007:48), a promise of *anonymity* is a promise that even the researcher will not be able to tell which responses came from which respondent. Informed consent was acquired by means of a separate document from the questionnaire, and was handled separately throughout the study to ensure the anonymity of the respondents.

Confidentiality, according to Polit and Beck (2008:750), refers to the protection of participants in a study, that their individual identities will not be linked to the information they provide and will not be publicly divulged. This information should not be divulged or

made available to any other person. This responsibility was adhered to only as far as positive identification of the subjects was concerned.

1.13.3 Right to privacy

Privacy is the freedom of an individual to determine the time, extent and general circumstances under which personal information will be shared or withheld from others (Burns & Grove 2009:715). The respondents in this study were informed that the information they provided would not be shared with their operational managers on the basis of discussing who had said what; such information would only be used when highlighting recommendations, without disclosing respondents' personal information.

1.13.4 Beneficence

Beneficence requires the researcher to actively promote good and do no harm (Burns & Grove 2009:689). It was anticipated that this study would result in positive outcomes for public hospitals and professional nurses in their service, by means of recommendations to improve effective communication and promote communication satisfaction.

1.14 SCOPE AND LIMITATIONS OF THE STUDY

The scope of the study was focused on selected public hospitals in the City of Johannesburg and the professional nurses working there. A constraint that could limit the study was:

- The questionnaire was available only in English, as the official language medium; while the majority of the respondents do not speak English as their home language.

1.15 ORGANISATION OF THE REPORT

The report stemming from the research study was organised in the following way:

Chapter 1 contains the introduction to the study, the background to the research, problem statement, the purpose and objectives of the study, the terms used, the research design and methodology and the ethical considerations.

Chapter 2 discusses the literature reviewed for the study on communication and the theory underlying communication satisfaction and effective communication.

Chapter 3 describes the research design and methodology.

Chapter 4 discusses the data analysis and findings.

Chapter 5 concludes the study with a summary of the main findings, conclusions, limitations and recommendations developed for clinical practice.

1.16 CONCLUSION

The aim of this study was to determine the level of communication satisfaction amongst professional nurses working in public health services in the City of Johannesburg. It attempted to explore the factors underlying communication satisfaction of professional nurses within these health care organisations. It is clear from the background of this study that ineffective communication can lead to poor performance and lack of results.

This chapter introduced and described the rationale for the study, the research problem, aim and objectives of the study. The significance of the study was briefly stated, emphasising the importance of the phenomenon under scrutiny. Conceptual and operational definitions were included for explanation and the research design was stated.

Chapter 2 discusses the literature review on information that was researched in relation to the study purpose.

Chapter 2
LITERATURE REVIEW

"A company's values lie between the ears of its employees".
Jack Welch (General Electric Pty. Ltd.)

2.1 INTRODUCTION

According to numerous research sources, the purpose of a literature review is to create an idea of what is known and what is still undiscovered about a particular study problem or phenomenon. It briefly describes current knowledge on the study problem, in order to provide the reader with a better understanding of how this study fits in with previous findings, thus giving the reader the opportunity to evaluate the contribution of the new study (Watson, McKenna, Cowman & Keady 2008:75; Jooste 2010:291).

The topic of this study is *Communication satisfaction of professional nurses working in selected public health care services in the City of Johannesburg*. The researcher chose this topic because, although quite a number of studies have been conducted on the job satisfaction of professional nurses *per se*, one element, communication (which is highlighted in each of these studies as ineffective), still appears to be under-studied. This is despite the fact that a number of the job satisfaction studies reviewed have even been South African based, for example those of Kekana et al (2007) and Morele (2005).

Communication satisfaction studies conducted in the past have focused on professions and organisations such as manufacturing industries (Tsai, Chuang & Hsieh 2009), legal departments (Jones 2006) and media centres (Coffman 2004 in Jones 2006), but are still not widely conducted in the nursing field. Studies conducted on communication satisfaction among nurses are based abroad; examples are the studies by Tzeng (2002) and Shader, Broome, Broome, West and Nash (2001). Only one study could be found on communication satisfaction conducted within South Africa, that by Meintjes and Steyn (2006), which focused on the higher education domain. That study attempted to measure the communication satisfaction of the personnel at the Johannesburg University during its transformational phase in 2005.

For the current study the researcher utilised primary and secondary literature resources, as well as the PubMed and Edulink electronic resources. The terminology that was used in this literature review included communication, satisfaction, organisation, job, professional nurse, public health organisation and dimensions.

Health care services, like all other organisations in South Africa, strive towards an effective communication system which will result in communication satisfaction among their employees and consequently a more satisfied workforce. A number of factors in the health care organisations contribute to this effectiveness of the communication systems. Qolohle, Conradie and Malete (2006:17) state that the South African government, as a large organisation, relies on groups such as doctors and nurses to accomplish its goals. It is their satisfaction with the communication system that could influence their behaviour in the organisation; therefore communication must be viewed as a powerful tool in the management of employee-organisation behaviour.

The success of the functioning of an organisation can depend on the extent of communication satisfaction among its employees. This statement is echoed by Downs and Hazen (1977:72), who conclude that “it is possible that the various dimensions of communication satisfaction can provide a barometer of organisational functioning, and the concept of communication satisfaction can be a useful tool in an audit of organisational communication”.

Communication satisfaction, especially when used in conjunction with other organisational concepts such as job satisfaction, is a complex, multi-faceted concept. Therefore it is necessary to discuss this concept according to the three dimensions of communication satisfaction mentioned by Downs and Hazen (1977), namely interpersonal communication; communication in group context; and communication in organisational context.

This chapter will describe the theory that underlies communication satisfaction and the process of communication. Thereafter it will provide recommendations for the improvement of organisational communication as acquired from the literature.

2.2 THEORETICAL FRAMEWORK

It is important for scientific studies to utilise appropriate theoretical frameworks upon and around which components of a study can be built. The primary purpose of this study was to determine the communication satisfaction of professional nurses working in public hospitals. The Downs and Hazen (1977) theoretical framework for communication satisfaction was identified as the most suitable framework for the purpose of this study, because it is based on the theoretical assumption that communication satisfaction is multi-dimensional.

2.2.1 Definition/explanation

The Downs and Hazen theoretical framework was developed by Downs and Hazen in 1977, initially to test communication satisfaction in general. Downs and Hazen (1977:70), following the example of previous researchers, used communication audits and conducted their own investigation into the concept of communication satisfaction. Their factor analyses of the concept resulted in eight stable constructs (dimensions) of communication satisfaction: Personal Feedback, Supervisory Communication, Subordinate Communication, Communication Climate, Corporate Information, Horizontal (Co-worker) Communication, Media Quality and Organisational Integration (Downs & Hazen 1977:70-75; Meintjes & Steyn 2006:154-155).

Studies conducted between 1984 and 1986 categorised these eight constructs under the three communication satisfaction contexts of Interpersonal Communication, Group Communication and Organisational Contexts. Gray and Laidlaw (2004:428) state that due to its comprehensiveness this framework is distinct from any other in that “it assesses the direction of information flow, the formal and informal channels of communication flow, the forms of communication and relationships with various members of an organisation”.

An advantage of basing a communication audit on this framework is that this audit is evaluative and will provide, according to Coffman (2004:1), a “snapshot” of the current communication processes in an organisation, and is formative in that it “points to areas in which the organisation can strengthen its performance”.

2.2.2 Contexts and dimensions of communication satisfaction

The Downs and Hazen model (1977) contains three conceptual contexts:

- Interpersonal communication context
- Group communications context
- Organisational communication context

Each of these contexts has a set of communication dimensions which influences it (Figure 2.1). These communication satisfaction dimensions (and their sub-components) were identified by Downs and Adrian (2004) and form the bases of the communication satisfaction theory. In this theoretical framework the eight dimensions are personal feedback; supervisory communication; subordinate communication; horizontal communication; organisational integration; corporate information; communication climate and media quality.

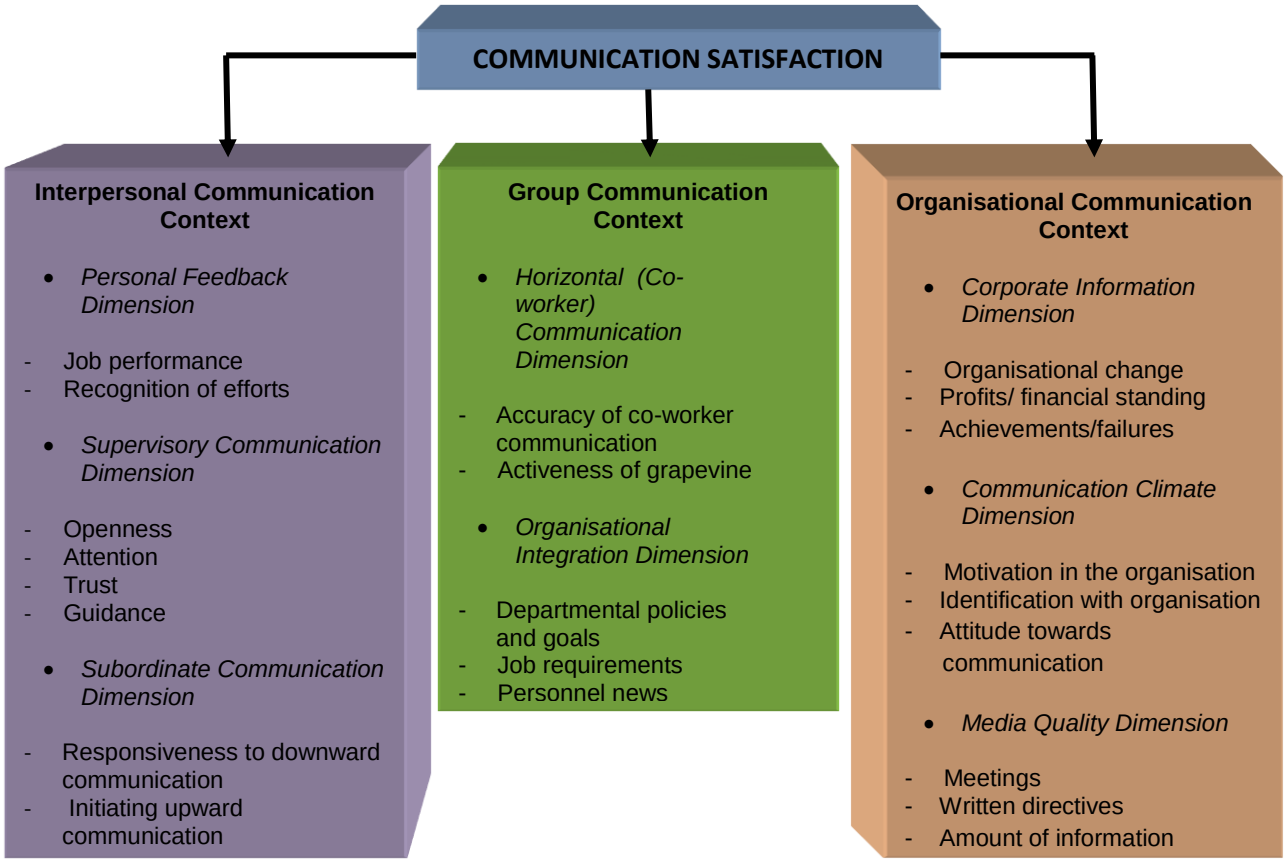

Figure 2.1: The Downs and Hazen Communication Satisfaction Framework
(Source: Adapted by Downs and Adrian (2004) from the Downs and Hazen (1977) model)

2.2.2.1 Interpersonal Communication Context

The Interpersonal Communication Context defines the communicative relationship between the manager and the employee in an organisation (Downs & Hazen 1977:72). There are three dimensions listed under this context (see Figure 2.2). Mueller and Lee (2002:222) state that the dimensions of personal feedback, supervisory communication and subordinate communication in the Downs and Hazen (1977) model represent communication outcomes in the interpersonal context. Each of these dimensions will be discussed in further detail.

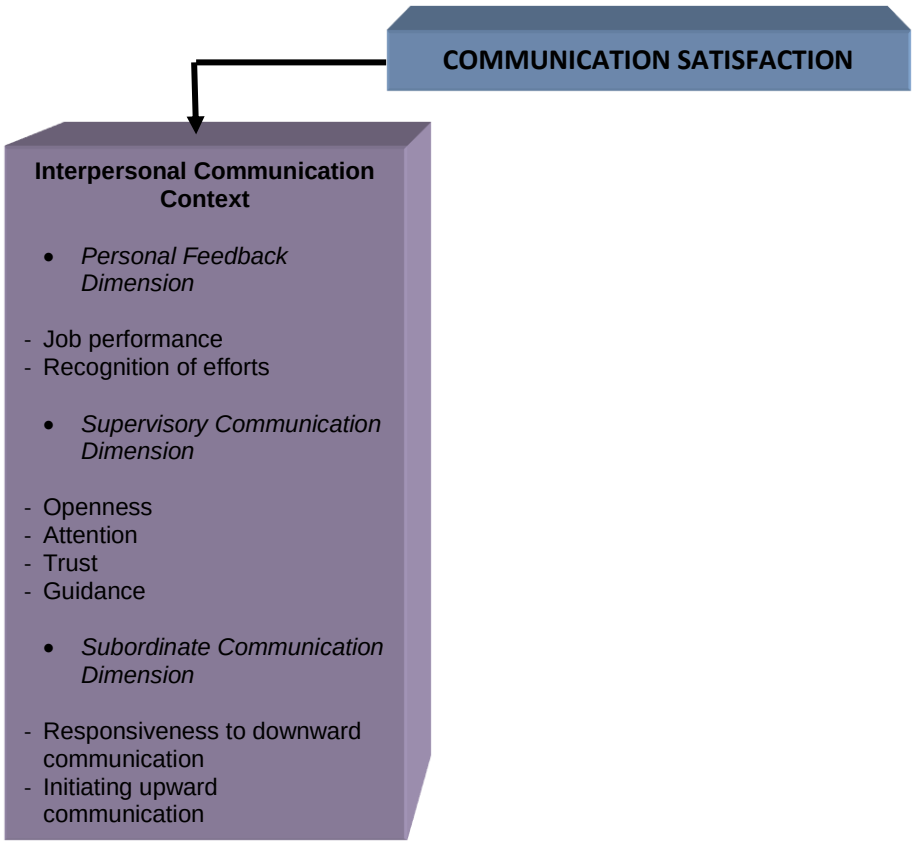

Figure 2.2: The interpersonal communication context and dimensions of the Downs and Hazen Communication Satisfaction Framework
(Source: Adapted by Downs and Adrian (2004) from the Downs and Hazen (1977) model)

2.2.2.1.1 Personal Feedback Dimension

Personal feedback refers to the desire of employees to know how their work is judged and their performance is appraised. Professional nurses display the same desire and seek approval and appraisal for work done. According to Muller et al (2006:309-310), feedback to employees is the factor that completes the communication cycle and makes

it two-way communication. Sufficient feedback to employees from managers is an essential measure to improve productivity and performance. In assessing the relationship between communication satisfaction and personal feedback, investigations should centre on how the work of employees is judged and how performance is appraised. This includes aspects such as the information about how the employee is being judged and recognition of the employee's efforts.

- Job performance

It is essential that employees receive information about how their performance is being managed by their supervisors. In the public sector the Performance Management and Development System (PMDS) is applied to all levels of employees (Gauteng Shared Service Centre (GSSC) 2011). This system grades all employees according to a classification of job grades. Jooste (2010:106) states that the introduction of the PMDS system has brought about significant improvement, as it provides a clear focus on what has to be achieved and has been mutually agreed upon. Key performance areas (KPAs) form a crucial part of the PMDS system. The KPAs are weighted out of a hundred marks and employee performance is measured against these key performance areas. Those cited in the PMDS document designed by GSSC in 2010 and revised in 2012 include:

- Orientation to the work in a public service context
- Planning and organising work to achieve objectives that meet service standards
- Leading a team to solve workplace problems and conflict
- Identifying performance requirements and improving work team performance
- Managing own performance and development of others
- Communicating in the workplace and work team
- Leading change in teams in the workplace
- Producing data and analysing statistics for workplace operations in the GPG (Gauteng Provincial Government)
- Delivering and monitoring client service
- Securing and allocating resources and budget to achieve workplace objectives
- Maintaining physical and/or electronic information records
- Using computers and/or equipment to achieve work team objectives

The PMDS, with regard to the implementation of the planning process, requires the unit manager to keep up to date with the goals and objectives of the other levels of management (Jooste 2010:106).

The private health care sector utilises a variety of performance management strategies; for example, one private health care group utilises the Maximising Performance Assessment System (Ackerman & Bezuidenhout 2007:71). In brief, the maximising performance is an assessment system containing five KPAs on which staff have to submit assignments in order to be assessed and rated:

- Managing work
- Building customer loyalty
- Quality orientation
- Adaptability
- Work standards

The latter (C-3 Workbook) contains basic standards of performance for the different categories of staff. If any deficiencies in performance are detected, these are indicative of the need for training and development.

- Recognition of efforts

Employees need to experience recognition for their efforts. By acknowledging the efforts of subordinates, encouraging questions and providing solutions to problems, the nurse manager can create a supportive communication climate (Booyens 1998:268). In this type of climate there is a spontaneous atmosphere within the organisation and employees feel free to express themselves.

It is essential for employees to receive timely information on how to do their jobs, but equally important is the acknowledgement of work well done. Kekana et al (2007:31) state that nurses in general value the opportunity and freedom to express their doubts about delegated duties should they not agree with them.

Nurse managers should concentrate on acknowledging their employees' achievements. To promote self-esteem and job satisfaction among employees, managers can give due

recognition for a job well done, such as no-cost rewards like writing complimentary letters to employees. Regular and consistent performance appraisals by supervisors should be encouraged (Kekana et al 2007:34).

2.2.2.1.2 Supervisory Communication Dimension

Supervisory communication refers to both the upward and downward communication that subordinates experience with their supervisors. The level of satisfaction professional nurses experience during supervisory communication depends on aspects such as the extent to which the supervisor is open to ideas, listens and pays attention to the employee, trusts the employee and offers guidance to solve job-related problems. These aspects should be investigated in an audit as means of improving supervisory communication (Jones 2006:38).

- Openness

Openness indicates the extent to which the supervisor is open to new ideas, and it links to the element of trust. Robbins, Odendaal and Roodt (2003:75) view openness as the extent to which a person can be relied on to be truthful when issues of trust are at stake. What constitutes open communication? According to Muller et al (2006:532), open communication is the sharing of all types of information throughout the organisation, across functional and hierarchical levels. In other words, in a situation of mutual trust and open communication, the supervisor can confidently be open to new ideas of colleagues and subordinates.

- Attention

According to Meintjes and Steyn (2006:159), attention refers to the extent to which the supervisor listens and pays attention to the employee. Van Staden, Marx and Erasmus-Kritzinger (2002:15) state that employees in an organisation have specific internal communication needs. These needs include direct and personal contact with superiors, an understanding of the job and the organisation, being informed about issues related to the job at all times, and an atmosphere of trust and mutual respect.

- Trust

Trust refers to the extent to which the supervisor trusts the employee and vice versa. Honesty, according to Robbins et al (2003:258), is absolutely essential in leadership and underlies the key dimensions of trust: integrity, competence, loyalty and openness (Robbins et al 2003:75). Leaders must be worthy of the trust of their followers; once the followers are assured of this trustworthiness, they will willingly follow the leader. “Knowledge-based trust” is the most prominent type of trust that exists in organisations and is based upon a history of interaction with someone, and knowing someone well enough to make a prediction on their probable behaviour (Robbins et al 2003:259).

James, Kotzé and Van Rooyen (2005:7) researched ineffective communication in general and found, in addition to a lack of self-confidence on the part of nurse managers and non-communication with professional nurses, “a problem of non-engagement between these two nursing categories that resulted in a lack of trust by the professional nurses”. The need to “take the initiative and offer support and encouragement of effective relationships among colleagues” is ultimately the function of the nursing manager (James et al 2005:5).

Kreitner and Kinicki (2007:352) highlight communication as one of the six guidelines for building and maintaining trust in relationships between managers and employees. This guideline (communication) embraces aspects such as telling the truth, keeping employees informed and providing accurate feedback. Jooste (2009:225) states that managers who supply their subordinates with appropriate information that will simplify work and is readily available reflect an open climate of trust in nurses to make their own decisions.

- Guidance

Guidance refers to the extent to which the supervisor offers guidance for solving job-related problems. Employees are faced with many job-related problems on a daily basis which require the insight of the manager. The employee needs regular guidance from management on how to handle challenges in the employee’s job (Jones 2006:10). However, according to James et al (2005:5), in the health sector the “disillusionment”

expressed by professional nurses is aggravated by non-communication and lack of feedback from nurse managers about their patient care activities.

Active staff participation in the decision-making process can lead to stability in the organisation. According to Lephalala, Ehlers and Oosthuizen (2008:63), nurse managers who encourage participation, value contributions from staff, promote decision making and influence coordination, could enhance the positive aspects of a working environment.

2.2.2.1.3 Subordinate Communication Dimension

Subordinate communication refers to the upward and downward communication that supervisors have with their subordinates. Only employees in a supervisory capacity will respond to these items on a survey.

It also refers to the confidence that supervisors place in their subordinates to initiate upward communication, and in turn the responsiveness of subordinates to downward-directed communication, thus indicating that subordinates trust their managers enough to communicate openly with them. Nurses need to trust their managers and foster open upward communication for the benefit of the patient.

Determining the relationship between communication satisfaction and supervisory communication requires an analysis of how comfortable employees are with initiating upward communication. When employees rate their supervisors highly on this dimension in an audit, this would indicate that the employees are responsive to directives, anticipate their managers' need for information, and are receptive to evaluation, suggestions and criticism (Jones 2006:39).

- Responsiveness to downward-directive communication

Downward-directive communication in this study refers to the extent to which employees are responsive to communication directed down to them by their managers. Muller et al (2006:303-305) describe communication patterns from the viewpoint of the manager, addressing issues such as who is talking to whom, what is said, how it is said, and who is listening (or not listening). The manager also takes note of non-verbal

behaviour. Communicating with a group is different from communicating with an individual, in the sense that the aspects of group size, competition, sophistication, organisation and structure become more important in communication with a group.

Receptiveness to evaluation, suggestions and criticism refers to the extent to which employees are receptive to such communications from management and vice versa. Because of the sensitive nature of evaluation, suggestions and criticism, managers should approach this task with caution. According to Jooste (2009:235), two-way communication between employees and their supervisors creates a platform where opinions can be exchanged, and there is openness to criticism. This is not where it should stop; managers must be confident enough, according to Jooste (2009:235), to communicate the views of employees (nurses) under their leadership to top-level management without hesitation. It is important that these nurses should be informed of the results of the communication with top-level management.

- Initiating upward communication

Upward communication refers in general to messages which flow from subordinates to superiors. Upward communication is initiated to ask questions, provide information and feedback and to voice opinions or make suggestions (Jones 2006:16). Accurate upward communication thus refers to the extent to which employees feel responsible for initiating such communication. It is often the case that if upward communication flow issues are present in an organisation, there will also be issues with downward communication.

Lower-level employees often distort information they convey up the chain of command, and this phenomenon is usually the case with people that have a high achievement drive (Jones 2006:16). Subordinates tend to convey only the information that shows them in the most favourable light. Information can also be viewed as power, and relinquishing information can imply a loss in power. Subordinates tend to “hoard as much information as possible for as long as possible” before they send it up the hierarchy (Jones 2006:16).

The anticipation of the manager's need for information refers to the extent to which employees anticipate the needs of the manager for information, even if not trained to do so. Managers need information from lower organisational levels to make decisions, and this information should not always be on a demand-and-supply basis but on an automatic and forthcoming basis (Jooste 2009:103). This is, however, not a given, as it is sometimes difficult for employees to gauge the needs of the manager, especially if the manager is not a pro-team type of manager who encourages inputs from lower-level employees. Managers should simply inform subordinates what it is that they as managers require, when, how often and in what format.

2.2.2.2 Group Communication Context

The Group Communication Context defines the communicative relationship between same-level employees in an organisation (Downs & Hazen 1977:72) and is the second context in the conceptual framework. There are two dimensions listed under this context (see Figure 2.3). Mueller and Lee (2002:222) state that according to the Downs and Hazen (1977) model, the two dimensions of co-worker communication (horizontal communication) and organisational integration, resort under communications in group context. Each of these dimensions will be discussed in further detail.

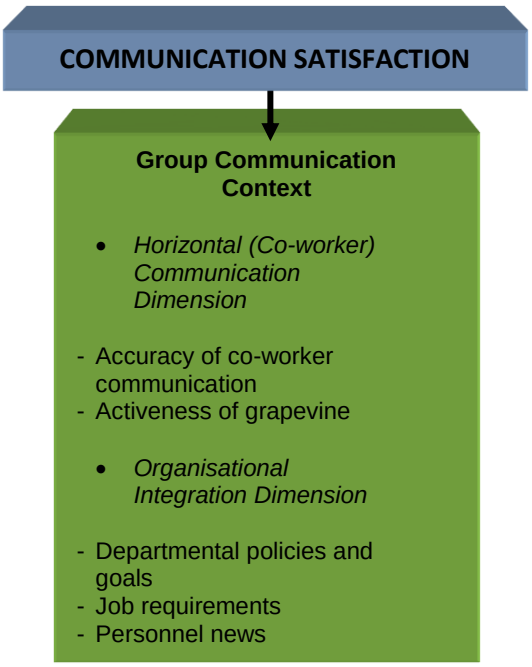

Figure 2.3: The group communication context and dimensions of the Downs and Hazen Communication Satisfaction Framework
(Source: Adapted by Downs and Adrian (2004) from the Downs and Hazen (1977) model)

2.2.2.2.1 Horizontal (Co-worker) Communication Dimension

Horizontal (Co-worker) communication refers to employees' informal communication with co-workers (Downs & Hazen 1977:70). The working atmosphere of employees in organisations must be conducive to interaction and communication with colleagues in their departments, so that employees on the job support each other and receive practical guidance from other staff members. This point also refers to how comfortable employees are with using informal communication channels to discuss issues with co-workers. In analysing co-worker communication, it is important to investigate issues such as the extent to which informal communication is active and accurate: that is, with regard to how accurate communication with other employees is and how active the informal communications network (grapevine) is in the organisation (Muller et al 2006: 304).

- Accuracy of co-worker communication

Horizontal communication has four main functions in an organisation, namely task or project coordination, problem solving, sharing of information and conflict resolution. Task or project coordination allows employees to share and discuss their thoughts and feelings on how respective members are contributing to the group's objectives. Problem solving allows employees to brainstorm ideas in different ways to solve challenges faced in the organisation. The sharing of information allows employees to gain knowledge that is often filtered out in downward communication. Conflicts in the organisation are resolved, as employees are allowed, due to the nature of horizontal communications, to have a free flow of communication (Jones 2006:18).

Often conflict is resolved directly at the lower level, without being brought to the attention of the supervisor (Jones 2006:18). It would be a waste of time and effort for information on issues that could be handled at a lower level to travel up through all the levels of the chain of command and back down again (Conrad & Poole 2002 in Jones 2006:18). A suggestion from Van Staden et al (2002:23) is that it would be a good idea for managers to become involved in communications at peer-group level in order for them to know "what is said on the ground" and to become more sensitised to the feelings and needs of subordinates.

Nurses, especially professional nurses, need to feel that they are part of a team and experience effective two-way communication with their nurse managers. However, this seems not to be the case in most public health services of the Department of Health (NDOH). Zuma (2007:52) states that there is a deafening silence in the nursing profession in situations which require nurses to speak up against the ills evident in their working environment.

- Activeness of the grapevine

The “grapevine” refers to the informal communication network that exists in all organisations. The grapevine helps employees to make sense of the world around them and provides relief from emotional stress (Muller et al 2006:147-148). It is important to know how comfortable employees are with utilising this communication network to discuss issues with co-workers. In the public sector, as in all other organisations, the grapevine is a lively one. How healthy it is is debatable, but what is a given is that in the public hospital setting information often follows the grapevine route; as a result important messages might end up being distorted and taken out of their originally intended context.

Rumours spread through the grapevine are in direct proportion to their importance to the employees and to the lack of information on the subject from official sources (Muller et al 2006:305). This informal communication network does not concentrate solely on gossip; in fact 80% of the information communicated via this network consists of business-related politics, and 70 to 90% of this information is usually correct as to detail. It serves an important purpose, as it fulfils a basic human need for social-interaction in the workplace, but it needs to be managed to increase productivity and job satisfaction (Booyens 1998:269).

Conrad and Poole (2002:74) state that informal communication networks might actually produce more accurate information than formal channels, because communication in informal networks is voluntary, uninhibited and not power-based. Mutual give and take occurs; communicators provide more detail in their messages and they are more willing to provide feedback as well (Conrad & Poole 2002:74).

2.2.2.2.2 Organisational Integration Dimension

Organisational integration refers to the satisfaction of employees with the amount of information they receive about their immediate work environment (Downs & Hazen 1977:70). This type of information could include information regarding departmental policies and goals, job requirements and personnel news (Jones 2006:40). An analysis of the amount of information that employees receive about their immediate environment indicates the issues that should be addressed. It should include information about the job progress of the employee, personnel news, departmental policies and goals, job requirements and the employee benefits and pay (Jones 2006:40).

- Departmental policies and goals

According to Meyer, Naudé, Shangase and Van Niekerk (2009:268), policies and procedures are guidelines enhancing the standard of nursing care in the nursing unit. Departmental goals are broad statements used to formulate departmental objectives that need to be achieved by members of the health care team (Jooste 2010:94).

Government regulations (rules) describe what can or cannot be done under certain circumstances and form part of the imposed external guidelines that are passed down from various sources of authority (Booyens 2008:67), such as legislation in the form of acts and/or regulations. Governmental regulations permit no variation and must be strictly adhered to in order to avoid disciplinary action. In the public health care service, rules and regulations are passed down from governmental level to the NDOH and from the NDOH to the actual health services (Booyens 2008:67).

Policies in the public health care services are kept in policy manuals which are held in the offices of the Assistant Director (AD) responsible for the specific nursing department. The goals of the NDOH and the public health care services are communicated by means of memoranda and intranet announcements. Information regarding departmental policies and goals should be available to all employees in that specific department and should preferably be formulated in written, understandable form, following a specific, concise and complete format. It should be stored in a policy manual that is easily accessible to all personnel (Jooste 2010:95).

When an organisation states an intention, the intention is formulated into a goal or aim (Jooste 2010:105), and objectives are set which indicate how the organisation intends to reach the set goal. Policies and procedures are perceived as means to accomplish set organisational goals and objectives (Jooste 2010:94). Policies, for that matter, can be utilised by implication or by expression. Policies by implication are not directly voiced or written but are established by a pattern of decisions (Jooste 2010:94).

According to Booyens (2008:59), policies have to be communicated throughout an organisation to be effective. Although a policy manual is the most common way of informing non-supervisory employees about policies, it should be followed up by oral explanations and interpretations provided by first-level supervisors.

- Job requirements and job progress

Every job has inherent job requirements (key performance areas) that the employee needs to adhere to. Job requirements should be communicated to the employee at the earliest convenient time to eliminate the possibility of mistakes (Jooste 2009:405). Information about the progress of employees (measuring how well they are doing their jobs on a performance appraisal system) must be shared with them on a regular basis.

Jooste (2009:405) views performance management as an assessment of the interest of subordinates in their jobs, good health, responsiveness and fairness of financial contributions. Nel, Van Dyk, Haasbroek, Schultz, Sono and Werner (2004:283) state that health care professionals expect the rewards received from the organisation to correlate with their performance. This compensation should be perceived by nurses as fair and equitable if they are to sustain a good employment relationship with their health services (Jooste 2009:288).

- Personnel news

Employees want to be informed regarding the well-being of co-workers. The way in which this information is conveyed to them will have a large impact on their level of psychological belonging. News regarding personnel in the nursing unit or larger organisational setting is viewed as important to the psychological well-being of the employees (Jones 2006:14).

2.2.2.3 Organisational Communication Context

The Organisational Communication Context defines the communicative relationships in an organisational context (Downs & Hazen 1977:72). According to Mueller and Lee (2002:222) there are three communication satisfaction dimensions, in the Downs and Hazen (1977) model that represents the communication experience in the organisational context. These communication dimensions include corporate information, communication climate and media quality, (see Figure 2.4). Each of these dimensions will be discussed in further detail.

Figure 2.4: The organisational communication context and dimensions of the Downs and Hazen Communication Satisfaction Framework
(Source: Adapted by Downs and Adrian (2004) from the Downs and Hazen (1977) model)

2.2.2.3.1 Corporate Information

Corporate information refers to the broadest kind of information about the organisation as a whole (Downs & Hazen 1977:72). When analysing the relationship between corporate information and communication satisfaction, it is important to assess the issues pertaining to corporate information and the amount of information employees

receive as a whole regarding changes in the organisation, profits and financial standing of the organisation and the achievements or failures of the organisation (Jones 2006:43).

- Organisational change

Change, according to Muller et al (2006:520), is a process resulting in differences of varying magnitude in the state of an organisation. It is unavoidable and occurs continuously, in some form or another, in all organisations; health care organisations are no exception. However, employees need to be aware of these changes as they might influence them personally or professionally, so the effective informing of employees becomes a challenge.

Jooste (2009:372) states that effective communication is essential if effective change is to occur in the organisation. Employees must be informed about the reasons for the change, but circulating this information through e-mails only is not enough. It will require a lot of face-to-face communication to get employees involved in the change process.

- Profits/financial standing

Unlike the private health care sector in South Africa, the public health care service is a non-profit, government-subsidised entity. Due to a constant lack of financial resources, the NDOH (one of the governmental departments included in the national budget annually) needs to perform proper financial planning (Zuma 2007:52). Annual budgets and strict financial management measures are the order of the day in all public health services. To make these measures materialise, all stakeholders (including professional nurses) need to be informed about financial constraint measures and the financial status of the NDOH.

- Organisational achievements/failures

Employees have a right to know whether or not their organisation is performing well. The achievements and failures of the organisation should be communicated to employees in an honest and transparent manner. Briefing sessions are essential to determine the strong and weak points of the organisation. Methods such as the SWOT

(Strengths, Weaknesses, Opportunities and Threats) analysis, a method that measures internal environmental strengths and weaknesses and external environmental opportunities and threats can be utilised to this end (Jooste 2010:109).

2.2.2.3.2 Communication Climate Dimension

Communication climate refers to communication on both organisational and personal levels. It pertains to the employees' perception of the overall health of the communication atmosphere, including satisfaction with personal and organisational communication (Downs & Hazen 1977:72; Jones 2006:41). Elements inherent in an ideal communication climate include: supportiveness, participative decision making, trust, confidence and credibility, openness and high performance goals (Meintjes & Steyn 2006:159).

- Motivation in the organisation

Communication in an organisation can be utilised to motivate and stimulate employees to meet the organisational goals. Communication can motivate employees by clarifying what it is that the employee is supposed to do and what can be done should the employee's performance fall below standard (Muller et al 2006:301).

A motivating communication climate in a health service can inter alia be created when nurse managers practice an open-door policy. An open-door policy simply means that a professional nurse may come to the office of the nurse manager at any time (on appointment preferably), and without interrupting his or her schedule of work to discuss any issue deemed relevant (Jones 2006:41).

Communication within an organisation must be helpful and interesting to its employees. Dolamo (2008:42) states that in order for subordinates to provide a good service they need to be informed by the leader, on a consultation basis, about the service they are providing and the needs they are facing. Information should be clear and readily available for the subordinates to make informed decisions. Leaders have a wide range of choices in providing more and better information, such as utilising electronic and printed media for example (Dolamo 2008:43).

- Identification with the organisation

The employee has to identify with the vision, mission, goals and objectives of the organisation in order to feel part of it. Organisational identification refers to the extent to which communication in an organisation makes the employee identify with it or feel a vital part of it. According to Downs and Adrian (2004:140), organisational information makes employees feel that they are "a vital part of the organisation".

- Attitudes towards organisational communication

Muller et al (2006:518) state that attitude is an internal, emotional opinion a person has towards people, things, actions and behaviour. The attitudes of employees at an organisation must be basically healthy. If the attitudes of employees are not healthy it might imply that there are certain barriers hampering the free flow of information.

One such a barrier could be difference in status between members of a group when employees at different levels of the hierarchy need to communicate with one another. Van Staden et al (2002:23) state that "with a positive and relaxed attitude" towards the communication process and one another, "this barrier can be overcome and valuable insights gained" from one another.

2.2.2.3.3 Media Quality Dimension

Media quality refers to the employees' reactions to several important communication methods, formats and channels (Downs & Hazen 1977:72). Assessment criteria pertaining to the media quality dimension on a communication audit will make reference to the degree to which meetings are organised, written directives and reports are clear and concise and the amount of communication received satisfactory (Downs & Adrian 2004:54; Jones 2006:42).

- Meetings

Meetings in an organisation occur when "two or more people gather to discuss and resolve issues of common interest" (Jooste 2010:100). An organisation is dependent on formal meetings for the smooth running of its day-to-day operations. These meetings

should be well organised and it is the extent to which these meetings are organised that is going to determine how successful they are.

Meetings are “one of the most effective communication tools of the work environment” (Jooste 2010:100), where ideas can be stimulated, plans of action generated, teamwork encouraged, guidance provided, employees empowered and productivity improved. “Effective meetings also ensure the continuous flow of information to all levels and between all health care professionals” in the organisation (Jooste 2009:402).

- Written directives

The medium in which organisations distribute their information to internal and external destinations could have a huge impact on the effectiveness of such information. It is the receiver that needs to make sense out of the intended message and interpret it as the correct intention of the sender. Thus the correctness of organisational media is essential. The correct medium should be used for the specific purpose intended; for example, a memorandum is used as a formal form of communication inside a nursing unit or for communication between the nursing unit and departments. The telephone or e-mail communication should be used in cases where information is required urgently (Meyer et al 2009:270).

Written communication in the form of directives and reports in an organisation must be clear and concise. Grammatical errors should be avoided. Messages should contain the gist of the matter but not be so brief as to create more questions than answers (Meyer et al 2009:267).

- Amount of communication

The amount of information the employee receives from the manager is closely aligned with communication overload, and must involve a precise process. Employees can easily feel overwhelmed by too much information – regardless of whether this information is applicable to their work situation or not. It is the responsibility of the manager to provide employees with correct and up-to-date information that is relevant and applicable to their work situation, but the manager should not restrict the flow of information that could stimulate growth and creativity.

2.3.3 Concluding remarks on the theoretical framework

This study is founded in a multi-dimensional communication context (public health care services). The Downs and Hazen model (1977), as discussed in the literature review thus far, formed the basis for this study. It was selected on the grounds that it was based on the theoretical assumption that communication satisfaction is multi-dimensional. It contains three contexts: the interpersonal communication, group communication and organisational communication contexts. Each of these contexts contains specific communication dimensions, which were individually discussed in detail. However as this study is founded within the broader communication domain, the communication process also have to be discussed.

2.3 COMMUNICATION

Communication is an integral part of our daily existence, but it needs to be purposeful and effective. However, before the concept of *communication* can be applied to any aspect of this study it is essential that the concept be viewed in more detail in terms of its definition, process, climate, types, methods, networks, flow, contexts, characteristics and barriers.

2.3.1 Definition of communication

Communication, according to Meyer et al (2009:265-266), is a two-way process whereby information (messages) are sent from one person (the sender) through a channel to another (the receiver), who responds after interpreting the message and taking into account the various communication barriers.

2.3.2 The communication process

A specific process is followed during communication that involves key elements including: a sender, a message, a specific message format, a receiver, an interpretation and a response (Muller et al 2006: 142). The communication process is displayed in Figure 2.5.

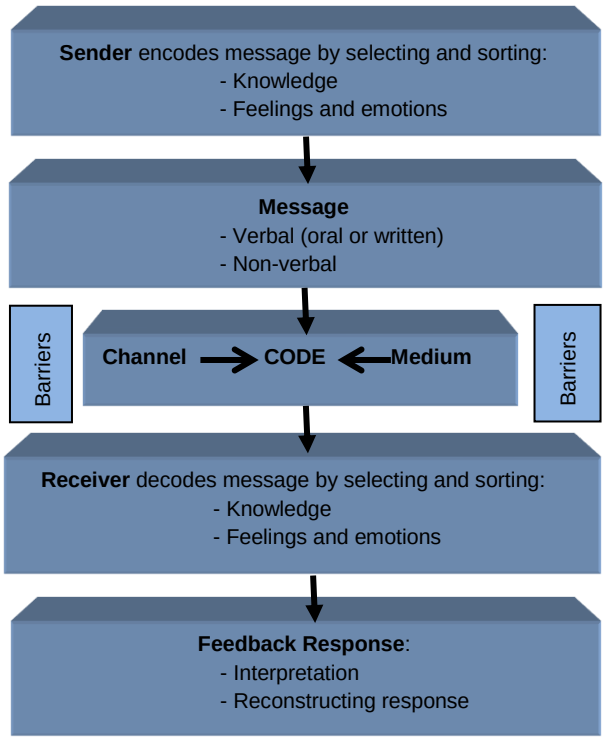

Figure 2.5: Process of communication
(Source: Muller et al 2006:142)

The communication process can be briefly described under the key elements mentioned above:

- The sender, also referred as the communicator, addresser or transmitter, is the person who initiates the communication activity and formulates the *message* (Van Staden et al 2002:13). The sender formulates thoughts into a message, using *codes* which the *receiver* can understand.

- The message is the information which is conveyed during the process of communication.

- The communication channel represents the way in which the message is sent from sender to *receiver,* and *feedback* is sent from receiver to sender. Communication channels can include verbal channels (voice, telephone, fax, intercom, letter, memorandum, report, meeting and interview) or non-verbal channels (pictures, graphs and body language) (Trenholm 2011:204).

- The code may be any set of symbols such as language, figures, pictures and sign language that the receiver can understand.

- According to Steinberg (2007:45-46), the message medium (plural media) is a kind of language that is divided into verbal and non-verbal media in which the message is sent. Van Staden et al (2002:14) refer to these media as methods of communication; the medium also represents the perceived form in which the message is transmitted.

- The receiver, also referred to as the addressee, respondent, destination or decoder, is the person to whom the sender directs the message.

- Interpretation is the responsibility of the receiver who needs to make sense out of (interpret and react to) the message which was received. The receiver interprets and decodes the code in order to understand it (Steinberg 2007:48-49).

- Feedback/Response is the message that the receiver sends in response to the sender's message. A response indicates the receiver's reaction and may take a verbal or non-verbal form. It also indicates that communication has occurred successfully.

- A communication barrier is any interference or "noise", but could also indicate anything which causes a communication breakdown or prevents the receiver from receiving the message (Van Staden 2002:14; Cleary 2008:11).

2.3.3 Communication climate

As individuals settle into an organisation, they start to communicate in ways they feel are appropriate to the organisation (Trenholm 1998:268). A communication climate refers to a psychological environment and can be defined as the general socio-emotional feeling that is produced between the leader and the group; thus, according to Trenholm (2011:185-186), a psychological and emotional contract that arises within the work group. Trenholm (2011:185) adds that a communication climate in an organisation may be either defensive (negative, controlling and punitive) or supportive (positive, open and encouraging) in nature.

In a defensive communication climate, the assumed superiority of the leader is supported by a hierarchical structure and chain of command, and this view of the supervisor is usually emphasised through control measures. The characteristics of a

defensive (negative) communication climate include behaviour such as controlling, punishing, evaluating, advice giving, superiority and certainty, while the characteristics of a supportive (positive) communication climate include behaviour such as listening, empathy, acceptance, shared problem-solving attitude, openness and equality (Grohar-Murray & DiCroce 2003:55).

Booyens (1998:267) emphasises the fact that top-level managers spend at least 80% of their time on communication and thus need to develop their communication skills. A defensive communication climate is created by nurse managers who cling to traditional barriers of bureaucratic organisation, where the assumed superiority of the leader is supported by a rigid hierarchical structure and chain of command. No inputs from subordinates are required during strategic planning; most procedures are standardised and are enforced by means of direct orders. A supportive communication climate, in contrast, fosters an acknowledgement of the ideas of many individuals, thus creating a free flow of communication between employees and supervisors at any level of the organisation.

The communication climate of an organisation links into the social working climate. According to Adam and Bond (2000:538), the social working climate refers to the interaction between persons at work, the group cohesiveness and the general team spirit. Nurses prefer to work in an environment with a good team spirit, where they can communicate freely with their nursing and medical colleagues. Adam and Bond (2000:541) point out that staff experience job dissatisfaction when they get the feeling that their supervisors undervalue their work and do not attend to their concerns appropriately.

Professional nurses, according to James et al (2005:9), “want to control their nursing practice”, and therefore also the climate in which they have to perform their nursing functions. A conducive nursing climate with access to properly functioning formal and informal communication channels can give professional nurses the authority to take control when performing their nursing tasks because they are knowledgeable and skilful (James et al 2005:9). This type of empowerment can only exist when the professional nurse is satisfied with the level of communication within this climate.

Communication audit questions that could stem from the analysis of the communication climate in an organisation will centre on how employees view the overall effectiveness of the communication. It could include questions on satisfaction with organisational and personal communication, the extent to which organisational communication motivates the employee to meet the organisation's goals, and whether the employee has the communication abilities to do so. It also involves issues such as the extent to which the employee can identify with and feel a vital part of the communication in the organisation.

Other important issues are whether the employee receives the information to perform his or her job in a timely manner and the extent to which conflicts are handled appropriately through proper communication channels (Downs & Adrian 2004:59).

2.3.4 Types of communication

The types of communication within an organisation can be divided, according to Muller et al (2006:142), into internal or external communication and subdivided into formal or informal communication, with communication methods underlying each type (Van Staden et al 2002:14-16), as displayed in Table 2.1. Because communication occurs between two or more people, it is important that group dynamics be considered, as well as interpersonal communication.

Table 2.1: Internal and external methods of communication

Methods	Internal communication methods	External communication methods
Oral	Face-to-face conversations Telephonic conversations Meetings Interviews Conversations (personal or telephonic) Announcements (personal or over an intercom system)	Face-to-face conversations Telephonic conversations Business meetings Interviews
Written	Internal mail, e-mail or memoranda Newsletters Telephone messages Slips Reports Minutes Notices on the notice board and in staff magazines	Business letters, e-mail or fax messages Advertisements Press releases Company websites such as Intranet
Non-verbal	Appearances Attitudes Facial expressions Gestures Tone of voice	Attitudes Appearances Gestures Expressions Tone of voice

(Adapted from: Van Staden et al 2002:14-16)

2.3.4.1 Internal communication

Internal communication occurs when communication is bounded within the parameters of the organisation. Organisational communication within the health care unit, according to Jooste (2010:208-209), is not confined within the unit itself; members of the health team also communicate within the health care institution.

2.3.4.2 External communication

The external communication extends to networks and organisations external to the institution. This type of communication (similar to internal communication) requires listening, verbal and non-verbal competencies, the ability to build supportive climates and to manage conflict (Jooste 2010:208-209).

When dealing with stakeholder links external to the organisation, it is important to draw attention to the fact that organisations have their own culture, and in linking to external networks the messages and specific vocabulary of the organisation must be clearly explained. It cannot be taken for granted that external networks linking with health care organisations will necessarily understand the health care language communicated by health care personnel in their internal organisational networks (Jooste 2010:209).

2.3.5 Methods/Media of communication

According to Muller (2009:203) the methods/media of communication can include oral verbal communication, non-verbal communication, written communication, information systems and electronic media and symbolic communications. Verbal- and non-verbal communications, in turn, are listed by Jooste (2009:210) as *types* of communication.

2.3.5.1 Oral/verbal communication

Oral/verbal communication refers to communication primarily associated with the spoken word (Jooste 2009:210; Cleary 2008:17-18). Formats used to conduct this type of communication include face-to-face, telephonic or formal gathering formats and all require proper communication skills.

- Face-to-face communication is, for instance, direct communication between a manager and staff.

- Communication by telephone is an impersonal medium of communication.

- Formal gatherings of individuals used to provide information and make specific decisions are another medium of oral verbal communication and are called meetings (Muller 2009:207).

2.3.5.2 Non-verbal communication

Non-verbal communication includes all forms of communication that do not involve the spoken or written word (Jooste 2009:211) and is the component with the greatest influence on communication. The conscious or subconscious use of body language such as facial expressions, hand signals and body posture are considered non-verbal forms of communication (Meyer et al 2009:273; Muller 2009:209; Cleary 2008:18-24).

Non-verbal communication, according to Afifi (2007:48-50), includes structuring and regulating interaction, creating and managing identities, communicating emotions, defining and managing relationships and influencing others.

2.3.5.3 Written communication

Written communication is perceived as equally important as oral verbal and non-verbal communication but is performed in written form, for example in policy statements, procedures, minutes, circulars and letters (Meyer et al 2009:267; Van Staden et al 2002:27; Muller 2009:227). Jooste (2010:20) adds to these recording, report writing, staff evaluation reports, communication books, daily, monthly and annual reports, electronic documents, research reports, audit documents and memorandums.

2.3.5.4 Information systems and electronic media

Technology plays a major role in communication, and therefore information systems must be up to date (Meyer et al 2009:272). Information systems such as computers, PowerPoint presentations and overhead projectors can be utilised in many ways within

an organisation for greater accessibility to information. Radio and television sometimes also help to inform employees on a large scale of happenings in an organisation.

2.3.5.5 Symbolic communications

Symbolic communications are performed by messages being conveyed consciously or subconsciously by symbols worn by people to reflect certain images, for example the insignia worn by the police or by nurses. The use of symbols such as hand-sign for the deaf and picture symbols for illiterate people resort under symbolic communication.

2.3.6 Communication networks/channels

Communication networks define the channels along which communication flows. They refer to the members in an organisation forming formal and informal links. Different types of communication network can co-exist and even overlap within one organisation and can take on the form of social, task, formal and informal networks. Jooste (2010:209) also refers to *virtual* networks for the purpose of electronic brainstorming and tele-health. The two channels through which communication is transferred may be either formal or informal (Muller et al 2006:304).

Communication networks can influence the speed with which tasks are performed, the accuracy of the task, the satisfaction attached to such a task and the flexibility of the task. The emphasis is on the type of communication network used in an organisation.

2.3.6.1 Formal communication

Formal communication networks or channels, according to Jooste (2010:209) and Muller et al (2006:304), can take many forms, such as reports of various kinds (including monthly reports and incident reports) meetings (between top management and between management and personnel), memorandums, newsletters and official notices (with regard to policies and procedures).

2.3.6.2 Informal communication

Informal communication in an organisation is unofficial internal communication through informal networks or channels. The types and modes of such communications, according to Muller et al (2006:147), can differ from organisation to organisation, but three types are often present, namely, *phatic communication* (referring to the daily conveying of feelings and common courtesy greetings), *informal social groupings* (referring to the natural formation of groups due to common shared interests) and the *grapevine* (referring to casual communication and rumours conveyed by an informal and unofficial communication system).

The grapevine is an unofficial system of communication and the information is based on casual communication and rumours. It helps employees to make sense of the world around them and provides relief from emotional stress (Muller et al 2006:304-305).

2.3.7 Communication flow

Communication flow refers to the direction in which messages travel in an organisation and includes upward, downward and lateral (horizontal) communication flow (Steinberg 2007:295-296)

2.3.7.1 Upward communication

Upward communication, according to Muller et al (2006:303), “flows to a higher level in the organisation or group”. It is aimed at informing managers about how things can be improved in the organisation and about the feelings employees have regarding general issues in the organisation (Steinberg 2007:295).

2.3.7.2 Downward communication

Downward communication refers to communication that “flows from one level of an organisation or group to a lower level” (Muller et al 2006:303). It is aimed at informing personnel about policies and procedures, the assigning of goals and objectives, providing job instructions to personnel, the highlighting of problem areas, disciplinary action and feedback on the performance of personnel (Steinberg 2007:295). Downs and

Adrian (2004:54) state that although quality downward communication is the best indication of organisational communication effectiveness, “some of the most important information processing goes from employees at one level to their superiors, on another”.

2.3.7.3 Lateral (Horizontal) communication

According to Jooste (2010:20), horizontal communication is the lateral exchange of messages between co-workers. This form of communication usually occurs between persons of equal hierarchical rank. It is also more informal than both downward and upward communication. There are no authority relationships and it assists employees to satisfy their needs for socialisation, to coordinate their activities with their departments, to improve their understanding of their individual and departmental responsibilities and to solve their own challenges before it becomes necessary for others to intervene (Steinberg 2007:295-296).

2.3.8 Communication contexts

Communication contexts, as defined in the terminology of this study (see section 1.7.3), refer to different types of communication situations; they are classified according to the number of people involved in the interaction as well as the degree to which they are able to interact. The three communication contexts applicable to this study include the interpersonal, group and organisational communication contexts.

2.3.8.1 Interpersonal communication context

Interpersonal communication refers to communication occurring between people face to face, according to Steinberg (2007:62). Daily communication interactions between managers and employees represent the interpersonal communication in the organisation. Van Staden et al (2002:26) state that most of the business day in organisations is spent communicating interpersonally. Interpersonal communication depends greatly on the ability of people to communicate effectively; knowledge of non-verbal communication (such as gestures and facial expressions) will improve interpersonal communication skills (Van Staden et al 2002:27).

2.3.8.2 Group communication context

Group communication is a result of the interaction of individuals in a group (Trenholm 2011:166). This interaction leads to the development of interdependent behaviour between the members of a group. Members start to pursue the same goals and develop and share stable and predictable norms, values and role structures. Shared behavioural standards (how to behave, what to value and who to be) develop, and members experience a sense of identity and psychological closeness. Thus a group identity develops (Trenholm 2011:166).

2.3.8.3 Organisational communication context

Organisational communication is, as already explained by Jones (2006:4) under the definition of the terms, a system identified by purpose, operational procedures and structure. Jooste (2010:208-209) adds to this definition by stating that organisational communication in a health care service is communication where team members communicate not only in the unit but also within the health care institution.

The purpose of organisational communication is to facilitate organisational goals and operationalize procedures by utilising functional communication networks and communication activities related to organisational goals and policies. To understand organisational communication better, a communication audit is essential because it will highlight how different systems function independently and as a whole (Jones 2006:5).

Public and private organisations are no longer perceived in a traditional way as having boundaries of hierarchy, function and geography. Organisations are now characterised by new sets of relationships between managers and employees. Organisations have thus moved from a mechanistic to an information-based world, with its focus on more creative, intuitive, empowered approaches to management (Jooste 2009:136).

Within the communication domain, features that are distinct to organisational communication include *lines of authority, organisational structures*, *communication networks* and *links to external environments* (Jooste 2010:208-209; Wood 2006:253).

2.3.8.3.1 Hierarchical structure/Lines of authority effecting communication

According to Steinberg (2007:295), information is distributed through an organisation within a hierarchical structure. This structure is often outlined in an organisational chart (a linear diagram indicating the status of different members of an organisation and the relationship between them). The hierarchical structure not only affects the interpersonal relationships between employees but also controls the channels of communication within the organisation (Steinberg 2007:295).

The lines of authority in this study refer to the rigid hierarchical structures found within health care institutions (Figure 2.6), depicting the different levels of power, chain of command and the status of each member in the hierarchy (Jooste 2010:132). Solid lines combining the levels and positions indicate the line function through which authority and communication take place.

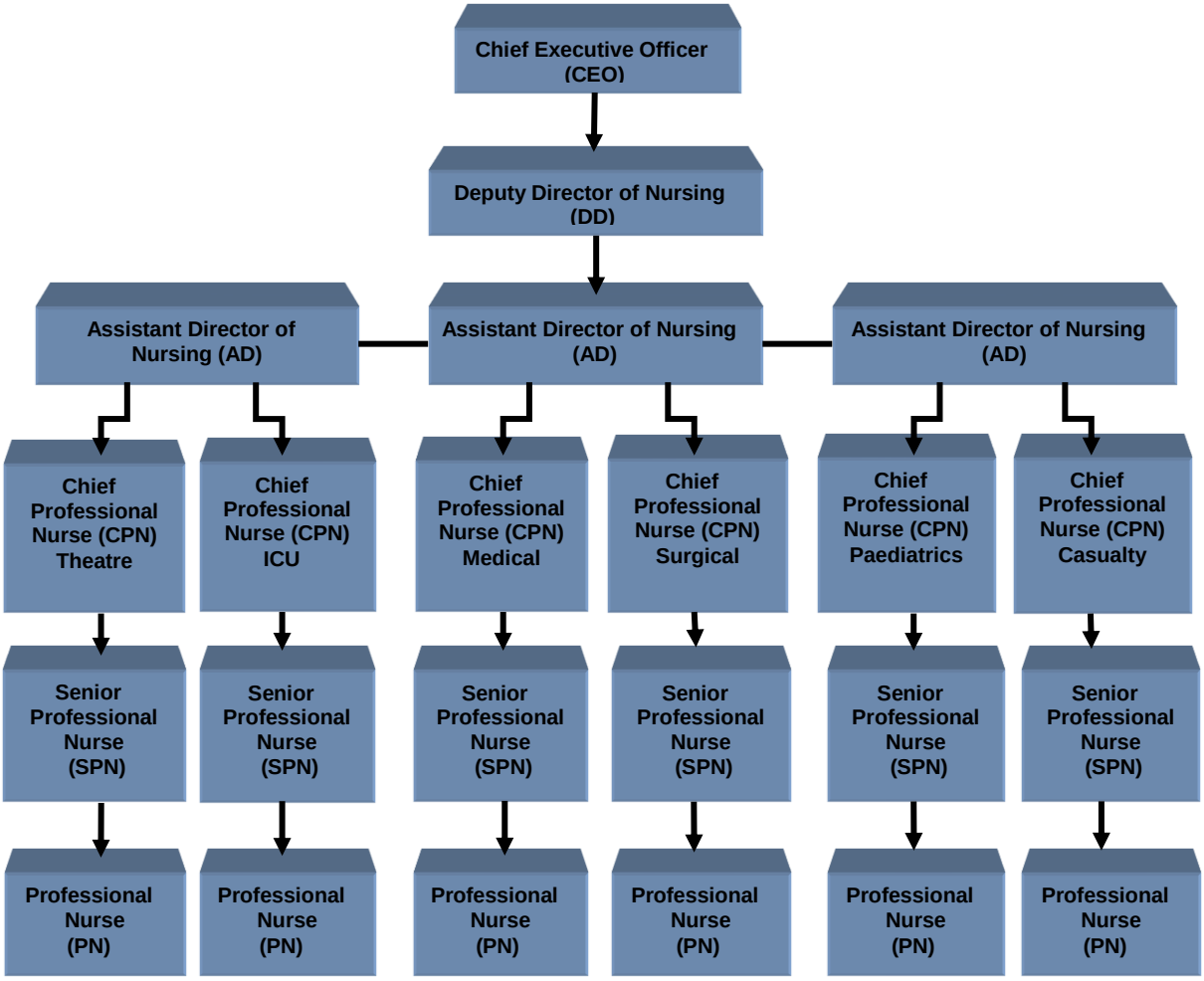

Figure 2.6: Lines of authority in a public health care organisation
(Source: Adapted from Jooste 2010:132)

Communication can travel up and down the lines of authority via the hierarchical structures according to the design of the structure. According to Jooste (2010:131-132), the design of an organisational structure refers to the task of “dividing up tasks and responsibilities” and to the “basic framework of formal relationships between health care professionals in an organisation”. For the purposes of this study, three functions within organisational structures will be discussed, namely the *line function*, *staff function* and the *organisational chart*.

- **Line functions**, according to Jooste (2010:132), refer to functions that are involved in or contribute to the main activity of the organisation. The term describes those activities that provide definition to the structure of the organisation and ensure service production and client satisfaction. Line managers have the complete and ultimate responsibility for directing the activities of their subordinates. They retain the total authority to carry out the functions that they are held responsible for. It is difficult to delegate this authority; if delegated it can only be successful if this is done within the line management organisation or structure.

- The term ***staff functions*** pertain to those functions that assist the line functions to achieve the primary objectives of the organisation (Jooste 2010:132). They indirectly relate to the main objectives of the organisation and assist line managers to achieve the said objectives. A staff manager should not have authority over any part of the line organisation and should take no action to interfere with the role or performance of line management. Thus staff managers have fewer subordinates and are concerned with activities more limited in scope and responsibility than those of the line managers. Examples of staff function units in health care institutions would be the human resources department, infection control and the research unit.

- **Organisational charts** are visual representations of organisations in terms of their personnel positions (see Figure 2.6). A typical chart should indicate the managers and subordinates that constitute the organisation. Additionally, an organisational chart should indicate the span of control, lines of authority and assignment of work (responsibilities), the last of which should be divided according to job descriptions.

  The chart furthermore indicates the relationships between staff in the organisation such as, firstly, line-directed relationships between managers and subordinates,

secondly the lateral relationships between different units on the same hierarchical level, and finally staff relationships between an operational manager and other areas where the operational manager will offer assistance to the line manager (Jooste 2010:132). There are different types of organisational charts (structure) that can have an influence on the communications in an organisation.

2.3.8.3.2 Organisational structures effecting communication

Organisational structures refer to the hierarchical lines of authority, which indicates the formal lines of communication within an organisation and which influences the flow of communication within the organisation. Subordinates are empowered when top management passes on information to them about the service and the legislation that regulates their health care practices (Jooste 2009:225). The five organisational structures that will be discussed for the purposes of this study include the tall, flat, matrix, centralised and decentralised structures.

- **Tall structures** refer to a structure with many intermediate levels from the top to the bottom, thus a vertical division of tasks, and consequently also the order of rank and direction of responsibility and accountability of the job level and employee in each job (Muller 2009:120). In a tall structure, communication on managerial level enjoys priority over that of colleagues, resulting in messages passing rapidly from top to bottom through the hierarchy. This situation can make communication become more cumbersome as it passes through each additional level, more distorted with increased levels in the structure, less understandable between top and bottom levels, and the organisation becomes progressively more impersonal the taller the structure.

- **Flat structures** refer to a number of separately identified organisational functions that are placed on a structural diagram which is more horizontally than vertically organised. Horizontal division of work takes place to indicate the number of posts that are filled on the same job level in the nursing unit and to indicate the relationship of authority between personnel (Muller 2009:121). Flat structures allow for easy communication which is direct and fast flowing. The information does not become distorted because fewer organisational levels are present in the structure.

- **Matrix structures** refer to structures where both vertical and horizontal coordination of the skills and efforts of numerous specialists occurs. It develops the communication skills of employees in relation to other professionals with whom these employees are compelled to interact, owing to a large number of short-term single objectives to be achieved as a group.

- **Centralised organisational structures** refer to structures where, according to Conrad and Poole (2002:66), only the managers at the top would make decisions in the organisation because the authority is centralised in a small core of managers.

- **Decentralised organisational structures** refer to structures where a process of change occurs and decision making is distributed down through the hierarchical structure to lower-level employees to empower them (Jooste 2009:225). *Decentralisation creates opportunities for innovation in the work situation by providing subordinates with more opportunities to develop their specific areas of expertise*. In a decentralised system, two-way interaction and information ensure that subordinates have ready access to information.

2.3.8.4 Links to external environments

Organisations do not limit their communication to within their own borders; they communicate with external stakeholders in their environment on a daily basis. During organisational communication with the external environment, communication should take the unique cultures of other organisations into consideration, and thus the messages and specific vocabulary that are sent out to these organisations need to be explained in unambiguous terms (Jooste 2010:209).

2.3.9 Characteristics of effective communication

Communication effectiveness, according to Cleary (2003:7), refers to communication that is effective when the message, as it was initiated and intended by the sender, concurs closely with the message perceived and responded to by the receiver. Understanding is usually the result of communication effectiveness. The greater the overlap is between the meaning of the sender and the meaning of the receiver, the more effective the communication transaction will be (Cleary 2003:7).

Effective communication can therefore be viewed as the successful transmitting of a message between sender and receiver. Jooste (2009:47) concludes that “effective communication results in fewer misunderstandings among employees and provides them with a common vision and understanding and unity of direction and effort”. It is thus essential for effective communication to occur between all health care professionals, administrators and the community.

2.3.10 Barriers to effective communication

Elaborating on the earlier definition provided by Van Staden et al (2002:13-14), Muller et al (2006:143) define a communication barrier as “anything that confuses or distorts the message, anything that competes against the communication or anything that prevents a message from being received”, thus hampering the understanding between sender and receiver (Cleary 2008:18).

Communication barriers identified by Muller et al (2006:143) include physical, physiological, psychological, perceptual and semantic barriers. Meyer et al (2009: 266), Cleary (2008:13-17), Grohar-Murray and DiCroce (2003:59) and Van Staden et al (2002: 30- 32) add culture, language, gender and lack of feedback to the list of communication barriers.

2.3.10.1 Physical barriers

Physical barriers refer to structural or system-based obstructers which confuse a message or prevent the message from being received. Physical communication barriers can take the form of noise, inadequate screen images, disconnected electronic system cables or indistinct telephone connections (Van Staden et al 2002:30; Cleary 2008:17).

2.3.10.2 Physiological barriers

Physiological barriers refer to physical impairments (hearing or sight impairments) and external factors (environmental temperature irregularities or hard, uncomfortable seats) that could have an impact on the physiological sensing abilities (Meyer et al 2009: 267; Van Staden et al 2002:30; Cleary 2008:17).

2.3.10.3 Psychological barriers

Muller et al (2006:143) state that psychological barriers to communication refer to emotional barriers such as anger, fear and depression, and such barriers are “all in the mind”, according to Cleary (2008:18). Van Staden et al (2002:31) explain that a positive or negative attitude, hostility, a relationship of fear, nervousness and poor self-image on the part of the sender or the receiver will influence the message.

2.3.10.4 Perceptual barriers

Perceptual barriers to communication refer to perceptual differences that stem from the frame of reference (gender, background, education and intelligence) of the people in the communication process and are based on cultural, biological and other differences such as background and experience (Meyer et al 2009:267; Cleary 2008:12-13). Insensitivity towards differences can lead to a judgemental attitude.

Many people with different perceptions are grouped together in a work situation and therefore, according to Van Staden et al (2002:31), employees must be aware of and be sensitive to perceptions different from their own. Jooste (2009:209) states that although “our cultural background and bias can be good if they allow us to use our past experiences to understand something new, it is when they change the meaning of the message that they interfere with the communication process”.

2.3.10.5 Semantic barriers

Semantic communication barriers refer to level of language proficiency, abbreviations used (especially acronyms and abbreviations characteristic to the specific organisation) as well as accent, different interpretations, vague wording, jargon and slang (Muller et al 2006:143; Steinberg 2007:49-50). Words and expressions form the basis of most communication. Often the meanings of words used to communicate are misunderstood or different meanings are attached to a specific word or expression.

2.3.10.6 Cultural and language barriers

Culture and language can also form a barrier to effective organisational communication (Meyer et al 2009:266). South Africa, like other countries, has a unique cultural make-up in which different cultures have existed alongside each other for centuries with limited cooperation and collaboration. The new democratic dispensation in 1994 brought with it a cross-cultural cooperation which was responsible for the development of the intercultural “rainbow nation” (Lesch 2007:42).

According to a South African census conducted in 2011, Gauteng had a 12 075 861 strong population residing within its borders. South Africa has 11 official languages, according to the Constitution of the Republic of South Africa. These languages include isiZulu, isiXhosa, Afrikaans, English, Setswana, Sepedi, Sesotho, Xitshonga, siSwati, isiNdebele and Tshivenda. According to the 2011 census, 8 916 713 (70.76%) of the Gauteng residents spoke a mixture of indigenous African languages, 1 603 464 (13.28%) spoke English and 1 502 940 (12.45%) spoke Afrikaans (RSA Census 2011). Therefore this population can be perceived as a multilingual and multicultural one. In certain situations the message can be lost when the sender is not linguistically skilled in more than one language.

2.3.10.7 Gender

To ensure effective communication in the workplace, gender should also be considered. Although men and women work side by side in the workplace it has been shown that they communicate with different styles. Because of differences in the socialisation men and women receive in their societies, they tend to speak and act differently (Steinberg 2007:152-153; Grohar-Murray & DiCroce 2003:59). Women tend to use communication to establish or maintain relationships, to learn from others and to share themselves, whereas men tend to use communication in an instrumental way – to accomplish goals. Furthermore, men tend to be more abstract, conceptual, general, theoretical and less personal than their female counterparts and are thus conditioned to assume a more direct and forceful approach to speaking, while women use a quieter, less forceful approach. Both genders, however, possess the ability to speak forcefully, directly and questioningly (Trenholm 2011:87-88; Grohar-Murray & DiCroce 2003:59).

2.3.10.8 Lack of feedback

Meyer et al (2009:267) state that even a lack of appropriate feedback could become a barrier to the process of communication, as it hinders the effective two-way flow of information between entities. When there is a lack of feedback from the receiver of the message, the sender will be uncertain whether the message that was sent or was received as intended in a clear and correct way (Muller et al 2006:307).

2.4 EFFECTIVE ORGANISATIONAL COMMUNICATION AND THE DOWNS AND HAZEN COMMUNICATION SATISFACTION MODEL (1977)

The three major characteristics of an effective communication system, according to Downs and Adrian (2004:139), include effective interpersonal communication, effective communication in group context and effective communication in organisational context. Communication satisfaction was traditionally thought of as a one-dimensional construct, but the work of Downs and Hazen (1977) revealed the multi-dimensional nature of communication satisfaction with these three distinct contexts. The three characteristics of an effective communication system thus interlink with the three conceptual contexts of the Downs and Hazen communication satisfaction model:

2.4.1 Effective interpersonal communication

Effective interpersonal communication is characterised by personal feedback (with special reference to job performance, performance management systems, recognition of effort, job challenge reports and the manager's insight), supervisory communication (with special reference to supervisory attention, supervisory guidance, trust, openness and amount of supervision), subordinate communication (with special reference to downward-directive communication, anticipation of the manager's information needs, communication overload, receptiveness to evaluation, suggestions and criticism and accurate upward communication) (Downs & Adrian 2004:139).

2.4.2 Effective communication in group context

Effective communication in group context is characterised by co-worker communication (with special reference to the informal communication network, compatibility of work

groups, adaptation of communication practices, peer group communication, and informal communication accuracy and activity), organisational integration (with special reference to job progress, personnel news, departmental policies and goals, job requirements, employee benefits), and corporate information (with special reference to organisational policies and goals, government regulations, organisational change, organisational profits/financial standing and organisational achievements/failures) (Mueller & Lee 2004:222).

2.4.3 Effective communication in organisational context

Effective communication in organisational context is characterised by organisational climate (with special reference to communication as motivator, communication abilities, organisational communication identification, job performance and communication and conflict management) and media quality (with special reference to the level of helpfulness and interest of organisational communication, meetings, correctness of organisational media, attitudes towards organisational communication and the amount of organisational communication) (Mueller & Lee 2002:222).

2.5 STRATEGIES FOR IMPROVING COMMUNICATION

Strategies for improving communication refer to the strategies that managers and employees can use to improve the effectiveness of communication in an organisation. In public health services and nursing units, strategies for improvement can assist in improving the effectiveness of communication between different categories of nurses.

2.5.1 Improvement factors

For organisations to improve the effectiveness of their communication, the factors that need to be addressed include the communication climate, communication channels, flow of communication, communicator abilities, culture, language and gender.

2.5.1.1 Communication climate change

A conducive communication climate, allowing access to properly functioning formal communication channels (such as properly written directives and well-organised

meetings) and informal communication channels (such as an accurate and active grapevine) can empower professional nurses to perform their nursing tasks with confidence because they are knowledgeable and skilful (James et al 2005:9). This type of empowerment can only exist when the professional nurse is satisfied with the level of communication within this climate.

2.5.1.2 Open channels of communication

To improve the efficacy of communication between all organisational stakeholders, the flow of the communication must be improved. Van Staden et al (2002:23) state that the flow of communication between people across levels in an organisation can be improved. This can be achieved by keeping communication channels constantly open, affording staff at lower levels unhindered access to their superiors, encouraging upward communication in the organisation, avoiding the passing of messages through too many intermediaries before reaching its final destination, keeping the chain of command as short as possible (with fewer management levels) and implementing coaching and mentoring programmes.

2.5.1.3 Changing organisational communication style

The breaking down of communication barriers demands a change from the traditional organisational style of communication to one that empowers and motivates employees and fosters creativity in them. The result will be an organisational communication style that is based on efficiency and a high performance ethic, without taking away authority and responsibility but rather the sharing of decision making (Skiti 2009:27).

2.5.1.4 Bridging cultural and language barriers

Culture and language can become barriers to the communication process. People tend to communicate in the culture and language with which they feel most comfortable. However, Fourie (2003:38) warns that repeated cross-cultural communications among the same people could eventually create an inter-culture with its own norms. The consequence of such an inter-culture could be cultural (communication) isolation. Lesch (2007:42) feels that for the linguistically challenged, the linguistic problem that arises is often solved by the mere provision of an interpreter, and interpreting becomes

particularly informative and worthwhile when distinctive languages and cultures are involved. Interpreting then becomes the reproduction of culture, as it transfers certain aspects of culture belonging to one group to those of another. Therefore language should be viewed within culture and not separate from culture (Fourie 2003:36).

2.5.1.5 Bridging gender inequalities

Grohar-Murray and DiCroce (2003:54-60) have identified ways to recognise and accept the differences in gender communication that exist between men and women. For men to improve their communication skills with women, they should listen more attentively to the feelings of women, not interrupt and solve the problem before the woman is finished speaking, and try to see the woman's point of view. Men also need to admit it if they did not understand the content of a conversation. On the other hand, women could improve their communication with men by being direct, allowing disagreement and questioning to be part of the conversation (Grohar-Murray & DiCroce (2003:54).

2.5.1.6 Adapting of communication practices

Communication practices need to be able to adapt to the specific communication requirement in a specific situation (Muller 2009:207). Adaptability, according to Muller (2009:207), also refers to increased use of electronic media, like management information systems, in organisational communication. The public health sector is still very paper bound, in that hard copies of documents are required for all transactions and interactions (Zuma 2007:52). A *paperless system,* where data are stored in electronic computerised format, would not only be more cost effective but also time saving, as retrieval time would be halved.

2.5.1.7 Refinement of feedback

The feedback experience is often perceived by subordinates as a *need to know* activity that is handled by managers as less important. Feedback is a very responsible action, whose impact should not be underestimated. It is the manager's responsibility to provide feedback to subordinates to enable them to grow and develop, but this is only if they consider the outcome of the feedback to be developmental for both of them (Jooste

2009:405). It should be a positive learning experience for the subordinate (Jooste 2009:233).

According to Muller et al (2006:310), feedback must be planned. After the topic or event for feedback has been established, it is necessary to refine the topic to what exactly it is about the topic that needs to be conveyed. Feedback must be provided as soon after the event as possible, and should be specific and impersonal (Jooste 2009:405). The manager should also take care about the manner of providing feedback in cross-cultural settings (such as is the case in public health services). Misinterpretations and misunderstandings can occur in giving feedback across cultures, and therefore different styles of giving feedback are required. Feedback in cultures that are more task orientated will focus on how to do the task well; feedback in relationship-orientated cultures will focus on both the person and the task; feedback in egalitarian (equal) cultures will focus on two-way feedback between superior and subordinate; and feedback in cultures where rules and procedures are applied more universally will be work related and provided at work (Jooste 2009:441).

2.6 CONCLUSION

This chapter presented a literature review as a background to the study. It described the theoretical framework underlying the study, namely the dimensions of the communication satisfaction framework by Downs and Hazen (1977), which consists of three main dimensions and eight communication satisfaction factors. The chapter described the communication process under types of communication, communication structures, characteristics of effective communication, communication climate, barriers to effective communication and misconceptions about communication. In conclusion, this chapter presented the strategies for improving communication according to various improvement factors.

The next chapter will discuss the research methodology followed when conducting this study.

Chapter 3
RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research design and methodology followed during this study. The research design will be discussed under the headings of the research approach and design, and the research methodology will be described under the headings of the population and sample, questionnaire development, the pre-test, and validity and reliability of the instrument. Notes on the actual data-collection process are also included.

3.2 RESEARCH DESIGN

Polit and Beck (2008:765) define a research design as the researcher's overall plan for obtaining answers to the research question, including specifications for enhancing the study's integrity. It spells out, in advance, the strategies the researcher plans to adopt in order to develop information that is accurate and interpretable.

The research design of this study was typified as a quantitative, exploratory and descriptive study design by means of a survey.

3.2.1 Quantitative approach

According to Burns and Grove (2009:22), quantitative research is a formal, objective, systematic process in which numerical data are used to obtain information; it is further used to describe variables, examine relationships between variables and determine cause and effect interactions among variables.

The quantitative research design was selected for the purposes of this study as the researcher aimed at describing and testing cause and effect interactions between the variables of the communication phenomenon among professional nurses.

3.2.2 Exploratory design

An exploratory research design, according to Polit and Beck (2008:21), will provide understanding of the underlying causes or full nature of a phenomenon. It will conduct research into an area that has not been studied and in which a researcher wants to develop initial ideas and a more focused research question (Neuman 2003:535).

The aim and objectives of this study were exploratory in nature and attempted to explore what constitutes effective communication in public health care services and the extent to which the professional nurses in these services are satisfied with the existing formal communication processes.

3.2.3 Descriptive design

The descriptive research design refers to an accurate portrayal or account of the characteristics of a person, situation or group in real life, and/or the frequency with which a certain phenomenon occurs, and implies the categorising of information (Burns & Grove 2009:45).

The researcher attempted to explore the communication phenomenon in real-life situations and to describe the research findings with regard to specific communication satisfaction dimensions that could possibly impact on the satisfaction of professional nurses in public health care services with their communication climate and to make recommendations to address the aspects with which they were dissatisfied.

3.2.4 Survey research

Baxter and Babbie (2004:168) state that the aim of survey research is to describe and explain statistically the variability of certain features of a population. The survey research method was appropriate to this study and was utilised for the data gathering and data analysis of this study because it has the ability to quantitatively measure answers to questions concerning the attitudes, beliefs and behaviour of a specific group (such as professional nurses) about a communication climate (such as that of the public health care services).

3.4 RESEARCH METHODOLOGY

Research methodology refers to the process or plan for conducting the specific steps of the study (Polit & Beck 2008:719). The steps may include the population, sampling and sampling method, data collection, validity and reliability of the data-collection instrument as well as the data analysis. For the purposes of this study the following were included:

3.4.1 Population and sample

The population of a study, according to Burns and Grove (2009:714), refers to all the elements including individuals, objects or subjects that meet the criteria for inclusion in a given universe. The sample refers to a subset of the population that is selected for the study (Polit & Beck 2008:731).

3.4.1.1 *Population*

The population for this study consisted of professional nurses, ranging from professional nurse (PN) to nurse manager categories such as Deputy Director (DD), Assistant Director (AD), Chief Professional Nurse (CPN) and Senior Professional Nurse (SPN). The population in this study was divided into three strata. Strata, according to Polit and Beck (2008:340), are mutually exclusive segments of a population, established by one or more characteristics (in this study nursing rank). The three strata comprised nurse managers, operational managers and professional nurses. The aim of dividing the population into different strata was to enhance representativeness of diverse segments of the study population, and also to seek comparisons between these strata. The total nurse manager, operational manager and professional nurse population for the three hospitals used in the study were **1001** (of which **20** were nurse managers, **300** operational managers and **681** professional nurses).

3.4.1.2 *Target population*

According to Burns and Grove (2009:724), the target population consists of a group of individuals who meet the sampling criteria and to which the study findings will be generalised. In order for a respondent to be included in this study, the respondents had to be a professional nurse with at least one year’s work experience (in the capacity of professional nurse) in one of the three selected public hospitals.

The rationale behind selecting only professional nurses for this study was twofold in nature. Professional nurses are decision-makers, implementers and supervisors of all nursing care activities in the wards/units, and therefore are very important recipients of and participants in health care service communication. Secondly, “practical constraints and people’s ability to participate in a study”, according to Polit and Beck (2008:338), might be a factor, considering the complex nature (English wording and level of insight required) of the questionnaire. Nursing staff hail from a multitude of vernacular and educational backgrounds and it might be challenging for especially lower category nursing staff to complete the questionnaire satisfactorily.

A total sample of **265** professional nurses working in the three selected hospitals was targeted in the study (of which **20** were nurse managers, **75** operational managers and **170** professional nurses).

3.4.1.3 Sample

A disproportionate stratified sampling method was used as a random sampling method to select the population for this study. Disproportionate sampling in stratification means that each stratum has an equivalent number of subjects in the sample despite the size of the strata (Burns & Grove 2009:697; Polit & Beck 2008:345-346). A sample of **265** professional nurses was drawn from professional nurses functioning in all departments within the three selected major public hospitals. The researcher used these three hospitals as they are situated in the City of Johannesburg and adhere to the criteria of the study. The three hospitals were numbered A, B and C in no particular order to ensure confidentiality.

A simple formula was initially used to determine the sample size. A sampling proportion of **25%** was taken from the total population of each of the three strata, which delivered the following sample ratio for the three categories of professional nurses: **5:75:170**, providing a rounded total of 250 respondents in the sample. The three strata were, however, greatly unequal in size. The nurse manager stratum was very small in this study, and therefore a larger proportion of the total population had to be utilised to be truly representative.

Because the nurse manager stratum was so small, the sampling proportions were altered to include 100% of the nurse managers, resulting in a sample of **20:75:170** to be more representative of the different strata (Table 3.1) and to represent the minority population stratum more adequately (Polit & Beck 2008:346).

Table 3.1: Disproportionate stratified sample of professional nurses

		Target Population				Proportionate Sample	Disproportionate Sample
Category		**Hospital A**	**Hospital B**	**Hospital C**	**Totals**	**25%**	**Total**
Nurse Managers	DD	1	1	1	3	1	3
	AD	8	5	4	17	4	17
	Subtotal	**9**	**6**	**5**	**20**	**5**	**20 (100%)**
Operational Managers	CPN	191	62	47	300	75	75
	Subtotal	**191**	**62**	**47**	**300**	**75**	**75 (25%)**
Professional Nurses	SPN	138	55	43	236	59	30
	PN	351	53	41	445	111	120
	Subtotal	**489**	**170**	**131**	**681**	**170**	**170 (25%)**
Total		**690**	**176**	**135**	**1001**	**250**	**265**

The target population (TP) indicates the total population that was initially intended, and the actual population (AP) the actual total population that was realised in the study (Table 3.2).

Table 3.2: Target versus actual population

Category	DD		AD		CPN		SPN		PN		Total	
	TP	**AP**	**TP**	**AP**	**TP**	**AP**	**TP**	**AP**	**TP**	**AP**	**TP**	**AP**
Hospital A	1	1	8	7	48	12	34	9	88	36	179	74
Hospital B	1	1	5	5	15	7	14	5	13	22	48	45
Hospital C	1	0	4	4	12	3	11	4	10	14	38	29
Totals	3	2	17	16	75	22	59	18	111	72	265	130

3.4.1.4 Criteria for inclusion

Polit and Beck (2008:338) view inclusion criteria as “eligible criteria that determine the characteristics that delimit the population of interest”. The selection of subjects for this study was based on the specific selection criterion that participants had to be professional nurses who had worked in the public health care service for at least one year.

3.5 DATA COLLECTION

According to Burns and Grove (2009:43), data collection can be defined as a “precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypotheses of a study”. The theoretical basis of a survey and the conceptualisation of the concepts of a study will guide the researcher as to which structured variables and attributes of variables will be measured (Botma et al 2010:131).

3.5.1 Data-collection method

The researcher handed participants consenting to participate in the study a questionnaire (see Annexure E) with a separate covering letter (see Annexure F). The covering letter clarified the purpose of the study and introduced the researcher. The letter noted the objectives of the study and approximate time required to complete the questionnaire, as well as the ethical requirements, stressing that participation was voluntary. The consent to partake in this study formed part of this letter.

The respondents were requested to read and sign the consent in the covering letter and hand it back to the researcher immediately after signing. They were then requested to deposit their completed questionnaires in containers placed at the offices of the Assistant Directors of Nursing of their hospitals. The researcher collected the completed questionnaires on a daily basis.

3.5.2 Data-collection instrument

In quantitative research there are several methods of data collection/gathering that are frequently used. Health professionals most frequently use self-report, observation and physiological measurement, followed by existing data and critical incidents (Botma et al 2010:133).

3.5.2.1 *Type of instrument*

The type of data-collection instrument the researcher used was a self-report consisting of a structured questionnaire (see Annexure E), using a five-point Likert scale. The communication satisfaction questionnaire by Downs and Adrian (2004) was selected for

this study on the basis of a literature study that was conducted to ascertain what research had been done in the domain of communication satisfaction, and specifically the communication satisfaction of professional nurses.

3.5.2.2 *The development and application of the Communication Satisfaction Questionnaire (CSQ).*

The Communication Satisfaction Questionnaire (CSQ) for this study was adapted from the questionnaire created by Downs and Adrian in 2004, which in turn was based on the Downs and Hazen model (1977) for assessment of organisational communication. Permission was obtained to utilise and adapt the Downs and Adrian questionnaire from the original creator (Annexure D).

Downs and Hazen (1977) identified three main contexts with eight underpinning dimensions that should be measured by a communications satisfaction questionnaire. This can be applied to probe the perceptions of respondents regarding the aspects influencing the extent of their communication satisfaction. The communication satisfaction contexts and dimensions of communication satisfaction are displayed in Table 3.3:

Table 3.3: Communication satisfaction contexts and dimensions according to Downs and Hazen (1977)

Communication satisfaction Contexts	Communication satisfaction Dimensions
Interpersonal communication	- Personal feedback - Supervisory communication - Subordinate communication
Communication in group context	- Co-worker (horizontal) communication - Organisational integration
Communication in the organisational context	- Corporate information - Communication climate - Media quality

The original Downs and Adrian (2004) CSQ comprised 51 questions covering eight communication satisfaction dimensions: personal feedback, supervisory communication, subordinate communication, co-worker communication, organisational integration, corporate information, communication climate and media quality, measured on a seven-point Likert-scale.

The adapted CSQ (Annexure E) for this study consists of 47 questions, modified in such a way as to suit the needs of the specific study. Among other changes, the researcher changed the questions in the adapted CSQ structurally and contextually to align them with the health care service setting. A five-point Likert-scale was used instead of the original seven-point Likert-scale to measure the level of satisfaction of the participants. The adapted scale ranged between 1 = *very dissatisfied* and 5 = *very satisfied*. The *indifferent* response alternative from the original CSQ was retained in the adapted CSQ. The results from the adapted CSQ should provide an accurate reflection of the overall communication climates of the selected health care services and adhere to the aim, objectives and research questions of the study, which attempted to determine:

- What constitutes effective organisational communication, and

- To what extent professional nurses in the public health care services experience communication satisfaction.

3.5.3 Assessment of effective organisational communication

Before the level of communication satisfaction can be assessed among a specific group of individuals, it is important to first establish what constitutes effective organisational communication. The presence of effective formal and informal communication channels within an organisation is a clear indication that the organisation is a healthy one (Conrad & Poole 2002:74).

Although formal channels operate well during the usual process of supervisors delegating orders and employees providing feedback and updates on the status of the organisation, Conrad and Poole (2002:74) believe that these channels are found to be ineffective when it comes to meeting unanticipated communication needs for managing of crises, exchanging information rapidly, dealing with complex problems or sharing of personal information. The way in which organisations compensate for the shortcomings of formal communication channels is by using informal networks (Conrad & Poole 2002:74).

The formal communication channels of the public health care services in South Africa consist of memorandums, management and unit meetings, e-mail messages, phone conversations and one-on-one employee-supervisor discussions. The informal communication networks include e-mail and cellphone text messaging, face-to-face peer meetings and one-on-one peer discussions. The effectiveness of the formal and informal communication channels within the public health care services was determined by analysing the responses to the open-ended questions on the CSQ.

To determine the effectiveness of the flow of information through the public health care service's formal and informal communication channels, the focus was directed to the questions which dealt with the formal channels (questions 10, 16, 17, 20, 21, 28, 37, 39, 40, 42) and the informal channels (questions 32, 34, 35, 36, 41) (Table 3.4).

Table 3.4: Formal/informal communication channel evaluation

Channel	Survey Item	
Formal	Questions 10 16 17 20 21	Corporate Information Items Information about health care service policies and goals governing regulations affecting the health care service changes in the health care service profits and/or financial standing of the health care service achievements and/or failures of the health care service
	Questions 28 37 39 40 42	Media Quality Items Extent to which the health care service's communications are interesting and helpful meetings are well organised written directives and reports are clear and concise the attitudes towards communication in the health care service are basically healthy the amount of communication in the health service is about right
Informal	Questions 32 34 35 36 41	Horizontal Communication Items Extent to which the grapevine is active in the health care service communication with other professional nurses is accurate and free flowing communication practices are adaptable to emergencies the work group of the professional nurse is compatible informal communication is active and accurate

3.5.4 Assessment of communication satisfaction

In assessing the communication satisfaction of professional nurses, communication satisfaction (as independent variable) was defined as how fulfilled professional nurses feel as regards information exchange and the various communication channels within their work environment. The dimensions for the measuring of communication satisfaction consisted of the eight communication satisfaction elements as highlighted by Downs and Hazen (1977) (as defined in Table 3.5), which were personal feedback; supervisory, subordinate and horizontal communication; organisational integration; corporate information; communication climate; and media quality.

Table 3.5: Communication Satisfaction Elements

Context	Dimension/ Corresponding Survey questions	Definition
Interpersonal	Personal feedback Questions: 11, 12, 13, 18, 22	Refers to how the work of the professional nurse is judged and performance appraised.
	Supervisor communication Questions: 24, 26, 29, 33, 38	Refers to the willingness and comfort of professional nurses with initiating upward communication.
	Subordinate communication Questions: 43, 44, 45, 46, 47	Refers to how satisfied professional nurses are with two-way (upward and downward) communication with supervisors.
Group	Horizontal communication Question: 32, 34, 35, 36, 41	Refers to how comfortable professional nurses are using informal communication channels to discuss issues with co-workers.
	Organisational Integration Questions: 8, 9, 14, 15, 19	Refers to how much information professional nurses receive about their immediate environment.
Organisational	Corporate Information Questions: 10, 16, 17, 20, 21	Refers to whether the amount of information professional nurses receive in total regarding the organisation's goals, policies and financial health is sufficient.
	Communication climate Questions: 23, 25, 27, 30, 31	Refers to how professional nurses view the overall health of communication, to include satisfaction with organisational and personal communication.
	Media Quality Questions: 28, 37, 39, 40, 42.	Refers to whether the amount of communication professional nurses receive (i.e. in meetings and through e-mail) is the right amount to help them adequately perform their job.

For questions pertaining to the dimensions measuring communication satisfaction variables (where participants were asked to select responses from a 5-point Likert scale

ranging from *very dissatisfied* to *very satisfied*), an item analysis had to be conducted. In other words, an item was considered to load significantly on a dimension if it had a primary component loading of .70 or above (Burns & Grove 2009:379).

The adapted CSQ as presented to the participants was constructed in two parts:

Part 1 consisted of the biographical data of respondents, including age, gender, home language, professional qualifications, present rank and work experience in nursing.

Part 2 consisted of the formal and informal communication channels and the eight communication satisfaction dimensions, namely personal feedback, supervisory communication, subordinate communication, horizontal communication, organisational integration, corporate information, communication climate and media quality.

The level of satisfaction of the respondents was measured by utilising closed-ended questions and a five-point Likert scale, with options ranging from very dissatisfied to very satisfied, on the following communication contexts:

- Interpersonal communication - 3 dimensions – 15 questions
- Communication in group context - 2 dimensions – 10 questions
- Communication in the organisational context - 3 dimensions – 15 questions

The order of the questions was designed to follow a logical flow and specific topics were grouped together. Information required was grouped from general to specific. Two open-ended questions were included to allow the participants to record responses not covered by the preceding items.

3.6 VALIDITY AND RELIABILITY

The “heart of trustworthy survey research lies,” according to Baxter and Babbie (2004:168), “with the reliability and validity of questions asked”. It is the reliability and validity of the questions asked that ensure the quality of survey research.

For the purposes of this survey the questions were derived from the well-established CSQ developed by Downs and Adrian (2004). The researcher also conducted a review

of published information with regard to the use of the CSQ in previous research studies to ensure the validity and reliability of the instrument.

3.6.1 Validity of the instrument

Validity, according to Burns and Grove (2009:380), refers to the extent to which an instrument "actually reflects the abstract construct being measured". Validity is a complex yet important aspect of research to both the researcher and to those parties who will read the report and who may consider using the findings in their practice (Burns & Grove 2009:380). To be judged as a valid instrument, an instrument needs to adhere to the principles of criterion validity, construct validity, face validity and/or content validity. The validity of the instrument used in this study was assured by adhering to the principles of face and content validity.

Face validity of an instrument means that the instrument *appears* to measure what it is supposed to measure (Burns & Grove 2009:381). This will clarify and assist with the *readability* of the questionnaire. The questionnaire was submitted to five senior professional nurses with a nursing management qualification, for comments and recommendations prior to, during and after the pre-test study. These nursing professionals evaluated the technical presentation and instrument design, namely layout, typographic quality, clarity of instructions, relevance, ease of completion and completion time of the instrument. Their comments were incorporated into the questionnaire where applicable.

Content validity refers to the degree to which the items in an instrument accurately represent the universe of content for the concept being measured (Polit & Beck 2008:750). Content validity in this study was enhanced by utilising the three communication contexts and eight communication satisfaction dimensions grounded in the empirical referents (Downs & Hazen 1977; Downs & Adrian 2004; Jones 2006), during the development of the study. The original eight communication satisfaction dimensions were substantiated and expanded on by means of a literature review (Burns & Grove 2009:90-91), as outlined in Chapter 2. In addition, the literature review involved the definition and explanation of all concepts contained in the conceptual framework, thus ensuring that all the major elements relevant to the construct being measured were examined.

3.6.2 Reliability of the instrument

According to Burns and Grove (2009:377), reliability refers to the consistency of a measure obtained in the use of a particular instrument and is an indication of the extent of random error in the measurement methods. It also refers to the degree of consistency or dependability with which an instrument measures the attribute it is designed to measure (Polit & Beck 2008:764). In other words, the reliability of a data-collection instrument refers to the consistency with which an instrument measures a specific construct (Burns & Grove 2009:377), thus the degree to which the instrument can be depended on to yield consistent results if used repeatedly over time, on the same individuals.

The reliability of the CSQ developed by Downs and Adrian (2004) lies in the fact that this instrument has been tested by several researchers. Studies by Downs and Adrian (2004:139) and Jones (2006:9) selected Downs and Hazen (1977) CSQ items on the basis of factor analysis out of an original pool of many questions. The factor analysis was based on the results of a questionnaire that was administered to 225 employees from a variety of organisations (Downs & Adrian 2004:139; Jones 2006:10). Based on the survey results, Downs and Adrian made adjustments and created an updated questionnaire, which was administered to four additional organisations. After the results were factor analysed, the eight stable dimensions of communication satisfaction were identified: personal feedback, supervisory communication, subordinate communication, horizontal (co-worker) communication, organisational integration, corporate information, communication climate and media quality (Downs & Adrian 2004:139; Jones 2006:10).

A Cronbach's alpha internal reliability test was performed to assess the reliability of the data-collection instrument – a test to prove that performance on any one item of the instrument is a good indicator of performance in any other item in the instrument. In this study the reliability of the instrument was enhanced by formulating the items as clearly as possible and refining them during the pre-test, for example by rephrasing questions. This was done to make it easier to complete the questionnaire.

Due to the validated status of the instrument, item analysis and a Cronbach's alpha internal reliability test were performed to assess the reliability of the instrument.

3.7 PRE-TEST

According to De Vos et al (2005:206), the pre-testing of a measuring instrument implies that the instrument is tried out on a small number of persons displaying characteristics similar to those of the target group of respondents. A pre-test was conducted on a population in a fourth public hospital on a population representative of the three strata of the study population (2 nurse managers, 4 operational managers and 10 professional nurses), with the same inclusive sampling criteria as the target population. The pre-test was done to assess the time required to complete the questionnaire, as well as the clarity of the questions. The results were presented to subject experts (senior lecturers in nursing administration) and one adjustment was made to the instrument in terms of its legibility. The font size used on the questionnaires had to be enlarged before it could be administered to the rest of the study population.

3.8 ETHICAL CONSIDERATIONS

To verify the integrity of the researcher, he hereby declares that he has acknowledged all sources and reference material utilised for the compilation of this research study in full to avoid the possibility of plagiarism.

During the conducting of any research study it is vital that the research procedures adhere to professional, legal and social obligations towards the participants (Polit & Beck 2008:753). In this study the following ethical considerations were adhered to in order to uphold the moral integrity of the study:

3.8.1 Acquiring permission

The final questionnaire and proposal were submitted to the Higher Degree Committee of the Department of Health studies, University of South Africa, for ethical clearance, and permission was obtained (Annexure A). This permission in turn allowed the researcher to request and obtain permission from the Director of the Gauteng Department of Health and Social Development (Annexure B), Chief Executive Officers of the participating hospitals (Annexure C) and the consent from the respondents participating in the study (Annexure F).

3.8.2 Right to self-determination or autonomy

The right to self-determination, according to Burns and Grove (2009:720), is based on the ethical principle of respect for people and indicates that persons have the right to self-determination and the freedom to participate or not to participate in research. People are in control of their own destiny and they should be treated as autonomous agents, who must be allowed to conduct their lives as they choose with no external control. A violation of this right will be coercion (when an overt threat of harm or excessive reward is presented to obtain compliance).

All nurse managers and professional nurses working in the three selected public hospitals were invited to participate in the study by means of a covering letter attached to the questionnaire. This letter explained the goals of the research and contained information pertaining to the identity and qualifications of the researcher, the institute where the research was registered and the methodology of the research. The covering letter particularly stressed the right to privacy of each participant and that participation was voluntary, without any risk of penalty or prejudice if nurses did not partake in the study. The respondents were also informed (via the covering letter) that they might withdraw at any stage and that if they did not wish to answer a specific question, they might choose not to do so without any negative consequences. Furthermore, the nurse managers and professional nurses serving as respondents were notified via the covering letter that the research report would be made available to them on request.

The researcher included an informed consent section with the covering letter that the participants had to sign. The informed consent section clearly and fully informed the respondents about what the research entailed and the tasks that they would be expected to perform, as advised by Terre Blanche, Durrheim and Painter (2006:66).

3.8.3 Anonymity and confidentiality

According to Bell (2007:48), anonymity is a promise that even the researcher will not be able to tell which responses came from which respondent. The signed consent forms were handled separately from the completed questionnaires throughout the entire data collection and data analysis processes to ensure the anonymity of the respondents.

Confidentiality, according to Polit and Beck (2008:750), refers to the protection of participants in a study, and a promise that their individual identities will not be linked to the information they provide and will not be publicly divulged. This information should not be divulged or made available to any other person. Confidentiality is a promise that the respondent will not be identified or the findings presented in an identifiable form. In this study anonymity and confidentiality were guaranteed because the respondents were not required to identify themselves on the questionnaires. Furthermore, the identity of the public hospitals that participated in the study will not be disclosed as a means of ensuring confidentiality.

The data gathered need to be released for the facilitation of positive guidelines, and this can only be achieved if the information is shared. The researcher was the only person who had access to the raw collected data. Confidentiality in this study was ensured in that the data collected and information supplied would be used only by the researcher for the purposes of this study.

3.8.4 Right to privacy

Privacy, according to Burns and Grove (2009:715), can be defined as the freedom of an individual to determine the time, extent, and general circumstances under which private information will be shared with or withheld from others. Based on the prescription of Levine (1986) in Burns and Grove (2009:193), the researcher made use of a covering letter with a separate informed consent form (Annexure F), which was voluntarily signed by all participants in the study to protect their right of privacy. In addition to the right of the participants to privacy the right to *equality* was also adhered to in this study, as all nurse managers and professional nurses were invited to participate on an equal footing.

3.8.5 *Beneficence*

Beneficence, according to Burns and Grove (2009:689), requires the researcher to actively promote good and do no harm. It was anticipated that this study would result in positive outcomes for the selected hospitals and the nurse managers and professional nurses employed in their service by means of recommendations on communication satisfaction to be applied.

3.9 DATA ANALYSIS

Data analysis refers to the categorising, ordering and summarising of data to obtain answers to research questions. The purpose of analysis is to reduce data to an intelligible and interpretable form, so that the relationships of the research problems can be studied and tested and conclusions drawn (De Vos et al 2005:218).

On the questionnaire, all scaled items were coded. Data were entered onto an Excel spreadsheet. The statistical analysis of the data obtained in this survey was performed with the assistance of an independent statistician and the data analysed by utilising the Statistical Analysis System (SAS JMP version 10.0) statistical software. The data analysis and findings of the study will be presented and discussed in chapter 4, in the form of tables, diagrams and graphs.

Descriptive analysis and frequency calculations were computed first, to report on the distribution of the respondents' biographical information (Jones 2006:26) and question responses. Item analysis was done with Cronbach's alpha values that indicated the reliability of each construct (dimension) and to test whether the communication satisfaction dimensions were measured in a useful way. The cut-off point for useful measurement for the Cronbach's alpha values in this study was 7.0.

The mean scores of the 40 communication satisfaction questions and the 8 communication dimensions were determined and the mean scores then rank-ordered to indicate which of these survey questions and dimensions the respondents ranked as the strongest and the weakest (Downs & Adrian 2004:145–147).

Furthermore, a one-way Analysis of Variance (ANOVA) test was performed in case of statistical significant differences between the three different strata of the study population in relation to their mean communication satisfaction scores.

3.10 CONCLUSION

This chapter discussed the research design and methodology and the compiling of the questionnaire as the research instrument by utilising literature guidelines. The method of data collection was explained. Validity and reliability, ethical considerations and the methods that were used for the data analysis were also included in this chapter.

Chapter 4 will have as its main focus the statistical analysis, description and interpretation of the research data and the findings will be discussed.

Chapter 4
ANALYSIS AND DISCUSSION OF DATA

4.1 INTRODUCTION

The aim and objectives of this study were to determine what constitutes effective organisational communication, referring to the effectiveness of communication channels and the level of communication satisfaction of professional nurses working in selected public hospitals in the City of Johannesburg. This chapter will discuss the findings of the analysis performed on the collected data. Discussions will be integrated in presenting the findings and will include references to the literature.

4.2 APPROACH TO DATA ANALYSIS

The target population included three strata, namely Nurse Managers (NMs), Operational Managers (OMs) and Professional Nurses (PNs) who had been working in three hospitals for a minimum of one year. The operational managers are the direct supervisors of the professional nurses in the wards/units. The nurse managers, operational managers and professional nurses of the three hospitals are viewed as three homogeneous groups, and the data obtained were analysed accordingly. No differentiation was made between the hospitals; only between the identified strata. The different hospitals will only be mentioned in the biographical information section for statistical purposes.

A structured questionnaire, using a five-point Likert scale ranging from “very dissatisfied” to “very satisfied”, and open-ended questions, were used to collect the data. The response alternatives were adapted from five to three to simplify the discussion by grouping together two positive response alternatives (*very satisfied* and *satisfied*) and two negative response alternatives (*very dissatisfied* and *dissatisfied*) into *satisfied* and *dissatisfied* respectively.

Polit and Beck (2008: 345) state that *N* indicates the total sample for a study; responses were indicated as percentages and rounded off to the first decimal point.

4.3 RESULTS

This section of the study will report on the research findings. Of the 265 questionnaires administered, 130 were returned; therefore a 49% response rate was obtained. This response rate is not unusual, because according to Polit and Beck (2008:305), the response rates of mailed questionnaires are usually less than 50%.

During the data-collection process the researcher discerned a disturbing indifference and lack of interest among the professional nurses towards not only the completion of the questionnaires but towards their work ethic in general.

4.3.1 Biographical information

For the purposes of describing the respondents, the following biographical variables are discussed:

4.3.1.1 Age

The results indicate that of the three respondent strata, 80 (88.9%) of professional nurses were aged between 21 and 49 years, falling into the younger age groups, whereas 21 (95.4%) of the operational managers ranged between 40 and 59 years of age, and 16 (88.8%) of the nurse managers were aged between 40 and 60 years plus. It can thus be concluded that there exists an age gap between the professional nurses and their supervisors of at least 10 to 15 years. A person's age can definitely influence the effectiveness of communication in an organisation, according to Muller et al (2006:307), as age is one of the variables that influences the language the person uses and also the definitions this person gives to words. Thus, if words are interpreted by different age groups in different ways, this can cause a barrier to communication. The findings are illustrated in Table 4.1.

Table 4.1: Age distribution of respondents (*N*=130)

AGE IN YEARS	NUMBER OF RESPONSES							
	NM (*n*=18)		OM (*n*=22)		PN (*n*=90)		Total (*N*=130)	
	f	%	f	%	F	%	F	%
21 - 29 year	0	0.0	0	0.0	19	21.1	19	14.6
30 – 39 year	2	11.2	1	4.6	35	38.9	38	29.3
40 – 49 year	6	33.3	14	63.6	26	28.9	46	35.4
50 – 59 year	6	33.3	7	31.8	9	10.0	22	16.9
60+ year	4	22.2	0	0.0	1	1.1	5	3.8
Total	18	100	22	100	90	100	130	100

4.3.1.2 Gender

It was necessary to determine the gender of the respondents in order to establish the gender mix among respondents and whether or not the male nurses experienced communication satisfaction in the same way as their female colleagues (Sullivan & Decker 2009:123-124). The findings are a true reflection of the current status in the nursing profession, as it is still a very female-dominated profession (SANC 2011). The gender mix of the respondents indicated that 119 (91.5%) of the respondents were female and 11 (8.5%) were male. Of the 119 females, 18 (15.1%) were nurse managers and 101 (84.9%) were professional nurses. All of the male respondents were professional nurses, thus indicating that none of the male respondents held a managerial position. The gender distribution is reflected in Figure 4.1:

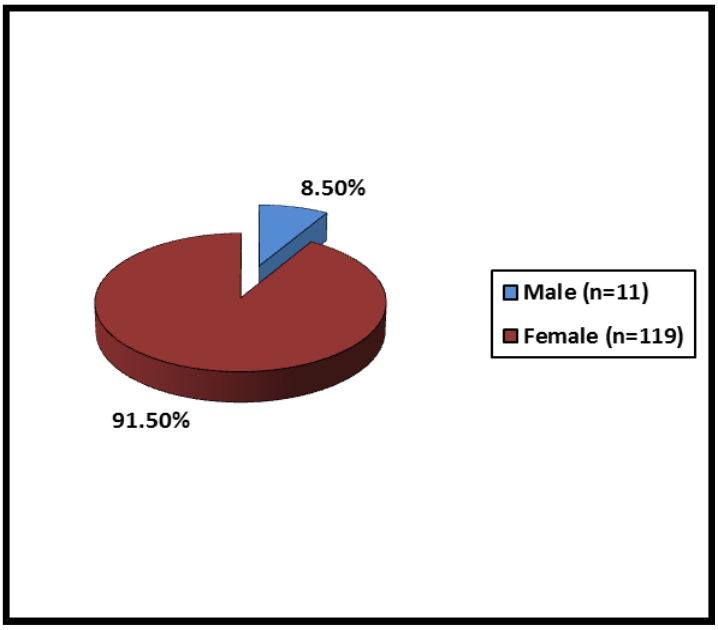

Figure 4.1 Gender distribution of the respondents (*N*=130)

4.3.1.3 Current nursing position held

As three strata of respondents participated in this study, it was necessary to ascertain the representation in the different nursing positions, as communication may take on different formats at the various levels. Of the nurse manager respondents, 3 (16.7%) held a Deputy Director of Nursing (DD) position, 15 (83.3%) held an Assistant Director of Nursing (AD) position. All the operational manager respondents (*n*=22; 100%) held Chief Professional Nurse (CPN) positions. Of the professional nurse respondents, 18 (20%) held Senior Professional Nurse (SPN) positions and 72 (80%) held Professional Nurse (PN) positions. The findings are illustrated in Table 4.2.

Table 4.2: Respondents' current position in health care services (*N*=130)

CURRENT NURSING POSITION	NUMBER OF RESPONSES							
	NM (*n*=18)		OM (*n*=22)		PN (*n*=90)		Total (*N*=130)	
	f	%	f	%	F	%	f	%
DD	3	16.7	0	0.0	0	0.0	3	2.3
AD	15	83.3	0	5.0	0	0.0	15	11.5
CPN	0	0.0	22	100	0	0.0	22	16.9
SPN	0	0.0	0	0.0	18	20.0	18	13.8
PN	0	0.0	0	0.0	72	80.0	72	55.4
Total	18	100	22	100	90	100	130	100

4.3.1.4 Duration in health care service and duration of position held

This item was divided into two sections: Section A inquired about the respondent's duration of service in the current health care service. Seventy (53.8%) of the respondents had been working in their current health care service for 9 or more years, 19 (14.6%) for 5 to 8 years, 34 (26.2%) for 1 to 4 years and only 7 (5.4%) of the respondents had been employed at their current health care service for less than one year.

These results can be viewed as an indication of work stability amongst the respondents, as the majority of the respondents (89 or 68.4%) had been working in their current health service for more than five years. Table 4.3 illustrates the duration of the respondents' employment in their current health care service.

Table 4.3: Duration of respondents in their current health care service (*N*=130)

DURATION IN CURRENT HEALTH CARE SERVICE	NUMBER OF RESPONSES							
	NM (*n*=18)		OM (*n*=22)		PN (*n*=90)		Total (*N*=130)	
	f	%	f	%	f	%	f	%
9 + years	14	77.8	20	90.9	36	40.0	70	53.8
5 – 8 years	2	11.1	2	9.1	15	16.7	19	14.6
1 – 4 years	2	11.1	0	0.0	32	35.5	34	26.2
Less than1 year	0	0.0	0	0.0	7	7.8	7	5.4
Total	18	100	22	100	90	100	130	100

Section B inquired about the duration of the respondents' employment in their current nursing position. Thirty-five (26.9%) of the respondents had spent 9 years and more in their current nursing position, 22 (16.9%) had spent 5 to 8 years, 55 (42.3%) had spent 1 to 4 years and 18 (13.9%) had spent less than one year in their current nursing positions. Table 4.4 illustrates these findings.

Table 4.4: Duration of respondents in their current nursing positions (*N*=130)

DURATION IN CURRENT NURSING POSITION	NUMBER OF RESPONSES							
	NM (*n*=18)		OM (*n*=22)		PN (*n*=90)		Total (*N*=130)	
	f	%	f	%	f	%	f	%
9 + years	11	61.1	14	63.6	10	11.1	35	26.9
5 – 8 years	5	27.8	5	22.7	12	13.3	22	16.9
1 – 4 years	2	11.1	2	9.1	51	56.7	55	42.3
Less than1 year	0	0.0	1	4.6	17	18.9	18	13.9
Total	18	100	22	100	90	100	130	100

From the findings it is evident that the majority (*n*=11; 61.1%) of nurse managers had spent 9 and more years in the profession, contrasted with the majority (*n*=51; 56.7%) of the professional nurses who had served in their current positions for one to four years, indicating a gap in work experience due to younger professional nurses entering the profession. The majority of the operational managers, as direct supervisors of the professional nurses (*n*=14; 63.9%), did have nine years and more work experience in their current positions. From these findings, it is apparent that few (*n*=22; 24.4%) professional nurses had served in their current positions for five years or longer in comparison to the larger number (*n*=68; 75.6%) who had served for four years or less. This might be due to job satisfaction/dissatisfaction issues such as experienced professional nurses being promoted, leaving the profession for greener pastures or

resigning from the nursing profession altogether (Arries 2006:33; Morele 2005:24; Health Systems Trust 2005:2).

4.3.1.5 Type of nursing unit

This item inquired from the respondents the type of nursing unit in which they were currently working in their health care service. The motive behind this inquiry was that the flow of communication to and from different units/wards could vary depending on the type of unit; in other words on the degree to which a unit/ward had opened or closed accessibility. The findings are displayed in Figure 4.2, which indicates the combined figures of the three strata.

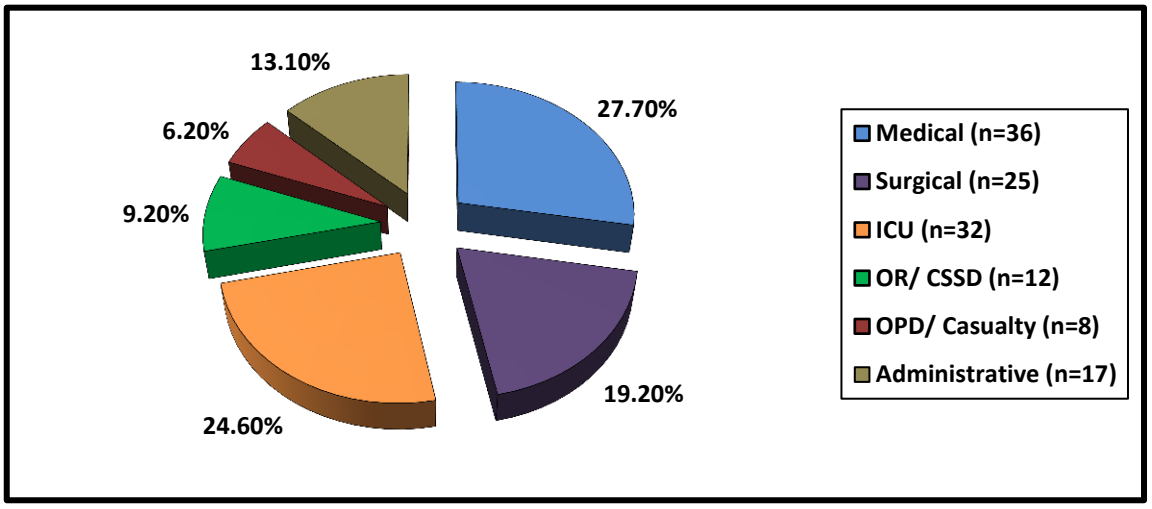

Figure 4.2: Type of nursing unit in which respondents were working (*N*=130)

The findings indicate that of the nurse manager respondents, 1 (5.6%) worked in the medical units and 17 (94.4%) in administrative/offices. Of the operational manager respondents, 4 (18.2%) worked in medical units, 7 (31.8%) in surgical units, 4 (18.2%) in ICU, 6 (27.3%) in operating room/central sterilising units and 1 (4.5%) in out-patient/casualty units. Of the professional nurse respondents, 31 (34.4%) worked in medical units, 18 (20%) in surgical units, 28 (31.1%) in ICU, 6 (6.7%) in operating room/central sterilising units (CSSD) and 7 (7.8%) in out-patient/casualty units. It is evident from the findings that 44 (33.85%) respondents worked in closed units such as operating room/CSSD and intensive care units, with limited accessibility, while the largest number of respondents (*n*=86; 66.15%) worked in open units where a more effective flow of communication could be expected.

4.3.1.6 Highest educational qualification

Inquiring about the respondents' highest educational qualifications was important in order to establish the respondents' academic level of functioning. According to the findings the respondents of this study seem to be well qualified, as at least 16.2% (*n*=21) held a university degree in nursing.

The findings also indicate that 36 (27.7%) of the respondents held post-basic diplomas in speciality areas such as ICU and operating room nursing science. Table 4.5 illustrates the highest educational qualifications of the respondents.

Table 4.5: Highest educational qualifications (*N*=130)

HIGHEST EDUCATIONAL QUALIFICATION	NUMBER OF RESPONSES							
	NM (*n*=18)		OM (*n*=22)		PN (*n*=90)		Total (*N*=130)	
	f	%	f	%	F	%	f	%
Basic Diploma	4	22.2	6	27.3	63	70.0	73	56.1
Post basic Diploma	6	33.3	10	45.4	20	22.2	36	27.7
Basic Degree	6	33.3	6	27.3	5	5.6	17	13.1
Post basic Degree	2	11.2	0	0.0	2	2.2	4	3.1
Total	18	100	22	100	90	100	130	100

4.3.1.7 Home language

This item inquired about the home language of the respondents, and was important in view of effective communication being the focus of the study. It is national policy that English is the official language to be used in all public service institutions for any form of communication. The majority of respondents across all three of the strata (*n*=96; 74%) spoke a vernacular language as home language. The home languages of the three strata of respondents are illustrated in Figure 4.3.

From Figure 4.3 it is clear that the home language of most nurse managers (*n*=8; 44.4%) and operational managers (*n*=6; 27.3%) was English. The most prominent home language of the professional nurses was isiXhosa, representing 20 (22.2%) of the respondents for that stratum.

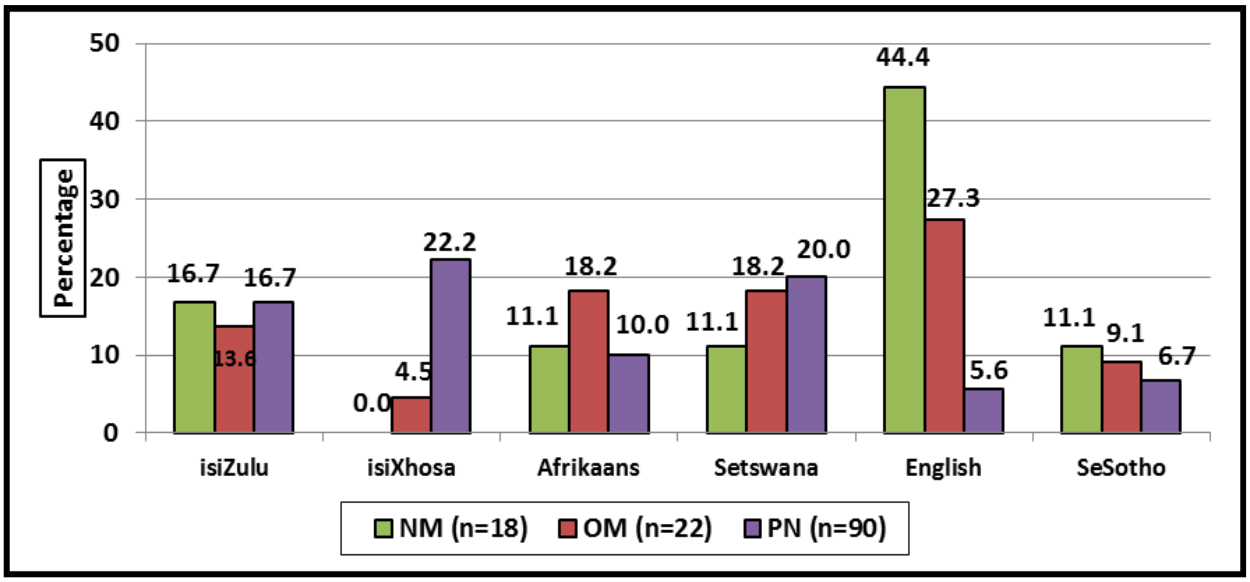

Figure 4.3: Home languages of respondents (*N* = 130)

The findings indicate that most of the professional nurses (*n*=85; 94.4%) do not speak English as their mother tongue. Only five (5.6%) of the professional nurse respondents speak English as a home language. This language barrier could form a stumbling block in the way of effective communication in the hospitals. It is an occupational expectation in the public health care service sector to deliver care, assist the multi-disciplinary team, write progress reports and give feedback to supervisors and managers in English.

4.3.2 Assessment of effective organisational communication

Objective one of this study sought to determine what constitutes effective organisational communication in the selected public hospitals in the City of Johannesburg. Effective communication in an organisation is dependent on the degree to which its employees are able to effectively use formal and informal communication channels (Trenholm 2011:185). An analysis of the formal and informal channels of communication existing in public hospitals, as utilised by nurse managers, operational managers and professional nurses, could provide an idea of communication effectiveness in these hospitals. The analysis of effective organisational communication includes the analysis of the formal and informal channels of communication of the three selected hospitals.

4.3.2.1 Formal communication channels

The two communication dimensions applicable to the formal communication channels are corporate information and media quality.

4.3.2.1.1 Corporate information

The corporate information dimension represents official organisational information that needs to travel through formal channels of communication, in order for information to filter through to all levels of the organisation. It includes information related to policies, governing regulations, organisational change, profits and/or financial standing and achievements/failures of the organisation. Hospitals as organisations also deal with the same corporate information items. The content of the corporate information dimension was obtained from items 10, 16, 17, 20 and 21 of the questionnaire. The findings are displayed in Table 4.6.

Table 4.6: Level of satisfaction with corporate information flowing through formal communication channels (*N*=130)

FORMAL CHANNELS			NUMBER OF RESPONSES							
Item	Corporate information		NM (*n*=18)		OM (*n*=22)		PN (*n*=90)		Total (*N*=130)	
			f	%	f	%	f	%	f	%
10	Information about hospital policies and goals	**Dissatisfied**	0	0.0	5	22.7	15	16.7	20	15.4
		Indifferent	2	11.1	7	31.8	17	18.9	26	20.0
		Satisfied	16	88.9	10	45.4	58	64.4	84	64.6
16	Information about governing regulations affecting the hospital	**Dissatisfied**	2	11.1	7	31.8	34	37.8	43	33.1
		Indifferent	0	0.0	13	59.1	28	31.1	41	31.5
		Satisfied	16	88.9	2	9.1	28	31.1	46	35.4
17	Information about change in your hospital	**Dissatisfied**	5	27.8	8	36.3	37	41.1	50	38.5
		Indifferent	2	11.1	12	54.5	28	31.1	42	32.3
		Satisfied	11	61.1	2	9.1	25	27.8	38	29.2
20	Information about profits /financial standing of the hospital	**Dissatisfied**	8	44.4	10	45.4	60	66.7	78	60.0
		Indifferent	5	27.8	11	50.0	19	21.1	35	26.9
		Satisfied	5	27.8	1	4.5	11	12.2	17	13.1
21	Information about achievements /failures of the hospital	**Dissatisfied**	4	22.2	7	31.8	42	46.7	53	40.8
		Indifferent	5	27.8	7	31.8	26	28.9	38	29.2
		Satisfied	9	50.0	8	36.3	22	24.4	39	30.0

- **Information about hospital policies and goals**

Item 10 assessed the level of satisfaction of respondents with information they receive about hospital policies and goals. Policies, according to Booyens (2008:59), have to be communicated throughout an organisation to be effective. Managers are intensely concerned with the content as well as the meaning of policies because they have to interpret and implement such policies. The most common way to inform non-supervisory employees regarding policies is by means of a policy manual, followed up by oral explanations and interpretations by direct supervisors (Booyens 2008:59).

From the findings it is clear that the majority (*n*=84; 64.6%) of the respondents were satisfied with this information. On the open-ended items the professional nurse respondents indicated that circulars pertaining to hospital policies and goals were not always written at their level and required simplification. This could be an indication that the hospital policies and goals are too complex in nature, or set out in complex language, and are not explained to junior staff members.

- **Information about governing regulations affecting the hospital**

Item 16 assessed the respondents' level of satisfaction with information about governing regulations affecting their hospitals. Governing regulations refer to external guidelines passed down from sources of authority (Booyens 2008:67). In South Africa regulations originate from government and are passed down to the NDOH and thereafter forwarded to the various health care services under its authority.

The analysed data indicated that 16 (88.9%) of the nurse managers were satisfied with this information. This is not unexpected, as the nurse manager is usually the first line of nursing authority to receive such information from the GDHSD. On the other hand, 7 (31.8%) of the operational managers and 34 (37.8%) of the professional nurse respondents indicated that they were dissatisfied with this information, an indication that this information does not filter through to lower-category staff members. It is disconcerting that 13 (59.1%) and 28 (31.1%) of operational managers and professional nurses respectively were *indifferent* to this information. This is an area of concern, as government regulations should be strictly adhered to by all public sector employees to

ensure that operational aspects are handled in the correct way, thus avoiding the need for disciplinary action.

- **Information about change in the respondents' hospital**

Item 17 assessed the respondent's level of satisfaction with regard to information about change in their hospitals. Muller et al (2006:520) state that employees need to be aware of all changes occurring in their organisation, as they might influence them personally or professionally.

A total of 11 (61.1%) nurse managers indicated that they were satisfied with the information they received, in contrast to both the operational managers (*n*=8; 36.3%) and professional nurses (*n*=37; 41.1%), who indicated their dissatisfaction with such information. This item also resulted in high *indifferent* responses from the operational managers (*n*=12; 54.5%). A number of operational managers were unsure as how to approach this item. They indicated in the open-ended items that not all information about change in the hospital was communicated to staff in written format, and if it was done at all it did not specify what was expected of the staff. The professional nurse respondents indicated that changes occurred in their hospitals without their being notified. They stated that staff on leave or night duty were not notified of changes and also stated that if change was communicated to professional nurses it was not done at their level. This seems to indicate that the way or format in which the change is communicated to them is ineffective.

- **Information about profits/financial standing of the hospital**

Item 20 assessed the respondents' level of satisfaction with the information they received regarding the profits and/or financial standing of their hospitals. The NDOH is a not-for-profit organisation, and therefore, according to Booyens (2008:163), could be mismanaged as it lacks shareholders that closely monitor its expenditure of funds.

Most of the respondents (*n*=78; 60.0%) indicated dissatisfaction with the financial information they received. Thirty-five (26.9%) of the respondents were *indifferent* on this item, because most of the respondents felt that they did not have any control over the financial status of the public hospitals in which they worked. The only comments on the

open-ended items pertaining to information about profits or financial standing came from the professional nurse respondents. They indicated that there was a general lack of information regarding the financial standing of their hospitals. It was stated that all stakeholders (including professional nurses) should be aware of financial constraints and the financial status of the public health sector.

- **Information about achievements/failures of the hospital**

Item 21 assessed the level of satisfaction of respondents with information they received with regard to the achievements and/or failures of their hospitals. Employees have a right to know how their organisation is performing, and therefore the achievements and failures of the organisation should be communicated to employees. If an organisation aspires to function effectively on an on-going basis it must ensure that employees at every level understand what is expected of them and that vertical and horizontal channels of communication are effective (Booyens 2008:215).

The findings indicate that 9 nurse managers (50.0%) and 8 operational managers (36.3%) were satisfied with this information, contrasted with the 42 (46.7%) of the professional nurse respondents who indicated their dissatisfaction with this information. The professional nurse respondents indicated on the open-ended items that information about events in their hospitals often did not filter through to them. This is not a positive tendency, as relevant information has to filter through to all levels of the hospital, to ensure that every nurse is aware of the achievements and failures of the hospital.

The professional nurses also indicated that e-mails and text message services, as other means of communication, are not utilised enough. These forms of communication are quick and reach a large number of receivers in a short space of time and can be used to great effect when information needs to be disseminated to a large audience. In order for subordinates to provide a good service, they need to be informed about the service they are providing. This information can be provided on a consultation basis by their supervisor to the subordinate (Dolamo 2008:42).

4.3.2.1.2 Media quality

The media quality dimension of the formal communication channels refers to the quality of the actual communication medium. In the hospital environment it relates to whether professional nurses experience their hospital's communication as interesting and helpful and if attitudes towards communication are healthy. It also relates to whether meetings are well organised, written directives are clear and concise and if the amount of communication in the hospital is about right. The specific items pertaining to the media quality dimension, according to the Downs and Hazen (1977) model, are items 28, 37, 39, 40 and 42, and are displayed in Table 4.7.

Table 4.7: Level of satisfaction with the media quality of formal communication channels (*N*=130)

FORMAL CHANNELS			NUMBER OF RESPONSES							
Item	Media quality		NM (*n*=18)		OM (*n*=22)		PN (*n*=90)		Total (*N*=130)	
			f	%	f	%	f	%	f	%
28	Extent to which the hospital's communications are interesting and helpful	**Dissatisfied**	4	22.2	8	36.3	42	46.6	54	41.5
		Indifferent	7	38.9	11	50.0	29	32.2	47	36.2
		Satisfied	7	38.9	3	13.6	19	21.1	29	22.3
37	Extent to which meetings are well organised	**Dissatisfied**	7	38.9	8	36.3	25	27.8	40	30.8
		Indifferent	5	27.8	8	36.4	23	25.5	36	27.7
		Satisfied	6	33.3	6	27.2	42	46.7	54	41.5
39	Extent to which written directives and reports are clear and concise	**Dissatisfied**	2	11.1	5	22.6	15	16.6	22	16.9
		Indifferent	5	27.8	6	27.3	22	24.4	33	25.4
		Satisfied	11	61.1	11	50.0	53	58.8	75	57.7
40	Extent to which attitudes towards communication in the hospital are basically healthy	**Dissatisfied**	7	38.9	14	63.6	32	35.5	53	40.8
		Indifferent	2	11.1	5	22.7	31	34.4	38	29.2
		Satisfied	9	50.0	3	13.6	27	30.0	39	30.0
42	Extent to which the amount of communication in the hospital is about right	**Dissatisfied**	7	38.9	9	40.9	29	32.2	45	34.6
		Indifferent	4	22.2	8	36.4	43	47.8	55	42.3
		Satisfied	7	38.9	5	22.7	18	20.0	30	23.1

- **Extent to which the hospital's communications are interesting and helpful**

Item 28 assessed the level of satisfaction of the respondents with the extent to which the communication at their hospitals was interesting and helpful. Messages should not pass through too many intermediaries before reaching their destination and should travel through the fewest possible management levels (Muller et al 2006:147).

Seven (38.9%) nurse managers indicated their satisfaction; however, 8 (36.3%) operational managers and 42 (46.6%) professional nurses indicated their dissatisfaction with this item. This could imply that professional nurses view the format in which they receive formal communication or the levels it needs to pass through as less attractive. On the open-ended items, professional nurses indicated that communication in their wards/units was seldom received in memorandum format. It was often received verbally and the messages were often inaccurate. There were too few notice boards for communication in the units.

- **Extent to which meetings are well organised**

Meetings form an important part of the daily activities of all three strata of respondents. Item 37 assessed the level of satisfaction of the respondents with the organisation of meetings. Jooste (2010:100) states that meetings are one of the most important tools in the work environment. Effective meetings ensure the effective flow of information to all levels and between all health care professionals (Jooste 2009:402).

The operational managers indicated that they were satisfied with the way meetings were organised, but that they would also appreciate short interim meetings with nurse managers to discuss unplanned events in the hospital. Although 42 (46.7%) of the professional nurses were satisfied with meetings (between operational managers and themselves, as stated in the open-ended items), 25 (27.8%) were dissatisfied, indicating that scheduled meetings did not start on time, that meetings made them feel intimidated and that opinions of subordinates were ignored. They stated furthermore that few meetings were scheduled for night staff and that most meetings occurred during the day. On the open-ended items, the nurse manager respondents said that not all of the professional nurses participated actively in meetings.

- **Extent to which written directives and reports are clear and concise**

According to Meyer et al (2009:267), it is important that written communication in the form of directives and reports in an organisation be clear and concise. Item 39 assessed the level of satisfaction of the respondents with the clarity and conciseness of written directives and reports in their hospitals.

From the findings it is evident that the majority (*n*=75; 57.7%) of the three respondent strata were satisfied with the quality of written directives and reports. This does not, however, mean that there is no room for improvement. On the open-ended items the nurse manager respondents indicated that professional nurses were not granted enough opportunities for questions, to facilitate better understanding of directives and reports.

Although 53 (58.8%) of the professional nurses indicated that they were satisfied with this item, they indicated in the open-ended items that written directives and reports were not always clear and that the language of communication (English) was not understood by all. They also indicated that managers did not utilise other means of communication (such as e-mails and text message services) enough to convey important information. The operational managers indicated that communication systems (e.g. speed dials and telephones) were available in the hospitals but not used correctly. Printed and written communication was also not utilised to its full potential. Communication occurred mostly orally and not in written format. Circulars were not distributed to all departments.

- **Extent to which attitudes towards communication in the hospital are healthy**

Item 40 assessed the level of satisfaction of the respondents with the extent to which attitudes towards communication in their hospitals were basically healthy. Arries (2006:33) states that relationships between managers and subordinates can become strained at times, as both parties adopt attitudes of contention and competition with each other. According to Van Staden et al (2002:23), however, a relaxed and positive attitude towards the communication process and one another can overcome communication barriers and valuable insights can be gained from one another.

The findings indicated that 9 (50.0%) of the nurse managers who were satisfied, contrasted with 14 (63.6%) of the operational managers and 32 (35.5%) of the professional nurses who were dissatisfied with the attitude towards communication in the hospital. The operational managers indicated in the open-ended items that the attitudes of their staff towards communication in their hospitals were generally very negative. They felt that professional nurses had a poor communication attitude and etiquette, especially on the telephone. The nurse managers indicated that professional nurses often did not use the correct channels of communication. The operational managers agreed with this statement and added that formal channels of communication were often not available to them to communicate with nurse managers. The professional nurses indicated that formal channels of communication were followed, but that the outcomes of such communications were often negative. They also indicated that their managers' attitudes towards communication in the hospital were very defensive in nature.

- **Extent to which the amount of communication in the hospital is about right**

Item 42 assessed the level of satisfaction of the respondents with the extent to which the amount of communication in the hospital is about right. According to Jooste (2009:235), leaders should not hesitate to communicate the views of nurses that work under their supervision to top-level management and provide them with feedback on the outcome of such communications. This flow of information could reach an equilibrium between information that nurses receive and information that is sent on.

From the findings it seems as though a great deal of uncertainty was experienced by the respondents in answering this question. Fifty-five (42.3%) indicated indifference to this item. This could indicate that they find themselves in a situation where in some instances they do get enough information but in other instances they do not.

4.3.2.2 Informal communication channels

In assessing the satisfaction with informal communication channels, only the horizontal communication is applicable, according to the Downs and Hazen (1977) model.

4.3.2.2.1 Horizontal communication

Horizontal communication satisfaction includes all informal communication aspects in an organisation such as informal communication networks (grapevine), communication with same-level employees, adaptability of communication practices in emergencies, compatibility of work groups and accuracy levels of informal communication. In a hospital environment all the above-mentioned informal communication aspects are applicable. Findings on specific survey items (32, 34, 35, 36 and 42) pertaining to the horizontal communication dimension are discussed and displayed in Figures 4.4 to 4.8.

- **Extent to which the informal communications network (grapevine) is active.**

Item 32 sought to explore the respondents' level of satisfaction with how active the informal communications network (grapevine) was in the respondent's hospital. The findings are illustrated in Figure 4.4.

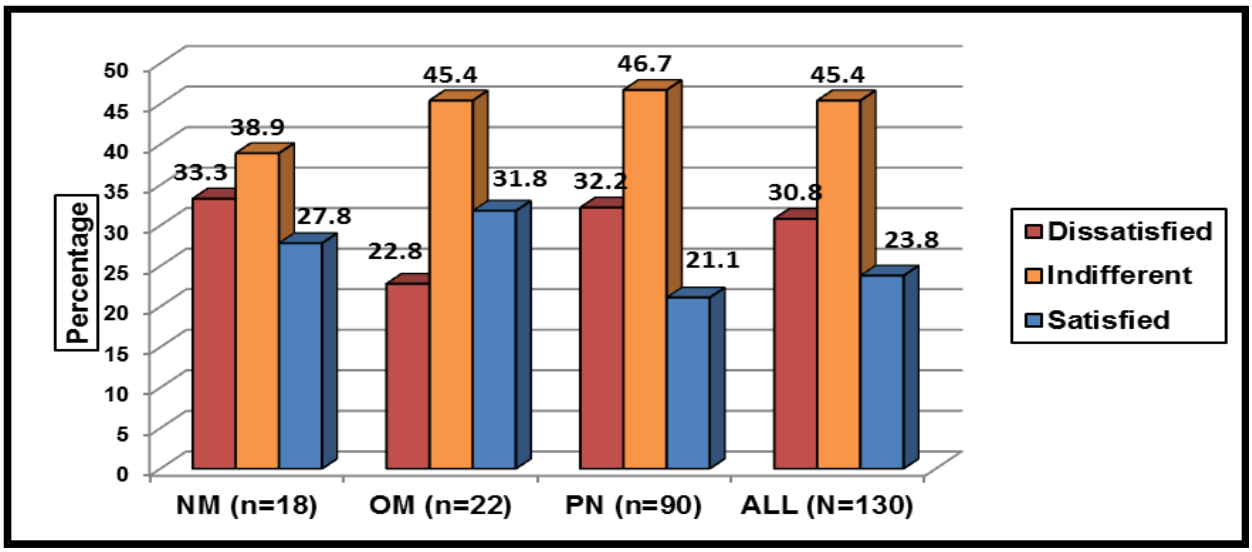

Figure 4.4: Respondents' level of satisfaction with the extent to which the informal communications network (grapevine) is active in the respondent's hospital (*N*=130)

According to Van Staden et al (2002:22-23), peer-group communication can be utilised to solve problems at a lower level in the organisation; they suggest that managers could become more aware of peer-group level communication to get more in touch with the feelings, opinions and needs of their subordinates.

The findings indicate that 40 (30.8%) of the respondents were dissatisfied, contrasted with the 31 (23.8%) of the respondents that indicated their satisfaction with this network. A third of both the nurse managers (*n*=6; 33.3%) and professional nurses (*n*=29; 32.2%) were dissatisfied with their informal communication networks, an indication that although an informal network in a hospital might be active, it might not meet the needs of the respondents. It must be borne in mind that even though informal communication networks exist in all organisations, they cannot be consciously restructured or amended to satisfy the needs of all.

The operational managers indicated in the open-ended items that there was a lot of *hearsay* information flowing in the hospitals. In addition to hearsay information, the professional nurses indicated that most of the information in their hospitals flowed through informal communication channels, but that there was a lot of gossip in the hospitals. It is often difficult for professional nurses to distinguish between correct and incorrect information received through the grapevine.

- **Extent to which communication with other employees at the level of the respondent is accurate and free flowing**

Item 34 sought to explore the extent to which the respondents' communication with other employees at their own level was accurate and free flowing. The findings are illustrated in Figure 4.5.

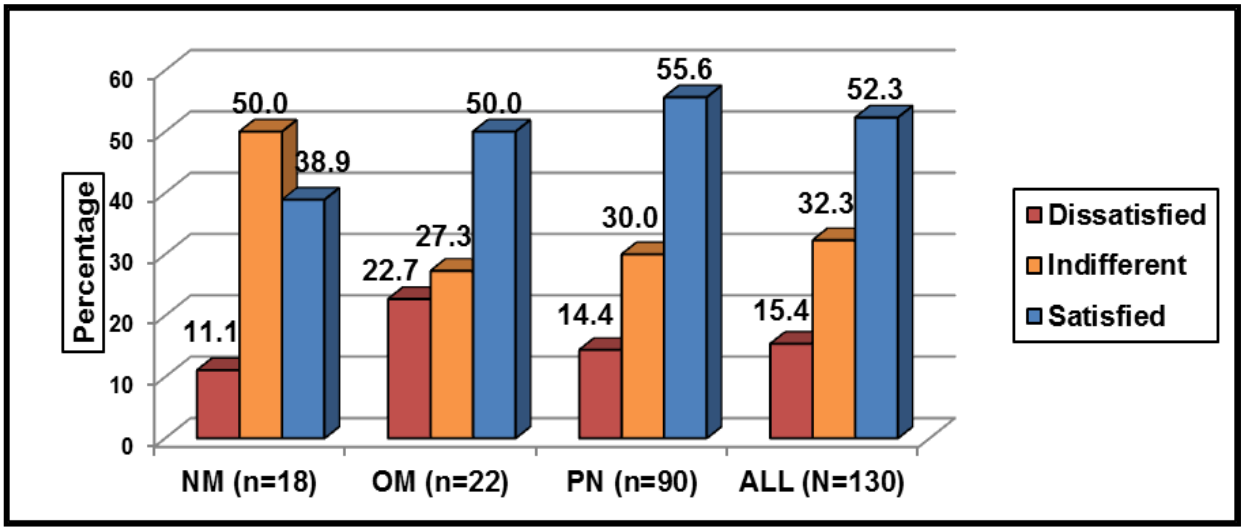

Figure 4.5: Respondents' level of satisfaction with the extent to which communication with other employees at the level of the respondent was accurate and free flowing (*N*=130)

The findings indicate that 68 (52.3%) of the respondents were satisfied with the extent to which communication with other employees at the same level was accurate and free flowing, an indication of accuracy and free flow of collegial communication in the hospitals. These findings were also echoed in the open-ended items. The operational managers indicated that they received a lot of information from their peers, and that most communication problems experienced by lower-category professional nurses were due to poor communication among their own ranks. In turn, the professional nurses indicated that it was easier to initiate horizontal communication than vertical communication in their units, but that language between same-level professional nurses was often also a problem. However communication travelling between employees at the same level in a hospital can be accurate and free-flowing. According to Muller et al (2006:305), the grapevine is managed by minimising rumours and keeping employees well-informed through the formal communication system.

- **Adaptability of communication practices to emergencies**

Item 35 sought to determine how far the communication practices in the hospitals are adaptable to emergencies. Public hospitals often experience emergencies for which effective communication is imperative. Emergency situations call for immediate and direct action, without questioning. In an emergency, communication, normally conducted in a democratic and participatory manner, could become more autocratic and goal-directed. The findings are illustrated in Figure 4.6.

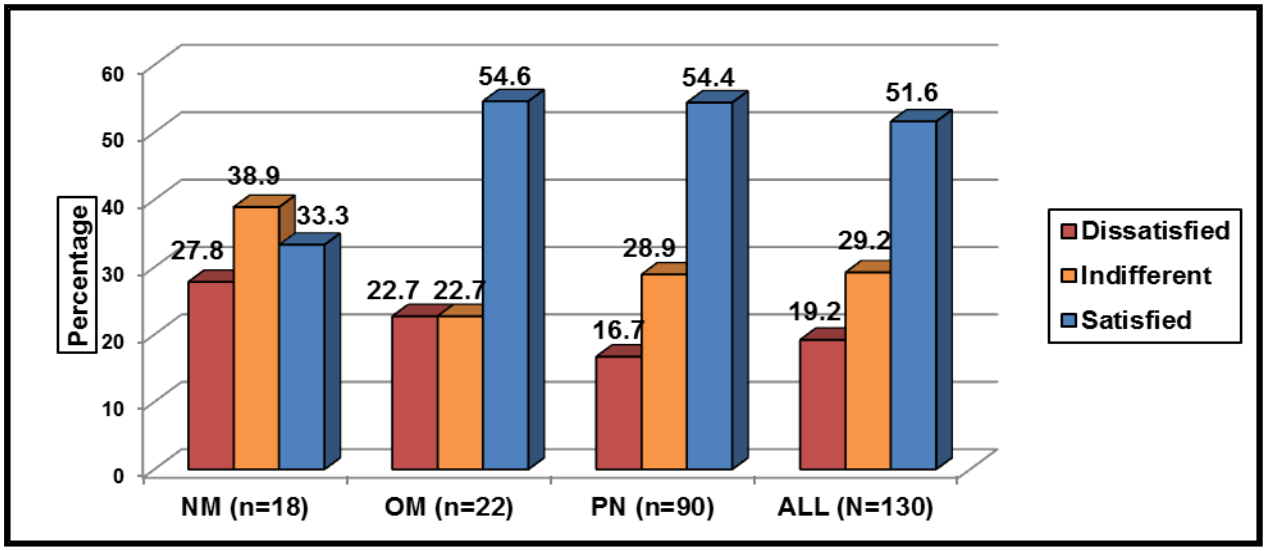

Figure 4.6: Respondents' level of satisfaction with the extent to which communication practices are adaptable to emergencies (*N*=130)

From the findings it is evident that the majority of the operational managers (*n*=12; 54.6%) and professional nurses (*n*=49; 54.4%) were satisfied with the adaptability of communications to emergencies in their hospitals. At operational level the nurses form the workforce and have to deal with emergencies at first hand. This could be an indication that they are adaptable in their communication practices. However, the majority of nurse managers (*n*=7; 38.9%) were indifferent regarding their view on the adaptation of communication practices. No comments were made on this item in the open-ended items by any one of the three strata of respondents.

- **Extent to which the work group of the respondent is compatible**

Item 36 sought to determine the level of satisfaction of respondents with how they experienced compatibility in their work groups. In a work group, compatibility and cohesion are essential for the existence of a harmonious and effective work environment, especially when groups like nurses have to work closely together. Communication is an important characteristic of group interaction, because the group decides on communication internally between members and externally with other groups (Jooste 2010:142). The findings are illustrated in Figure 4.7.

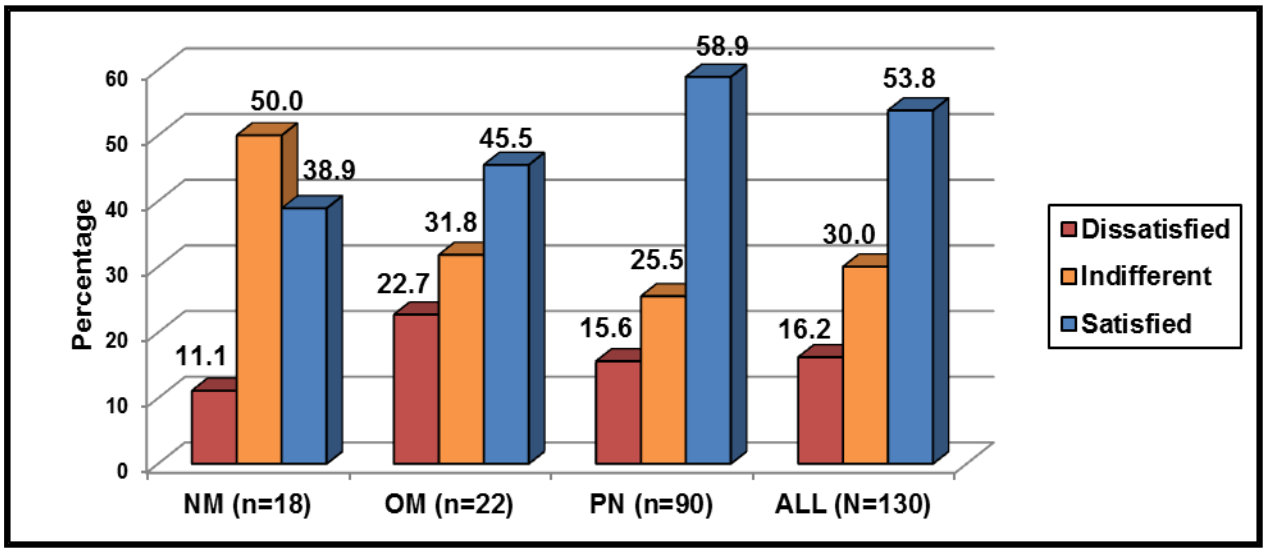

Figure 4.7: Respondents' level of satisfaction with the extent to which their work groups are compatible (*N*=130)

The findings indicate that of the three strata of respondents, the professional nurse stratum indicated a high level of satisfaction (*n*=53; 58.9%), while the nurse managers indicated a low satisfaction level (*n*=7; 38.9%) with the extent to which their work groups

were compatible. This low score could be an indication that they did not experience their own work group as compatible. The operational managers and the professional nurses indicated in the open-ended items that they generally felt part of a work group, but as regards communication, the professional nurses indicated that they did not feel part of the team due to the lack of communication with them. They also indicated that they experienced very little direct communication with the nurse managers.

- **Extent to which informal communication is active and accurate**

Item 41 sought to explore how active and accurate respondents felt informal communication in their various hospitals to be. Informal communication forms an essential part of an organisation's communication network, but it needs to be active and accurate to be effective. The findings are illustrated in Figure 4.8.

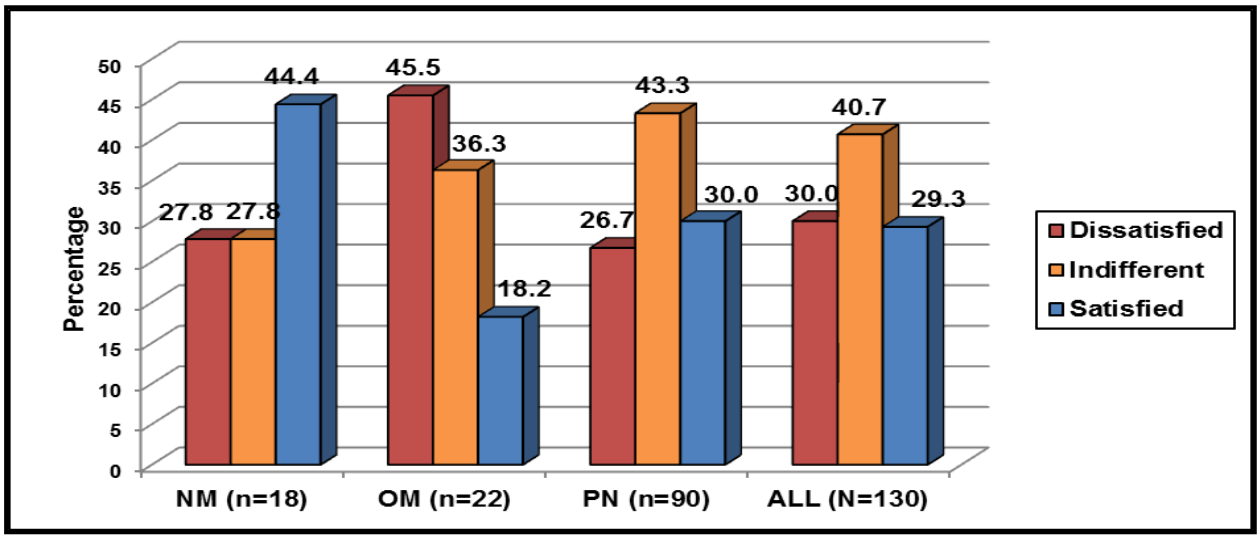

Figure 4.8: Respondents' level of satisfaction with the extent to which informal communication is active and accurate (*N*=130)

From the findings it is evident that 10 (45.5%) of the operational managers experienced dissatisfaction, contrasted with 8 (44.4%) of the nurse managers that were satisfied and 39 (43.3) of the professional nurses that were indifferent to the activity and accuracy of informal communication in their hospitals. To support these findings, the operational managers indicated in the open-ended items that informal communication in the hospitals was not always accurate. They stated that events occurred in the hospitals of which staff were unaware. Issues were communicated differently to different staff, causing confusion.

4.3.3 Assessment of the level of communication satisfaction

Objective two of this study sought to determine the level of communication satisfaction among nurse managers, operational managers and professional nurses working within the selected hospitals. The communication satisfaction of these three strata of nurses were analysed against the three communication contexts and eight communication dimensions of the Downs and Hazen (1977) model.

4.3.3.1 Interpersonal communication context

The first of these contexts is the interpersonal communication context, which has three dimensions: personal feedback, supervisor-communication and subordinate communication.

4.3.3.1.1 Personal feedback dimension

The personal feedback dimension refers to the information that employees in an organisation receive about their actual work and work performance. Successful feedback, according to Muller et al (2006:356), is when the results of such feedback provide employees with clear and direct information on work performance. This dimension includes aspects such as how the work of the employees compares with that of others and how this performance is managed. It also addresses aspects such as the recognition of the employees' efforts, reports on the handling of problems in the employees' jobs and the extent to which the employees' manager understands problems faced by employees in their jobs. According to the Downs and Hazen (1977) model, items 11, 12, 13, 18 and 22 were applicable to this dimension.

In the hospital environment and the nursing profession, feedback (especially personal feedback) is regarded by most nurses as a measurement of their work performance. Not all nurses perceive personal feedback as positive, due to a number of reasons, but Jooste (2009:405) states that feedback should be provided only if the outcome thereof is considered to be developmental to both parties involved. Booyens (2008:246) echoes this statement and adds that feedback should be provided close to an event to ensure that the experience remains fresh in the minds of both the parties. The responses for the personal feedback dimension are reflected in Table 4.8.

Table 4.8: Level of satisfaction with the personal feedback of the interpersonal communication context (*N*=130)

INTERPERSONAL COMMUNICATION			NUMBER OF RESPONSES							
Item	Personal feedback		NM (*n*=18)		OM (*n*=22)		PN (*n*=90)		Total (*N*=130)	
			f	%	f	%	f	%	f	%
11	Information about how your job performance compares with others.	**Dissatisfied**	2	11.1	9	40.9	27	30.0	38	29.2
		Indifferent	7	38.9	4	18.2	29	32.2	40	30.8
		Satisfied	9	50.0	9	40.9	34	37.8	52	40.0
12	Information about how you are being performance managed.	**Dissatisfied**	6	33.3	7	31.8	32	35.6	45	34.6
		Indifferent	7	38.9	8	36.4	28	31.1	43	33.1
		Satisfied	5	27.8	7	31.8	30	33.3	42	32.3
13	Recognition of efforts.	**Dissatisfied**	4	22.2	13	59.1	41	45.5	58	44.6
		Indifferent	7	38.9	2	9.1	23	25.5	32	24.6
		Satisfied	7	38.9	7	31.8	26	29.0	40	30.8
18	Reports on how problems in your job are being handled.	**Dissatisfied**	7	38.9	13	59.1	36	40.0	56	42.3
		Indifferent	2	11.1	5	22.7	32	35.6	39	30.0
		Satisfied	9	50.0	4	18.2	22	24.4	35	26.9
22	Extent to which managers/supervisors understand problems faced by staff.	**Dissatisfied**	7	38.9	10	45.5	34	37.8	51	39.2
		Indifferent	0	0.0	5	22.7	23	25.5	28	21.6
		Satisfied	11	61.1	7	31.8	33	36.7	51	39.2

- **Information about how the job performance of the respondent compares with others**

Item 11 sought to establish the level of satisfaction of the respondents with information about how the job performance of the respondent compared with that of others. It is human nature for employees to compare their performance with others in an effort to assess whether their performance is better or worse than that of the next person. Booyens (1998:275) states that managers are often reluctant to provide feedback to employees with regard to their work performance because the manager is afraid that positive feedback might prompt the employee to demand an increase in salary or a promotion, while negative feedback might elicit arguments.

From the findings it is clear that the operational managers experienced the personal feedback dimension as unsatisfactory (with reference to all five items). Nine (40.9%) of them experienced comparison of their job performance with that of others as either satisfactory or unsatisfactory, indicating that not all of the respondents were satisfied with this feedback. Nine (50.0%) of the nurse managers indicated their satisfaction on this item but commented in the open-ended items that due to communication problems the feedback from professional nurses was not always complete or accurate. The operational managers indicated that they did not receive enough feedback regarding their job performance from the nurse managers. In the open-ended items the professional nurses indicated that the feedback they did receive from their supervisors (operational managers) about their jobs was adequate but that the feedback they received from the nurse managers was inadequate. This was reflected in the data, with 34 (37.8%) of the professional nurses indicating satisfaction and 27 (30.0%) dissatisfaction with the information on how their job performance compared with others.

- **Information respondents receive about their performance management**

Item 12 sought to determine the respondents' level of satisfaction with the amount and quality of information they received about their performance management. Mashiane (2006:53) is of the opinion that all of the performance management systems that have been used in the NDOH thus far have failed because the aspirations of employees have not been taken into consideration, and employees do not know exactly what the supervisor expects of them.

According to Jooste (2009:330-331), performance management is a continuous communication process which is undertaken as a partnership between managers and subordinates. Performance management therefore establishes clear expectations and understanding with regard to the subordinate's job description. It establishes the manager's contribution to meeting the goals of the hospital, sets concrete terms on how to do the job well, establishes how job performance is measured and identifies barriers to performance (and how they can be overcome).

In response to this item, 7 (38.9%) of the nurse managers were indifferent and 6 (33.3%) were dissatisfied with the amount and quality of information they received about their performance management. This indicates an apparently negative view held by

nurse managers with regard to the amount and quality of information they received about their performance management. (It could also possibly indicate that they were unsure as to how to approach this item.) The performance management of the nurse managers is not hospital based (internally) but performed by a central office (which is a managerial entity external to the actual hospital). They indicated in the open-ended items that professional nurses were not very receptive to evaluations and suggestions from nurse managers.

Eight (36.4%) of the operational managers were also indifferent about the amount and quality of information they received about their performance management. This is disconcerting, as the performance management of operational nurses is done internally at hospital level; therefore it would be expected that they would take a greater interest in information regarding their own performance management. The operational managers indicated that the performance management process could be more transparent. They also indicated that their subordinates were not informed regarding their performance – they had to assume that it was good or bad. The latter sentiment was also reflected in the responses of the professional nurses, 32 (35.6%) of whom expressed their dissatisfaction and 28 (31.1%) their indifference to the amount and quality of information they received about their performance management.

- **Recognition of efforts**

Item 13 sought to determine the respondents' level of satisfaction with the recognition they received for their efforts. According to Jooste (2009:168), subordinates working in teams, led by competent leaders, will have an opportunity for personal development and recognition.

The findings indicate that 13 (59.1%) of the operational managers and 41 (45.5%) of the professional nurses were dissatisfied, in comparison to only 4 (22.2%) of the nurse managers that expressed dissatisfaction with the amount and quality of recognition they received for their efforts. In the open-ended items the professional nurses indicated that too little praise was given to them by their supervisors/managers for work well done. Some indicated that there was too much shouting at staff. Others stated that they needed more acknowledgement of good work in order for them to feel motivated in their job.

- **Reports on how problems in the respondent's job are being handled**

Item 18 sought to determine the respondents' level of satisfaction with the amount and quality of reports on how problems in their jobs were being handled. The main focus of problem solving is on finding a solution to a certain problem, and once a decision has been set in motion, evaluation must follow to provide the necessary feedback on its outcome to employees (Muller et al 2006:80-84).

The findings indicate that only 35 (26.9%) of all the respondents were satisfied with the amount and/or quality of the reports they received on how their job-related problems were handled. Thirteen (59.1%) of the operational managers and 36 (40.0%) of the professional nurses were dissatisfied with the amount and or quality of such reports. This is disconcerting, as it indicates that almost two-thirds of the respondents may feel that management does not take heed of their problems or that management does not consider them important enough to provide sufficient feedback at regular intervals.

The nurse managers indicated in the open-ended items that two-way communication to share problems and/or ideas did not occur in the hospitals. The operational managers stated that staff problems were often not addressed by the nurse managers. The professional nurses indicated that communication regarding problems in the units mostly flowed one way (upwards). They (especially the junior professional nurses) felt that their problems were ignored by nurse managers. This is a worrying tendency because, according to Muller (2009:191), problem solving is an essential part of nursing management and therefore the nurse manager must consistently demonstrate problem-solving skills.

- **Extent to which managers/supervisors understand problems faced by staff**

Item 22 sought to determine the extent to which managers/supervisors understand problems faced by staff. Jooste (2009:235) states that leaders should be sensitive to the expectations of subordinates in the provision of problem-solving solutions by honouring appointments with them, opening discussions with them and where necessary assisting them with their problems.

Communication will guide the leader to determine the extent of problems, prioritise them, assess potential causes, gather information, identify and evaluate possible solutions, transform decisions into action plans, communicate these action plans, and implement and evaluate the outcomes of the plans in a written or verbal communication format (Jooste 2009:208-209). Problems faced by subordinates in the work environment must be understood by supervisors; otherwise subordinates will, according to Arries (2006:33), feel alienated and experience their workplace as inhuman, due to managers who are not very sympathetic towards them.

The findings indicate that the majority, 11 (61.1%) of the nurse managers were satisfied with the extent to which managers/supervisors understood problems faced by staff, contrasted with the 10 (45.5%) of the operational managers and 34 (37.8%) of the professional nurses that indicated their dissatisfaction with the extent to which managers/supervisors understood problems faced by staff. In the open-ended items the operational managers indicated their experience that nurse managers were very rigid in their approach to communication; they stated that professional nurses were more comfortable communicating with their operational managers about job-related issues. The professional nurse respondents also indicated that the nurse managers were unapproachable. Some indicated that “staff are reluctant to verbalise their problems because managers are always in a bad mood”.

4.3.3.1.2 Supervisor communication dimension

The supervisor communication dimension pertains to how professional nurses perceive communication by their supervisors. Supervision, according to Muller et al (2006:358), is the process of striving for quality outputs in a work team and can be achieved through monitoring, guiding and supporting employees in an effort to achieve the goals of the organisation. Supervision includes the extent to which supervisors listen to, offer guidance to, trust, are open to ideas from and effectively supervise subordinates. Responses to the items of this dimension provide an understanding of the willingness and comfort of professional nurses with initiating upward communication. Items 24, 26, 29, 33 and 38 were applicable to this dimension, according to the Downs and Hazen (1977) model. The findings are displayed in Table 4.9.

Table 4.9: Level of satisfaction with supervisor communication of the interpersonal communication context (*N*=130)

INTERPERSONAL COMMUNICATION			NUMBER OF RESPONSES							
Item	Supervisor communication		NM (*n*=18)		OM (*n*=22)		PN (*n*=90)		Total (*N*=130)	
			f	%	f	%	f	%	f	%
24	Extent to which your supervisor listens and pays attention to you.	**Dissatisfied**	11	61.1	6	27.3	25	27.8	42	32.3
		Indifferent	3	16.7	7	31.8	15	16.7	25	19.2
		Satisfied	4	22.2	9	40.9	50	55.5	63	48.5
26	Extent to which your supervisor offers guidance for solving job-related problems.	**Dissatisfied**	4	22.2	9	40.9	25	27.8	38	29.2
		Indifferent	5	27.8	4	18.2	18	20.0	27	20.8
		Satisfied	9	50.0	9	40.9	47	52.2	65	50.0
29	Extent to which your supervisor trusts you.	**Dissatisfied**	4	22.2	6	27.3	14	15.5	24	18.5
		Indifferent	3	16.7	3	13.6	24	26.7	30	23.1
		Satisfied	11	61.1	13	59.1	52	57.8	76	58.4
33	Extent to which your supervisor is open to ideas.	**Dissatisfied**	9	50.0	4	18.2	22	24.4	35	26.9
		Indifferent	2	11.1	10	45.4	17	18.9	29	22.3
		Satisfied	7	38.9	8	36.4	51	56.7	66	50.8
38	Extent to which the amount of supervision given to you is about right.	**Dissatisfied**	0	0.0	4	18.2	16	17.8	20	15.4
		Indifferent	5	27.8	8	36.4	20	22.2	33	25.4
		Satisfied	13	72.2	10	45.4	54	60.0	77	59.2

- **Extent to which the supervisor listens and pays attention to the respondent**

Item 24 sought to determine the level of satisfaction among respondents with regard to the extent to which their supervisor listens and pays attention to them. Nurses view their relationship with their managers as an important factor in their overall job satisfaction and intention to remain in their hospitals (Dhlamini 2012:62-63).

The findings indicate that 11 (61.1%) nurse managers were dissatisfied with the extent to which their supervisors (managerial committees and central office) listened and paid attention to them, as against 50 (55.5%) of the professional nurses and 9 (40.9%) of the operational managers that indicated their satisfaction with the extent to which their supervisors (nurse managers) listened and paid attention to them. The fact that nurse managers were dissatisfied with this item could indicate a breakdown in communication between the nurse managers and their managerial committees at central office.

- **Extent to which the respondent's supervisor offers guidance for solving job-related problems**

Item 26 sought to determine the level of satisfaction of the respondents with the extent to which their supervisors offered guidance for solving job-related problems. According to Enslin (2005:31), nurses in the South African nursing profession feel that no one cares and that they have no support for the problems experienced on a daily basis like shortages in stock, equipment and staff. Yoder-Wise (2003, cited in England 2005:8) states that nurses look up to nurse leaders for guidance and learning experiences; thus nurse leaders can bring out the best in their personnel by guiding them.

The findings indicate that, except for a small percentage of operational managers (*n*=4; 18.2%) that indicated indifference, the majority of the operational managers were in two minds about the extent to which their supervisors offered guidance for solving job-related problems; they indicated both their satisfaction and dissatisfaction as regards this item at the same percentage (*n*=9; 40.9%). Nine (50.0%) of the nurse managers and 47 (52.2%) of the professional nurses were satisfied with the extent to which their supervisors offered guidance for solving job-related problems.

- **Extent to which supervisors trust their subordinates**

Item 29 sought to determine the level of satisfaction of respondents with the extent to which their supervisor trusted them. It is not a given that all managers trust their nurse subordinates. James et al (2005:9) found that professional nurses experience not being trusted to make sound judgements, however they want to be recognised as professionals and not merely as workers.

The findings indicate that 76 (58.4%) of the respondents were satisfied with the trust placed in them by their supervisors. However, this is not the opinion held by all. Professional nurses indicated in the open-ended items that communication between the nurse managers and professional nurses was not transparent and that openness was sometimes lacking. They stated that too often communication was done in secret.

- **Extent to which your supervisor is open to ideas**

Item 33 sought to determine the level of satisfaction among the respondents with the extent to which their supervisors were open to ideas. Professional nurses should be allowed the opportunity to experiment with new ideas as they strive for autonomy. Sengin (2003:317) states that autonomy is to be independent within one's practice and to take responsibility and accountability for practising according to one's discretion.

The findings indicate that half (*n*=9; 50%) of the nurse managers were dissatisfied, contrasted with 51 (56.7%) of the professional nurses that indicated their satisfaction with their supervisors' openness to ideas. However, the professional nurse respondents did indicate in the open-ended items that decisions were sometimes made by nurse managers without consideration of the ideas and suggestions of staff. The professional nurses indicated that personal issues often form a barrier to communication in the hospitals – "it is like their (referring to the nurse managers) superior status forms a barrier in the communication process...".

- **Extent to which the amount of supervision given to you is about right**

Item 38 sought to determine the level of satisfaction of the respondents with the extent to which the amount of supervision given to them was about right. Supervisors are, according to Muller et al (2006:351-352), responsible for directing work towards attainment of unit/ward objectives, and thus they have to inspect, guide, support, evaluate, approve and correct the work of others. To succeed the supervisor should have good interpersonal relations and communicate effectively laterally as well as vertically.

The findings revealed that 77 (59.2%) of the respondents were satisfied with the amount of supervision given to them. The professional nurses, however, indicated in the open-ended items that their nurse managers displayed an autocratic leadership style in which staff were told and not asked. They further indicated that openness (transparency) was not adequate in their hospitals.

4.3.3.1.3 Subordinate communication dimension

The subordinate communication dimension of interpersonal communication revolves around the perceptions of managers with regard to the communication of their subordinates: measuring how responsive subordinates are to downward-directed communication and criticism, how they anticipate the manager's need for information and initiate upward communication, and the extent to which the manager can avoid communication overload (from subordinates). In the instrument the subordinate communication dimension section, for obvious reasons, only allowed the nurse managers and operational managers to answer the questions. The questions applicable to the subordinate communication dimension were items 43, 44, 45, 46 and 47 according to the Downs and Hazen (1977) model. The findings are displayed in Table 4.10.

Table 4.10: Managers' level of satisfaction with the subordinate communication dimension of the interpersonal communication context (*N*=40)

INTERPERSONAL COMMUNICATION			NUMBER OF RESPONSES					
Item	Subordinate communication		NM		OM		Total	
			f	%	f	%	f	%
43	Extent to which your staff are responsive to downward directed communication.	**Dissatisfied**	5	27.8	3	13.6	8	20.0
		Indifferent	6	33.3	6	27.3	12	30.0
		Satisfied	7	38.9	13	59.1	20	50.0
44	Extent to which your staff anticipate your needs for information.	**Dissatisfied**	2	11.1	1	4.5	3	7.5
		Indifferent	7	38.9	10	45.5	17	42.5
		Satisfied	9	50.0	11	50.0	20	50.0
45	Extent to which you can avoid having communication overload	**Dissatisfied**	0	0.0	5	22.7	5	12.5
		Indifferent	9	50.0	8	36.4	17	42.5
		Satisfied	9	50.0	9	40.9	18	45.0
46	Extent to which your staff are receptive to evaluations, suggestions and criticism.	**Dissatisfied**	4	22.2	7	31.8	11	27.5
		Indifferent	2	11.1	5	22.7	7	17.5
		Satisfied	12	66.7	10	45.5	22	55.0
47	Extent to which your staff feel responsible for initiating accurate upward communication.	**Dissatisfied**	0	0.0	8	36.4	8	20.0
		Indifferent	8	44.4	7	31.8	15	37.5
		Satisfied	10	55.6	7	31.8	17	42.5

- **Extent to which the managers' staff are responsive to downward-directed communication**

Item 43 sought to determine the level of satisfaction of nurse managers and operational managers with the extent to which their staff were responsive to downward-directed communication. Enslin (2005:31) criticises the NDOH by stating that there is only one direction of communication and that is downwards.

The findings indicate, however, that 20 (50.0%) of both strata of respondents were satisfied with the extent to which their staff were responsive to downward-directed communication. The operational managers normally receive downward-directed communication from the nurse managers, while the professional nurses normally receive their downward-directed communication from the operational managers.

Except for downward-directed communications in written format (i.e. policy statements and circulars), it seldom occurs that professional nurses receive downward-directed communication on a face-to-face basis from the nurse managers, as a strict chain of command and communication is followed in the hospitals. The professional nurses indicated that they interacted better with their direct supervisors (operational managers) than with their nurse managers. Although this is not a perfect situation, it is still a good indicator of organisational effectiveness (Downs & Adrian 2004:54), in that important information in the hospitals does travel from one level (direct supervisors/operational managers) to another level (professional nurses).

- **Extent to which the manager's staff anticipate the manager's need for information**

Item 44 sought to determine the level of satisfaction of nurse managers and operational managers with the extent to which their staff anticipated their need for information.

Often subordinates think that the information they have is not useful to their managers or that the managers are already aware of this information, and so do not convey the message to them, thus creating a barrier to effective communication in the hospital. Jooste (2009:210) calls this phenomenon *smothering*, whereby managers may take it

for granted that their subordinates have an automatic impulse to send useful information up to them, though this is definitely not the case.

The findings indicate that 20 (50.0%) of both strata of respondents were satisfied with the level to which their subordinates anticipated their need for information. It must, however, be borne in mind that the nurse manager requires information from the operational manager and the operational manager requires information from the professional nurse.

The slight dissatisfaction (*n*=3; 7.5%) with this item could stem from the fact that nurse managers seldom receive information directly from professional nurses. **I**n the open-ended items the nurse managers indicated that the professional nurses did not communicate spontaneously with them regarding patient-related issues; for example, after a doctor's rounds the nurse manager seldom received vital patient-related information. This comment and the 17 (42.5%) respondents from both strata that indicated their indifference on this item could indicate that information is not following the hierarchical structure correctly, whereby patient information needs to travel vertically from the professional nurse to the operational manager and then on to the nurse manager.

It is imperative that the nurse manager be informed of the status of all patients at all times. This is a point of concern because in the absence of the operational managers, as direct supervisors of the professional nurses, the nurse managers could encounter a lack of vital patient information from professional nurses.

- **Extent to which the supervisor can avoid having communication overload**

Item 45 sought to determine the level of satisfaction of nurse managers and operational managers with the extent to which they avoided having communication overload. Communication overload refers to the amount of information that managers receive. When the amount of information exceeds the need for information the manager can experience information overload.

According to Muller et al (2006:147), one of the critical factors associated with internal formal communication in an organisation is to avoid information overload by selecting

the appropriate communication channels. The suitability of the selected communication channel should be investigated: whether it is the right channel for the specific information. More than one channel can be used in the case of general information, so as to avoid managers having to deal with information that does not pertain to them.

The findings indicate that 18 (45.0%) of the respondents were satisfied with the degree to which they could avoid having communication overload. This could indicate a line of communication that is not fully functional, considering the 17 (42.5%) respondents that indicated indifference on this item. Managers often become overloaded with unnecessary information, and precious time is consumed sifting through irrelevant information. Communication overload could also indicate a communication chain that functions too slowly (Van Staden et al 2002:19), meaning that communications are not dealt with in an efficient and timely manner.

- **Extent to which staff are receptive to evaluation, suggestions and criticism**

Item 46 sought to determine the level of satisfaction of nurse managers and operational managers with the extent to which their staff were receptive to evaluation, suggestions and criticism. Two-way communication between the managers and their subordinates is essential to create a platform where opinions can be raised and criticism given openly (Jooste 2009:235).

The findings indicate that more than half (*n*=22; 55%) of the respondents were satisfied with their subordinates in this regard. It is a positive sign when managers perceive their subordinates as receptive to evaluation, suggestions and criticism. It cannot, however, be stated as a generalisation that all subordinates will accept evaluation and criticism without some form of resistance. In the open-ended items the nurse managers indicated that their staff perceived “correctional communication” as punishment. The more junior nurses in particular did not want to be told that they were making mistakes. One nurse manager stated that “staff take criticism very personally – it often turns into a union or labour issue”.

- **Extent to which staff feel responsible for initiating accurate upward communication**

Item 47 sought to determine the level of satisfaction of nurse managers and operational managers with the extent to which their staff initiated accurate upward communication. According to Muller et al (2006:147), the encouragement of upward communication is a critical factor associated with formal internal communication in an organisation.

The findings indicate a discrepancy between the satisfaction levels of nurse managers (*n*=10; 55.6%) and operational managers (*n*=7; 31.8%). The satisfaction level of the nurse managers could be due to the operational managers reporting directly to them, and the low satisfaction level of the operational managers due to the professional nurses not always reporting to them. This might indicate the phenomenon whereby subordinates hoard as much information as possible for as long as possible (Jones 2006:16).

4.3.3.2 Group communication context

The group communication context contains two communication dimensions, namely horizontal communication and organisational integration. The organisational integration dimension will be discussed below and the horizontal communications dimension omitted here, as it has already been analysed under the assessment of effective communication channels (refer to 4.3.2.2).

4.3.3.2.1 Organisational integration dimension

The organisational integration dimension relates to the information that employees receive about their job progress (how employees are developing in their jobs), news regarding personnel, departmental policies and goals, their job requirements and employee benefits and pay. Nurses as part of organisations (hospitals) can also relate to this dimension. In this dimension, items 8, 9, 14, 15 and 19 are applicable. The findings are displayed in Table 4.11.

Table 4.11: Level of satisfaction with the organisational integration of the group communication context (*N*=130)

GROUP COMMUNICATION			NUMBER OF RESPONSES							
Item	Organisational Integration		NM (*n*=18)		OM (*n*=22)		PN (*n*=90)		Total (*N*=130)	
			f	%	f	%	f	%	f	%
8	Information about your progress in your job.	**Dissatisfied**	2	11.1	8	36.3	35	38.9	45	34.6
		Indifferent	2	11.1	1	4.6	11	12.2	14	10.8
		Satisfied	14	77.8	13	59.1	44	48.9	71	54.6
9	News regarding personnel.	**Dissatisfied**	0	0.0	10	45.5	31	34.4	41	31.5
		Indifferent	2	11.1	7	31.8	27	30.0	36	27.7
		Satisfied	16	88.9	5	22.7	32	35.6	53	40.8
14	Information about departmental policies and goals.	**Dissatisfied**	2	11.1	5	22.7	14	15.5	21	16.1
		Indifferent	0	0.0	7	31.8	17	18.9	24	18.5
		Satisfied	16	88.9	10	45.5	59	65.6	85	65.4
15	Information about the requirements of your job.	**Dissatisfied**	2	11.1	5	22.7	11	12.2	18	13.8
		Indifferent	5	27.8	6	27.3	16	17.8	27	20.8
		Satisfied	11	61.1	11	50.0	63	70.0	85	65.4
19	Information about employee benefits and pay.	**Dissatisfied**	6	33.3	13	59.1	43	47.8	62	47.7
		Indifferent	5	27.8	6	27.3	16	17.8	27	20.8
		Satisfied	7	38.9	3	13.6	31	34.4	41	31.5

- **Information about the progress of respondents in their jobs**

Item 8 sought to determine the respondents' level of satisfaction with the amount and quality of information about their job progress.

The findings indicate that 71 (54.6%) of all the respondents were satisfied with the information they received about the progress in their jobs; however the professional nurse stratum indicated a lower satisfaction level (*n*=44; 48.9%), contrasted with 14 (77.8%) nurse managers and 13 (59.1%) operational managers that expressed their satisfaction with this item. The majority of the professional nurses (*n*=62; 68.8%) indicated in the open-ended items that they were not informed about the progress in their jobs. This is a worrying tendency, as all employees should be informed regarding their job progress on a regular basis.

Managers have control over the individual goal-setting and planning of the progress and appraisal of the subordinates' performance (Muller 2009:354); therefore the task of

teaching them about the performance appraisal and informing them of their progress in their jobs also rests with the manager.

- **News regarding personnel**

Item 9 sought to determine the respondents' level of satisfaction with news regarding personnel. Jones (2006:14) states that an important factor in the psychological well-being of employees in organisations is news they receive about fellow personnel.

The findings indicate that most of the nurse managers (*n*=16; 88.9%) were satisfied with this news regarding personnel. In the open-ended items the nurse managers indicated that their hospitals did not have a functional newsletter that could highlight positive incidents in the hospitals to motivate staff and boost morale. The operational managers echoed this statement in their responses by stating that they too saw the need for newsletters in their hospitals. The professional nurses were indecisive about this item but did indicate that notices about personnel news were lacking in their hospitals.

- **Information about departmental policies and goals**

Item 14 sought to determine the level of satisfaction of the respondents with the amount and quality of information about departmental policies and goals. Jooste (2010:94-95) states that information about departmental policies and goals should be written, understandable, clear, concise and stored in an easy accessible policy manual format. Departmental policies and goals could also be, and in some public hospitals are, stored in electronic format in a computer file system.

The findings indicate that the majority of the respondents (*n*=85; 65.4%) were satisfied with the amount and quality of information they received about departmental policies and goals. All three strata of respondents indicated in the open-ended items their satisfaction with this item; however, the professional nurses indicated that, like hospital policies and goals, departmental policies could also be simplified for all levels of staff to understand them. This simplification refers, according to the professional nurses' comments in the open-ended items, to "the wording of the policies and goals" that are "incomprehensible for most professional nurses".

- **Information about the requirements of the respondents' job**

Item 15 sought to determine the level of satisfaction of respondents regarding the amount and quality of information about their job requirements (job description). The job description, according to Muller (2009:123), spells out the responsibilities and duties of the employee and the authority relationship in a unit.

The findings indicated that the majority of the respondents (*n*=85; 65.4%) were satisfied with the information about the requirements of their job. All three strata of respondents indicated in the open-ended items that they were satisfied with such information they received. This is a very good indicator of organisational communication effectiveness because, as Jooste (2009:405) states, job requirements have to be communicated to each employee as early as possible to eliminate the chances of mistakes to the maximum.

- **Information about employee benefits and pay**

Item 19 sought to determine the respondent's level of satisfaction with the amount and quality of information about employee benefits and pay. Mashiane (2006:53) questions the quality of information that nurses in the NDOH receive regarding their remuneration, by querying the number of nurses who know what determines the salary they are paid and the incentives they receive. Jooste (2009:288) states that in any employment relationship, sustaining leadership and managing performance will become difficult if employees do not perceive their compensation as fair and equitable. Therefore it is important for employees to have insight into their remuneration system.

The findings indicated that 62 (47.7%) of the respondents were dissatisfied with information about their benefits and pay, indicating that there exists a lack of quality information in this regard, affecting the professional nurses at all levels in the hospitals; especially the operational managers (*n*=13; 59.1%) and professional nurses (*n*=43; 47.8%) who expressed their dissatisfaction.

The professional nurses indicated in the open-ended items their experience of communication, especially with the human resources departments in their hospitals, as very problematic. They stated that their supervisors had no human resources-related

knowledge and thus were unable to deal effectively with their human resource-related issues such as benefits, salary and promotional and leave issues.

4.3.3.3 Organisational communication context

The organisational communication context contains three communication dimensions, namely corporate information, communication climate and media quality. Both the corporate information and media quality communication dimensions have been analysed in the assessment of effective formal communication channels (refer to 4.3.2.1.1 and 4.3.2.1.2 respectively) and therefore only the communication climate dimension will be discussed under the organisational communication context.

4.3.3.3.1 Communication climate dimension

The communication climate dimension pertains to the climate in which communication has to occur in organisations. In hospitals this climate refers to the communication atmosphere between the subordinate nurse and the nurse manager. The communication climate dimension sought to explore the extent to which professional nurses experienced communication at their hospitals as motivating. It further explored the extent to which communications made nurses identify with their hospitals and how timeously nurses received information.

The communication climate dimension also sought to explore the extent to which hospital employees had communication abilities and how conflicts were handled at their hospitals. According to the Downs and Hazen (1977) model, items 23, 25, 27, 30 and 31 were applicable to the communication climate dimension. The findings are displayed in Table 4.12.

Table 4.12: Level of satisfaction with the communication climate of the organisational communication context (*N*=130)

ORGANISATIONAL COMMUNICATION			NUMBER OF RESPONSES							
Item	Communication Climate		NM (*n*=18)		OM (*n*=22)		PN (*n*=90)		Total (*N*=130)	
			f	%	f	%	f	%	f	%
23	Extent to which your hospital's communication motivates you to meet its goals.	**Dissatisfied**	7	38.9	10	10.5	36	40.0	53	40.8
		Indifferent	2	11.1	9	40.9	24	26.7	35	26.9
		Satisfied	9	50.0	3	13.6	30	33.3	42	32.3
25	Extent to which hospital employees have communication abilities.	**Dissatisfied**	7	38.9	10	45.5	35	38.9	52	40.0
		Indifferent	7	38.9	10	45.5	30	33.3	47	36.2
		Satisfied	4	22.2	2	9.0	25	27.8	31	23.8
27	Extent to which communication in your hospital makes you identify with it or feel a vital part of it.	**Dissatisfied**	2	11.1	5	22.7	40	44.4	47	36.1
		Indifferent	11	61.1	14	63.6	28	31.1	53	40.8
		Satisfied	5	27.8	3	13.6	22	24.5	30	23.1
30	Extent to which you receive the information required to do your job in time.	**Dissatisfied**	2	11.1	5	22.7	20	22.2	27	20.8
		Indifferent	5	27.8	4	18.2	21	23.3	30	23.1
		Satisfied	11	61.1	13	59.1	49	54.5	73	56.1
31	Extent to which conflicts are handled appropriately through proper communication channels.	**Dissatisfied**	2	11.1	9	40.9	25	27.8	36	27.7
		Indifferent	5	27.8	7	31.8	31	34.4	43	33.1
		Satisfied	11	61.1	6	27.3	34	37.8	51	39.2

- **Extent to which the communication at the respondent's hospital motivates the respondent to meet its goals**

Item 23 sought to determine the level of satisfaction of the respondents with the extent to which the communication of their hospital motivated them to meet its goals. Jones (2006:41) states that the communication atmosphere in an organisation determines the level of the employees' satisfaction with personal and organisational communication.

The findings indicate that 53 (40.8%) of the respondents were dissatisfied and only 42 (32.3%) satisfied with the extent to which the communication of their hospitals motivated them to meet its goals. This is worrying, because organisations are usually goal orientated. If the communication of an organisation does not motivate its employees to meet its goals, it will have a negative effect on the achievement of those set goals.

- **Extent to which hospital employees (nurses) have communication abilities**

Item 25 sought to determine the level of satisfaction of the respondents with the extent to which hospital employees have communication abilities. The ability of both managers and employees to communicate, according to Van Staden et al (2002:26), forms an essential element of the effectiveness of an organisation.

The findings indicate that 52 (40.0%) of the respondents were dissatisfied and 47 (36.2%) indifferent. This is a disconcerting finding, because in a hospital environment the continuity of accurate communication is pivotal and therefore communication skills are imperative. The nurse managers indicated in the open-ended items that the operational managers had a need for training and mentoring in communication skills. They also highlighted poor listening skills among the staff as a barrier to effective communication in their hospitals. In turn the operational managers indicated that the professional nurses (especially the neophytes) were lacking in communication skills and that record-keeping as a form of communication needed improvement.

- **Extent to which communication in the hospital make the respondents identify with it or feel a vital part of it**

Item 27 sought to determine the level of satisfaction of the respondents with the extent to which communication in their hospital helped them to identify with it or feel a vital part of it. Organisational communications, according to Downs and Adrian (2004:140), can make employees feel like essential parts of such an organisation.

From the findings it is clear that 47 (36.1%) of the respondents were dissatisfied and 53 (40.8%) indifferent to this item. The nurse managers indicated in the open-ended items that they often felt excluded from the nursing team as they received little feedback about patient-related issues. The operational managers indicated that issues were not discussed with all levels of staff simultaneously and that communication was selective. The professional nurse respondents indicated that the nurse managers did not respond to staff spontaneously. According to the professional nurses, the nurse managers were not visible enough because they did not visit the units often enough to speak to the staff, thus creating an illusion of being separate from the staff.

- **Extent to which respondents receive the information required to do their jobs in time**

Item 30 sought to determine the level of satisfaction of the respondents with the extent to which they receive the necessary information to do their job in time. According to Kekana et al (2007:34), staff should regularly be updated with information on how to do their jobs.

The findings indicate that 73 (56.1%) of the respondents were satisfied with the extent to which they received information to do their job in time. In the open-ended items, however, the operational managers indicated that staff were often informed only two to three weeks afterwards of an event that had occurred at their hospitals and could influence their jobs. Professional nurses indicated that information was forwarded to them at the last minute and not in good time. Information was often delayed in the absence of operational managers.

- **Extent to which conflicts are handled appropriately through proper communication channels**

Item 31 sought to determine the level of satisfaction of the respondents with the extent to which conflicts were handled appropriately through proper communication channels. Van Staden et al (2002:37) state that if conflict is managed well it can establish a work environment that is creative, stimulating and vibrant, but if it is handled incorrectly it will result in further destructive behaviour and hostility.

The findings indicate that only 51 (39.2%) of the respondents were satisfied with the extent to which conflicts were handled appropriately, utilising communication channels. In the open-ended items the nurse managers and operational managers pointed out that staff in the hospitals displayed a general disregard for communication channels. These managers viewed the communication practices of professional nurses, especially junior professional nurses, as very disrespectful.

For their part, the professional nurses indicated that misunderstandings led to conflict in the units, stating that nurse managers did not intervene in these conflicts soon enough. They also indicated that communication was not always conducted in a professional

manner; they felt that more senior professional nurses did not respect junior professional nurses during communication. The inputs of the junior professional nurses were not respected.

4.4 INTERNAL CONSISTENCY OF THE CSQ DIMENSIONS

4.4.1 Cronbach's alpha internal consistency analysis

Item analysis was done to assess the reliability of the different dimensions or constructs in the questionnaire via Cronbach's alpha values. Dimensions can also be referred to as constructs or concepts. The overall Cronbach's alpha value for reliability can be stated as follows: a Cronbach's alpha above 0.8 indicates good reliability; a Cronbach's alpha between 0.6 and 0.8 indicates acceptable reliability; and a Cronbach's alpha below 0.6 indicates an unacceptable reliability. (Some authors use a cut-off of 0.7, which is suggested by Nunnally (1978) for acceptable reliability.) A reliable Cronbach coefficient alpha value is a validation that the individual items of a dimension measure the same dimension (concept) in the same manner (or consistently). Burns and Grove (2009:379) suggest that a Cronbach's alpha coefficient value of 1.00 denotes optimal reliability, in that each item in the instrument measures exactly the same thing.

To ensure that the CSQ dimensions were all computed at a coefficient value of 0.7 or above, a Cronbach's alpha internal reliability analysis was conducted. The results of this internal reliability coefficient of the communication satisfaction dimensions are displayed in Table 4.13:

Table 4.13: Reliability coefficient of the communication satisfaction dimensions (*N*=130)

Factor/Dimension	Cronbach's alpha
Subordinate Communication	0.9020
Supervisor Communication	0.8758
Communication Climate	0.8523
Media Quality	0.8274
Personal Feedback	0.8177
Corporate Information	0.8071
Horizontal Communication	0.7996
Organizational Integration	0.7467

From the findings it is evident that all of the constructs were measured with good reliability. Therefore it can be accepted that the reliability of the data collection instrument is good as well.

4.4.2 Rank mean scores

The mean scores of each of the five questions for the respective CQS dimensions were totalled to establish the ranking order of these dimensions from the strongest to the weakest, according to the ranking of the questions within these dimensions. In the formal channel dimension, the corporate information items totalled 2.91; the media quality finished for the respondents at 2.96. The horizontal communication items in the informal channel dimension finished at 3.21. These scores were analysed according to a rank order of means on a 1-5 scale and are displayed in Table 4.14:

Table 4.14: Rank order of means on a 1–5 scale (*N*=130)

Rank	NM (*n*=18)		OM (*n*=22)		PN (*n*=90)		ALL (*N*=130)	
	Mean	Dimension	Mean	Dimension	Mean	Dimension	Mean	Dimension
1	3.66	Organisational Integration	3.24	Subordinate Communication	3.38	Supervisor Communication	3.34	Subordinate Communication
2	3.53	Subordinate Communication	3.17	Supervisor Communication	3.24	Horizontal Communication	3.31	Supervisor Communication
3	3.39	Corporate Information	3.14	Horizontal Communication	3.19	Organisational Integration	3.22	Organisational Integration
4	3.15	Supervisor Communication	2.98	Organisational Integration	2.97	Communication Climate	3.21	Horizontal Communication
5	3.15	Communication Climate	2.81	Corporate Information	2.96	Media Quality	2.96	Communication Climate
6	3.13	Horizontal Communication	2.80	Communication Climate	2.88	Personal Feedback	2.96	Media Quality
7	3.12	Media Quality	2.80	Media Quality	2.84	Corporate Information	2.91	Corporate Information
8	3.10	Personal Feedback	2.70	Personal Feedback	0.00	Subordinate Communication – not applicable	2.88	Personal Feedback

The strongest of the overall rank order mean scores was 3.34 (items 43, 44, 45, 46 and 47 from the subordinate communication dimension). The weakest rank order mean score for all the respondents was 2.88 – items 11, 12, 13, 18 and 22 from the personal feedback communication dimension).

It is worthy of note that the mean score for the subordinate communication dimension ranked very strongly for the nurse manager and operational manager respondents. This phenomenon also appeared in the open-ended question section, where the operational managers indicated good interaction with the nurse managers, and the professional nurse respondents indicated their openness towards communication with their direct supervisors (operational managers) in the units. The personal feedback communication dimension ranked weakly amongst both the nurse manager and operational manager strata of respondents, indicating that there exists a lack of feedback between all categories of nursing staff in the health care services.

4.4.3 One-way Analysis of Variance

A one-way Analysis of Variance (ANOVA) test was performed to identify statistically significant differences between the communication satisfaction dimension mean scores of the three strata of respondents (Burns & Grove 2009:505). The analysis of variance in statistics refers to a collection of statistical models and their associated procedures whereby the observed variances are partitioned into components according to variables. Thus ANOVA refers to a statistical technique that assists with inferring whether there are real differences between the means of three or more groups or variables in a population, based on the sample data (HR Statistics 2011:14).

The results revealed statistically significant differences between the different strata of nurse managers and operational managers in two of the communication satisfaction dimensions tested, namely the organisational integration and corporate information dimensions. These differences are displayed in Table 4.15 and Table 4.16 respectively:

Table 4.15: One-way Analysis of Variance (ANOVA) test for the organisational integration communication satisfaction dimension

ORGANISATIONAL INTEGRATION	DF	Sum of Squares	Means Square	F Ratio	*F*
Between the NM and OM categories	2	4.914076	2.45704	5.0341	0.0079*
Error	127	61.985616	0.48808		
Total	129	66.899692			

The *p*-value of 0.0079 ($F_{2,129}$≈5.03), which is smaller than 0.05, indicates that there is a significant difference between the mean organisational integration scores of the different management levels in the hospitals at a 95% level of confidence.

Table 4.16: One-way Analysis of Variance (ANOVA) test for the corporate information communication satisfaction dimension

CORPORATE INFORMATION	DF	Sum of Squares	Means Square	F Ratio	*F*
Between the NM and OM categories	2	4.792963	2.39608	5.0341	0.0129*
Error	127	67.611960	0.53238		
Total	129	72.404923			

The *p*-value of 0.0129 ($F_{2,129}$≈4.50), which is smaller than 0.05, indicates that there is a significant difference between the mean corporate information scores of the different management levels in the hospitals at a 95% level of confidence.

The nurse managers reported a higher level of satisfaction with both the organisational integration (average mean score of 3.66) and corporate information (average mean score of 3.39) dimensions than the operational managers in both dimensions (see Table 4.14). This phenomenon could be due to the high level of exposure the nurse managers enjoy and their direct contact with these dimensions due to their post status in the health service. There were no other significant differences between the strata of respondents.

4.5 CONCLUSION

This chapter discussed the data analysis and findings of the study by utilising descriptive and inferential statistics. The analysed data included the biographical data of the respondents, the assessment of effective communication channels and the assessment of the level of communication satisfaction of the respondents. The analysed data were displayed using tables, pie graphs and bar graphs.

Chapter 5 will conclude the study and will discuss the conclusions, recommendations and limitations of the study.

Chapter 5
FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter will conclude and provide a brief overview of the study, which focused on the communication satisfaction of professional nurses. A quantitative approach, utilising an explorative and descriptive design, was used to conduct the study. The population consisted of professional nurses working in selected public hospitals in the City of Johannesburg, and data were collected by means of a structured questionnaire. The study was conducted to determine the level of communication satisfaction that professional nurses experience in their hospitals. The Downs and Adrian CSQ (2004) was used to assess the level of communication satisfaction of three strata of professional nurses. Conclusions were drawn and considered. Recommendations were made on strategies which could improve the level of communication satisfaction of professional nurses in their hospitals as well as for nursing practice and nursing research. In this chapter the findings, conclusions, recommendations, limitations and areas for further research will be presented.

5.2 THE PURPOSE AND OBJECTIVES OF THE STUDY

This study was conducted to determine what constitutes effective formal organisational communication and to establish the extent of communication satisfaction amongst professional nurses in selected public hospitals in the City of Johannesburg.

The study objectives were to:

- Establish what constitutes effective organisational communication
- Explore the extent of communication satisfaction of professional nurses in public health care services
- Make recommendations to improve communication in the public hospitals.

5.3 INTERPRETATION OF THE RESEARCH FINDINGS

The results derived from the collected data were presented and interpreted in Chapter 4, thus generating the findings, which will be presented in line with the objectives of the study under the following headings: biographical information, effective organisational communication and communication satisfaction. The following concluding statements can be made:

5.3.1 Biographical information

Of the total number (*N*=130; 100%) of respondents, 18 (13.85%) were from the nurse manager stratum, 22 (16.92%) from the operational manager stratum and 90 (69.23%) from the professional nurse stratum.

The majority of the professional nurses (*n*=80; 88.9%) fell into the age group of 21–49 years, whereas 21 (95.4%) of the operational managers fell into the age group 40–59 years and 16 (88.8%) of the nurse managers fell into the 40–60 years plus group.

Seventy (53.8%) of the respondents had been working in their current health service for 9 or more years, 19 (14.6%) for 5 to 8 years, 34 (26.2%) for 1 to 4 years and only 7 (5.4%) of the respondents had been employed at their current health service for less than 1 year.

Thirty-five (26.9%) of the respondents had spent 9 years and more in their current nursing position, 22 (16.9%) 5 to 8 years, 55 (42.3%) 1 to 4 years and 18 (13.9%) had spent less than 1 year in their current nursing position.

The home language of most nurse managers (*n*=8; 44.4%) and operational managers (*n*=6; 27.3%) was English. The most prominent home language of the professional nurses was isiXhosa, spoken by 20 (22.2%) of the respondents for that stratum.

5.3.2 Effective organisational communication

The first research objective for this study sought to determine what constitutes effective organisational communication. This objective was achieved by assessing the

communication dimensions resorting under formal and informal communication, as suggested by Jones (2006:21).

5.3.2.1 Formal channels of communication

Questions related to the formal channels of communication (corporate information and media quality) produced the following results:

- *Satisfaction with corporate information*

The majority of the respondents indicated their satisfaction with information about hospital policies and goals (*n*=84; 64.6%); however, the professional nurses were dissatisfied with information about governing regulations affecting the hospital (*n*=34; 37.8%), information about change in their hospitals (*n*=37; 41.1%), information about profits/financial standing of their hospitals (*n*=60; 66.7%) and information about achievements/failures of the hospital (*n*=42; 46.7%). Forty-one (31.5%) of all the respondents were indifferent towards information about governing regulations affecting the hospital, 42 (32.3%) were indifferent towards information about change in their hospitals and 38 (29.2%) were indifferent towards information about the achievements/failures of the hospital. Sullivan and Decker (2009:99) state that nurses would be incorrect to think that it is only top management that is required to have insight into policies (politics) governing organisational activities and goals. Nurses can become political entrepreneurs by utilising strategic alliances and by improving their skills and building relationships with others.

- *Satisfaction with media quality*

The respondents indicated a low level of satisfaction with media quality: only 29 (22.3%) were satisfied with the extent to which the hospital's communications were interesting and helpful, 39 (30.0%) were satisfied with the extent to which attitudes towards communications in the hospital were basically healthy and 30 (23.1%) were satisfied with the extent to which the amount of communication in the hospital was about right. On the other hand, the respondents indicated a higher level of satisfaction with the extent to which meetings were well organised (*n*=54; 41.5%) and the extent to which written directives are clear and concise (*n*=75; 57.7%).

5.3.2.2 Informal channels of communication

Questions pertaining to the informal channels of communication (horizontal communication) produced the following results:

- *Satisfaction with horizontal communication*

The findings indicate that 40 (30.8%) of the respondents were dissatisfied, compared with 31 (23.8%) of the respondents that indicated their satisfaction with the extent to which the grapevine was active in their health care service and the extent to which informal communication was active and accurate. Sixty-eight (52.3%) of the respondents were satisfied with the extent to which communication with other employees at the same level was accurate and free flowing. The majority of operational managers (*n*=12; 54.6%) and professional nurses (*n*=49; 54.4%) were satisfied with the extent to which communication in their hospitals was adaptable to emergencies. Only 7 (38.9%) of the nurse managers indicated their satisfaction with the extent to which their work groups were compatible. Ten (45.5%) of the operational managers were dissatisfied, compared with 8 (44.4%) of the nurse managers who were satisfied, and 39 (43.3) of the professional nurses who were indifferent to the activity and accuracy of informal communication in their hospitals. All managers need to attempt to improve their understanding of and contributions to the informal communication channels in their organisations, according to Marquis and Huston (2012:425), due to the prominence of grapevine communications in organisations.

5.3.3 Communication satisfaction

The second research objective for this study sought to determine the extent to which professional nurses in the public health care services experience communication satisfaction. The dimensions of communication satisfaction (inter alia personal feedback, supervisor communication, subordinate communication, organisational integration and communication climate) will be discussed below to provide further insights into the statistical differences between the levels of communication satisfaction amongst the three respondent strata. The dimensions pertaining to the formal and informal channels of communication (corporate information, media quality and horizontal communication) were discussed under 5.3.2.1 and 5.3.2.2.

5.3.3.1 Interpersonal communication

In the Interpersonal Communication context, the satisfaction of the respondents with the personal feedback, supervisor and subordinate communication dimensions will be discussed.

- *Satisfaction with personal feedback*

This dimension rated among the lowest of the levels of satisfaction among all three strata of respondents. They indicated that none of them felt satisfied with the supervisor's/manager's understanding of their job-related problems because of the ineffective way problems were handled, because their efforts were not properly recognised, because they received inadequate information on how they were being performance managed and because they did not receive information about how their job performance compared with that of others. According to Dolamo and Peprah (2011:180), evaluation of staff performance in hospitals is often problematic because some staff feel victimised by their supervisors and others feel that their supervisors do not understand the process. In the data obtained, this was reflected in the low number of professional nurses (*n*=34; 37.8%) who indicated satisfaction with the information on how their job performance compared with that of others.

- *Satisfaction with supervisor communication*.

More than half of the respondents indicated satisfaction with their supervisors' communication practices, thus feeling satisfied with how open their supervisors were to ideas (*n*=66; 50.8%), how much their respective supervisors listened to them, paid attention to them (*n*=63; 48.5%), offered guidance for solving job-related problems (*n*=65; 50.0%), and trusted them (*n*=76; 58.4%). The nurse managers, especially, indicated dissatisfaction with the extent to which their supervisor (central office) listened and paid attention to them. The professional nurse respondents indicated that they did not feel satisfied during their limited communications with nurse managers; they found it more comfortable to communicate with their direct supervisors (operational managers).

- *Satisfaction with subordinate communication.*

Although respondents from both management strata indicated their satisfaction with this dimension, the operational managers indicated a higher level of satisfaction with the extent to which their staff were responsive to downward directed communication (*n*=13; 59.1%) than did the nurse managers (*n*=7; 38.9%). In the open-ended items, both strata made comments that indicated an inclination towards dissatisfaction with some of the items in the dimension. The supervisors/managers did indicate that although staff were responsive to directives and did anticipate their supervisor's/manager's need for information to some extent, they were not very receptive to evaluation and not very open to suggestions and criticism. Some even took criticism as a personal attack. It was mainly the operational managers that indicated information overload as a problem (*n*=5; 22.7%). They form the link between the nurse manager and the professional nurse and therefore also bear the burden of forming the information link between the three strata. Yoder-Wise (2011:565) states that information overload occurs when one is overwhelmed by too much information too fast and too often, and does not have the skills to interpret the data into useful information. By developing data- and information-collecting methods, as well as receiving and sending skills, this overload could be reduced and efficiency and productivity increased (Yoder-Wise 2011:565).

5.3.3.2 Group communication

In the Group Communication context, the satisfaction with the organisational integration dimension will be discussed.

- *Satisfaction with organisational integration*

The survey results indicated that although all three strata of respondents were satisfied with this dimension, the nurse managers were satisfied with information about their progress in their jobs (*n*=14; 77.8%), news regarding personnel (*n*=16; 88.9%) and information about departmental policies and goals (*n*=16; 88.9%) – understandably so, as they are at the helm of the nursing sections of their hospitals. The professional nurses were satisfied with information about departmental policies and goals (*n*=59; 65.6%) and information about the requirements of their jobs (*n*=63; 70.0%).

5.3.3.3 Organisational communication

In the Organisational Communication context, satisfaction with the communication climate dimension will be discussed.

- *Satisfaction with communication climate*

A few nurse managers (*n*=4; 22.2%) reported satisfaction regarding communication abilities among hospital employees, while a small number of professional nurses (*n*=34; 37.8%) indicated satisfaction with the extent to which conflicts were handled appropriately through the proper communication channels in the hospital.

Booyens (2008:192) states that managers should manage conflicts that will arise by formalising ways of recognising, avoiding and resolving conflicts. Only once all nurses are able to communicate properly will they feel that communication motivates them to meet the goals of their hospitals. More than half of the respondents indicated their satisfaction with the extent to which they received information to do their jobs in time (*n*=73; 56.1%). Nurse managers were dissatisfied with (*n*=7; 38.9%) and indifferent to (*n*=7; 38.9%) their employees' abilities to communicate. The operational managers echoed this dissatisfaction (*n*=10; 45.5%) and indifference (*n*=10; 45.5%) with their employees' ability to communicate.

5.4 GENERAL CONCLUSIONS

The general conclusions for this study are founded on the three communication contexts and eight communication dimensions defined by the conceptual framework for this study designed by Downs and Hazen (1977).

Considering the population used in this study, the majority of the professional nurses fell into the age group of 21–49 years, the operational managers into the age group 40–59 years and the nurse managers into the 40–60 years plus group. The findings of the study can be summarised as follows:

5.4.1 Interpersonal communication

In the interpersonal communication context, the respondents indicated dissatisfaction with the items in the personal feedback, supervisory and subordinate communication dimensions:

5.4.1.1 Personal feedback

- Nurse and operational managers experienced personal feedback as unsatisfactory and indicated that the feedback received from professional nurses was not always complete or accurate. A continuous and accurate flow of feedback between managers and subordinates seems to be inadequate, and in some instances lacking.
- Information regarding performance management received by the professional nurse stratum was insufficient.
- The operational managers and professional nurses felt that their efforts were not properly recognised.
- The professional nurses felt that nurse managers did not seem to understand the job-related problems of subordinates and appeared not to have effective problem-solving skills.

5.4.1.2 Supervisor communication

- Professional nurses indicated satisfaction with how open their supervisors were to their ideas and how much their supervisors listened to and paid attention to them. Only the nurse manager strata indicated dissatisfaction with the latter aspect.
- The professional nurses were satisfied with the guidance their direct supervisors (operational managers) offered on solving job-related problems and with the extent to which their direct supervisor trusted them.

5.4.1.3 Subordinate communication

- Operational managers indicated satisfaction with the extent to which their staff were responsive to downward directed communication, but felt they were lacking in initiating accurate upward communication with managers.
- Nurse managers and operational managers remarked that staff were not very receptive to evaluation and not very open to suggestions and criticism.
- Operational managers indicated information overload as a problem.

5.4.2 Group communication

Communication in group context delivered the following areas of dissatisfaction within the horizontal communication and organisational integration dimensions:

5.4.2.1 Horizontal communication

- Nurse managers and professional nurses were dissatisfied with the extent to which the grapevine and informal communication were active in their hospitals.
- Nurse managers indicated their dissatisfaction with the extent to which their work groups were compatible.
- Operational managers experienced dissatisfaction with how active and accurate the informal communication networks in their hospitals were (if indeed they were working at all).

5.4.2.2 Organisational integration

- Both nurse managers and professional nurses were satisfied with the information received about departmental policies and goals and the requirements of their jobs, but only the nurse managers were satisfied with the information received about progress in their jobs.

5.4.3 Organisational communication

The results for the corporate information, communication climate and media quality dimensions of the organisational communication context included:

5.4.3.1 Corporate information

- Professional nurses were dissatisfied with the amount, availability and accuracy of information about governing regulations affecting the hospital where they were employed.
- Professional nurses were dissatisfied with the amount and quality of information about change, profits and financial standing and achievements and failures of their hospitals.

5.4.3.2 Communication climate

- Nurse managers reported an apparently poor communication ability among professional nurses.
- More than half of all three strata of the respondents indicated dissatisfaction with the extent to which they received timely information related to doing their jobs.
- Professional nurses indicated dissatisfaction with the extent to which conflicts were handled appropriately through the proper communication channels in the hospital.

5.4.3.3 Media quality

- Most of the respondents in all three of the strata indicated their dissatisfaction with the extent to which the hospital's communications were interesting and helpful, attitudes of staff were healthy and the amount of information they received in their hospitals.
- Most of the respondents in all three of the strata indicated satisfaction with the organisation of meetings and with the extent to which written directives and reports were clear and concise.

5.5 RECOMMENDATIONS FOR THE IMPROVEMENT OF COMMUNICATION SATISFACTION OF PROFESSIONAL NURSES IN PUBLIC HOSPITALS

Utilising the foregoing conclusions as a basis, the following recommendations are made at operational level, supervisory level and managerial level to improve the effectiveness of communication (and ultimately the communication satisfaction of professional nurses) in public hospitals.

The broad findings and the proposed recommendations for addressing the identified limitations within the interpersonal, group and organisational communication contexts are set out in table format. These recommendations identify what should be done, by whom and the frequency of the interactions. Recommendations to improve the communication within the interpersonal communication context are displayed in Table 5.1.

Table 5.1: Recommendations for improving communication in the interpersonal communication context

INTERPERSONAL COMMUNICATION CONTEXT			
Limitation	**What should be done**	**Responsible person**	**Frequency**
Dimension 1: Personal feedback: An unsatisfactory level of feedback between managers and subordinates manifests in:			
• Lack of information on performance management	Schedule and adhere to fixed performance management meetings for staff in the year. Keep job descriptions (KPAs) and performance agreements on file in hard copy or electronic format accessible to individual staff members.	Nurse managers and operational managers	Four performance meetings a year: - 1st meeting for contracting, before the end of the preceding year - 2nd, 3rd and 4th meetings are used for review of performance.
• Lack of recognition for inputs and work done well	Acknowledge nurses who deliver quality and excellent work inputs, not only by means of material rewards but also by means of verbal and or written recognition.	The direct supervisor of each employee, thus nurse and operational managers for professional nurses, and heads of departments at central office for nurse managers	On a continuous basis, but especially after review interviews by direct supervisors and annually by management.
• Supervisors not understanding the job-related problems faced by staff	Be more attentive to job-related problems experienced by nurses, by knowing what issues are at stake in the operational areas and by being more visible in the functional units/departments/areas of the hospital. Guide professional nurses in work-related problem solving by encouragement, directing and mentorship.	Nurse managers and operational managers Operational managers	On a continuous basis by observing, listening and identifying problem areas or aspects.

Table 5.1: continued

INTERPERSONAL COMMUNICATION CONTEXT				
	Limitation	**What should be done**	**Responsible person**	**Frequency**
		If problems persist, take a constructive leadership role in bringing all the relevant role-players together, use techniques such as brainstorming and the nominal group technique to come up with possible solutions. Thereafter, be instrumental in applying/implementing the most feasible solution and monitor progress.		
Dimension 2: Supervisory communication:				
	• Lack of supervisory attention	Observe, listen to staff and pay attention to their needs and ideas. This can be enhanced by creating staff forums to share ideas and information between different categories of staff.	Operational managers and heads of departments at central office	On a continuous basis by awarding staff a platform and opportunities to ventilate.
Dimension 3: Subordinate communication:				
	• Lack of upward directed communication by professional nurses	Avoid downward dominated communication by utilising formal communication structures to allow interactive communication (i.e. meetings or forums) and maintain an open climate conducive to the initiation of upward communication. Use face-to-face communication, presenting the manager to staff as a real person that understands their needs and challenges. Keep operational managers informed about relevant matters.	Nurse managers and operational managers Nurse managers and operational managers Nurse managers	Continuously, by actively listening and by practising two-way communication. Operational managers to share information as soon and as comprehensively as possible with their work groups.
	• Sensitivity of subordinates to evaluation, suggestions and criticism	Reduce sensitivity of staff to evaluation, suggestions and criticism from managers by providing feedback in a tactful, supportive and one-to-one way focused on developmental needs.	Nurse managers and operational managers	During all forms of feedback by focusing on both positive and negative aspects.
	• Information overload	Individuals should prioritise information and assignments into *high*, *medium* and *low* priority categories in order to effectively manage the demands.	Operational managers	As soon as information is received.

The recommendations for improving communications in the group communication context are displayed in Table 5.2.

Table 5.2: Recommendations for improving communication in the group communication context

GROUP COMMUNICATION CONTEXT			
Limitation	**What should be done**	**Responsible person**	**Frequency**
Dimension 4: Horizontal communication:			
• Dysfunctional informal communication channels (inactive grapevine and/or inaccurate information flowing through the grapevine)	Preferably only information with a low priority should be sent through the grapevine. Provide staff with accurate information to avoid distortion of information by hearsay and gossip.	All managers/staff that deal with the distribution of information in the hospital	During all forms of communication which involve change and which will affect employees.
Dimension 5: Organisational integration:			
• Lack of information on job progress	Update staff on progress in their jobs (how well they are developing in their jobs) by providing them with feedback and guiding career planning.	Nurse managers and operational managers	Job progress meetings annually would be sufficient.
• Incomprehensible departmental policies	Policies should be written in a simple, clear and concise format enabling easy comprehension. All new and key concepts should be defined and explained, and a list of abbreviations should be included.	All managers who develop and distribute policies to staff	During the development and revision of policies.

Table 5.3 displays the recommendations for improving communication in the organisational communication context.

Table 5.3: Recommendations for improving communication in the organisational communication context

ORGANISATIONAL COMMUNICATION CONTEXT			
Limitation	**What should be done**	**Responsible person**	**Frequency**
Dimension 6: Corporate information:			
• Lack of information about governing regulations affecting the hospital	Update nurses on policies (from the GDHSD and the SANC for example) affecting the hospital and nursing practice *per se*. Make regulations available to staff by maintaining a file for such documents in the office of operational managers. Attach a signature list with every document to ensure that important information is actually received and read in the units.	Nurse managers and operational managers Nurse managers	Monthly in-service training sessions per unit to introduce and discuss regulations, circulars and new or revised policy. Make available copies in nursing units or provide operational managers with copies.
• Lack of information about change, financial standing, and achievements of the hospital	Implement a corporate communication channel which informs all employees via the electronic media about impending change, profits, financial standing and achievements or failures of the hospital. Start a newsletter highlighting events in the hospital.	This is a top management function. Allocate task to creative staff, interested in compiling this newsletter and include the responsibility in their KPAs.	General staff meetings can be scheduled as the distribution of information/news becomes necessary.

Table 5.3: continued

Dimension 7: Communication climate:				
	• Lack of motivation and organisational identification	Organisational identification should be evident in the conduct, behaviour and identification of institution managers at all levels. Involve staff in activities to improve the hospital's professional image. Probe staff by means of the SWOT analysis and surveys on possible improvements.	A suggestion might be to compile a team of different role players in the hospital and the community to encourage this organisational identification.	Utilise general staff meetings for this purpose every six months. An annual planning session.
	• Limited communication abilities of hospital staff	After a needs analysis, schedule communication skills workshops to address the needs of staff at different levels of proficiency in order to enhance communication abilities.	Nurse managers, operational managers and clinical education staff from nursing colleges / universities	Workshops can be scheduled every six months.
	• Insufficient information to do the job	Provide staff with updated and relevant information on issues (i.e. new technologies and changes in protocols) that could affect their jobs.	Nurse managers and operational managers.	Provide information timeously – provide priority information first and other information later.
	• Lack of proper channels of communication through which to handle conflicts appropriately.	Adopt an open-door policy in order to be approachable in addressing issues in the workplace. Educate staff on the effective prevention and handling of conflict. Schedule conflict management training sessions for nurse managers to equip them to handle the day-to-day conflict situations in the hospitals.	Nurse managers and operational managers Nurse managers and operational managers Heads of departments at central office	Managers at all levels to have set and publicised consulting times Training sessions twice a year. According to the skills development programme of the GDHSD.
Dimension 8: Media Quality:				
	• Inappropriate / inadequate formats of communication	Distribute important information in formal written format (i.e. memorandums, policy statements, procedures). Follow up verbal messages with written messages for verification. Distribute messages through electronic media (i.e. via e-mail or as text messages) as well.	Top managers, nurse managers and operational managers all have a role to play.	All documents of high importance. Every time a verbal message is sent. Every time a verbal/written message is sent.
	• Poor staff attitude during communication with fellow staff members and towards formal forms of communication (i.e. ignoring/ avoiding written information)	Encourage a courteous attitude during all forms of communication in the hospital by being respectful of one another, acknowledging cultural differences and language difficulties. Nurse managers and/or operational managers to conduct unit rounds with junior staff too, to encourage staff commitment to two-way communication. Provide a space on documents where staff can sign after reading the information to ensure that they have received the information.	All categories of nursing staff. Nurse managers can set the example to the juniors. All categories of nursing staff, and once again nurse managers can act as role models for junior staff. Nurse managers and operational managers	During all forms of communication in the hospital. On all documents distributed in the hospital.

5.6 LIMITATIONS OF THE STUDY

The limitations applicable to this study are as follows:

- The questionnaire was available only in English, as English is the official language medium in all government institutions; however, the majority of the respondents do not speak English as their home language.
- The third response alternative of the Likert scale in the questionnaire, namely *indifferent,* appears to have been an unsuitable term, affecting the interpretation of the data. Using the term *uncertain* instead could have facilitated a better understanding of what was expected and would have provided valid data.
- The open-ended items elicited many irrelevant comments. Some of the respondents, for example, used the opportunity to deviate from the topic and commented on job satisfaction. However, this option also seems to have elicited a great deal of useful information of which reference was made in the findings of the study.

5.7 RECOMMENDATIONS FOR FURTHER RESEARCH

In view of the findings of this study, the following recommendations for further research are suggested:

- Similar studies should be conducted within other public health care services in other demographic areas to establish the effectiveness of their communication channels and explore the level of the communication satisfaction of their staff, as valuable information was gathered in the present study.
- A follow-up study is to be conducted at these particular three hospitals a year from the implementation of the recommendations, to determine what changes have been effected in relation to the improvement of communication channels and the level of communication satisfaction of professional nurses.
- Similar studies could be conducted in private health care services to determine the challenges experienced in private hospitals with regard to communication channels and communication satisfaction.
- Qualitative follow-up studies could be performed to elicit more information from respondents, due to the limiting nature of the quantitative methodology of this study.

5.8 CONCLUSION

The researcher conducted this study with the aim of determining what constitutes effective organisational communication and to establish the extent of communication satisfaction amongst professional nurses in selected public hospitals in the City of Johannesburg. A quantitative study with an exploratory and descriptive design was conducted to this end.

A disproportionate stratified sampling method, whereby professional nurses were selected according to nursing rank, was chosen for this study. The response rate was 49% and a total of 130 respondents participated in the study. These professional nurses were requested to complete a questionnaire to assess their levels of communication satisfaction.

From the analysis of the findings of the Communication Satisfaction Questionnaire administered, it is clear that the most noteworthy indicator of communication satisfaction is the organisational integration abilities of the nurse managers and the operational managers, and the level of trust and openness that professional nurses experience between themselves and the operational managers. The study established that professional nurses are experiencing dissatisfaction with a number of communication factors. These factors include the absence of effective two-way communication exchange in the hospitals, a lack of information regarding changes in the health care services, a lack of information on government, GDHSD and South African Nursing Council regulations that affect the health care services, and a lack of information pertaining to the financial standing and achievements or failures of the health care services.

Recommendations were formulated to address the communication dimensions that were rated as unsatisfactory by the three different strata of respondents. Realising these recommendations in the practical setting would demand the involvement and active participation of all stakeholders, from the most senior of managers down to the junior professional nurses – as they will become the supervisors or nurse managers of tomorrow.

REFERENCES

Ackerman, ER & Bezuidenhout, MC. 2007. Staff dissatisfaction in the theatre complex of a private hospital. *Curationis* 30(3):68-73.

Adam, S & Bond, S. 2000. Hospital nurses' job satisfaction, individual and organizational characteristics. *Journal of Advanced Nursing* 32(3):536-543.

Adler, ES & Clark, R. 2003. *How it's done: An invitation to social research* 2nd edition. Belmont, CA: Wadsworth/Thompson Learning.

Afifi, WA. 2007. Nonverbal communication. In Whaley, BB. & Samter, W. (Eds), *Explaining communication. Contemporary theories and exemplars*. Mahwah, New Jersey: Lawrence Erlbaum.

Arries. E. 2006. Humanising the workplace. *Nursing Update* 30(1):33.

Baxter, LA & Babbie, E. 2004. *The basics of communication research*. Belmont: Thomson Wadsworth.

Bell, J. 2007. *Doing your Research Project: A guide for the first-time researchers in education, health and social science*. 4th edition. Open University Press.

Blom, B. Speech delivered at the Nursing 2000 Conference, 4-6 September 2000.

Booyens, SW (ed). 1998. *Dimensions of Nursing Management*. 2nd edition, 10th impression. Kenwyn: Juta.

Booyens, SW (ed). 2008. *Introduction to Health Services Management*. 3rd edition. Cape Town: Juta.

Botma, Y, Greeff, M, Mulaudzi, FM & Wright, SCD. 2010. *Research in Health Sciences*. Cape Town: Pearson Education.

Burns, N & Grove, SK. 2009. *The practice of Nursing Research: Appraisal, Synthesis, and Generation of Evidence*. 6th edition. Philadelphia: Saunders.

Cleary, S. 2003. *The Communication Handbook: A student guide to effective communication*. 2nd edition. Landsdowne: Juta & Co, Ltd.

Cleary, S. 2008. *Communication: A Hands-on Approach*. Landsdowne: Juta & Co, Ltd.

Coffman, J. 2004. *Strategic communication audits*. Prepared for the Communications Consortium Media Centre. From http://www.mediaevaluationproject.org/WorkingPaper1. (Accessed by Jones (2006) 12 October 2005 and by researcher 30 January 2011).

Concise Oxford Dictionary. 2009. 11th edition. Cape Town: Oxford University Press.

Conrad, C & Poole, MS. 2002. *Strategic organizational communication in global economy.* Orlando: Harcourt.

De Vos, AS, Strydom, H, Fouchė, CB & Delport, CSL. 2005. *Research at grass roots for the social sciences and human services professionals.* 3rd edition. Pretoria: Van Schaik.

Democratic Nursing Association of South Africa.1996: Ethical Standards for nurses. Pretoria: DENOSA.

DENOSA, see Democratic Nursing Association of South Africa.

Dhlamini, S. 2012. Job satisfaction. *Nursing Update* 37(7):62-63.

Dolamo, BL. 2008. Transforming health services delivery: the leadership perspective. *Nursing Update*, 32 (4):40-44.

Dolamo, BL & Peprah, EO. 2011. *Contemporary Issues in Health Services Management*. Cape Town: Pearson Education.

Downs, CW & Hazen, MD. 1977. A factor analytic study of communication satisfaction. *The Journal of Business Communication* 14(3):63-73.

Downs, CW & Adrian, AD. 2004. *Assessing organizational communication: Strategic communication audits*. New York: The Guilford Press.

England, S. 2005. *That first day*. 38th Biennial Convention Centre. Sigma Theta Tau International Honour Society of Nursing. Indianapolis, Indiana, USA.

Enslin. P. 2005. Problems in the nursing world. *Nursing Update* 29(4):31.

Fourie, J. 2003. The quality of translation regarding medical research questionnaires. Unpublished MA Thesis, Stellenbosch: University of Stellenbosch.

Gauteng Shared Services Centre. 2011. Performance Management and Development System.

Gray, J & Laidlaw, H. 2004. Improving the measurement of communication satisfaction. *Management Communication Quarterly* 17(3):425-448.

Grohar-Murray, ME & DiCroce, HR. 2003. *Leadership and Management in Nursing*. 3rd edition. New Jersey: Prentice Hall.

Hargie, O & Tourish, D. 2000. *Handbook of communication audits for organisations*. New York: Routledge.

Health Systems Trust, 2005: South Africa facing nursing crisis. Pretoria: DENOSA, p. 2.

HR Statistics. 2011. Statistical analysis reporting template for researchers: Working document HR2011-2. HR Statistics (Pty) Ltd.

James, SV, Kotzé, WJ & Van Rooyen, D. 2005. The relationship experiences of professional nurses with nurse managers. *Health SA Gesondheid* 10(1):4-14.

Jones, CT. 2006. *In search of communication satisfaction at the State Bar of Georgia*. Unpublished Masters Dissertation: Georgia State University.

Jooste, K. (ed). 2009. *Leadership in Health Services Management*. 2nd edition. Cape Town: Juta.

Jooste, K. 2010. *The principles and practice of nursing and health care*. Pretoria: Van Schaick Publishers.

Kekana, HPP, Du Rand, EA & Van Wyk, NC. 2007. Job satisfaction of registered nurses in a community hospital in the Limpopo Province South Africa, *Curationis* 30(2):24-35.

Kreitner, R & Kinicki, A. 2007. *Organisational behaviour*. 7th edition. New York: McGraw Hill.

Landman, WA, Mouton, J & Nevhutalu, KH. 2001. *Chris Hani Baragwanath Hospital Ethics Audit: Research Report No. 2*. Pretoria: Ethics Institute of South Africa.

Lephalala, RP, Ehlers, VJ & Oosthuizen, MJ. 2008. Factors influencing nurses' job satisfaction in selected private hospitals in England. *Curationis* 31(3):60-69.

Lesch, HM. 2007. Lost in translation. *Nursing Update* 31(2):42-44.

Marquis, BL & Huston, CJ. 2012. *Leadership Roles and Management Functions in Nursing: Theory and Application*. Philadelphia: Lippincott Williams & Wilkins.

Mashiane, N. 2006. Who's got the power? *Nursing Update* 30(10):53.

Meintjes, C & Steyn, B. 2006. A critical evaluation of the Downs-Hazen instrument (CSQ) by measuring employee communication satisfaction at a private higher education institution in South Africa. *Communicatio: South African Journal for Communication Theory and Research* 32(1):152-188.

Meyer, SM, Naudé, M, Shangase, NC & Van Niekerk, SE. 2009. *The Nursing Unit Manager: A Comprehensive Guide*. 3rd edition. Sandton: Heinemann Publishers.

Morele, MN. 2005. Job Satisfaction of Registered Nurses in a Selected Public Health care service in Pretoria. Unpublished Masters Dissertation: University of Pretoria.

Mueller, BH & Lee, J. 2002. Leader-member exchange and organizational communication satisfaction in multiple contexts. *Journal of Business Communication* 39(2):220-244.

Muller, ME, Bezuidenhout, MC & Jooste, K. 2006. *Healthcare Service Management*. Cape Town: Juta.

Muller, ME. 2009. *Nursing Dynamics*. 4th edition. Sandton: Heinemann.

National Department of Health (NDOH). 2007. *A policy on quality in health care for South Africa* (Abbreviated version). Pretoria: Government Printers.

Nel, PS, Van Dyk, PS, Haasbroek, GD, Schultz, HB, Sono, TJ & Werner, A. 2004. *Human Resources Management*. New York & Cape Town: Oxford University Press.

Nel, PS, Swanepoel, BJ, Kirsten, M, Erasmus, BJ & Tsabadi, MJ. 2005. *South African Employment Relations: Theory and Practice*. 5th edition. Pretoria: Van Schaik.

Neuman, WL. 2003. *Social Research Methods: Qualitative and Quantitative Approaches*. 5th edition. Boston: Pearson Education, Inc.

Nunnally, JC. 1978. *Psychometric theory.* 2nd edition. New York: McGraw-Hill.

Polit, DE & Beck, CT. 2008. *Nursing Research: Generating and Assessing Evidence for Nursing Practice.* 8th edition. Philadelphia: Lippincott, Williams & Wilkins.

Polit, DE & Beck, CT. 2012. *Nursing Research: Generating and Assessing Evidence for Nursing Practice.* 9th edition. Philadelphia: Lippincott, Williams & Wilkins.

Qolohle, MD, Conradie, HH & Malete, NH. 2006. A qualitative study on the relationship between doctors and nurses offering primary health at KwaNobuhle (Uitenhage), *South African Family Practitioner* 48(1):17a and 17b.

Robbins, SP, Odendaal, A & Roodt, G. 2003. *Organisational behaviour*. Cape Town: Pearson Education.

RSA. *Census*. 2011. From: http://www. Census 2011.gov.za/ © Statistics South Africa, 2012 (accessed 16 November 2012)

Ruff, B, Mzimba, M, Hendrie, S & Broomberg, J. 2011. Reflections on health-care reforms in South Africa. *Journal of Public Health Policy* **32**: S184–S192.

Sengin, KK. 2003. Work-related attributes of registered nurses; jobs satisfaction in acute care hospitals. *Journal of Nursing Administration* 33(6):317-320.

Shader, K, Broome, ME, Broome, CD, West, ME & Nash, M. 2001. Factors influencing satisfaction and anticipated turnover for nurses in an academic medical centre. *Journal of Nursing Administration* 31(4):210-216.

Skiti, VVB. 2009. Barriers in implementing Total Quality Management in Kraaifontein public health care facility in the Western Cape. Mini Masters of Business Administration, University of Stellenbosch.

South Africa. 2003. *Nursing Act, no. 33, 2005*. Pretoria: Government Printer.

South African Nursing Council. 2012. Statistics for 2011. From: http://www.sanc.co.za/ ©2011 (accessed 29 May 2012).

Steinberg, S. 2007. *An Introduction to Communication Studies*. Cape Town: Juta & Co. Ltd.

Sullivan, EJ & Decker, PJ. 2009. *Effective Leadership and Management in Nursing*. 7th edition. London: Pearson Prentice Hall.

Terre Blanche, M, Durrheim, K & Painter, D. 2006. *Research in Practice: applied methods for the social sciences*. 2nd edition. Cape Town: University of Cape Town Press.

Trenholm, S. 2011. *Thinking through communication: An introduction to the study of human communication*. 6th edition. USA: Pearson Education, Ltd.

Tsai, M-T, Chuang, S-S & Hsieh, W-P. 2009. An integrated process model of communication satisfaction and organizational outcomes. *Social Behaviour and Personality: An international journal* 37(6):825-834.

Tzeng. H. 2002. Satisfying nurses on job factors they care about: a Taiwanese perspective. *Journal of Nursing Administration* 32(6):306-309.

Van Staden, E, Marx, S & Erasmus-Kritzinger, L. 2002. *Corporate communication: Getting the message across in business*. Pretoria: Van Schaik.

Von Holdt, K & Maseramule, B. 2005. 'After apartheid: decay or reconstruction in a public hospital?' in Webster, Edward & Karl von Holdt (eds.) *Beyond the Apartheid workplace: studies in* transition. Scottsville: University of KwaZulu-Natal Press.

Watson, R, McKenna, H, Cowman, S & Keady, J. 2008. *Nursing Research: Designs and Methods*. Philadelphia: Churchill Livingstone.

Wood, JT. 2006. *Communication mosaics. An introduction to the field of communication*. 4th edition. Belmont, CA: Thomson Wadsworth.

Yoder-Wise, PS. 2003. *Leading and Managing in Nursing*. 3rd edition. St. Louis: Mosby.

Yoder-Wise, PS. 2011. *Leading and Managing in Nursing*. 5th edition. St. Louis: Mosby.

Zuma, SM. 2007. Quality workplace = Quality patient care. *Nursing Update* 31(5):52.

ANNEXURE A:

PERMISSION FROM THE HIGHER DEGREE COMMITTEE OF THE DEPARTMENT OF HEALTH STUDIES, UNIVERSITY OF SOUTH AFRICA

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC 57/2011

Date of meeting: 2 December 2011 Student No: 3096-473-3

Project Title: Communication satisfaction of professional nurses working in selected public health care services in the City of Johannesburg.

Researcher: JD Wagner

Degree: MA Health Studies Code: DIS702M

Supervisor: Prof MC Bezuidenhout
Qualification: D Litt et Phil
Joint Supervisor: Prof JH Roos

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof E Potgieter
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Prof MC Bezuidenhout
For **ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE B:

PERMISSION FROM THE GAUTENG DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

Concept letter for Permission to conduct a Research study

To: Me. Sue Le Roux
Office of the Director: Policy, Planning and Research
GAUTENG DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT (GDHSD)
37 Sauer Street
Marshalltown
Johannesburg
2001

From: Student: Mr. J-D. Wagner
Degree: M.A. (Health Studies) student
Student No: 3096-473-3
Institution: UNISA

Date: 2011-08-31

Re: **Request for permission to conduct a research study**

Permission is hereby requested from the GDHSD by the research student, Mr. J-D. Wagner to conduct research within selected public hospitals in the city of Johannesburg. I am a Masters' degree student at the University of South Africa, under the supervision of Prof. M.C. Bezuidenhout and Prof. J.H. Roos.

The title of the study is: **COMMUNICATION SATISFACTION OF PROFESSIONAL NURSES WORKING IN SELECTED PUBLIC HEALTH CARE SERVICES IN THE CITY OF JOHANNESBURG**.

The research objectives are to:

- establish what constitutes effective formal organisational communication.
- explore to what extent the professional nurses in public health care services are satisfied with the existing formal communication processes.
- develop guidelines for the improvement of formal communication processes within the public health care services.

The researcher envisages utilising a total of 250 Professional nurses (that adhere to the set inclusion criteria for the population) from three hospitals in the city of Johannesburg as target population.

Ethical clearance for this study was obtained from the University of South Africa and the ethical clearance number is: **HSHDC 57/2011** .

Findings of the study will benefit the health services concerned as well as the broader Department of Health. There will be no risk for participants and confidentiality will be guaranteed. The identity of the participants will not be revealed when the results of the study are published. Participants reserve the right to autonomy and can withdraw without penalty at any stage of the research. The data will only be available to the researcher, supervisors and statisticians to ensure confidentiality. Results of the study will be made available to the GDOH.

This request is accompanied by copies of relevant documentation as stated below:

- Research proposal.
- Data collection instrument (Questionnaire).
- Consent form for Participants in the study.
- Cover letter to Participants of the study.
- Approval letter from the Higher Degree Committee of the University of South Africa.
- Gauteng Department of Health (GDOH) Proposal Evaluation Form.

I trust that my application will receive your favourable consideration.

Yours faithfully,

Mr. J-D. Wagner

Cell phone: 083 235 6674
Telephone: (011) 665 9146
E-mail address: jdwagner8@gmail.com

Prof. M.C. Bezuidenhout: (012) 429 6369
Prof. J.H. Roos: (012) 429 6447

CONDITIONS OF APPROVAL OF A RESEARCH STUDY PROPOSAL

health and social development
Department: Health and Social Development
GAUTENG PROVINCE

Vision of the Department

"To be the best provider of quality health and social services to the people in Gauteng"

POLICY, PLANNING AND RESEARCH (PPR)
Enquiries: Dr B Ikalafeng
Tel: +2711 355 3500
Fax: +2711 355 3675 Email: Bridget.Ikalafeng@gauteng.gov.za

CONTACT DETAILS OF THE RESEARCHER	
Date	06 February 2012
Contact number	n/a
Email	JD.Wagner@gauteng.gov.za
Researcher /Principal investigator (PI)	J-D Wagner
Supervisor	Prof M.C Bezuidenhout
Institution	University of South Africa
Research title	Communication satisfaction of Professional nurses working in selected public health care services in the city of Johannesburg.

This approval is granted only for a research proposal submitted to GDHSD by J-D Wagner entitled "Communication satisfaction of Professional nurses working in selected public health care services in the city of Johannesburg."

Approval is hereby granted by the Gauteng Department of Health and Social Development for the above mentioned research study proposal for a study to be conducted within GDHSD domain. Approval is limited to compliance with the following terms and conditions:

1. All principles and South African regulations pertaining to ethics of research are observed and adhered to by all involved in the research project. Ethics approval is only acceptable if it has been provided by a South African research ethics committee which is accredited by the National Health Research Ethics Council (NHREC) of South Africa; this is regardless of whether ethics approval has been granted elsewhere.

   Of key importance for all researchers is that they abide by of all research ethics principles and practice relating to human subjects as contained in the Declaration of Helsinki (1964, amended in 1983) and the constitution of the Republic of South Africa in its entirety. Declaration of Helsinki upholds the following principles when conducting research, respect for:
   - Human dignity;
   - Autonomy;
   - Informed consent;
   - Vulnerable persons;
   - Confidentiality;
   - Lack of harm;
   - Maximum benefit;
   - and justice

2. The GDHSD is indemnified from any form of liability arising from or as a consequence of the process or outcomes of any research approved by HOD and conducted within the GDHSD domain;
3. Researchers commit to providing the GDHSD with periodic progress and a final report; short term projects are expected to submit progress reports on a more frequent basis and all reports must be submitted to the Director: Policy, Planning and Research of the GDHSD;
4. The Principal Investigator shall promptly inform the above mentioned office of changes of contact details or physical address of the researching individual, organisation or team;
5. The Principal Investigator shall inform the above office and make arrangements to discuss their findings with GDHSD prior to dissemination;
6. The Principal Investigator shall promptly inform the above mentioned office of any adverse situation which may be a health hazard to any of the participants;
7. The Principal Investigator shall request in writing authorization by the HOD via PPR for any intended changes of any form to the original and approved research proposal;
8. If for any reason the research is discontinued, the Principal Investigator must inform the above mentioned office of the reasons for such discontinuation;
9. A formal research report upon completion should be submitted to the Director: Policy, Planning and Research of the GDHSD with recommendations and implications for GDHSD, the Directorate will make this report available for the HOD.

This approval is granted only for a research proposal submitted to GDHSD by J-D Wagner entitled "Communication satisfaction of Professional nurses working in selected public health care services in the city of Johannesburg."

AGREEMENT BETWEEN THE GAUTENG DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT (GDHSD) AND THE RESEARCHER

Ms Sue le Roux
Director: Policy Planning and Research

Date: 8/02/2012

Signature:

Name and surname of Principal Researcher

Research/Academic Institution

Date:

Signature:

This approval is granted only for a research proposal submitted to GDHSD by J-D Wagner entitled "Communication satisfaction of Professional nurses working in selected public health care services in the city of Johannesburg. "

ANNEXURE C:

PERMISSION FROM THE CHIEF EXECUTIVE OFFICERS OF THE SELECTED HOSPITALS

GAUTENG PROVINCE
HEALTH AND SOCIAL DEVELOPMENT
REPUBLIC OF SOUTH AFRICA

HELEN JOSEPH HOSPITAL

Mr. J.D Wagner
M.A. (Health Studies) Student
UNISA

Dear Mr. Wagner

RE: **"Communication satisfaction of professional nurses working in selected Public Health care Services in the City of Johannesburg"**

Permission is granted for you to conduct the above research as described in your request provided:

1. Helen Joseph Hospital will not anyway incur or inherit costs as a result of the said study.
2. Your student shall not disrupt service at the study sites.
3. Strictly confidentiality shall be observed at all time.
4. Informed consent shall be solicited from patients participating in your study.

Please liaise with the Head of Department and Unit Manager or Sister in Charge to agree on the dates and time that would suit all parties.

Kindly forward this office with the results of your study on completion of the research.

Yours sincerely

pp Mhakalala.

Ms. JV Jordan
Assistant Director- Nursing

health and social development
Department: Health and Social Development
GAUTENG PROVINCE

RAHIMA MOOSA HOSPITAL

Office of the CEO
Rahima Moosa Hospital

Mr JD Wagner
M.A. (Health Studies) Student
UNISA

Dear Mr. Wagner

RE: "Communication satisfaction of professional nurses working in selected Public Health care Services in the City of Johannesburg"

Permission is granted for you to conduct the above research as described in your request provided:

1. Rahima Moosa Hospital will not in any way incur or inherit costs as a result of the said study.
2. Your study shall not disrupt services at the study sites.
3. Strict confidentiality shall be observed at all times.
4. Informed consent shall be solicited from patiens participating in your study.

Please liaise with the Head of Department and Unit Manager or Sister in Charge to agree on the dates and time that would suit all parties.

Kindly forward this office with the results of your study on completion of the research.

Yours sincerely,

Nursing Service Manager
Rahima Moosa Hospital

health and social development
Department: Health and Social Development
GAUTENG PROVINCE

CHARLOTTE MAXEKE JOHANNESBURG ACADEMIC HOSPITAL

Office of the CEO
Enquiries: L. Mngomezulu
(011): 488-3793
(011) 488-3753
14th February 2012

Mr. J.D. Wagner
M.A. (Health Studies) Student
UNISA

Dear Mr. Wagner

RE: "Communication satisfaction of professional nurses working in selected Public Health care Services in the City of Johannesburg"

Permission is granted for you to conduct the above research as described in your request provided:

1. Charlotte Maxeke Johannesburg Academic hospital will not in anyway incur or inherit costs as a result of the said study.
2. Your study shall not disrupt services at the study sites.
3. Strict confidentiality shall be observed at all times.
4. Informed consent shall be solicited from patients participating in your study.

Please liaise with the Head of Department and Unit Manager or Sister in Charge to agree on the dates and time that would suit all parties.

Kindly forward this office with the results of your study on completion of the research.

Yours sincerely

Dr. T.E. Selebano
Chief Executive Officer

ANNEXURE D:

PERMISSION FROM THE CREATOR OF THE ORIGINAL CSQ, TO USE AND ADAPT THE CSQ FOR THE PURPOSES OF THE STUDY

Requesting permission to use CSQ from the original creator Dr Cal W. Downs

Dr Downs

Good afternoon

I am a student from the University of South Africa, currently studying towards my Master's degree in Health Studies.

The title of my study is: COMMUNICATION SATISFACTION OF PROFESSIONAL NURSES WORKING IN SELECTED PUBLIC HEALTH CARE SERVICES IN THE CITY OF JOHANNESBURG.

For the purposes of this study I intend on using the Communications Satisfaction Questionnaire (CSQ) developed by you. My promoters have advised me to seek permission for the use of this communications audit instrument from the original creators and hence my application to you for permission to utilise this instrument for the purposes of data collection in my study. I also intend on adapting the instrument to suit the public health service organisation terrain in South Africa.

Whilst awaiting a reply from you I have taken the liberty of adapting the original questionnaire to suit the purposes of my study. Please peruse through the attached adapted questionnaire and feel free to advise me on the amendments that I have made to the original questionnaire.

Please rest assured that I have not administered this questionnaire to any of my intended study population as of yet, as I am awaiting your permission to do so. You will note that I have also coded the questionnaire for statistical purposes.

Feel free to contact me any time in regards to this request as I am quite eager to commence my data collection process.

If you require any further information, I would kindly oblige.

My student details are:

Name: Mr J-D Wagner
University: University of South Africa (UNISA)
Student number: 3096-473-3
Promotor: Prof. M.C. Bezuidenhout (mcbezuidenhout@telkonsa.net)
Vice Promotor: Prof. J.H. Roos (roosjh@unisa.ac.za)
Address: Mr J-D Wagner
62 Van Ryneveld Street
Dan Pienaarville
Krugersdorp
1739
Gauteng
South Africa
Mobile: +27 (0)83 235 6674
e-mail address: jdwagner8@gmail.com

Dear JD:

I am willing to give people permission to use the ComSat if they agree in writing to the following conditions.

1. This is a one-time permission.
2. The instrument will be used for an educational research only; it may not be used for consulting.
3. You will furnish me a copy of the report.
4. You will not publish IN ANY FORM the factor structure. This is proprietary information.

With kindest regards,

Cal W. Downs, Ph.D.
Communication Management, Inc.
785-550-9080
Communication Management, Inc.

LETTER OF AGREEMENT TO CONDITIONS FOR USE OF COMSAT SURVEY

15 September 2011

To: Cal W. Downs, Ph.D.
Communication Management, Inc.
785-550-9080
Communication Management, Inc

Herewith I, J-D Wagner (Master's degree student at the University of South Africa) declare that I understand and agree to the conditions set as prerequisite for permission to use the ComSat survey created by you. The conditions I agree to stipulate that:

1. This is a one-time permission.
2. The instrument will be used for an educational research only; it may not be used for consulting.
3. I will furnish Dr C.W. Downs a copy of the report.
4. I will not publish IN ANY FORM the factor structure, as this is proprietary information.

Thanking you in advance for your kind consideration of my request to use the ComSat survey for my research.

Kind Regards,

J-D Wagner

University of South Africa

Student number: 3096-473-3

Mobile: (027)-083-235-6674

E-mail: jdwagner8@gmail.com

Reply from Dr C.W. Downs on 17 September 2011

J-D Wagner:

Your permission letter is fine. Go ahead with the study.

Cal W. Downs, Ph.D.
Communication Management, Inc.

ANNEXURE E:

QUESTIONNAIRE

Questionnaire

Questionnaire No.	Office use only	
	V 1 ☐☐☐	1-3

Title: Communication Satisfaction Questionnaire

Aim: The purpose of this questionnaire is to determine the level of communication satisfaction among professional nurses working in public health services in the city of Johannesburg.

Instructions:

1. Complete the questionnaire by marking the most appropriate space on the scale below with an **X** e.g.

	Aspects of information often associated with a persons' job:	Level of satisfaction					Office use only
		Very dissatisfied	Dissatisfied	Indifferent	Satisfied	Very satisfied	
Item No.	Item						
1	Extent to which I am satisfied with information content	1	2	3	X	5	

2. Please complete all the questions.

3. Do not write in the "**office use only**" sections.

4. Only indicate one choice/ answer per question.

5. This questionnaire consists of **5** (five) pages.

Section A: Biographical Information

1. Age:

Item No.	Item	Indicate one choice	Office use only	
1.1	Under 20		V2 ☐	4
1.2	21-29			
1.3	30-39			
1.4	40-49			
1.5	50-59			
1.6	+ 60			

2. Gender:

Item No.	Item	Indicate one choice	Office use only	
2.1	Male		V3 ☐	5
2.2	Female			

3. Current nursing position/ position held:

Item No.	Item	Indicate one choice	Office use only	
3.1	Deputy Director of Nursing (**DD**)		**V4** ☐	**6**
3.2	Assistant Director of Nursing (**AD**)			
3.3	Chief Professional Nurse (**CPN**)			
3.4	Senior Professional Nurse (**SPN**)			
3.5	Professional Nurse (**PN**)			

4. Duration in health care service and position

Item No.	Item	Indicate one choice	Office use only	
4A. Period working in current health care service:				
4.1	Less than 1 year		**V5** ☐	**7**
4.2	1 – 4 years			
4.3	5 –8 years			
4.4	9+ years			
4B. Period in current position:				
4.5	Less than 1 year		**V6** ☐	**8**
4.6	1 – 4 years			
4.7	5 –8 years			
4.8	9+ years			

5. Type of nursing unit you are working in:

Item No.	Item	Indicate one choice	Office use only	
5.1	Medical		**V7** ☐	**9**
5.2	Surgical			
5.3	ICU			
5.4	Operating room/ CSSD			
5.5	OPD/ Casualty			
5.6	Administrative/ Office			

6. Highest educational qualification:

Item No.	Item	Indicate one choice	Office use only	
6.1	Basic diploma (i.e. R386 or R425)		**V8** ☐	**10**
6.2	Post Basic diploma (i.e. ICU or PHC)			
6.3	Basic degree (i.e. B. Cur)			
6.4	Post Basic degree (i.e. Honours or Masters)			

7. **Home Language**:

Item No.	Item	Indicate one choice	Office use only	
7.1	isiZulu		**V9** ☐	**11**
7.2	isiXhosa			
7.3	Afrikaans			
7.4	Setswana			
7.5	Sepedi			
7.6	English			
7.7	Sesotho			
7.8	Xitsonga			
7.9	siSwati			
7.10	isiNdebele			
7.11	Tshivenda			

Section B: Information related to your job

Listed below in the table are several kinds of information often associated with the job of an individual. Please indicate how satisfied you are with the amount and/or quality of each kind of information below:		Level of satisfaction					Office use only	
Item No.	Item	Very dissatisfied	Dissatisfied	Indifferent	Satisfied	Very satisfied		
8	Information about your progress in your job.	1	2	3	4	5	V10☐	12
9	News regarding personnel.	1	2	3	4	5	V11☐	13
10	Information about hospital policies and goals.	1	2	3	4	5	V12☐	14
11	Information about how your job performance compares with others.	1	2	3	4	5	V13☐	15
12	Information about how you are being performance managed.	1	2	3	4	5	V14☐	16
13	Recognition of your efforts.	1	2	3	4	5	V15☐	17
14	Information about departmental policies and goals.	1	2	3	4	5	V16☐	18
15	Information about the requirements of your job.	1	2	3	4	5	V17☐	19
16	Information about government regulations affecting your hospital.	1	2	3	4	5	V18☐	20
17	Information about changes in your hospital.	1	2	3	4	5	V19☐	21
18	Reports on how problems in your job are being handled.	1	2	3	4	5	V20☐	22
19	Information about employee benefits and pay.	1	2	3	4	5	V21☐	23
20	Information about profits and/or financial standing of the hospital.	1	2	3	4	5	V22☐	24
21	Information about achievements and/or failures of your hospital.	1	2	3	4	5	V23☐	25

Section C: Communication Satisfaction issues

Please indicate how satisfied you are with following:		Level of satisfaction					Office use only	
Item No.	Item	Very dissatisfied	Dissatisfied	Indifferent	Satisfied	Very satisfied		
22	Extent to which your managers/supervisors understand the problems faced by staff.	1	2	3	4	5	V24☐	26
23	Extent to which your hospital's communication motivates you to meet its goals.	1	2	3	4	5	V25☐	27
24	Extent to which your supervisor listens and pays attention to you.	1	2	3	4	5	V26☐	28
25	Extent to which hospital employees have communication abilities.	1	2	3	4	5	V27☐	29
26	Extent to which your supervisor offers guidance for solving job-related problems.	1	2	3	4	5	V28☐	30
27	Extent to which communication in your hospital make you identify with it or feel a vital part of it.	1	2	3	4	5	V29☐	31
28	Extent to which your hospital communications are interesting and helpful.	1	2	3	4	5	V30☐	32
29	Extent to which your supervisor trusts you.	1	2	3	4	5	V31☐	33
30	Extent to which you receive the information required to do your job in time.	1	2	3	4	5	V32☐	34
31	Extent to which conflicts are handled appropriately through proper communication channels.	1	2	3	4	5	V33☐	35
32	Extent to which the informal communications network (grapevine) is active in your hospital.	1	2	3	4	5	V34☐	36
33	Extent to which your supervisor is open to ideas.	1	2	3	4	5	V35☐	37
34	Extent to which communication with other employees at your level is accurate and free flowing.	1	2	3	4	5	V36☐	38
35	Extent to which communication practices are adaptable to emergencies.	1	2	3	4	5	V37☐	39
36	Extent to which your work group is compatible.	1	2	3	4	5	V38☐	40
37	Extent to which your meetings are well organised.	1	2	3	4	5	V39☐	41
38	Extent to which the amount of supervision given you is about right.	1	2	3	4	5	V40☐	42
39	Extent to which written directives and reports are clear and concise.	1	2	3	4	5	V41☐	43
40	Extent to which the attitudes toward communication at your hospital are basically healthy.	1	2	3	4	5	V42☐	44
41	Extent to which informal communication is active and accurate.	1	2	3	4	5	V43☐	45
42	Extent to which the amount of communication at your hospital is about right.	1	2	3	4	5	V44☐	46

Section D: Communication responsibilities of the manager

For the next five questions, indicate your satisfaction with the following only if you are responsible for staff as a manager or supervisor:		Level of satisfaction					Office use only	
Item No.	Item	Very dissatisfied	Dissatisfied	Indifferent	Satisfied	Very satisfied		
43	Extent to which your staff are responsive to downward-directive communication.	1	2	3	4	5	V45☐	47
44	Extent to which your staff anticipate your needs for information.	1	2	3	4	5	V46☐	48
45	Extent to which you can avoid having communication overload.	1	2	3	4	5	V47☐	49
46	Extent to which your staff are receptive to evaluations, suggestions and criticisms.	1	2	3	4	5	V48☐	50
47	Extent to which your staff feel responsible for initiating accurate upward communication.	1	2	3	4	5	V49☐	51

Section E: Opinion of all respondents

Item No.	Item	Office use only
48	**If the communication associated with your job could be changed in any way to make you more satisfied, please indicate how.**	

Item No.	Item	Office use only
49	**Please indicate in the space provided below whether you have any other comments on the communication satisfaction that you experience in your nursing unit and/or hospital, (except for what you indicated in the questionnaire above).**	

THANK YOU FOR TAKING THE TIME TO PARTICIPATE IN THIS SURVEY.

ANNEXURE F:

THE COVERING LETTER AND RESPONDENT'S CONSENT

62 Van Ryneveld Street
Dan Pienaarville
Krugersdorp
1739

Dear Participant

Information and Informed Consent

You are invited to voluntarily participate in a research study entitled: "Communication satisfaction of professional nurses working in selected public health care services in the city of Johannesburg". I am currently a student undertaking my master's degree at the University of South Africa (UNISA), under Prof. M.C. Bezuidenhout and Prof. J.H. Roos.

This study will explore your perceptions on your satisfaction with formal communication processes in your health service, and will lead to guidelines for professional nurses to improve communication processes.

The provided questionnaire will be used as means of collecting information from you in order to develop understanding of your perceptions regarding your satisfaction with communication processes in your health care service. Completing this questionnaire will take approximately 30 minutes of your time.

The study will not cause any harm and is completely confidential. Your identification and details will be protected throughout the research process and with publication of the results. All information will be stored in a safe place for at least two years after the report has been published and no one but the research team will have access to it. You reserve the right to withdraw from the study at any time.

If you have any questions, the following persons are available to be contacted:

Researcher:	J-D Wagner	083 235 6674
Supervisor:	Prof. M.C. Bezuidenhout	012 429 6369
Co-supervisor	Prof. J.H. Roos	012 429 6447

Your participation will be appreciated,
J-D Wagner

Researcher:  **Date:** 01 August 2011

Consent by the participant:

I ....., have been fully informed of the purpose and the procedure to follow for this study entitled: "Communication satisfaction of professional nurses working in selected public health care services in the city of Johannesburg". I also understand that my participation is completely voluntary and that I reserve the right not to participate or to withdraw from the study at any time should I wish to do so. I understand that if I have any questions at any time, they will be answered. I hereby voluntarily consent to take part in this research study.

Participant: ..... **Date:** .....