

**THE PERCEPTIONS OF NURSES REGARDING COMMUNICATION WITH NURSE  
MANAGERS IN A PUBLIC HOSPITAL IN WESTRAND IN GAUTENG PROVINCE**

by

**NYAKU ELIZABETH MANANISO**

submitted in accordance with the requirements

for the degree of

**MASTER OF ARTS**

in the subject

**HEALTH STUDIES**

at the

**UNIVERSITY OF SOUTH AFRICA**

SUPERVISOR: PROF ZZ NKOSI

January 2015

**STUDENT NUMBER: 47962356**

**DECLARATION**

I declare that **THE PERCEPTIONS OF NURSES REGARDING COMMUNICATION WITH NURSE MANAGERS IN A PUBLIC HOSPITAL IN WESTRAND IN GAUTENG PROVINCE** is my own work and that all the sources that I have quoted in the study have been acknowledge throughout the context and by means of complete references. This work has not been submitted before for any degree at any institution of higher learning.

A handwritten signature in black ink, appearing to read 'Mananiso', is enclosed in a thin black rectangular border.

Nyaku Elizabeth Mananiso

**Full Names**

January 2015

**Date**

# **THE PERCEPTIONS OF NURSES REGARDING COMMUNICATION WITH NURSE MANAGERS IN A PUBLIC HOSPITAL IN WESTRAND IN GAUTENG PROVINCE**

STUDENT NUMBER: 47962356  
NAME: NYAKU ELIZABETH MANANISO  
DEGREE: MASTERS IN ARTS  
DEPARTMENT: HEALTH STUDIES  
INSTITUTION: UNIVERSITY OF SOUTH AFRICA  
SUPERVISOR: PROF ZZ NKOSI

## **ABSTRACT**

The aim of the study was to explore the perceptions of nurses regarding communication with nurse managers in the workplace. The design of the study was a generic qualitative. The methodology of choice was qualitative, explorative method. The sample was non-probability and the approach or technique used was purposive sampling method. It comprised of thirty nurses, ten of each category. The category was a component of professional nurses, enrolled nurses and enrolled nursing auxiliary nurses.

The data collection method used in the study was in-depth interviews using a self-designed interview guide. Face to face interviews was conducted in a quiet room within the hospital ward as a natural setting. Data was collected using a voice recorder for the sake of protecting the missing of information which may be important. The data analysis was with the help of employing transcribing and coding of voice recorded data and observation noted during the collection of data.

The findings showed that there were dynamics in communication from all nurse categories and that also indicated that there was a need to conduct a research so that the root cause may be identified and suggestions to be put in place to curb the challenges.

In conclusion it showed that communication is the key problem of all and it is a worldwide problem.

### **Key words:**

Communication; nurse managers; nurses; perceptions.

## **ACKNOWLEDGEMENTS**

- The first acknowledgement goes to the Almighty, the creator who gave me strength and wisdom to conduct the study under His protection and guidance. He gave me focus mind and perseverance to complete the study.
- A special thanks to my supervisor Prof ZZ Nkosi, its being a blessing to be granted and awarded a person of your calibre by God. Your support, guidance, mentoring displayed a caring attitude that fosters and encouraged the will to go on. It has been through your presence as my mentor that all things became possible. May the Creator shower you with good heart and abundant blessing in all your endeavours.
- The CEO of the hospital, Mr GJ Dube, Nursing Service Manager, Mrs M Khoza for allowing me to conduct the study within the hospital premises. It really showed that you have a mission and vision in improving the institution.
- My immediate supervisors Mrs N Serunye, Mrs S Khasake and Mrs M Bottoman for continuous guidance and support by displaying excitement which gave me the will to go on.
- The nurse managers in the ward, who permitted the nurse participants to show up during the interviews despite the busy ward duties, they were supposed to carry out.
- The nurse participants, who managed to partake in the interview. Your contribution was highly appreciated and valued and will always respect the diligence you have displayed.
- A special thanks to my family, relatives and friends for sensitising me of my career goals, continuous support and accepting a compromise for family quality time.
- To my friends Matheko Moletsane, Zozo Monageng, Disebo Sefihlolo and Daisy Masopye thank you for inspiring me and always being courageous.
- The editor, Professor Masemola for a sterling job.
- Mrs Rina Coetzer for editing and formatting my document.

**MAY THE GOOD LORD BLESS YOU ALL ABUNDANTLY**

## *Dedication*

*This study is dedicated to my dad, Mr Edward Doctor Mananiso who  
instilled courage and hope to my academic success*

# TABLE OF CONTENTS

## Chapter 1

### Orientation to the study

1.1	INTRODUCTION .....	1
1.2	BACKGROUND TO THE RESEARCH PROBLEM .....	2
1.3	STATEMENT OF THE RESEARCH PROBLEM.....	4
1.4	DEFINITION OF KEY CONCEPTS .....	5
1.4.1	Nurse manager .....	5
1.4.2	Nurses .....	6
1.4.3	Communication.....	6
1.4.4	Perceptions.....	7
1.5	RESEARCH AIM/PURPOSE .....	7
1.6	RESEARCH OBJECTIVES.....	7
1.7	RESEARCH QUESTIONS.....	8
1.8	PARADIGM.....	8
1.9	RESEARCH DESIGN .....	9
1.10	SAMPLING .....	9
1.10.1	Site sampling .....	9
1.10.2	Data source sampling .....	10
1.11	POPULATION.....	10
1.11.1	Participants' target population .....	10
1.11.2	Participants' sample frame .....	10
1.11.3	Participants' sampling technique .....	10
1.11.4	Sample size .....	11
1.12	DATA COLLECTION .....	11
1.12.1	The data collection instrument.....	11
1.12.2	Administering the data collection instrument .....	11
1.12.3	Data analysis .....	12
1.12.4	Data and design quality .....	12
1.12.4.1	Credibility.....	12
1.12.4.2	Confirmability .....	12
1.12.4.3	Dependability.....	13
1.12.4.4	Transferability.....	13
1.13	ETHICAL CONSIDERATIONS .....	13

1.13.1	Participants/human data sources.....	13
1.13.2	Process to obtain informed consent.....	13
1.13.3	Steps to take in case of adverse events .....	14
1.13.4	The institution site.....	14
1.13.5	The scientific integrity of the research .....	14
1.13.6	Domain specific ethical issues.....	14
1.14	SIGNIFICANCE OF STUDY .....	16
1.15	SCOPE AND LIMITATIONS .....	16
1.16	CONCLUSION.....	16

## Chapter 2

### Literature study

2.1	INTRODUCTION .....	18
2.2	THE DEFINITION AND MEANING OF COMMUNICATION .....	19
2.3	DEFINITION OF PERCEPTIONS IN COMMUNICATION .....	21
2.4	COMMUNICATION TYPES/FORMS .....	25
2.5	STRATEGIES OF COMMUNICATION .....	26
2.6	COMMUNICATION STYLES.....	28
2.7	ADVANTAGES OF EFFECTIVE COMMUNICATION.....	29
2.8	BARRIERS OF EFFECTIVE COMMUNICATION.....	29
2.8	CONCLUSION.....	30

## Chapter 3

### Research methodology

3.1	INTRODUCTION .....	31
3.1.1	The research paradigm.....	31
3.2	METHODOLOGY .....	34
3.3	RESEARCH DESIGN.....	37
3.4	POPULATION AND SAMPLING.....	39
3.4.1	Population.....	39
3.4.2	Sampling.....	40
3.5	ETHICAL CONSIDERATIONS .....	42

3.5.1	Autonomy.....	43
3.5.2	Informed consent and voluntary participation .....	44
3.5.3	Confidentiality, privacy and anonymity.....	45
3.5.4	Privacy .....	46
3.5.5	Beneficence and prevention of harm .....	48
3.5.5.1	Psychological harm.....	49
3.5.5.2	Emotional harm.....	49
3.5.6	Justice.....	50
3.6	TRUSTWORTHINESS .....	51
3.6.1	Credibility.....	51
3.6.2	Confirmability .....	52
3.6.3	Dependability.....	53
3.6.4	Transferability.....	54
3.7	DATA COLLECTION .....	55
3.7.1	Administration the data collection instrument .....	59
3.7.2	Conducting the interview .....	60
3.8	DATA ANALYSIS.....	62
3.8.1	Collection and recording data .....	64
3.8.2	Managing data .....	65
3.8.3	Reading and memoing.....	65
3.8.4	Describing, classifying and interpreting .....	66
3.8.5	Representing and visualising.....	66
3.8.5.1	Themes.....	67
3.8.5.2	Sub-themes .....	67
3.8.5.3	Excerpts.....	67
3.8.6	Coding of data in data analysis.....	67
3.8.7	Transcribing interviews and reducing data .....	68
3.8.7.1	Transcribing process .....	69
3.9	CONCLUSION.....	70

## Chapter 4

### Data analysis and interpretation of research findings

4.1	INTRODUCTION .....	71
4.2	DEMOGRAPHICS OF THE RESEARCH PARTICIPANTS .....	72
4.3	CODING FINDINGS .....	72
4.3.1	Coding .....	72
4.4	SIMILARITIES AND DIFFERENCES OF COMMUNICATION PERCEPTIONS .....	74

4.4.1	Perceptions of communication according to professional nurses .....	74
4.4.2	Perceptions of communication according to enrolled nurses .....	76
4.4.3	Perceptions of communication according to enrolled nursing auxiliary nurses .....	77
4.5	THE THEMES, SUB-THEMES AND EXCERPTS .....	78
4.5.1	Theme A: Meaning .....	79
4.5.1.1	Sub-theme 1: Tool .....	80
4.5.1.2	Sub-theme 2: Exchange .....	80
4.5.1.3	Sub-theme 3: Passing of message .....	81
4.5.1.4	Sub-theme 4: Meaningless .....	81
4.5.2	Theme B: Feelings.....	81
4.5.1.2	Sub-theme 1: Mistrust.....	83
4.5.2.2	Sub-theme 2: Hopelessness.....	83
4.5.2.3	Sub-theme 3: Helplessness.....	83
4.5.2.4	Sub-theme 4: Despondency .....	84
4.5.2.5	Sub-theme 5: Inferiority complex .....	84
4.5.2.6	Sub-theme 6: Mood fluctuation.....	84
4.5.2.7	Sub-theme 7: Pain .....	85
4.5.2.8	Sub-theme 8: Hurt .....	85
4.5.2.9	Sub-theme 9: Fear.....	86
4.5.2.10	Sub-theme 10: Anger.....	86
4.5.3	Theme C: Behaviour.....	86
4.5.3.1	Sub-theme 1: Isolation.....	87
4.5.3.2	Sub-theme 2: Unapproachable .....	88
4.5.3.3	Sub-theme 3: Aggressive .....	88
4.5.3.4	Sub-theme 4: Avoidance .....	89
4.5.3.5	Sub-theme 5: Poor communication.....	90
4.5.3.6	Sub-theme 6: Bullying.....	92
4.5.3.7	Sub-theme 7: Inaction.....	93
4.5.3.8	Sub-theme 8: Defense mechanism.....	93
4.5.3.9	Sub-theme 9: Negativity .....	94
4.5.4	Theme D: Communication skills .....	94
4.5.4.1	Sub-theme 1: Non-verbal communication.....	95
4.5.4.2	Sub-theme 2: Listening skills .....	96
4.5.4.3	Sub-theme 3: Mannerisms.....	97
4.5.4.4	Sub-theme 4: High pitched voice.....	98
4.5.5	Theme E: Competence.....	98
4.5.5.1	Sub-theme 1: Incompetence.....	99
4.5.5.2	Sub-theme 2: Poor interpretation.....	100
4.5.6	Theme F: Professionalism .....	101
4.5.6.1	Sub-theme 1: Privacy .....	102
4.5.6.2	Sub-theme 2: Confidentiality.....	103
4.5.6.3	Sub-theme 3: Gossiping .....	103

4.5.7	Theme G: Effects/Consequences .....	104
4.5.7.1	Sub-theme 1: Laziness .....	105
4.5.7.2	Sub-theme 2: Grudges .....	105
4.5.7.3	Sub-theme 3: Conflicts .....	105
4.5.7.4	Sub-theme 4: Absenteeism .....	106
4.5.7.5	Sub-theme 5: Resignation .....	109
4.5.7.6	Sub-theme 6: Quitting nursing .....	110
4.6	CONCLUSION .....	111

## Chapter 5

### Discussions, limitations, conclusions and recommendations

5.1	INTRODUCTION .....	112
5.2	DISCUSSIONS .....	113
5.3	LIMITATIONS .....	115
5.4	CONCLUSIONS .....	116
5.5	RECOMMENDATIONS .....	117
5.5.1	Education .....	118
5.5.2	Practice .....	119
5.5.3	Research .....	119
5.6	CONCLUSION REMARKS .....	120
	REFERENCES .....	121

## LIST OF TABLES

Table 3.1	Themes and sub-themes .....	67
Table 4.1	Themes and sub-themes in communication .....	78

## LIST OF ABBREVIATIONS

CINAHL	Cumulated Index to Nursing and Allied Health Literature
SA	South Africa
SANC	South African Nursing Council

## LIST OF ANNEXURES

Annexure A	Ethical clearance certificate from Unisa
Annexure B	Letter of request to Department of Health in Gauteng
Annexure C	Permission letter from Department of Health (Gauteng)
Annexure D	Letter of request to hospital management
Annexure E	Permission from the hospital management (CEO and Nursing Service Manager)
Annexure F	Letter of request and informed consent to participants
Annexure G	The interview guide
Annexure H	Transcription

# CHAPTER 1

## ORIENTATION OF THE STUDY

### 1.1 INTRODUCTION

Communication in the nursing environment is one of the most important interactions that take place every moment of the day. It is one of the basic and yet important life skills. Effective communication is thus vital for the adequate management of the hospital environment. Communication consists of interactive behaviour between people and it involves the transmission of a message from one person to the other (Muller 2011:201-202).

Continuous communication in a nursing service has greatly improved on-going working relationship among nurses of other categories and nurse managers. Nurses are responsible for communication among each other on how to enhance service delivery of nursing care. Research findings have indicated that nurse managers have tendency of delaying important messages that they receive from top management. The reason for the delay was viewed as a possibility that managers may be refining the details of the messages so that it can suit their presentation (Keyton 2011:89). The other reason for the delay was thought of too many activities to do than delivering messages timeously. This delay affected communication to nurses of other categories because messages were received at a later stage.

The health care environment is based on communication and is information intensive, meaning communication is continuous on day to day execution of nursing activities thus information is important and is designed to increase productivity. In hospitals, nurses are in constant care and communication with one to deliver effective nursing care. Communication is essential for the coordination of nursing activities, allowing nurses to work together in addressing new challenges in the health care environment to promote quality nursing care (Grobler 2012:25).

Limited research exists in exploring and describing the meaning of verbal communication problem between nurses and nurse managers in a hospital setting. Thus this study focus was exploring the perceptions of nurses with regard to communication with the nurse managers in a specified Westrand region.

Communication in language formation consist of limited number of units strung together according to cultural rules and professional rules of nurses and nurse manager, thus the unclear information from nurse manager to nurses of other categories may create barriers in communication establishment. Communication is a language expressed verbally and or non-verbally and may seem to be the key factor that enhances or detracts from the way we communicate with others. Behaviours involved in non-verbal communication also need to be clear and understood. Communication in the nurse-nurse relationship is an interaction that is multidimensional and complicated by human responses of both participants (Rowlands & Callen 2013:20).

## **1.2 BACKGROUND TO THE RESEARCH PROBLEM**

Communication at management level is part of administrative work. In studies from Keyton, Caputo, Ford, Fu, Leibowitz, Liu, Polasik, Ghosh and Wu (2013:152) the business communication behaviours about verbal communication in the workplace was studied, but there was a gap because the participant in the study were not interviewed about their experiences on perceptions of communication in the workplace. In this study as in study by Keyton et al (2013) focus was on perceptions and meaning of communication between nurses and nurse managers in a hospital. The study has been observing and hearing communication behaviours which were reported in verbal communication and these communication behaviours comprised of four main factors which were identified as information sharing, relational maintenance, expressing negative emotions and organising communication behaviours.

Nowadays the nursing professionals are being challenged by a delayed stream of messages from more senior management and provincial department than ever, and they cannot just cope with it at all. Communication protocol has changed the whole game of communicating and it is influencing nurses. What was overload in the 1970s has turned into minimal load in the new century, though it is encompassed by complexities. So it is little wonder that nurses' minds need simple, clear messages just

to cope timeously. According to the Sunday times (Maseko 2014:4), the best way to enter minds that hate complexity and confusion is to oversimplify your messages.

The nurse managers in a hospital setting play an important role in facilitating verbal and non-verbal communication with nurses to improve the delivery of nursing care. The public service should be committed to continuous, honest and transparent communication. This involves communication of services, products, information and problems which may disturb and delay the efficient delivery of services as expected by the employer. If applied properly the principles were to help to demystify the negative perceptions that the nurses in all categories who experience communication challenges about the attitude of nurse managers (Armstrong, Bhengu, Kotze, Nkonzo-Mthembu, Ricks, Stellenbergh, Van Rooyen & Vasuthevan 2013:184).

The scope of practice of registered nurses emphasises the right to information of nurses from their immediate managers, thus this can be practiced by nurse managers to their nurses as the nurses are not happy with the communication by their nurse managers to facilitate nursing care (SANC 1984, Paragraph 2(2)(n)).

Nurses should focus on their professionalism and patient care in their communication. The nursing strategy(2008:11) focuses on the importance of professional respect with regards to communication and service delivery. Inappropriate verbal and non-verbal communication between nurses does not uphold professional conduct. Batho-Pele and the White paper on transformation as guidelines and statutory documents outline the need for appropriate communication between nurse managers and nurses of other categories. Nurses' coping behaviour with difficult verbal communication pertain to how nurses deal with conversations they perceive as difficult after the encounter of conflictual situations (Armstrong et al 2013:271-272).

The following was identified during a meeting between nurses and nurse managers:

- Nurses focused on their personal problems in their discussions during service delivery.
- Nurse managers failed to communicate health care decisions that were taken in respect of service delivery.

- On observation, nurses stated that they have a language bank at the hospital, and that communication channels such as notice boards are underutilized by nurses of other categories who have language problems.
- Nurses felt unprepared to deal with changes due to being unclear about what is communicated and expected of them in changing circumstances.
- Nurses do not partake in decision being communicated to them.

There may be barriers in the transmission of communication; this is common in verbal and non-verbal communication. There may be various physical problems like emotional barriers on the part of the receiver of information. This clearly means that nurse managers were expected to use the tools of effective communication by engaging nurses in communication and be able to identify barriers during communication because, as the higher level of authorities, it may improve productivity. Various problems could lead to wrong interpersonal messages. Apart from internal variables that impede communication in the hospital, there are also other factors like incomprehensible use of non-verbal language, emotional content of the message, timing of transmission of the message and incongruity between verbal and non-verbal communication (Muller 2011:206).

### **1.3 STATEMENT OF THE RESEARCH PROBLEM**

Communication has changed the whole game of communicating and influencing nurses: because of the perceptions of nurses regarding communication with nurse managers the service delivery became impaired. Across a range of nursing population and hospital settings, a variety of studies have revealed troubling disparities in the health care communication, use of positions by managers and nurses' comments associated with poor communication in the hospital. As nursing care becomes more complex and there's information demand, nurses with limited literacy becomes disadvantaged when striving to deliver nursing care (Koch-Weser, Rudd & De Jong 2010:1).

The problem with communication was that nurses do not get information at the expected time frames and when they consult nurse managers they are given attitude. At times offensive non-verbal queues and language was used. The use of offensive communication makes nurses to be afraid to ask for information. There was also delay of circulars which were from the Department of Health because some are believed to be

altered to suit the institution. This means that nurses receive same information but the policies are different. The impact of such acts leads to job dissatisfaction and is displayed by high rate of absenteeism and resignations.

There are many challenges to effective communication between nurses and nurse managers, and it includes the synchronous nature of communication, the diversity in education and training of nursing professionals and the impact of hierarchy. There was also a perception and view of power differentials between nurse managers and nurses of other categories which inhibited communication. Additionally, different perceptions of nurses with regard to communication yielded a high rate of resignations and mobile nature of nurses in the hospital was at most not synchronous and was characterised by high levels of interruptions (Rowlands & Callen 2013:21).

Nurses are trained to communicate differently; thus, unlike the other different professional groups, they are more likely to communicate with each other. Communication as the tool to effective service delivery between nurses and nurse managers is to be of importance but there are obstacles preventing this. These obstacles included behaviours like listening skills, sharing information, asking questions and a lot more (Keyton et al 2013:153). The real problem was the changing of original documents and yet nurses receive information from their colleagues from other hospitals and there was a vast difference and that led to confusion as the truth was not known.

## **1.4 DEFINITION OF KEY CONCEPTS**

The key concepts used in the study included nurse managers, nurses, communication and perception. "The nurses" involves nurses of all categories available in the hospital. They are defined as follows:

### **1.4.1 Nurse manager**

The nurse manager is a registered nurse who is on post appointed as a professional nurse, as ranked by South African Nursing Council. According to Occupational Specific Dispensation grading the nurse manager is known as the operational manager and the assistant director. The assistant manager deals with administration duties and thus

should be in possession of a qualification in nursing administration to be able to facilitate nursing activities. The operational manager is the second manager who in most cases is at the first contact with nurses in the ward and he/she reports to the assistant manager. The operational manager is also supposed to be in possession of a qualification in nursing administration because he/she is on the operational level and in absentia of the assistant manager the operational manager often take office as a reliever. The nurse manager is a nurse who is responsible for the administration of nursing service in collaboration with those of other departments. This nurse administrator is known as the nurse manager because of his/her managerial duties that includes communication management (Mellish, Oosthuizen & Paton 2011:71-72).

#### **1.4.2 Nurses**

Nurses are all persons who are rendering nursing care in the health care setting. A nurse as defined by in the Nursing Act supports, cares for and treat health care user to achieve or maintain health and where this is not possible, cares for a health care user so that he/she lives in pain free state and with dignity until death (Armstrong et al 2013:174).

In the context of this study, nurses who were inclusive of all were categories who do not parttake in managerial positions. These categories were professional nurses, enrolled nurses and enrolled nursing auxiliary as determined by the regulating body the South African Nursing Council. These nurse categories practice under the Scope of Practice, R2598 chapter 2, 5 and 6 (SANC 1994).

#### **1.4.3 Communication**

Communication is the process of giving information and it can be verbal or non-verbal in nature. Verbal communication encompasses oral, spoken language which can includes casual greeting of colleagues, a list of instructions to nurses from the nurse manager. Non-verbal communication is regarded as a digital system like e-mails. facebook, expressions like grimaces, sign language, circulars, memorandums, drafts, policies and standards which are commonly used in the hospital. Communication composes of finite, discrete and arbitrary units (Keyton et al 2013:158).

In the context of this study, verbal communication is to be in the form of oral, spoken language as defined above whereas the non-verbal communication of focus is on circulars, memorandum and drafts which are a key challenge in the hospital communication.

#### **1.4.4 Perceptions**

It is how the nurses consider or look at the communication between them and the nurse manager. Perceptions mean a way one thinks about or understand someone or something (Oxford English Dictionary 2012:446). Perception has a meaning that differs from observations, reflections, opinions, and visions. Perceptions are a way of observing and processing those things that are present to the self within the context of lived experience.

In this study, perceptions were means to denote the meaning, or and views of nurses with regard to communication with the nurse managers. Perceptions are a way of observing and processing those things that are present to the self within the context of lived experience (Streubert & Carpenter 2011:3). Perceptions are not objective; rather, it is more than the act of observing. It is a way of observing and processing these things that are present to the nurse within the context of own lived experience.

### **1.5 RESEARCH AIM/PURPOSE**

The purpose of this research study was to explore the perceptions of nurses regarding communication with the nurse managers in a public hospital in the Westrand in Gauteng Province. This research sought to explore the meaning of communication perceptions between nurses and nurse managers.

### **1.6 RESEARCH OBJECTIVES**

The objective of this research study was to explore the perceptions of communication between the nurses and nurse managers in a public hospital in the Westrand in Gauteng Province, that is:

- To explore and describe the meaning of communication perceptions between nurses and nurse managers in a public hospital in the Westrand in Gauteng Province.
- To suggest recommendations that will enhance communication in a public hospital in the Westrand in Gauteng Province.

## **1.7 RESEARCH QUESTIONS**

- What are the perceptions of communication between nurses and nurse managers in a public hospital in the Westrand in Gauteng Province?
- What is the meaning of communication perceptions between nurses and nurse managers in the public hospital in the Westrand in Gauteng Province?

## **1.8 PARADIGM**

Paradigm is a set of assumptions patterns concerned with what is the reality of study which is known as the ontology, the reality of knowledge which is known as the epistemology and certain ways of knowing about that reality which is also known as methodology. it is also described as a way of looking at a natural phenomenon that encompass a set of philosophical assumptions andd the guidance to approach to inquiry (Polit & Beck 2008:761).

The paradigm in the context of research enables the researcher to engage and come to understanding the world of research and the phenomenon under study. A paradigm is based on knowledge that helps in the maintenance of symbolic communication, maintenance of social life by minimising dominance, and distribution of power. It was also associated with inequalities and this, in the context of this study, was to assist nurse managers to heighten their communication skills so that they can maintain the integrity of their managerial and leadership roles.

The paradigm that this research study has followed was qualitative, and substantiated by constructivism. In constructivist , the reality relied on multiple and subjective mentally construed from the participants. The qualitative methodology assist in obtaining evidence by inductive process thus the emergence of deep narration of the participant's version (Polit & Beck 2008:221).

## **1.9 RESEARCH DESIGN**

Qualitative design was used because it tries to explore and find meaning in something and it deals with verbal or textual material. A generic explorative design was used in the study. The approach focused on exploring the perception and meaning of communication of lived experiences for better understanding on social and historical context (Polit & Beck 2008:223). The generic approach will explore the perception and meaning of communication between nurses and nurse managers in the hospital environment. In this study, the perceptions on verbal and non-verbal communication between nurses and nurse managers will be explored.

Explorative studies aim to provide new insights into things which in this study are to be on communication perceptions and meaning attached by nurses. Sometimes, this was a first step to other forms of research but at other times it was sufficient in itself (Jolley 2010:67-69). Exploratory studies in research explore and describe a phenomenon of interest and generate new knowledge (Houser 2013:135).

## **1.10 SAMPLING**

Qualitative research study sampling was concerned with measuring attributes and relationships in a population. In this study, non-probability sampling method was to be used. The non-probability sampling method used judgement of the researcher to select research participants who know the most about the phenomenon under study. It was construed from objectivity of the researcher (Polit & Beck 2008:337).

### **1.10.1 Site sampling**

The site sampling was the site where the research participants were consulted and it has taken place in the context of this study it is the public hospital in the Westrand in Gauteng Province. The site sampling technique during the conducting of the study was a purposive sampling technique and the site sample size was in one hospital only. Inclusive in the site sample frame was a list of public hospitals in the Westrand in Gauteng Province and only one site was studied.

### **1.10.2 Data source sampling**

Nurses of all categories were included, meaning professional nurses, enrolled nurses and enrolled nursing auxiliaries in a Public Hospital in Westrand.

## **1.11 POPULATION**

All categories of nurses working in Leratong Hospital.

### **1.11.1 Participants' target population**

A population of ten nurses per category which was chosen was as follows 10(ten) Professional nurses, 10 (ten) Enrolled nurses and 10 (ten) Enrolled Nursing Auxiliaries which totals to thirty (30) nurses in all. the target population was sampled at a specific hospital as it was site were they accessible.

### **1.11.2 Participants' sample frame**

A list of all nurses employed in a specific public public hospital in Westrand.

### **1.11.3 Participants' sampling technique**

A purposive sampling technique was used with the aim to sample heterogeneity among different categories of nurses at different times in different ward settings because it was information rich on purpose of the study.

A small number of each category of nurses was selected to maximise the diversity relevant to the research question. The small number was selected because in qualitative studies samples size is determined by guiding principles in data saturation which was also the case with this study. Meaning from each category was as follows: ten Professional nurses, ten Enrolled nurses and ten Enrolled Nursing Auxiliaries to obtain in depth understanding of complex experience or the event with regard to their perceptions of communication with the nurse managers.

#### **1.11.4 Sample size**

Thirty nurses were eligible for the interview until data saturation occurs.

### **1.12 DATA COLLECTION**

A self-designed interview guide was used. The document was neither borrowed nor a copyright. Unstructured interviews were employed in the interview guide to collect personal and social information which was collected from human data sources and the participants were not subjected to physical examination.

#### **1.12.1 The data collection instrument**

The interview guide is the important tool to collect and collate responses of the participants. In this study a self-designed interview guide was used. The instrument was designed by the researcher by formulating questions which were in line with the title to address the questions and the objectives of the research study. Privacy and confidentiality was addressed as the research intention was not to endanger the participants in any form.

#### **1.12.2 Administering the data collection instrument**

The nurses of all categories were identified according to the list of nurses provided, as it shows all categories employed in the hospital and their total number of each. They were given information and explanation regarding the importance of the research study conducted (see Annexure F). They also gave informed consent after reading and signing, and an appointment was to be scheduled according to their suitability as most worked shifts. In-depth interviews were conducted and the interviews were conducted during the nurses' spare time. The researcher arranged time, a room for the interview which was user friendly and it may include duty rooms in the wards. Privacy was ensured at all times and, as the preference is given, the interview was conducted in the working environment.

### **1.12.3 Data analysis**

Data analysis can be described as a part for searching themes in data of recurrent behaviors and body of knowledge. Interviews were transcribed immediately after data were conducted (Polit & Beck 2008:517-518). Qualitative analysis involves breaking data into small units, coding and naming the units. Analysis of interviews was done and also coding was done to attach meaning and make up overall meaning and descriptions to accurately communicate lived experiences. In the context of this study data was analysed in the content of narrative to identify the themes and sub-themes.

### **1.12.4 Data and design quality**

The study was qualitative and the data quality design was maintained by employing trustworthiness. The latter was executed as follows:

#### **1.12.4.1 Credibility**

The credibility of the study was achieved through the maintenance of confidence in the truth of data collected and interpretation thereof as this was a measure to enhance believability. There was spending of more time with the participants (nurses), thus there was a demonstration of believability in findings of external readers who would be invited should a need arise to read and code according to the experiences or the meanings attached. The responses from nurses of different categories were to be read by an external researcher to determine the truth value (Polit & Hungler 2008:539).

#### **1.12.4.2 Confirmability**

In this study confirmability was achieved through maintaining objectivity and involving a neutral researcher/interviewer with expertise. The findings, conclusions and recommendations were compared with the researchers' findings, and these were used to support the truth value as a confirmation. Reflexive analysis was also used so that the researcher became aware of own influence in data (Polit & Beck 2008:196).

#### **1.12.4.3 Dependability**

For achieving dependability there was peer examination audit, where the peer was to follow the same process or procedure as the original researcher to determine if there is stability and acceptability of data. The peer was invited to interview nurses using the same questionnaire and thereafter was to determine if the responses are repeated and were found to be acceptable (Polit & Beck 2008:196).

#### **1.12.3.4 Transferability**

The transferability was achieved through member checking by the expert researcher such that in other hospital settings or institutions where there was a communication challenge recommendations can be transferable without the changes in the context confirm the study's trustworthiness. The expert researcher was suggested to follow or use the same data collection tool and see if the same results would be yielded (Polit & Beck 2008:202).

### **1.13 ETHICAL CONSIDERATIONS**

Permission to conduct the study was sought from the following:

- Unisa Department of Health Studies of Higher Degrees Committee
- Gauteng Department of Health
- A specific public hospital in Westrand in Gauteng
- Participants of the study

#### **1.13.1 Participants/human data sources**

The intended age range for participation in this study was 18 years and older and the informed consent was attached.

#### **1.13.2 Process to obtain informed consent**

The study participants were given information about the study and allowed to ask question where they do not understand. Confidentiality and privacy was ensured, and

no one was forced to participate in the study. The participants were also given the informed consent document to sign as declaration to partake in the study.

### **1.13.3 Steps to take in case of adverse events**

The physical, social or psychological harm or injury that may be experienced by the participants if attributable to their participation in the study was curbed by halting the participants until such time that stability is achieved. In case counselling may be a necessity arrangements were to be made with the social workers and psychologists and referrals were done with the permission of the hospital management.

### **1.13.4 The institution site**

Process to obtain approval to conduct the research study was achieved by writing request letters. There were: three letters: one for the Chief Executive Officer of the hospital, one letter was forwarded to the Strategy Policy and Research Gauteng Department, and the other one was to the request for an interview room in case the ward is not conducive and the letter was to be handed to the facility manager.

### **1.13.5 The scientific integrity of the research**

The data collection followed the University of South Africa's protocol (see Annexure A), and the recording and reporting of the research results were done accurately. There was no compensation including reimbursement amount, gifts or services to be provided to participants during the study conduction.

### **1.13.6 Domain specific ethical issues**

The following ethical issues were deemed necessary during the execution of the study:

- **Confidentiality**

Confidentiality as an ethical principle means information concerning the participants or persons in general will only be disclosed only when a consent is being given or when required by the court of law. This in research is treated with strictest measures to

protect the leaking of information. the applications of legislation was also observed e.g. The Access to information Act and The Protected Disclosure Act (Saks & Allsop 2013:112).

Confidentiality was achieved by not divulging information shared by the respondent. The research participants were to be promised that no information will be shared and that every item of information shared during the session was between the researcher and him/her and my supervisor.

- **Beneficence and prevention of harm**

Beneficence is a moral way of doing things meaning it is a responsibility to act in a manner that will benefit the participants (Armstrong et al 2013:145).

Beneficence was achieved by maximising benefit for the research participant. The action to demonstrate that included maintaining confidentiality, offering privacy and preventing harm at all costs.

- **Justice**

Justice in healthcare means fair distribution of goods and services or also means giving each what is due. In the context of research it means fairness should be maintained and equality included (Armstrong et al 2013:145).

Justice was achieved by treating all research participants equally. A non-discriminating attitude was displayed and the setting was to be consistent for all categories of nurses.

- **Privacy**

Privacy means protection from public it is similar to confidentiality in application though it means doing things or talking to people in a private environment. In research privacy means personal information should be protected from leaking to the public (Armstrong et al 2013:164).

Privacy was achieved by screening for the research participants, offering private rooms where they felt free to respond. The research participants were prevented from harm at all cost.

- **Veracity**

Veracity is an obligation to tell the truth at all times. It means being truthful and not to deceive others. Truthfulness is generally expected as part of respect owed to people. In the context of research it means participants must be told the truth at all times (Muller 2009:63).

Truthfulness was emphasised at all times in a non- coercive manner and research participants were told the truth at all times at consistent patterns. In case if there are alterations the research participants were kept informed at all times.

#### **1.14 SIGNIFICANCE OF THE STUDY**

The significance of the research study is to make recommendations to address communication between nurses and nurse managers in public hospitals in Gauteng and world-wide.

The study findings are intended to assist in improving communication between nurses and nurse managers in the public hospital in Gauteng.

#### **1.15 SCOPE AND LIMITATIONS**

The scope of the research study is to the nursing staff of all categories i.e. professional nurses, enrolled nurses and enrolled nursing auxiliaries except student nurses because they were not yet permanently employed and allocated in such wards. The limitations of the study are that the study is conducted in one hospital and students are not included.

#### **1.16 CONCLUSION**

This chapter discussed the outline of the entire study – inclusive of the background and the introduction, problem statement, research aim or objectives, research questions and

definition of key concepts. The methodology was discussed, albeit in detail in successive chapters.

This study is a qualitative research of exploratory nature as it was to assist with the exploration of nurse's perceptions regarding communication with nurse managers. As aforementioned, a single setting was studied meaning one public hospital was studied among three hospitals in the Westrand in Gauteng Province and excluded in the nursing personnel are student nurses because of their rotation they were not easily accessible as they attended theoretical block in college and took a month or two before they come for clinical exposure.

## **CHAPTER 2**

### **LITERATURE STUDY**

#### **2.1 INTRODUCTION**

A literature review is the critical summary of research on the topic of interest, often prepared to place the research problem in context. It includes the overall body of literature, as well as critique of seminal individual studies and helps to lay the foundation for the study in context (Polit & Beck 2008:106). The literature for this study was supported by selection of databases from Ebsco host, Academic Premier search and Cumulative Index to Nursing and Allied Health (CINAHL).

Communication management books, nursing management books and legal and ethical frame documents were consulted. This chapter contains an overview of perceptions of nurses regarding communication with nurse managers. It also outlines the meaning of communication, communication types or forms, communication styles, perceptions in communication and strategies in communication.

Nurses are central to the proper functioning of the hospital as a healthcare organisation. They have a unique advocacy role in the hospital. To be effective, it is essential that nurses are able to communicate concerns about communication in relation to working conditions with their nursing managers. Communication problems in the hospital have implicated in unsafe practices and perceptions which are suppressed. The nursing management can be compromised when nurses do not believe they can speak up or be heard by the nurse managers (Garon 2012:361). Linking the hospital safety and the smooth running of the institution there is a need for change in communication perceptions.

Communication issues have also been shown to influence nurses' job satisfaction and retention and are a key factor in the development of healthy work environment. Hospital communication includes lack of inter professional collaboration and thus influences the job satisfaction of nurses. Communication issues do not only impact on the nurses but

too can affect the entire work environment, because when nurses are silenced such that issues may not be brought to open. This can lead to nurse managers being unable to address the communication perceptions which affect the smooth running of the hospital (Garon 2012:362). The organisational structure and practices also influence the relative openness of the communication climate, thus there are different perceptions with regard to the communication.

Difficult communication may force nurses to resign and this can lead to downsizing human resources which includes all categories of nurses in the hospital. This result in elimination of skilled nurses and will contribute to a talent drain. Since nurses are a scare skill hospitals must prepare for leadership turnover by developing succession management plan to develop and identify potential leaders (Westphal 2012:928).

Nurse managers are constantly faced with new information regarding health service delivery. However recent evidence shows that nurses of other categories remain concerned about the manner in which new information is communicated to them. The nursing leadership can effect organisational change to enhance a healthy workplace culture by improving communication (Ceravolo, Schwartz, Foltz-Ramos & Castner 2012:600).

Nursing is seldom a solitary occupation, that means nurses and nurse managers must learn to work and communicate with each other for the smooth running of the hospital. Working together can however, create tensions especially when there is miscommunication. It is good to talk but if there's different perceptions associated with what is communicated the reflection may give off a different picture or understanding (Chan, Jones & Fung 2011:1169).

## **2.2 THE DEFINITION AND MEANING OF COMMUNICATION**

Communication is the process of exchange of information or messages among people. It involves deas and views to another person in an the ability to convey ideas and views to another person in an understandable manner (Armstrong et al 2013:261). In this study communication is central to nurse-nurse manager relationship and is also a key to nurse satisfaction.

Hospital or organisational communication is not confined to messages within or to any particular stakeholder group. For hospital organisation to exist, communication must occur between nurses and nurse managers and all other stakeholders groups. This means that current and potential nurses who in future may be on managerial positions or attain regulatory role there is a need to develop communication skills. The hospital communication at management level is devoted on structuring or controlling the organisation, whereas the general hospital communication is devoted to negotiating and coordinating work activities meaning it is communication that produces the work (Keyton 2011:11-12).

A hospital is a dynamic system of nursing members influenced by internal and external communication. The influence is through communication structure which is in a purposeful and ordered way to achieve superordinate goals. Thus, hospital communication is the complex and a continuous process through which nurses participate in creating and maintaining change (Keyton 2011:33) because the communication process is lateral, both upwards and downwards and horizontal. Horizontal communication is when managers of different departments communicate among each other and vertical is when managers communicate with their co-workers and visa-versa.

Good communication makes a difference, but if not it can cause nursing related conflicts and may have direct and indirect costs. Communication is significantly interesting in hospitals because it promotes good retention and attraction rates for nurses (Brinkert 2011:81). Supportive and collaborative communication from nurse managers is very important for nurses coping with ambiguities related to manage service delivery.

Communication is the means of facilitating sound human interaction. Everything we do in the work environment has a payoff. The same is true for nurses' interaction with nurse managers. Communication is a tool for the promotion of positive and effective human living and interaction. It furthermore involves the transmission and reception of ideas, thoughts, feelings and experiences between two points or poles.

Communication is central in a hospital setting, and may be productively or destructively managed (Brinkert 2010:146). Communication is about getting together nurse managers and nurses to address power and relationship issues underlying content

concerns. It needs clarifying that nurse managers and nurses share goals and help overcoming resentment and come to mutual understanding. Communication competence is widely regarded as basis for many other behaviors important successful teamwork and leadership. The modern nursing professional environment is also influenced by modern technologies which also necessitate change in communication perceptions (Waldeck, Durante, Helmuth & Marcia 2012:230).

### **2.3 DEFINITION OF PERCEPTIONS IN COMMUNICATION**

The epistemology of perceptions is the theory of knowledge and is the central issue in communication. It is a root of all empirical knowledge that is grounded in how we see, hear, touch, smell and taste the world of communication. Perception is not objective; rather, it is more than the act of observing meaning it is a way of observing and processing aspects which are present to the nurse within the context of lived experience (Streubert & Carpenter 2011:73-75).

Understanding current barriers to communication elicits different perceptions of information dissemination. The nurses perceptions are not independently of the outcomes because as they reflect, which is another form of perception there is a lot of mistrust to their nurse managers in regard to communication. Relationships are mutually defined meaning the way the nurse manager communicates to the nurses it may yield reactions in different forms (Oprah 2014/04:117).

Perceptual differences are frequently arising from different categories of nurses. This is inclusive of the speed at which the communication travels throughout the hospital and the fact that it is primarily distributed verbally suggests that there may be misinformation and distortions and that subject to nurse's values and perceptions being influenced (Ellis, & Hartley 2009:160).

Chan et al (2010) have pointed that individuals perceptions of the same communication differ radically and this applies to nurses and nurse managers too. The differing perceptions are one of the common communication barriers. Nurses have different background of knowledge and experience thus they perceive communication from the different perspective (Chan et al 2010:2022). The types of perceptions in communication determine how one will communicate and receive information from

others. Perception in communication is based on three elements which are how well nurse managers communicate, how well nurses receive communication and what is communicated. These elements are products of how you view yourself e.g. that you remember things better when you relate to self and that you tend to ignore that which differs with your own view or perception (Cherry & Jacob 2014:323).

In the previous research it has shown that culture use distinctive styles of speech and it tend to play a role during speaking to one another. The different categories of nurses with different cultural backgrounds may end up experiencing miscommunication and conflict. The point is that communication and cross-cultural communication will continue to be an important area of organisational understanding (Muller 2011:205).

In the sources from a variety of studies in communication there was no an exact study conducted relating to the perceptions in communication in a health setting. The concept perception has many meaning e.g. observations, reflections, opinions, visions, ideas etc. (Rowlands & Callen 2013:226). According to Ceravolo et al (2012:3), the nursing leadership can effect organisational change to enhance a healthy workplace culture by improving communication.

Communication involves the transfer of meaning from a sender transmitting a message and a receiver understanding this. Communication entails different forms. This means if nurse managers communicate in a medical terminology that is above the level of other nurse categories, then there is no communication because understanding is not achieved (Cherry & Jacob 2014:324-325).

Nurses have an obligation to develop good communication skills so that accurate and comprehensive information is obtained and can enable the complete and accurate recording of facts. Record-keeping is the fundamental aspect of nursing care and management and nurse managers have to ensure that accurate and comprehensive records are kept of the information that other nurses receive verbally during their meetings. Nurses are entitled to a safe environment, which is partly established by good communication and the recording of discussed issues by nurse managers.

Communication is a tool for the promotion of positive and effective human living and interaction. It furthermore involves the transmission and reception of ideas, thoughts, feelings and experiences between two points or poles.

Verbal communication involves the use of words in speaking, listening, and writing. It involves verbal factors in communication process which are centered primarily in the sender and the receiver; it includes oral and written communication (Ellis & Hartley 2014:61).

Memo's need to be properly read and communicated and the words used must mean the same thing for both sender and receiver. Memo's when read and understood, constitute a form of communication. This includes e-mail, bulletin and other visual displays. Communication also entails non-verbal messages and symbols. Body language, gestures, and facial expressions often "say" more than words. This simply means that in the nursing profession communication plays a major role.

The art of communication is a vital factor that should give warmth and meaning to nursing practice. The way in which the nurse manager's image and actions are communicated to the nurses of other categories will determine the degree of trust that the nurses and the institution has in their managers. In turn, this affects the measure of service delivery that nurses render as per nursing act. Armstrong et al (2013:2261-265) state that a scientific knowledge base, theory-base practice, adroit psychomotor skills alone do not enable a nurse to provide optimal patient care. However, when nurses expose these practice elements to the catalyst of the astute communications technique, diligently honed and regularly exercised then nurses may savor professional fulfillment.

The nurse manager must constantly bear in mind the fact that they (managers) and other nurses in the hospital are interpreting and enforcing the hospital's duty that is rendering the nursing care .The communication system within the hospital is the decisive factor in the provision of safe environment for all and safe patient care, in the patient care in particular (Sullivan & Decker 2012:126).

The health care environment is communication intensive. In hospitals nurses are in constant care with one another to deliver effective care and communication. The health care delivery system including nursing environment depends on communication to

facilitate delivery of nursing services by nurses. Communication is the glue that binds all various elements like co-ordination of nursing activities, allowing nurses to work together through new challenges in the health care to produce quality nursing (Grobler 2012:25). In the scenario of today nursing institutions are required to expand their services to redress the needs of clients. There is more merging and acquisition upcoming through communication of nurse managers, job satisfaction of nurses can be met (Grobler 2012:124).

The Department of Health, in cooperation with Constitution of the country, has a standardised communication strategy to conform to the demands of the service consumer (South Africa 1996). This means that hospitals can retrieve or design communication strategy to meet the needs of employees. This includes the ethical consideration of communication with regard to the transmissions and protocols. Data communication in the public and private organisations uses networking as a form of exchanging information, so that there is implementation of changes in the delivery of nursing care.

It is therefore through the user and the supplier of information that there is enhancement of service delivery in the organisation. This means that the user in this instance is the body of nurses of other categories and the supplier is the nurse manager in the health organisation as stated in the problem statement.

Communication is the science and practice of transmitting information. It is a form of interaction including the following factors, an initiator, recipient, mode/vehicle, a message and an effect. It promotes interaction and interpersonal skill. It is the most the important tool for the smooth running of the organisation, thus it has to be analysed and be well facilitated. It is through this process that most of the actions are carried out to promote the health status of the nurses. The importance of communication is its base for actions, as it an action on its own. It enhances facilitation of actions and can be addressed in different forms e.g. verbal, non-verbal or in writing. It has to be participative in nature, gender sensitive and a two-way process. Culturally acceptable methods of communication should be used so that interpretation of messages or communication can be well established. Also the must be special methods developed for the disabled nurses in the hospital (Muller 2011:205).

## 2.4 COMMUNICATION TYPES/FORMS

The hospital strategic communication styles create, maintain, and change the hospital by communicating verbally or non-verbally. This is because organisations emerge from communication (Keyton 2011:15). Verbal communication can take different forms and in hospital it is used when delegating and giving verbal messages. Non-verbal communication encompasses body movements, it is easy to read and in most cases it is given priority as it carries more meaning than verbal communication (Armstrong et al 2013:265-269).

There are two major types/forms of communication verbal and non-verbal. Verbal communication involves the use of words in speaking, listening, and writing. It involves verbal factors in communication process which are centered primarily on the sender and the receiver; it includes oral and written communication. Memos as verbal written form of communication need to be properly read and communicated and the words used must mean the same thing to sender and receiver. Memo's when read and understood, constitute a form of communication. This includes e-mail, bulletin and other visual displays (Keyton 2011:16).

In verbal communication behaviour, the content and structure of nurse managers' conversations are readily observable by nurses. This makes it easy for nurses to view, record and their perceptions becomes an obvious data sources. Among verbal communication of more interest is observation during information giving and exchanging of information between nurse managers and nurses, also to nurses among themselves (Muller,2011:202) .

Communication also entails non-verbal messages and symbols. Body language, gestures, and facial expressions are often observed more than words. This simply means that in the nursing profession communication plays a major role regardless of verbal or non-verbal form. Written communication as a form of non-verbal means it should be clear and accurate meaning the meaning of the communication must not be changed to suit the management (Waldeck et al 2012:235). In attendance of one of the meetings there were a lot of non-verbal responses e.g. nurses opinions, ideas or consideration under the discussed matter were not given attention.

Understanding current barriers to communication elicits different perceptions of information dissemination. Communication is the means of facilitating the human interactions. Everything we do in the work environment has a payoff. The same is true for nurses' interaction with nurse managers. The nurses perceptions are not independent of the outcomes because as they reflect, which is another form of perception, there is a lot of mistrust to their nurse managers in regard to communication. Relationship are mutually defined (Dr Phil 2014).

Nursing is seldom a solitary occupation, that means nurses and nurse managers must learn to work and communicate with each other for the smooth running of the hospital. Working together can however, create tensions especially when there is miscommunication. It is good to talk, but if there are different perceptions associated with what is communicated the reflection may give off a different picture or understanding (Chan et al 2012:2020).

Keyton (2011:18) and Chan et al (2012:2020) have pointed out that individual perceptions of the same communication differ radically and this applies to nurses and nurse managers. The differing perceptions are one of the common communication barriers. Nurses have different background of knowledge and experience thus they perceive communication from the different perspective (Chan et al 2012:2023). The types of perceptions in communication determine how one will communicate and receive information from others. Perception in communication is based on three elements which are how well nurse managers communicate: how well nurses receive communication and what is communicated. These elements are products of how you view yourself, e.g., that you remember things better when you relate to self and that you tend to ignore that which differs with your own view.

## **2.5 STRATEGIES OF COMMUNICATION**

The hospital communication structure is formal and may affect communication patterns. This is because the nurses at the bottom of the structure may receive little information when a tall structure is used as a strategy to communication. Alternatively, if a non-formal structure is adopted the effect is that nurse managers may alter or translate the messages to suit their purposes, values and their allegiances (Ellis & Hartley 2009:26).

Although communication skills are top ranked requirements for nurses and nurse managers unfortunately there is no prevalence of such skills. One of the strategies which may enhance this is competencies in communication as this will change the perceptions of nurses towards the nurse managers. The definition of competencies in communication is all about involving listening and speaking as professionals. I believe that through that a strong, clearer delineation of specific communication which is hospital related might be in order in the profession (Waldeck et al 2012:231).

The written words and the writing process itself are powerful tools that can have a real strategic impact on hospital communication between nurses and nurse managers. Nurses and nurse managers should know when to stop talking and start listening. This is important especially when emotions are high because of misunderstandings and misconceptions. However, many nurses find themselves on the job feeling unprepared for the communicative challenges they face. Nurses become more informed due to on-demand information and research by asking questions, challenging one another and assuming the role of communication with nurse managers (Waldeck et al 2012:236).

According to the White Paper on transformation of the health system of South Africa: Government Gazette (16 April 1977), communication strategies have been restrictive to the disadvantaged but has favored urban-based, literate and target audiences. These strategies were suggested to be inadequate and narrow in their focus as health promotion tools, because of the language of health promotional messages and its ethnocentric nature.

There has been identification of areas of principal activity for effective health promotion and communication strategy namely:

- Development of public policies and legislation
- Communication
- Skills development
- Promoting healthy physical and social environments
- Empowerment of communities and individuals to promote their own health

- Focused reorientation of health services and service delivery so that health for all South Africans is promoted through the creation of social, political, economic and physical environment, helping to make healthy choices easy.

Batho Pele Principles also emphasise that certain communication rights of individuals should be respected. These include the following:

- Consultation
- Value for money
- Redress
- Standards
- Leadership
- Reward and innovations
- Information
- Transparency (South Africa 1997:7)

## **2.6 COMMUNICATION STYLES**

Styles in communication includes passive, aggressive and assertive. In the previous research it has shown that culture use distinctive styles of speech and it tend to play a role during speaking to one another. The different categories of nurses with different cultural backgrounds may end up experiencing miscommunication and conflict. The point is that communication and cross-cultural communication will continue to be an important area of organisational understanding (Benedict 2014:2).

Passive communication is the communicating style which the nurses fail to say what they means to their nurse managers, and this is because of the professional etiquette and hospital communication structure. An aggressive communication style is communicating in a manner which limits the understanding of opinions, values, or beliefs of others. This means in the hospital nurses managers display aggressive communication which delimits nurses of other categories and that leads to them perceiving the communication differently. On the other end, assertive communication is a style that allows nurses and or the nurse manager to act in his/her own best interest without infringing the rights of others. Assertive communication in a hospital setting is

not practiced and this also makes nurses to view or have different perceptions with regard to communication with their leaders (Cherry & Jacob 2014:322-332).

The styles of communication also include open and closed statements. Open statements are statements which invite debates, discussions and arguments, closed statements require only a “yes” or “no” response is expected and this characterises more of instructions than negotiation.

## **2.7 ADVANTAGES OF EFFECTIVE COMMUNICATION**

Communication is a tool that is able to drive nursing activities. It is important because it is able to build sound interpersonal and intrapersonal relationships. These types of relationships will assist in the smooth running of the hospital. The advantages of effective communication in the context of this study are as follows:

- It will improve communication skills and enable nurses and nurse managers to get on well with each other thus improve life-long relationships.
- It will improve productivity because there will be heightened interpersonal and intrapersonal relationships within the nurses and nurse managers and among each other.
- It will serve as a retention strategy to curb absenteeism and reduce the high rates of resignations and patient care will also reach targets as expected thus client satisfaction.
- Effective communication will reduce mortality rates and morbidity in the hospital because experienced nurses may choose to stay regardless of other insufficiencies. This on its own will reduce severe adverse events, and will attract clients because there will be outstanding client satisfaction.
- Effective communication will make nurses feel supported and cared for by their nurse managers and this will strengthen the sense of belonging and the beneficiaries of the end products will be patients (Jooste 2009:16).

## **2.8 BARRIERS OF EFFECTIVE COMMUNICATION**

The barriers in communication are vast in organisations and may pose risks which may lead to loss of workforce. Communication is a complex implement and it is not afforded

even by people who engages in it on daily basis. The current status is that South Africa has officialised eleven languages and only a less than fifty percent of the population are able to communicate in all the languages (Armstrong et al 2013:263).

The hospital is a social environment thus it comprise of employees who comes from different cultural background and the nurses and nurse managers are part of these employees. This clarifies that language will be a barrier especially to those groups who are dominated by the surrounding community language. Inequality in the cultural background also played part in contributing to communication barriers. The professional status also is another barrier which was also identified during the interview and led to nurses resigning and absenting themselves from work. In the study conducted the barriers were identified and concluded as follows:

- Language proficiency
- Level of education which included professional rank
- Cultural background
- Age was also a barrier identified because young nurses said they are addressed any how just because managers are older than them and yet professionalism is ruled out

## **2.7 CONCLUSION**

The manner in which communication is to be perceived is that nurses are to consistently take credit on nurse manager's ideas but the challenge is their perception towards how the communication of ideas is sent across (Muller 2011:204). Nurse managers as leaders are to accept accountability and make a change. If nurse managers want to see different results they need to maintain transparency and honesty in communication.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

This chapter discusses the research paradigm, methodology and the research design used to conduct the study. In addition to research paradigm, methodology and design is population and sampling, sampling criteria, sampling size, sampling technique and approach, data collection, data collection technique, and data analysis.

The research method and design that is utilised was qualitative in nature and the approach was exploratory. Qualitative research method comes from a strong tradition in the physical and social sciences and it demonstrated different approaches to scholarly inquiry than quantitative research. Qualitative researches rely on text and image data. The role of explorative research was to explore and describe phenomenon in real life situations (Holland & Rees 2010:114-115). Descriptive studies or research do not involve the researcher intervening by giving solutions as a form of treatment. In this this type of study was easy to recruit participants because there was no physical invasion involved.

##### **3.1.1 The research paradigm**

The qualitative research design paradigm is the broadest and this means it uses the research design that draws out the research participant's account of meaning, experience and or perceptions. Qualitative research was the best way to start to answer clinical and research question about which was little known or when a new perceive was needed (LoBiondo-Wood & Haber 2010:100). In this study focus was on the perceptions and meaning of communication between nurses and nurse managers. This was the major reason for this study because little was known about nurses' perception and meaning of communication with their nurse managers. The study was intended to enable the identification of new perceptions of nurses and will help to answer the research questions.

A research paradigm or model should be viewed as a lens that helps to sharpen focus on the phenomenon under study and was to yield new evidence for the practice. The paradigm that was used in this study was qualitative and its nature is naturalistic. The naturalistic ontological assumption stated that reality is multiple and subjective. It further emphasises that human construct is mentally. This means that from the categories of nurses' different perceptions and meanings in communication with nurse managers was constructed according to lived experiences in the original/natural environment (Polit & Beck 2008:15).

The epistemological paradigm assumption states that the researcher interacts with the participants and the findings are a creation of the interactive process. The assumption in this study was achieved by posing questions as in the interview guide but may not be systematic as numbered. The participants were clarified with questions without leading them on how or on what to respond to.

The logic of qualitative research is based on a world view that is holistic and has a belief set as follows:

- That there is no single reality.
- That reality based on perceptions is different for each person and changes overtime because perceptions differ with every person and there is a possibility many different meanings.
- That what we know has meaning only within a given situation or context (Polit & Beck 2008:15).

The naturalistic paradigm in qualitative research is also known as narrative paradigm, and in this study the underlying nurse's perceptions in communication with the nurse managers were explored under strict controls meaning the researcher's preconceived ideas were or interpretation about the phenomena under study were not considered. Qualitative design was also known as a constructivist paradigm, meaning that reality is not a fixed entity rather a construction of nurses partaking in the research (Polit & Beck 2008:15).

Qualitative research is systematic and uses a subjective approach to describe life experiences and attaching meaning to them. This paradigm was not a new idea in the

social or behavioural sphere. The qualitative research was a way to gain insight by means of discovering meanings. The insights and meanings were obtained through improving the comprehension as a whole so that a broader picture can be established. The meaning and insights gained can be used to guide the nursing practice and help in development of knowledge in increasing nursing knowledge. Comprehension is vital to critique the studies in publications and use the results in the practice (Burns & Grove 2005:52).

Qualitative research study encourages embracing the wholeness of humans focusing on the nurses perceptions and meaning of communication in a natural setting. Qualitative researches methods are grounded in the belief that objective data do not capture the whole human experience (LoBiondo-Wood & Haber 2010:100).

Qualitative research is relevant to clinical setting because empirical knowledge and approaches have proven to be of limited service in answering some challenges of the nurses and pressing clinical questions in cases where human subjectivity and interpretation are involved. This type of research method provides unique perspective and has the ability to guide the nursing practice. It thus contributes to instrument development and develops nursing theory as it is the intention of this study, to suggest recommendations that will enhance communication (LoBiondo-Wood & Haber 2010:102).

In this study, qualitative research method was used for exploring and describing meaning, which was then followed by the interpretation of the perceptions and meaning of communication of nurses regarding communication with nurse managers. Communication for nurses and nurse managers was used to convey accurate and the right information in the hospital to influence behaviour (Dickson & Flynn 2009:2830).

This is because communication perception is more of human phenomenon (Streubert & Carpenter 2011:3). Qualitative study is done for the development of nursing knowledge. In this study the important question of nurse's perception when communicating with nurse managers is an essential because of reasons to high rate of resignation which is thought provoking.

## 3.2 METHODOLOGY

Methodology was concerning questions about the manner in which knowledge was gained about the perceptions and the meaning of communication between nurses and nurse managers. Qualitative methodology emphasises that reality can be discovered by looking at the perspective of people who live in it, thus in this study nurses are the individuals who experience and spent most of their time in the hospital where communication challenges exists (Creswell 2013:22).

Methodology is a research process designed to develop or refine methods of obtaining data, organising it and or analysing the collected data. It refers to the logical process followed during the application of scientific method and techniques when a certain phenomenon is investigated. It is a step by step process which was to be followed when using a specific research design and thus kept the focus in context (Polit & Beck 2008:758). This study focused on qualitative methodology.

Qualitative research methodology is guided by a unique pattern as well as specific philosophical base. Its focus is more on the process and less on the product thus it is characterised as inductive process. The research is conducted in a real life situation where there is a feel and understanding of the phenomenon under study though not at a broader premise. The strategy in methodology includes population sampling, data gathering or collection and data analysis. In qualitative study data analysis and data gathering are likely to result simultaneous (Burns & Grove 2005:535). It has a long distinguished and sometimes anguished history in human disciplines.

The methodology of qualitative research is of focus on how evidence was obtained. In the naturalistic paradigm inductive process is the preferred way. The phenomena under study was holistic, meaning all aspects which revealed the nurse's perception in communication with the nurse managers will be emphasised during the interview process as stated in the interview guide. Qualitative research is useful for guiding nursing practice, building nursing theory and contributing to instrument development. Findings can be used to improve the communication of nurses and nurse managers in the hospital. The importance of qualitative research to instrument development is evident in the work of a nurse scientist (Hedges & Williams 2014:188-189). Qualitative

research combines the science and art of nursing to enhance the understanding of human health experience.

The focus on obtaining data was subjective and this meant that the explored narrative information took place and qualitative analysis was done. The paradigm seeks in-depth description and understanding of events in all their complexity of nurse's beliefs and actions (Brink, Van der Walt & Van Rensburg 2012:121). This was achieved by allowing the nurses to interrogate the interview guide and clarity was given where necessary. The focus was on data processing and its collection which was of importance (Polit & Beck 2008:14).

In this study, a generic qualitative explorative method was used. It focused on exploring perceptions of nurses regarding communication with their nurse managers. Perceptions are a way of observing and processing those things that are present to the self within the context of lived experience and it is a way of nurses perceiving nurse managers in the context of persona and social interaction (McCabe & Timmins 2006:9). For example nurses of different categories in the unit/ward may have different perceptive interpretations about their communication with their nurse manager in a personal and social context. The point of emphasis is that every nurse's interpretation is based on what the nurses perceive to be a reality, and that reality has developed and constructed over a prolonged period of processing, receiving and interpreting information as well as engaging in human interaction.

Qualitative research implied an emphasis on the qualities of entities and on processes and meanings that are not easily experimentally examined or measured in terms of amount or quantities. Qualitative methods are used to study human phenomena which are grounded in social sciences, and thus communication is a human phenomenon. Communication is a knot that ties social relations together which in this study it facilitates nurses' relations with nurse managers so that nursing care is well facilitated. This is because human phenomena are not convertible to mathematical formulas thus a quantitative method would yield expected results. A qualitative researcher stresses the socially constructed nature of reality, meaning the intimate relationship between the researcher and what is being studied allows the researcher to look for complexity of perceptions rather than narrowing the explored meanings into few categories (Denzin & Lincoln 2000:9).

Qualitative research is a field of inquiry in its own right. It crosscuts disciplines, fields and subject matters studied under this methodology. It is interconnected by a family of terms like, in this study, nurses' perceptions on communication with their nurse managers may be termed differently by different categories of nurses, although the context will be the same throughout. Inclusive in the connection is concepts, assumptions, surrounding, traditions associated with the foundationalism, positivism and many more research perspectives (Denzin & Lincoln 2000:2).

The practice of qualitative method stretches to clinical setting as in this study focus it is in the hospital setting. The qualitative research method offers the opportunity to focus on finding answers to questions centred on social experience. The hospital as a social institution was the relevant setting for conducting the study. In this social institution nurses spend most of their time rendering services and communicating with the nurse managers. The research setting will thus enabled the perception exploration and meaning attached to it by the research participants. The foundation of qualitative method was focusing on how human phenomena are created and what meaning it gives to human life experience. This was because focus was about describing the fundamental patterns of human thoughts and behaviour (Speziale & Carpenter 2011:58) through observations.

Qualitative methods rely on the observation of behaviour which also relied on natural environment, thus often referred to as participant observation. In this regard the hospital was the natural environment and it qualifies because naturalistic and the explorative are characteristics of qualitative studies. Qualitative studies help to put things in perspective, which can also help to guide the practice decisions (Rubin & Bellamy 2012:244-245) so that there is achievement of the smooth running of the hospital and in this context it may also helped to curb absenteeism and resignations which hamper the service delivery.

The method also played a part in evidence based practice and was not restricted to clinical decisions only but it focused on effectiveness of questions which prompted undertaking the study. Qualitative studies help practitioners to better understand what is like to their client's experience. This in this study has helped the nurse managers to

understand the nurses' perceptions and the meaning attached in relation to communication with them and how best they can improve on that.

Qualitative research is relevant to clinical setting because empirical knowledge and approaches have proven to be of limited service in answering some challenges of the nurses. There are pressing clinical questions in cases where human subjectivity and interpretation are involved. It involved the studies conducted and collection of a variety of empirical materials like case studies, personal experience, introspection, life history that describes meaning in and problematic moment's human beings lives in (Denzin & Lincoln 2000:3).

Qualitative research is a situated activity that locates the observer in the world. Similarly in this study a researcher is located as an observer of perceptions and meaning of communication between nurses and nurse managers in both the verbal and non-verbal responses during the interview. It consists of a set of interpretive, material practices that makes the world visible. These practices changes the world by turning it into a series of representations, including field notes, interviews, conversations, photographs, voice and pictorial recordings or a mixture of both and memos to the self (Denzin & Lincoln 2000:3).

### **3.3 RESEARCH DESIGN**

A research design is an overall plan for obtaining answers to questions in the research. The research design is regarded as the blueprint of the study, meaning it is the overall plan and the backbone of the research for obtaining answers to the questions being studied and for minimising challenges that are experienced during the research process (Polit & Beck 2008:66).

It is a plan which has a specific model to follow throughout the methodology until the analysis process. It maximise control over factors that could interfere with the trustworthiness of the findings (Burns & Grove 2005:211). The design guides the researcher in planning and implementing the study in a way that is likely to achieve intended goals. Research design is used in two ways, as a whole strategy for the study or as a structure in which the study is implemented. In this study a generic qualitative method was used focusing on the explorative approach.

Explorative studies are aimed at providing natural, holistic and inductive characteristics or views of particular nurses with regard to communication with nurse managers in a hospital. Meaning the designs was used to gain more information in relation to the perceptions of nurses regarding communication with nurse managers in a hospital. Explorative studies are aimed at increasing the knowledge of the field of study (Burns & Grove 2005:357).

Inductively the data was constructed in form of patterns, categories and themes to organise more abstract units of information. It involved the researchers working back and forth between the themes until comprehensive set of themes were achieved including through application of complex reasoning. The nurse participants were involved actively so that they can contribute in helping to shape themes and subthemes including excerpts that emerge during the process (Creswell 2013:45).

The paradigm design produced explored descriptive data in the research participants own spoken words. This involved identifying the belief system and value system of the nurses that will underlie the phenomenon. The concern was about understanding the nurse's perception in a natural setting (De Vos, Strydom, Fouche & Delport 2003:79). The answers provided by qualitative data reflect important evidence that provided valuable insight about a particular phenomenon which was communication in this study in a clinical setting.

The explorative descriptive approach as used in this study is a qualitative approach used to explore, describe and analyse the processes that present with nurses as human interactions. The method offered an opportunity on finding answers to questions centred on social experience e.g. hospital. It generated information through inductive reasoning. Inductive reasoning is a process that describes details of the experience by moving from specific to more general picture of the phenomena. Studying nursing issues/matters in a context of human philosophy put emphasis on subjectivity rather than objectivity because qualitative explorative, descriptive encourages description of events (Burns & Grove 2005).

Explorative design requires engagement with the self and others. This meant it involved opening yourself up to a phenomenon without preconception. Explorative studies are

narrative in nature, and narrative methods are concerned with historical times. Like in this study focus on the nurses perceptions regarding communication with nurse managers will also be from variation of years of categories though this may not necessarily be put as the key element in analysis. Instead the measure only helped to conclude that even allocated in the same ward/unit perceptions towards the manager may vary as per nurse category (Lessem & Schieffer 2010:78).

The design of this study was focused on exploring the perceptions and meaning of communication, describing and doing the analysis and interpretation of lived experience for better understanding on social and historical context (Polit & Beck 2008:223). The approach described and explored the meaning and the interpretation of perceptions of nurses in communication with the nurse managers in the hospital environment. In this study, the analysis and meaning of verbal and non-verbal communication between nurse managers and nurses in a public hospital was also described and explored. The method also enabled the analysis, meaning, interpretation and exploration of nurse and nurse manager relationship in communication in and outside the working environment.

### **3.4 POPULATION AND SAMPLING**

#### **3.4.1 Population**

Population was defined as the whole group of persons or individuals, elements or objects that are of interest to the researcher, they met the criteria in the study that was to be conducted. The population in the criteria was to be accessible, willing to participate and should not be coerced as this was contradicting the ethical considerations in research (Brink 2012:132, Burns & Grove 2008:746).

The target population in this study was the accessible nurses of all categories namely professional nurses, enrolled nurses, enrolled nursing auxiliaries. The study population that was studied was secluded within a hospital and were according to availability and was not to disturb the ward routine or their off duties. Appointment was scheduled according to availability and as the manager may release the nurse who meet the inclusion criteria. The inclusion criteria meant that nurses were according to the population characteristics e.g. as required by the study they were supposed to be bold and speak freely without having an element of intimidation. Included in the

characteristics were nurses who were able to express their feelings with regard to the subject matter that has been studied.

### **3.4.2 Sampling**

Sampling is the process of selecting a part of the participants to represent the entire population (Polit & Beck 2008:339). It will achieve this by employing a sample plan which clearly explains the sample size, sample method and the procedures for recruiting. The elements of the population in this study were nurses of all categories namely professional nurses, enrolled nurses and enrolled nursing auxiliaries.

In qualitative studies as in this study non-probability sampling techniques is typically employed. It is an economical and more convenient technique which is suitable in a clinical setting. Non-probability sampling requires the researcher to judge and select research participants who know more about the phenomenon under study (Brink et al 2012:139). The sampling plan was constructed from an objective judgement of a likely starting point and the direction the sampling takes. The sampling type does not contribute to generalisation, thus the researcher is more concerned with understanding the experience of categories of nurses in communication with their nurse managers.

Non-probability sampling is non-random sample method of research participants. The reason to use this sampling technique is to develop understanding of a complex issue through collection of in-depth rich data (Taub, Douiri & Walker 2014:269). The sampling method is less likely to be representative of the target population. The quality of data obtained from this type of sampling technique has the potential to be high when the researcher has willing participants who are able to express themselves without feeling intimidated. This is also true in this study because perceptions are complex as it was explained differently by different nurse population or categories. This meant that it was not estimated that each element was to be included to participate in the study. This also was applicable in this study because not every nurse was expected to partake in the study regardless of their availability or the shift they are allocated in.

Qualitative studies almost always use small non-random samples. In this study, 30 nurses were used as a sample size comprising of 10 professional nurses, 10 enrolled nurses and 10 enrolled nursing auxiliary nurses. the aim was to explore the meaning of

communication perceptions of nurses with their nurse managers and uncover realities to find clarity and the findings are not generalised. The rich data source of the study is nurses of all categories because they communicate closely with the nurse managers (Creswell 2013:157).

The sampling size comprises of thirty nurses, of which ten was from each category and each category was extensively interviewed. The sample size in qualitative research plays an important role in maintaining the credibility of the study. The eligibility criteria include the characteristics of the target population. The criterion is developed from the research problem, aim/objectives of the study and literature review. As in this study the key problem is how different categories of nurses from the same hospital or ward perceive the communication with the nurse managers (Brown 2012:257).

Non-probability samples are not selected randomly, and are the right approach in the study for conducting clinical studies. The study sample is based on researchers' belief to purposely select participants who are judged typically to be having knowledge of the phenomenon of the study. It is a subjective sampling approach thus bias in the study is minimised and conclusions may not be necessarily drawn from the data (Polit & Beck 2008:341).

The sampling strategy to be used in this qualitative research is purposive sampling. Purposeful sampling was a sampling strategy that the researcher selects research participants and sites for study because they can purposefully inform an understanding of the research problem and the phenomenon under study. It relied on the researcher's judgement hence is also known as judgemental sampling. The strategy allows the selection of the sample members to participate in the study as they are relevant to the objectives of the study. The aim is to cover all the important perceptions of nurses of different categories as according to target population (Taub et al 2014:270).

A purposeful sampling strategy was used in this study with and it is appropriate for qualitative research study as it allows the researcher to gain new insights into the perceptions of the phenomenon under study. A purposive sampling strategy was used to select a distinct group of nurses that have lived the experience of how communication with nurse managers is perceived. Focus of this sampling strategy was specific thus it allowed the researcher to hand pick nurses who meet the inclusion criteria (Brown

2012:259). The aim to sample heterogeneity among different categories of nurses at different times in different wards in the hospital was because it will be information rich on purpose of the study and will benefit the study (Brown 2012:259).

Additional to heterogeneity is a mixture of gender of both males and females of all categories included in the sample frame, and the aim is to determine different reflections of perceptions in relation to gender point of view. The overall point for sampling all categories of nurses and the gender involvement was to elicit an element of biasness in the study (Polit & Beck 2008:355-359).

A small number of each category of nurses was selected to maximise the diversity relevant to the research question meaning from each category it was as follows: a number of professional nurses, enrolled nurses and enrolled nursing auxiliary nurses to obtain in-depth understanding of complex experience or event with regard to their views of communication with the nurse managers.

### **3.5 ETHICAL CONSIDERATIONS**

The study was approved by the University of South Africa Ethics Committee (see Annexure A), the Gauteng Department of Health Research Committee (see Annexure C) and the Chief Executive Officer of a specific public hospital in Westrand in Gauteng Province (see Annexure E). Research participants were informed about the ethics involved and adherence will be consistently upheld (see Annexure F). The environment for the research study in this study was the hospital, which was the natural environment where communication between nurses and nurse managers was occurring and can be easily observable. Inclusive in the natural setting was emergent nature of design, researcher-participant interaction and the researcher as an instrument. The ethical considerations were applied before, during and after the conduct of the research and it was continuously and consistently adhered to (LoBiondo-Wood & Haber 2010:247).

Ethics in research were about making sure that the benefits gained from research were as great as possible and risks were minimised, made acceptable and were freely consented to by participants. Ethics encouraged a responsibility that could improve the participants' experience (Mcintosh-Scott, Mason-Whitehead & Coyle 2014:206-207). Ethics is a branch of philosophy that tries to enable clear thinking about right and wrong

in human causes of action. It involved the process of moral reasoning to decide what is right or wrong then do what is right. Ethics constantly changes. Ethics means an act which can be the rules for proper conduct. It demarcates clearly what is ought to be done or not to be done. Research ethics means doing morally right or wrong in a research study. Ethics is defined as dealing with doing well and avoiding harm. The research ethics are about making sure that the benefits gained from the research are as great as possible and risks are minimised.

Ethics underlie various aspects of the mandate to protect research participants from physical, mental and social harm. The fact that nurses are human beings who partaken in the research study means it was important to handle and recognise ethical issues. Ethics sensitised the researcher about what was improper in scientific research and ways on how to elicit offending the participant throughout the study (De Vos et al 2003:66). Research ethics are a way of ensuring that the researcher is to abide by standards of professionalism and honesty. The intentions of research ethics is that the researcher should gain respect and trust from the research participants and the community at large visa-versa.

The ethical principles which were used in this study are autonomy, informed consent and voluntary participation, confidentiality, privacy and anonymity, beneficence and prevention of harm, justice. These ethical considerations were explored as follows:

### **3.5.1 Autonomy**

It means a right of a research participant to self-determination. In the context of this study, it means there should be respect for the unconditional worth for the research participants and respect their thought and action. This implies that participants have right to choices and decision making during the conduct of the research study (Muller 2009:62). In this study the participants had a right to answer questions without the interference of the researcher by answering according to their understanding of the questions posed to them. This had strengthened the responses because the information was in such a way that it demonstrated the understanding of their perceptions and the meaning of communication with their nurse managers. There was also an open platform for clarity seeking questions which were addressed when the interviewee

requested such. The right to autonomy was safeguarded by the researcher avoiding to link the participants with their own responses (Burns & Grove 2005:188).

Autonomy was based on ethical principle of respect for a person, meaning people who in research language are known as research participants. They should be free from external controls which could impair the integrity of the study. Autonomy like informed consent and voluntary participation implied that participants should be informed about the proposed study and a voluntary response to participate should be allowed. This included information about withdrawing from the study at any time when they wished to or when they experienced some level or element of discomfort to continue with the interview during the conduct of the study (Burns & Grove 2005:181). In this study this aspect of the ethics was explicitly outlined in the consent form that participants read and signed prior partaking in the study interview.

The right to self-determination/autonomy may be violated when the researcher uses coercion, by restricting the research participants on how to respond to questions. The deception and coverting of collection of data was avoided thus the research participants were allowed to practice and control the manner in which they were to respond e.g. there were instances where the participants requested the question to be skipped and would respond later on. Thus in this study such violation was addressed by informing participants that data collected was to be analysed and frequently used words/phrases were changed to themes through the process of coding which could help in defining solutions. Participants in this study were protected by assessing if they do not display diminished autonomy attributes or being posed to some degree of violation of their rights e.g. they were to be mentally sound.

### **3.5.2 Informed consent and voluntary participation**

Informed consent from the research participant was very critical and demanded non-coerciveness as it automatically was fostering voluntary participation. It was crucial when engaging the participant in any stage of the study that despite consented they were allowed to express any element of discomfort. The researcher had a duty to explain and check if the participants were fully informed about the context of the study (De Vos et al 2003:67).

In this study for achieving consent from the research participants full, accurate information was given about the research study, the process and procedure that was to be followed, data collection process using the voice recorder and that the advantages of conducting the study was to be discussed that it was to improve communication in the hospital. The disadvantages which were to be discussed were to be focused on harm that was likely to occur though it was gauged to be very minimal if any may incur. The class of harm which was anticipated included physical harm, emotional and psychological harm (Armstrong et al 2013:170).

The consent was in a written form and participants were allowed time to read before they sign as they will bind them to voluntary participation. The content of the consent was clearly explaining the purpose of the study and also bringing awareness that the participants may withdraw from the research study any time they want or wish and will not be posed to threats. The participants were allowed to complete the consent in the form of attaching signature when ready whether before or after the interview.

The participants were explained to that the recorded data was for assisting in analysing data and that it will help in reflecting and reliving to the researcher what was discussed during the interview. There was a reassurance throughout the interview that the voice recorded information will not be made accessible to anyone except the supervisor who is involved in facilitating the research study.

### **3.5.3 Confidentiality, privacy and anonymity**

Confidentiality encompassed autonomy and anonymity. It was the researcher's management of the participants' private information to include confidentiality as part of ethical considerations in this study. Confidentiality means that private data collected from the nurses was not to be disclosed and this included no name calling or any identifying them publicly. The intention of the measure was to prevent discrimination of nurses by the nurse managers. This put emphasis in strengthening anonymity, autonomy and privacy. In this ethical principle mismanagement of data without participant's permission may lead to stigma as participants are employees and to the researcher the attributes that may be scrutinised from the researcher may include contravening anonymity, hospital feedback will be on findings and recommendation but no naming and raw data (Polit & Beck 2008:180). The greatest risk of anonymity may

also pose threats to the nurses and that could paint a bad picture on the researcher's credibility and reliability.

Anonymity is the part of privacy and confidentiality and it put emphasis on avoiding using real names of the participants. This ethical principle it helps to protect the identity of nurses who are participating in the study. In this study participants were reassured of privacy confidentiality and anonymity but they were also informed that expert research supervisor and data analysers were to access their information but their real names would not be used. The allocated unreal names in form of alphabets was to be able to identify the categories so that there is consistency as stated in the sampling process (Polit & Beck 2008:180)

In the case of the voice recorded during data collection names were not asked but ranks were requested as it would serve as a measure to show that the sampling criteria was not compromised. The voice recorder was programmed in alphabetical order meaning only voices were recorded and participants were called with pseudo names according to the alphabet allocated to them. There was a separate data sheet which the research participants names were kept and this was solely for the reference of the researcher when a need arisen. This had further strengthened confidentiality in a research study (Kvale & Brinkmann 2009:67).

In case of this study an interview was conducted in private place within the hospital in the ward where there was reduced movements and intimidation. The measure was undertaken because it was strengthening the natural setting where communication usually took place in most of the times. The participants were assured of confidentiality but they were also informed that the results may be publicly reported but their identity was protected. This also fostered the researcher to allay anxiety by making it clear from the onset of the study that some researchers may have to access the data for analysis and critiquing of facts should a need arise (Burns & Grove 2005:188).

#### **3.5.4 Privacy**

Every participant has the right to privacy, this law in research was the most important because if not adhered to the progress of the study may be delayed or disabled. Every participant has the right not to have the privacy of their communication infringed. This

means that the researcher was expected to not give full details of what happened during the data collection and that include the physical, psychological and emotional status of the participants (South Africa 1996:2[14]).

The right to privacy is the research ethic which put emphasis on the research participants' right to determine time, extent and general circumstances under which the participants' information will be shared or withheld from others. As in above statements the researcher informed the participants that they should be aware who will gain access of data collected and the reasons why (Burns & Grove 2005:186) and in case the participant felt uneasy he/she was allowed to make own decision as an autonomous human being.

The privacy of the nurse participants was protected after a risk benefit assessment was done so that proper privacy measures may be employed. The measures included assessing risks that could be involved in physical, emotional and psychological context and there was no element of physical harm depicted. The participants were sensitised that the questions asked in the interview were sensitive to some extent. It was clearly explained that there would be probing in some question responses which may necessitate that they elaborate further, and in that case they must avoid use of nurse manager's real names as they also qualify for privacy. They were further explained that though questions in the interview guide were numbered the posing of questions may not necessarily be as in the document. There was shared information with the participants that some of the questions may necessitate some emotional or psychological effects during the responses as disclosing information about their manager was considered critical and had some element of sensitivity.

In this study, this was given attention and was to be repeatedly discussed with participants to enrich their understanding and acceptance. The participants were told on the onset of the study interview that data collected was to be made accessible to research supervisor for the sake of data analysis. To strengthen the view participants were told about protecting information by maintaining anonymity and protecting the voice recorder accessibility. They were also informed that after analysis feedback sessions was to be arranged and also they will be invited to witness the discarding of data especially the voice recorder if they wish to be present. The participants were

informed about the expert researchers' knowledge of research ethics and the extent to which they maintain compliance in that regard.

### **3.5.5 Beneficence and prevention of harm**

It means the idea of doing well and benefiting individuals. In the perspective of research it means the researcher had a responsibility to benefit the research participants. The principle is simply self-explanatory meaning what was done during the research study should be of gain than harm, although this may be key to research it may not always be possible or easy to know exactly what was of benefit to another person with what was or may simultaneously harm them. The responsibility to beneficence pertains to nurses who were engaged in research (Hedges & Williams 2014:226). In this study the benefit for the nurses was the improved communication skill with and by nurse managers. The hospital was also going to benefit as an institution by having high or improved staff retention and attraction. As it was explained in the problem statement that due to communication challenges there has been increased staff resignations and this research was a measure to assist to curb that.

Harm means a form of discomfort. It means discomfort may have arisen from being involved in the investigation and should be minimal if any as it was expected to be minimal in comparison to and with comparable situation in real life. Research should not cause harm to participants as this would foster the nurse participants withdrawing from the study even if not completed. It would appear safe at all times by safeguarding the sensitivity of the questions and responses. It should be clear that harm for the participant could be physical, psychological or emotional (Armstrong et al 2013:164).

The study did not involve physical harm, but it was anticipated as may be due to unforeseen circumstances e.g. slippery floors. The worst physical harm which was to be considered though of very minimal risks but not to be avoided was the injury due to slippery floors, which could disrupt the research process. In this study there was no physical harm that was anticipated but it was monitored closely and safeguarded by strengthening access to the interview room. The idea was that the safety of the research participants was of great importance as their contribution to the study was to benefit nurses by voicing out their perceptions of communication with their nurse managers and enable the researcher to draw up corrective measures in the form of

suggestions or recommendations. The safety precautionary measure which was of importance included checking floors if not slippery.

#### **3.5.5.1 *Psychological harm***

Psychological harm included stress, depression, anxiety and psychosomatic symptoms that may be experienced by the nurse participants. This type of harm was anticipated because nurses of other categories were opening up to tell their perceptions and meaning of communication with their nurse managers. This type of harm was notably to potentiate an element of discomfort though not severe it might also expose assertiveness in nurse participants. In this study, the psychological harm was very mild but as a researcher it was on the forefront mind that the principle of autonomy to be considered. This was that the response of every participant was unique in their own make and thinking and so does their perceptions and meaning of communication with their nurse managers.

The psychological harm was prevented by telling the nurse participants that their responses were to be concealed. This means that the researcher was not to discuss their responses with anyone, will not use their real names, will prevent the leaking of information and recorded information, will prevent and protect access to the voice recorder except for the data analyser and the expert researcher, and will prevent movements or distractions during data collection and interpretations of findings. The participants were warned that during data collection some questions may be sensitive but the intention is to achieve a rich, dense description of the perceptions and meaning of their communication with the nurse managers.

#### **3.5.5.2 *Emotional harm***

In most cases emotional harm was considered to be secondary to physical and psychological harm or any of each of these harms. It involved the distraction of mentality and may have an impact on the study by time consumed in the form of pausing and allowing the participant to recover. It included symptoms like stress, feeling down, anxiety, expressive moods and an element of uneasiness. Again, in this study this type of harm was anticipated to be at a minimal level. This was because of the type of questions asked in the interview about the study conducted. The cause of the harm

may be due to the participant feeling uneasy because they were talking about their managers whom some respect as professionals. In this instance counselling was to be arranged so that nurse participants do not exit the interview and be left with emotional instabilities. The leaking of voice recorded information was protected and it included maintaining anonymity and making the voice recorder inaccessible.

### **3.5.6 Justice**

The principle of justice means the right to fair treatment that meant every participant was to be treated fairly and receive equal treatment from the researcher. Every participant was, therefore, deemed equal in the world of research and had equal protection and benefit of the research according to the ethical considerations. This emphasis in the context of research was an expectation that participants should be treated equally and benefit equally too. It also means participants should enjoy all the rights as set in the ethical considerations of research. This was achieved by employing a non-discriminating attitude to all the participants regardless of their categories/ranks (South Africa 1996:2[9]).

Justice means fairness, non-discriminating/non-judgemental. In research justice means choosing research participants who possess characteristics relevant to the purpose of the study. Fairness includes giving benefits promised to the participants and that in this study was measures that could be applied to improve communication between nurses and nurse managers. Fair selection of research participants was another aspect of justice hence all categories of nurses were represented in the study. The reason to such selection was that there should be fair distribution of risks and benefits as a predisposition by the phenomenon under study (Armstrong et al 2013:145). Justice also implied equal access to all the participants and in this study it was in terms of the interview time of the participants. All participants were allowed time to respond to all question as in the interview guide and they were receiving clarity where it was needed.

Research participants were selected for the reasons directly related to the communication problem or the phenomenon being studied. The matter in this study was addressed through describing the communication perceptions and meaning which prompts to staff resignation. The other promise was a mini session giving findings to improve communication and help to curb staff retention. Also a copy of findings was to

be printed for participants to read at home because communication is a social as well as a soft skill which can facilitate personal and professional growth and interrelationships (Burns & Grove 2005:187).

### **3.6 TRUSTWORTHINESS**

The trustworthiness of the study refers to rigour in qualitative research. It is also a criterion for the internal validity of a study and is relevant in naturalistic inquiry. It is the measure taken by the researcher to evaluate whether the research study findings are a true reflection of the data collected from the research participants and not the researcher's perceptions (Polit & Beck 2008:536-537). The model from Lincoln and Guba (1985) is used in this study to maintain the firmness of the study. There are four criteria used in qualitative research to establish the trustworthiness, and these are: credibility, confirmability, dependability and transferability. It has been found that transferability is a complex criterion to apply in qualitative studies.

#### **3.6.1 Credibility**

Credibility was the criteria in establishing the trustworthiness of the study. It was an activity that involved the provision of external checks of the inquiry and it was likely found that credible findings and interpretations were produced (Lincoln & Guba 1985:301) through the technique of prolonged engagement with the nurse participant during the interview. The technique enabled a way to learn the nurses' culture, build trust and to persistently observe them closely as they respond to interview questions. Additionally it assisted because as they elicited some emotions there was a pause and the voice recorder also had those pauses and some of the nurses requested the skipping of the questions and would respond later.

The credibility of the study was achieved through avoidance of interference during the interview and maintenance of focus in the truth of data and interpretation thereof. While spending more time with the nurse respondents, there was a clear demonstration of believability in their responses and there was no distortion of responses on the answering of questions also as in the voice recorder. The same question was answered the same way by different categories of nurses though the verbatim was different but the coding according to their experiences or the meanings attached were classified

under the same theme. The responses from nurses of different categories would be listened to repeatedly, and there was a fit for the truth value between the nurses' participants and the problem statement (Polit & Beck 2008:539).

### **3.6.2 Confirmability**

Confirmability was the next technique which was employed in establishing the trustworthiness of the study conducted. The confirmability was about to ascertain that the findings were grounded from the data collected on interview notes and the voice recordings done. Also included to guarantee the technique was the potential suitability of data in terms of accuracy, relevance or perception meaning as given by nurses during the interview and elicited the opinions of the researcher. In this study the concern was about maintaining relevance of data representing the information given by nurse participants by listening to the voice recorder repeatedly and ensuring that data represent the voice of the participants (Brink et al 2012:173).

In this study confirmability was achieved through maintaining objectivity and involving a neutral focus by revisiting the voice recorder and ensuring that data represents responses from the nurse participants. The findings, conclusions and recommendations were compared with the observations, interview notes and the voice recordings findings and that were supporting the truth value as a confirmation. A reflexive journal was compiled from the notes taken during the interview and the observations noted at that time. A reflexive analysis was also used during the coding process so that the researcher becomes aware of own influence in data (Polit & Beck 2008:196).

Throughout the research study conducted, data showed that findings and interpretations were clearly linked despite the different categories of nurses being interviewed but their responses were related though exact words were different. The process of coding assisted to put categories in themes and subthemes and later the excerpts were cited to ascertain that the research process was focused on the nurses' perceptions regarding communication with the nurse managers and the originality of wording was consistently maintained to prevent changing what was said as it would impair the truth value which may also not confirm reality as said during the interview.

### **3.6.3 Dependability**

Dependability is a criterion for evaluating integrity in qualitative studies. It depends on credibility of the research study and was more based on the findings. In this study dependability was dealt separately as a technique of establishing trustworthiness and it was achieved through maintenance of transparency. It refers to evidence that is consistent and stable. In the study the consistency and stability was maintained through asking same questions during the interview regardless of the category of the nurse participant (Polit & Beck 2008:539-540).

In achieving dependability there was an audit examination, where the researcher had maintained the stability of data over time during the process of interview while the researcher was to determine if there is stability and acceptability of data by also considering the findings. The peer researcher will be invited to do member checking and determine if the interview findings would be the same if the interview was repeated (Polit & Beck 2008:539).

There has been transparency in the sense that despite nurses being interviewed in the natural setting there was a freelancing of communicating own views of communication perception. The dependability was also achieved by maintaining the research process of qualitative research (Gerrish & Lacey 2010:139).

In this study dependability was achieved by conducting a dependability audit which focused on the process and the outcome of the data collection, the interview process. As it had happened during the interview the process of interviewing was according to scheduled appointments and to avoid distracting the nurse participants from their duties in the ward. Included in the process was the taking of interview notes and the use of a voice recorder throughout the interview for every nurse who was interviewed (Lincoln & Guba 1985:317).

The outcome, which was the product of the interview, was achieved by listening repeatedly to the voice recorder and checking against the notes taken to measure the accuracy of data collected. There was also formulation of transcripts which were sampled according to ranks to ascertain if they supported the phenomenon under study. The responses of nurse participants were confirming the same responses though in

different form because of the categories but the meaning of their communication perceptions was of the same intent.

#### **3.6.4 Transferability**

Transferability as a criterion of establishing trustworthiness of the study means the extent to which the qualitative research findings can be transferred to other settings or groups. Focus was on the amount of data obtained from nurse participants during data collection and the validated information from the findings to formulate a thick description of explored communication perceptions of nurses (Polit & Beck 2008:202).

In qualitative studies, transferability is not easily attained (Polit & Beck 2008:202). It means the extent to which findings can be transferred to other setting and still yield same results. Transferability strategies in qualitative study are common and important in disability ethnography study because it gives a thick description of information during data collection. The strategy used to address transferability in sample selection was by using a panel of judges to help in selection of participants, but characteristics of participants, data can be used also. In relation to the use of data the researcher must determine if the content of the interviews, the behaviours and the observed events are typical or atypical (Lincoln & Guba 1985:14). In this study, transferability was achieved by comparing the characteristics of nurses during data collection by observing the behaviour of the research participants, their responses to questions during the interview and identifying whether data is typical.

There was a context of similarities during the judging of responses of the interview from comparison of nurse's demographics who were interviewed. Meaning the findings from interviewed professional nurses, enrolled nurses and enrolled nursing auxiliaries were transferable and confirming the problem statement.

The nominated sample of nurses for the study gave a thick description of their perceptions of communication with their nurse managers and thus enabled the researcher to make decisions regarding the transferability. This could enable readers of the information to transfer the same information to different settings because of shared characteristics (Creswell 2013:252).

### **3.7 DATA COLLECTION**

The letters for requesting permission to conduct the study were forwarded according to the University of South Africa's policy. In addition, the letter for requesting the venue which will ensure privacy and confidentiality for the participants will be forwarded to the facility manager of the hospital.

Data collection in this study is done through the permission obtained from the Head of department of Unisa, the Head of Department from the Department of Health, the CEO of the hospital and the Nursing Service Manager of the hospital. The focus on collecting data will be subjective and this will be achieved by allowing the nurses to interrogate the interview guide and clarity will be given where needed. The focus will be on data and the process of its collection is of importance (Polit & Beck 2008:14).

Data collection is a process that will be used to collect information from the research participant with view to generate tentative new insight and helping to consider possibilities which may not have been considered. The qualitative study as a guide to practice uses a variety of observational and interviewing techniques/methods. The techniques which are used focus also on different ways of data analysis. In this study, unstructured to semi-structured interview will be employed and in-depth interview will be used (Rubin & Bellamy 2012:246) using an interview guide.

The unstructured interview means there should be no issuing of interview guide upfront for the interview; this was applied in this study because regardless of numbering the questions in the interview guide it was not meaning that participant will be questioned as that. Questions were posed at random to reduce stereotyping (Chan et al 2010:2022). In this study the participants were explained that despite the numbering of the questions probing further after they had responded to a question will be included and posing of questions will be at random to enhance the interview responses.

Data collection and data analysis occurred simultaneously in qualitative research studies. These processes required planning of data collection to be in an orderly manner which will help in analysis process facilitation. In this study collection will be through using the interview guide, taking field notes in the form of transcribing and using a voice recorder. The voice recorder was being programmed to label participants in an

alphabetical order and the nurses may be asked their rank or category before the interview so that the sampling number and ranks are according to the set sampling criteria. There will be extra batteries for the voice recorder and a smart phone may be available for recording as a supplementary in case the voice recorder memory is full (De Vos et al 2003:341).

Validation was a matter of triangulating evidence from different sources about same study events. Participants' validation may be carried out by listening to the recorded collected data and compare with the notes taken during the interview to determine the credibility of the study. Triangulation was used to get different perspectives at different angles so that there can be provision of insight about events and relationships. This is truer in this study that communication perceptions and meaning from nurses of different categories may give insight on the relationship which is a part communication drive with nurse managers (Gomm 2008:243).

Interviews and observations were the main sources of data collection in qualitative research. An interview guide was often used, but the purpose was not to control the interview but to maintain consistency in posing questions during the interview. This interview guide was used or designed to provide items for discussion. The main intention was to attain rich description and thus it was important to ask questions in a way that can facilitate the obtaining of much information as possible. The interview guide comprised of open-ended questions as it was the best way to obtain more information from the participants. Open ended questions were type of questions that answer what, where, who, when, why and how (Hedges & Williams 2014:192). This type of interview encourages the respondents to define the important dimension of the phenomenon and to elaborate on what was relevant to them than receiving guidance from the researcher.

An interview is a verbal communication between a researcher and the research participants during which information is obtained for a research study. Interviewing is a flexible technique that can allow the researcher to explore greater depth of meaning than can emerge when using other techniques. It involves asking people questions and equally listening carefully to the answers given. It also involves the use of interpersonal skills to elicit more information and observe the participant during the process of interview. The interview is described as an interviewer-respondent interaction (Denzin

& Lincoln 2000:654) meaning there should be establishment of human-human relationship and the desire to understand than to explain.

The advantage of using interviews is that they allow for the collection of data from participants who are unable to complete questionnaires e.g. nurses in this study are too busy, some may be tired or they may forget to complete the questionnaire (Burns & Grove 2005:540). The strategy in this study will provide in-depth information from nurses on their perceptions and meaning in communication with their nurse managers. Thus the approach of face-face will be employed in a natural setting. The natural setting in this study is the hospital environment which is non-threatening or destructive room which will be used to enhance the narration in the best possible environment (Kvale & Brinkmann 2009:177). The function of the interview is to encourage research participants to talk freely about their perceptions in communication with their nurse managers.

The interview helped the participants to tell their side of the story in relation to their perception and meaning of communication with their nurse managers. Its purpose was to get information needed to establish a working hypothesis about the nature of nurse's perceptions and meaning. An interview is also a step of forming interrelationship with the nurse participants meaning the researcher and participants' social relationship increases. The participants are to tell their stories in their own words and understanding and include the meaning they attach to the subject matter. The use of the interview guide ensures that the researcher will obtain all the information required and give the research participants to respond freely and provide as much detail as they wish (Creswell 2013:173-174).

It can be structured or unstructured or a mixture of semi-structured interview (Burns & Grove 2005:396). The interview will be unstructured to semi-structured in nature with emphasis on asking open-ended questions. The unstructured interview is a measurement strategy common in qualitative research and descriptive studies. An unstructured interview can provide a greater breadth of data in qualitative type of research. It is known as the open ended interview. Unstructured interviews typically comprise of in-depth interview and participant observation, and thus can be viewed as field work type of an interview. This type of interview is used to capture data of a codable nature. It is a face-face type of an interview. The unstructured interview is freer

flowing with the interview guide structure limited to the focus of the phenomenon under study. The Unstructured interview uses in-depth interview which provide more quality data for less though it is costly by nature. Unstructured interviews seek to emphasise the depth validity of each participants' interview and will enhance the story telling to determine the flow of a dialogue. Unstructured interviews are unstandardised meaning the form and order of questions is not identical for each interview. This type of interview is appropriate for descriptive and exploratory research thus probing follow up is possible.

Open-ended questions are used by the researcher when the researcher wants the research participants to respond in their own words or when the researcher does not know all of the possible alternative responses. This applies in this study not all responses are unknown and will be picked during the interview (Creswell 2013:190). Open-ended questions encourage the research participants to explain their perception in a broad manner without limitations and this may yield rich useful detailed information the phenomenon under study. The approach will be a standardised interview using the interview guide because it reduces the bias of the researcher during the data collection. In this approach questions will be asked in a list of open ended order with the same wording each time. A neutral probe will be employed where clarity will be deemed necessary because the interviewee is expected to explain his/her perceptions without being led.

The preparation of questions in an interview guide were in a sequence of inductive reasoning, meaning that the question were from general to specific so that explanations and illustrations can be achieved. The questions prepared by the researcher may be in a logical manner and structured but the participants may not. This also applies that when preparing questions for the interview the researcher knows what he/she wants but does not know how the participants will respond (Polit & Beck 2008:394). Thus in such cases there may be follow-up questions designed to elicit more information or details.

In this study, the interview was conducted like a normal conversation but with a purpose in a quiet room depending on the availability of that room. There were no bystanders in the room only the researcher and the nurse interviewee. Nurse's appointments were confirmed a day prior and on the morning of that day. The interview guide was issued and the respective nurse was allocated time to read through the questions and ask

where he/she needs clarity. It was explained to the nurse participants that the format of questioning will not be exactly as in the interview guide but it entirely depends on the answering of the participant and some questions were necessitating probing. The aim of probing was to enable the interviewee/research participants who are nurses in this study to elaborate on their perceptions and meaning of communication with the nurse managers.

During the interview, a voice recorder was used to collect data and the time spent with every nurse was estimated not to exceed 45 minutes-60 minutes. The estimated period of the interview was 5 nurses per day and only 2 sessions of the interview per week were scheduled. Meaning at least four weeks was to be allocated to collect data from all the target population and the time frame was likely to change as some of nurses were on day offs and some were busy with nursing care in the wards. The interview guide designed comprised of 12 questions which were inclusive of the grand tour question. The grand tour question was employed because it was helping the researcher to terminate the interview session in a manner that will leave the interviewee at an ease state, but the flexibility was to be encouraged by the responses.

### **3.7.1 Administering the data collection instrument**

The administration of the data collection instrument, which was essentially the interview guide (see Annexure G), was the process in data collection. It was the issuing of the instrument to the participants for the sake of preparing them for the interview session. The administration of the data collection instrument (interview guide) was done on the day of the interview as scheduled per nurse participant. The research participants were given a chair to relax, greeted asked if he/she was ready for the interview and the interview guide was issued inside the interview room. Ethical considerations were discussed and clarity was given as a means of addressing the concerns of the research participants. Participants were given at least five minutes to read questions on the interview guide and be allowed to ask questions and clarity where it was needed before the starting of the actual interview. In mostly the key questions was about questions which nurses found to be the same and it was explained to them that they differ in meaning. The participant's readiness was determined by asking if the interview should start or how much time was needed to refine misunderstandings and misconceptions. Despite issues of confidentiality being on the interview guide, a verbal conversation was

also cited to reassure the participants. The other question of concern from the nurses was: who is the manager they are to respond about in the interview?

The nurses who were available were given the informed consent form accompanied by the interview guide and allowed to read through and sign thereafter. The signed consent form was also discussed in-depth and the implications it carries were explained as this was helping to relieve anxiety and threats to the nurses. An appointment was scheduled with the nurse participant, according to their suitability and availability in the hospital meaning nurses will tell of their free time. They were informed of the study significance and the rationale to participate before data collection. The intention of information giving was in context of showing the seriousness of the study so that it could propel honest response.

### **3.7.2 Conducting the interview**

The conducting of the interview was carried out in an environment that encouraged spontaneous behaviour and honest response as observation and interview notes taking was part of data collection. It was solely done by the researcher. Privacy, confidentiality and anonymity maintained throughout to minimise the attributes as they may contravene with the ethical considerations used in research.

The interviews were conducted in a private room and during the nurse's spare time and some were conducted after work. The advantage was that nurses used their off duty time and I one day they had a half day and that was used to pursue the interview. The private room was not as quiet as expected though it was less threatening, and there were restriction of movement around and in the room. A label of do not disturb was posted on the door to promote privacy also a lock and key was used to restrict movements.

The research participants opened the floor for the interview to do more of the narration and an ice breaking question asked what their rank or nurse category was. The interviewer did not lead the interviewee in responding and this allowed the interviewer to do more of the listening than talking. In minimising the interruptions interview notes were taken though the voice recorder was also helping to capture information that may

be missed. Clarity was given to clarity seeking questions and that was anticipated at the beginning of the interview but it ended up being done throughout the actual interview.

The voice recorder was used and the settings were in a way that enabled the recording of time taken per interview. The participants were also made to understand prior responding to questions. Privacy was ensured at all times by not using or asking names and departments where they work and work routine was not disturbed. Included in this reassurance was the explanation that the recorded information was not to be accessed by anyone except the researcher and other researchers who were to be helping in the analysis of data when the need arose. This served as a precautionary measure so that nurse participants should not think that the data they provided has leaked. They were explained to concerning the procedures that might be followed after the data analysis and the acceptance of the data collected. Part of the explanation was that the recorded information might be discarded to further strengthen the privacy and confidentiality of their information.

The use of the voice recorder freed the research interviewer on concentrating to the questions and the dynamics of the interview. It reduced and prevented the interruptions from the researcher except for cases where probing was a necessity otherwise it might have engaged a platform which could have ended up debating with the interviewee. The interviewee's words, their tone, and pauses were recorded permanently and hence it was possible to return again and again for listening (Kvale & Brinkmann 2009:179).

The use of the voice recorder during data collection initiated the transcription of the interview, which means that the voice recorded interviews were generally written word for word without changing the meaning. Each interview was transcribed in a single page and there were blocked brackets for coding on end of the sentence which needed coding. Each page was numbered so that information linkage could be achieved. The voice recorded interviews were listened daily after at least five nurses have been interviewed to explore the content and pick up the similarities and differences as according to their responses. During the listening the voice tone, inflections were considered and the question that made the participant to respond in that way was explored simultaneously with the participant including the pausing as it indicated the emotions on the phenomenon under study (Burns & Grove 2005:548) and it was also a measure that indicated if the study was worth or very important to undertake.

Data reduction was done through a process of reducing collected data so that it can be manageable. This process did not encourage ignoring key meanings but it enabled the researcher to apply strategies like coding, development of themes and sub-themes which were emerging. The data collected in qualitative research was massive thus data reduction was necessary for making the attachment of meaning.

The participants were allowed to questions if any and thanked for participating in the research study and were promised to be invited to attend a feedback session so that they can hear how their contributions will effect change and shape communication in the hospital.

### **3.8 DATA ANALYSIS**

Data analysis in qualitative research is a process of identifying patterns, commonalities and regularities in the transcribed interview. It involves an examination of text and is termed as hands on process as it is time consuming because massive amount of data was collected. There is a lot of reflection on possible meanings and the relationship of data (Brink et al 2012:193). In this study data analysis is guided by De Vos et al (2005:337).

It is a method used to organise raw data and putting it in a way that provided answers to the research questions. It entailed categorising, ordering, manipulating and summarising the data and describing it in meaningful terms. The analysis strategy in qualitative research study was narrative. This applied in this study because it was purely a descriptive study which used unstructured to semi-structured interview guide in data collection. The analysis strategy in qualitative was to be planned before collection of data as they are likely to occur simultaneously (Brink et al 2013:192).

It is a systematic organisation and synthesis of research data. It is the synthesis of all data collected. Data is sifted and conflicting views is reconciled and also to dudge what evidence is reconciled. In qualitative research data analysis occurs simultaneously with data collection. The data analysis takes two forms: analysis at the research site during data collection and analysis away from the research site after data collection. It was the process of bringing order, structure and meaning to the masses of data collected and

convert it into findings (De Vos et al 2005:337). The importance of data analysis is to single out the uniqueness of each research participant's response in the phenomenon under study.

The analysis demanded the reading of the whole transcription and listening to recorded interviewed data, voices and the inflections that escaped to be noticed during the interview (Hedges & Williams 2014:195). Qualitative data analysis maintained a balance between the maintenance of the richness of data and the evidentiary value of data during the reduction phase. The reason behind was that because the qualitative data was much easier to understand because of the told stories.

The analysis of data involves the examination of words, because data in qualitative research is non-numerical and it involves the integration and synthesis of collected data. The massive amount of data collected is in form of spoken words, audiotapes, videotapes and or photographs (Brink et al 2013:193). In this study data was collected in the form of spoken words and the use of a voice recorder and a little bit of observation was employed so that the interviewee must not think the researcher is not interested on the conversation. Through this form of data collection, a lot of time is spent reflecting on possible meanings and the perceptions of what is being recorded during analysis.

Analysis of data in qualitative research was a labour intensive activity that required creativity, sensitivity in conceptualisation and sheer hard work. It took the form of loosely structured narrative material like verbatim, meaning in exactly the same words as were used originally. The words for word analysis means during the data analysis no meaning was changed or converted as it may change what the participants have said (De Vos et al 2003:343). The alternative is that in qualitative research the researcher is free to modify the originality during the course of study because of the insight. This type of analysis has a flow of reasoning from concreteness to increasing abstraction. The method uses special type of data collection and data analysis (Burns & Grove 2005:536).

During the collection and analysis of data it is important for the researcher in qualitative research to be able to separate what is already known or what the researcher thinks about the phenomenon under study from what the participants are telling. Preconceived

ideas are dangerous because they may foster bias in the study. In order to avoid making assumptions, it is important that the researcher becomes aware of own knowledge, opinions and experiences so that they do not interfere with the ability to truly hear and understand the experience of the participants. Otherwise there was the risk of producing results that are merely reflections of the researcher (Hedges & Williams 2014:193).

The styles of analysis in this study are the editing analysis style and immersion style. The editing styles enhance development of category scheme by reading through data collected and search for meaningful parts. During this style coding was used to organise data and connect categories. The editing style was achieved through data reading, categorising it through coding by using procedures within the study (Polit & Beck 2008:508).

Qualitative researchers use common steps in analysing data and it started during data collection. These steps were according to De Vos et al (2005:337) and included:

- Collection and recording data
- Managing data
- Reading and 'memorising'
- Describing, classifying and interpreting data
- Transcribing and data reduction.
- Representing and visualising
- Coding

### **3.8.1 Collection and recording data**

The data analyses take two forms in qualitative study: it is at the research site during data collection and in this study it was in the interview room. The other analysis form is away from the research site after data collections which in this study it was away from the hospital environment, and that was not done because the shift from the natural environment would have posed threat of bias in the study.

### **3.8.2 Managing data**

It means management of data collected away from the site where it was collected. In this study because of the use of a voice recorder a quiet place was a necessity to prevent background noise. This helped with eliciting the transcription from the recorded data and field notes and the entire data will be organised as it made the analysis to be more efficient and data to be easily retrievable (De Vos et al 2003:343).

Along the process of managing data there was a creation of files from the original collection on the interview notes and voice recorded information. The alphabet allocated to the participant was put on and the file was organised in an alphabetical order.

### **3.8.3 Reading and memoing**

The reading of collected data encourages getting the feeling for the whole conversation. The transcriptions are to be read and re-read until sense is achieved as it was during the interview. The reading and re-reading also encourages familiarity and the researcher engages in the process of editing as though it is an active session. This process simply relives the interview whilst analysing. The re-reading makes the researcher to immerse the self on data collected (immersion of data). It is important because the voice recorder contain more words (De Vos et al 2003:343).

The immersion style involves reflection meaning the data collected was read and re-read. In instances where the researcher was interacting with participants then there were to reflect in and on every contact with each participant during data collection. Inclusive in data collection was the use of voice recorder which further necessitates listening repeatedly and continues categorising and coding data. The field notes were also used to maintain the richness of data (Polit & Beck 2008:508). The making of memos about the context was through reflections on data and discussion with the participants.

The collected data was read repeatedly, and notes were made on the margins of the interview notes. There was also the listening on the voice recorder and some note making was done to compare with the interview notes.

### **3.8.4 Describing, classifying and interpreting**

This step in data analysis included noting the regularities, participants selected for the study and describing the data collected and categorising it differently. During data classification, data is reduced to small manageable themes. This meaning in the context of this study is that the perceptions and meaning of nurse's communication with nurse managers were described differently as each nurse is a unique human being in thinking, viewing and speaking. The classifying of data comprised of categorising, looking for themes or the dimensions of data. It involves identifying general themes which can be viewed as sub-themes during data analysis (De Vos et al 2003:343-344).

The description of data in data analysis is simultaneous with interpreting step. The interpretation of data analysis means explaining the meaning and translation of what is said into research language. In this study the perceptions of nurses and their meaning of communication with nurse managers will be explained as it will be forming part of their personal views and social views. The explained data will then be categorised either in themes or subthemes through the coding process.

### **3.8.5 Representing and visualising**

Representing in this study will mean pointing out the meaning as each participant will during the interview. This included similarities and differences noted and general features were also looked into. The perceptions will also be pointed out and it is anticipated that different wording for perception will be unique as each participant has their own way of explaining their views or perceptions of communication with their nurse managers. Visualising data means giving or allocating a picture of the narration of the interviewee. The step of representation and visualisation will enhance the formation of visual image in a table form as below. In this study the perceptions and meaning of communication as collected data will yield a visual matrix which can help with further description and interpretation and also will highlight the relationship among the indicators.

**Table 3.1: Themes and sub-themes**

<b>Themes</b>	<b>Sub-themes</b>
Perceptions of communication	Perceptions, content
Meaning of communication (feelings)	Feelings, meaning
Behaviour in communication	Attributes or characteristics
Effects of communication	Exhibited behaviours

### **3.8.5.1 Themes**

As in the above diagrammatic figure, themes were key issues that relate to the perceptions of nurses regarding communication with the nurse managers. In qualitative study themes are also known as categories which in this study they serve as broad units of information containing codes forming a common idea (Creswell 2014:186).

### **3.8.5.2 Sub-themes**

The sub-themes were subjects of discourse or discussion and it means the composition of topic under study. In this study the sub-themes were about explored meanings of communication perceptions from nurses and with addition of observations noted during the interview.

### **3.8.5.3 Excerpts**

Excerpts are the exact words said by the research participants without changing the meaning during the interview in the data collection process. In this study this was further strengthened by interview notes and the use of the voice recorder and also designing of transcripts to enable the coding process. The compliance to maintain excerpts as explained in previous chapters was to help in eliciting bias in the study and the changing the meaning which may impair what the study was means to research.

### **3.8.6 Coding of data in data analysis**

Coding means categorising or organising data, and code means a symbol or an abbreviation used to classify words or phrases in data collected. It helps to bracket chunks and writing a word representing a category. It involves taking a text data or

observations gathered during data collection, segmenting sentences or paragraphs into categories and labelling them with a term. The term is usually based on the actual language of the research participant (Creswell 2014:189). This study will use coding and codes by noting kind of indicators and things that are going on in the phenomenon being studied, the form a phenomenon takes and any variation within the phenomenon.

Coding of data was used to organise data collected in an interview through spoken words and the voice recorder, because using the voice of the research participant enabled evaluation of existing instruments (LoBiondo-Wood & Haber 2010:103). The categorising and coding of themes was achieved through refining the categories. There were methods or types of coding data in qualitative study and that include open coding, axial coding and selective coding (Moule & Goodman 2014:415). There were also the other types of coding which when the researcher collect own data and transcribe arise, these includes expected codes, surprising codes which are usually not anticipated and unusual codes (Creswell 2013:184).

In open coding data was broken into parts and compared for similarities. This type of coding helped with the generation of categories that capture the same actions, events and objects that were grouped together. The axial coding was where the categories and sub-categories are linked around the axis of a category. The selective coding involved the integration and refining of the theory. The three coding types were used in this study but the most appropriate is the open coding type (Moule & Goodman 2014:416).

The coding of data was facilitated by three activities which are: data reduction, data display and conclusion-drawing or verification. Data reduction was as important because it assisted with reduction of frequently emerging categories. After such reduction has occurred there was data display and conclusions and verification were to be done. In this study this activity takes place by involving the research experts and the supervisor of the study so that common understanding is attained.

### **3.8.7 Transcribing interviews and reducing data**

Transcribing is an interpretative process where differences between oral and written texts give rise to a series of practical and principal issues. Transcribing is a conversational interaction between two physically present persons and the data

collected becomes abstracted and fixed in written form (Kvale & Brinkmann 2009:178). In this study transcribing of data is very important as it will help with reduction of data from the massive data collected.

The purpose of transcribing interviews in qualitative study is important because it serves as the researcher's raw data and it influences the nature and direction of the analysis. It is necessary in this study as it will help to achieve the research goals (David & Sutton 2004:91). There will be use of a voice recorder and the advantage of a voice recorder is that it will be played and replayed until the whole data is captured and transcribed in a typed form so that coding can be easily achieved.

Transcription of data using a voice recorder is also known as verbatim transcription because the exact words spoken by the participants are put in written or typed form. The accuracy of the transcription is very important because analysis in qualitative studies enhances trustworthiness, as it will reflect the totality of the interview experience validly (Polit & Beck 2008:508).

### **3.8.7.1 *Transcribing process***

In this study transcribing was dual, meaning from the voice recorder and whilst listening to the interviewee. The voice recorded interviews were recorded word for word during the transcribing. The voice recorder was paused and replayed. Typing was employed and there was space left for every interview and it was recorded as in the voice recorder. There was space left for coding also. The typed pages of a voice recorded data were labelled or numbered according to alphabets or numbers in the voice recorder to avoid mixing of data collected (Burns & Grove 2005:547). After writing, the voice recorder was replayed and whilst listening the written transcript was read. The features relating to perceptions and meaning of communication were the most appropriate to answer the research questions thus the analysis will focus on meaning and perceptions of communication. Each transcribed piece of data was checked for accuracy because inaccurate wording may change the entire meaning of the sentence (Waltz, Strickland & Lenz 2010:236).

### **3.9 CONCLUSION**

This chapter focused on research paradigm, design, population, and method. Ethical considerations with regard to data source, data collection, data collection instrument, process were observed. The scientific integrity of the study as well as data quality was maintained. Data was analysed guided by De Vos et al (2003).

## **CHAPTER 4**

### **DATA ANALYSIS AND INTERPRETATION OF RESEARCH FINDINGS**

#### **4.1 INTRODUCTION**

This chapter mainly focuses on data analysis and interpretation of the results of this study in order to obtain a better understanding of each item of nurse participation information from the data that was collected. Data analysis refers to the methodological and interpretive presumptions that the researcher brought to bear on their data. The chapter further reflects on the nurse manager's relationship with the nurse participants and the phenomena under study (Botma, Greef, Mulaudzi & Wright 2010:292).

The discussions are based on data analysis and interpretation of findings from the interview and the voice recordings. The data analysis process depends on research design and methodology of the study undertaken. The interpretation of the findings of the researched phenomena which is communication will be described as it has been explored.

The purpose of interpretation of findings is to describe similarities, differences and tell stories about nurses' perceptions of communication with their nurse managers. It will also bring awareness to the nursing management and other managers of other disciplines how communication is important and how it can bring about the smooth running of the institution. The findings will also clarify the uniqueness of each nurse practitioner who participated in the research on their own version of communication perceptions and the meaning they have attached when communicating with their nurse managers.

The purpose of the research study was to explore the perceptions of nurses regarding communication with nurses managers and the meaning of communication according to own understanding and to suggest recommendations on how communication can be improved so that the managers can utilise as a tool them as a tool for staff retention. In a world view of the research, study nurse and nurse managers should do introspection

and reflect on and in situations where they missed this important social tool for creating harmony in the workplace.

## **4.2 DEMOGRAPHICS OF THE RESEARCH PARTICIPANTS**

The research participants were drawn from the same institution but different disciplines. There were 30 nurses who participated in the interview of the study. Among this number a mixture of gender was also included across all categories males were six, professional nurses were three, enrolled nurses were two and enrolled nursing auxiliary was one. The breakdown of 30 was 10 professional nurses, 10 enrolled nurses and 10 enrolled auxiliary nurses. The age and years of experience was not considered but preference was given to nurses who were employed over five years in the institution.

## **4.3 CODING FINDINGS**

The concept coding means organising data by bracketing chunks and writing a word representing a category. It involved taking a text, data or gathered during data collection, segmenting sentences or paragraphs or images into categories and attaches labelling to the categories with a term. The term is often based in the actual language of the participants. In this study coding was focused on themes, sub-themes and excerpts. The themes are as a category and the coding paradigm was voice recordings especially the tone of the participants and observation done during the data collection (Creswell 2013:184).

### **4.3.1 Coding**

The coding which was identified from the data collected comprised of the three types.: focused on observations though at a minimal level and that included expected codes, surprising codes and unusual codes. Expected codes are types of codes were what nurses described as the structures of communications. This type of codes were identified regardless of ranking, except that the meaning from Professional nurses was based at a high context and complexities were also identified, e.g., they said communication is a tool, interaction and the hierarchy was also spelled out. The other categories gave the simplest form of their perception and meaning of communication within a practice and that gave rise to acknowledging concrete experience. In that

context it lead to acknowledgement that communication will remain a core of uniqueness regardless where it is applied (Sully & Dallas 2010:22-23).

Inclusive in the expected codes were listening skill, behavioural aspects and emotions involved. The said words were also integrated in the form of excerpts so that it can clearly describe the perceptions that nurses have with regard to communication with their nurse managers. 'Surprising codes' were codes which were not anticipated but somehow they emerged. The codes in this study were few and included cell phones used as means of communication structure as described by a certain rank of nurses. The traditional technological instrument that would not be surprising would have been the mention of a telephone but it came up unexpectedly and it included the use of culturally sensitive language (Sully & Dallas 2010:140-141).

On exploring further the relation of culture it appeared that the use of mannerisms and non-verbal cues by nurse managers left nurses confused and it was then perceived as disrespect to them (Sully & Dallas 2010:140-141). Additionally, what was a surprising code was a mention of the word discrimination. The exploration of the mentioned word described the discrimination in context of ranking. On exploring further it was distinct that nurse managers communicate better with Professional nurses to a certain level but when it comes to addressing the nurses of other categories they are ridiculed and disrespected. Unusual codes were very rare codes which happened to emerge when least expected and at times they never made full sense relating to the phenomenon under study. In this study, such codes were identified on communication interpretation. It has been unusual to hear such codes been explored in a different way. One of the nurses said the ethnicity and also where you come from is of importance to other nurse managers and in exploring further then came up emotions, poor reflection which impair relationships in the workplace.

The most unusual code was about the reflection of nurses towards the nurse manager especially after an unpleasant experience during the communication. The voice recordings clearly described that there was no reflect in and reflect on after a miscommunication and on exploring further it was explained that there is no apologies afterwards even when emotions were involved. The perceptions of nurses was that nurse managers do not know how to respond when situations arise hence a use of

defence mechanism was described differently e.g. a manager will attack nurses and when they retaliate she would say they are rising her blood pressure.

#### **4.4 SIMILARITIES AND DIFFERENCES OF COMMUNICATION PERCEPTION**

##### **4.4.1 Perceptions of communication according to professional nurses**

The interviewed professional nurses described communication as a tool for interaction that involved message, sender and the receiver of the message. In further defining the meaning of communication, they said it is in the form of verbal and paper. A broader way of communicating verbally it clearly showed that only work related matters which are mostly patient centred are discussed and human resources matters. The other verbal communication which these categories of nurses has verbalised about is giving of meetings feedback when it suits the particular manager. The verbal communication was further clarified as high tone voice used accompanied by some form of mannerism which demonstrated insubordination because some nurses experienced being shouted in front of the patients and some in front of colleagues.

The most offending was the sadness and tearfulness which I observed as a researcher during the interview. That clearly indicated that it has been a long sitting problem and the unfortunate part is that nurses do not know where or to whom they can turn to. The interview appeared to be a platform of a debriefing session and some even said "it feels better now that I have talked to somebody". In the further probing it came clear that managers are unapproachable, have poor listening skills, have restricted communication such that nurses cannot talk freely around them hence they keep to themselves.

The communication structures that this category of nurses described included the organogram, notice boards, communication books and circulars. The circulars were central because some are internal and some are external. These circulars were said to be arriving late and that impact on the work they do. Inclusive was that some of the circulars involving patient care and when they arrive late there is risk posed to patients already. The effect is that nurses find themselves incompetent, irresponsible and somehow being hazardous to their patients.

The social and personal communication was found to be absent thus some nurses verbalised that due to work pressure and poor relations with nurse managers it led them to absenting themselves from work and additionally some are still looking forward to resigning. The bigger picture is that regardless of the increased workload, shortage of resources nurses concur to continue the service but due to managers attitude to them they have no option but to leave the institution. The issue of favouritism was cited as a high profile issue, especially to nurses of lower categories who are favoured by the nurse manager just because she or he has been allocated in the same discipline for too long, and gossiping professional nurses arise and the manager cannot hardly discipline the nurse concerned, e.g., a manager being a friend of an enrolled nursing auxiliary.

The paper communication which is a form of non-verbal was found to be another challenge in communication. The nurses cited circulars which come late in the wards and that it affects their work as some of them guide them on new trends that are to be implemented. There also emerged that these circulars are at times not understood and they lack meaning to them if the manager is unable to explain. It was also found during the interview that some managers do not even know about the circulars and yet it is impacting on the delivery of service. The key concern was that this can hamper patient safety and the official competencies will be questionable because of the manager's ignorance.

The professional nurses were concerned about their roles and responsibilities as they in most cases find themselves lacking the direction from their managers as their leaders. A long conversation about the feelings of hopelessness and frustrations were also identified. The mostly encountered by nurses is the fear of nurse managers because of the portrayed attitude and the insensitivity they display towards them. Additionally to the communication behaviour which was a form non-verbal professional nurses said managers are unapproachable, ignorant and that leads to them feeling neglected and not being free to discuss issues that affect them in the workplace.

Professional nurses cited that managers befriend nurses of lower categories who have been working in the ward for too long. This increases the gossiping which also exacerbates conflicts in the ward. A nurse from this category pointed out that the worst nightmare is when the manager sabotages their creativity in the ward as they are trying to find ways of improving the service they render. "I am frustrated because the project I

initiated is held back by my manager, just because it is not from his/her initiatives". The nurse concerned showed sadness all over her face and the tone of voice became low and shaky.

#### **4.4.2 Perceptions of communication according to enrolled nurses**

The enrolled nurses during the interview had their own version of communication definition and the perceptions and the meaning they have attached. This category of nurses defined communication as a way of talking in the workplace, an exchange of information a way of passing a message to someone and also as a harmonious way of sharing information and there is listening involved.

They perceived communication as the attitude that they experience from their nurses managers and this bothered them that is it because they are a lower category. There was an emergence of emotions which clearly demonstrated that the treatment they receive from the nurse managers takes the form of bullying type of communication.

On several occasions, a nurse who verbalised confusion and mistrust from the manager expressed the thought by imitating the manager and was able to exclaim the unprofessionalism in a broader context. A nurse from the category of these nurses cited their confusion of understanding what neither are the communication structures that are used because the nurse managers hardly demonstrate to them nor teach them. There were a lot of frustrations and emotions evoked. Part of the emotions was picked from the pitching of voices and sadness observed from the nurses. The voice recorder also has some areas of pausing before responding or the seeking of clarity from the question asked. The effects picked up was that nurses are afraid to lose their qualifications but if that was not the case physical fight could have erupted because of the treatment they receive from the nurse managers.

The nurses in this category claimed that there are instances where they are ridiculed such that tension reaches its highest peak. A nurse from this category said" I will go to the toilet and cry", the other one said a relieving factor is to go out and smoke to feel better and the others said we are rescued by our other colleagues or professional nurses who happen to be around.

The solution that interviewed nurses cited was that they are looking forward to resigning but because they are not always sure of being employed easily they are still stucked in the hospital but I was assured that the search is continuing. They made it clear that they do not expect honey and milk where they will be employed but the point is they will be out of the recent institution. A lot of bad experiences were clouded by bitterness and they claim that it is because they are from a lower category.

#### **4.4.3 Perceptions of communication according to enrolled nursing auxiliary**

This category of nurses had a different version of defining the perceptions of communication and the meaning encompassed. Firstly, to them a nurse manager was regarded as a supervisor, a woman or man, a leader and a mother or a father but there was/is no parental-manager support. The bigger picture was that managers do not demonstrate motherhood hence communication has no meaning to them. Their definition was put across in simple terms that communication is the way of talking, how you respond, interpret messages and the listening. They further described the communication structure as meetings in the ward, verbal and non-verbal communication. It has also seemed as if the difference between types or forms of communication is misunderstood by these nurses.

The exploration of this category of nurses painted a picture of nurse managers who do not have listening skills, they are judgemental and in this regard the issue of age difference and ranking was cited. The most effecting comment was the gossiping nurse's issues either with colleagues in the ward or in other wards. It was a bad feeling to them and such it evoked emotions like frustrations, anger and loss of morale. They were worried that managers make examples about their colleague's issues when addressing them. This is how the integrity on privacy and confidentiality was of paramount concern. They made it clear that they do have problems which impact on their productivity at work but because there is a social barrier to managers, this restricts communication. Their biggest fear was hearing their personal issues being discussed or known by other colleagues.

When personal and social perceptions of communication were explored one could also identify the non-engagement view of the officer because of the expressions exhibited and the repetition of the phrase that 'my manager does not listen'. They perceived

communication with nurse managers to be the most difficult than when communicating with colleagues of the same category. Their only well-established communication is based on work-related issues. The mostly work-related issues were said to be problems they experience among shifts, complications in the ward. They were worried that it is ruled out that they are also human beings despite being nurse professionals. They verbalised that at times managers become very rude such that one wish to could have stayed home than to be in the misery. In other instances they apologise even if not wronged anyone, some said my coping mechanism is stay away from my manager, “I cannot share the same room with her even during lunch and tea breaks. Managers intimidate nurses of and from the interview it came out clear that it’s because of low ranking or category.

#### 4.5 THE THEMES, SUB-THEMES AND EXCERPTS

During data collection and analysis there was an emergence of themes, sub-themes from the interview and the voice recorder transcriptions. Literature through books and Journals both of nursing and communication were reviewed and integrated with the exact findings from the interview refer the table below:

**Table 4.1 Themes and sub-themes in communication**

<b>Themes</b>	<b>Subthemes</b>
A. Meaning	<ul style="list-style-type: none"> <li>• Tool</li> <li>• Exchange of information</li> <li>• Passing of messages</li> <li>• Meaningless</li> </ul>
B. Feelings	<ul style="list-style-type: none"> <li>• Mistrust</li> <li>• Hopelessness</li> <li>• Helplessness</li> <li>• Despondent</li> <li>• Inferiority complex</li> <li>• Mood fluctuation</li> <li>• Pain</li> <li>• Hurt</li> <li>• Fear</li> <li>• Anger</li> </ul>
C. Behaviour	<ul style="list-style-type: none"> <li>• Isolation</li> <li>• Aggressive</li> <li>• Avoidance</li> </ul>

Themes	Subthemes
	<ul style="list-style-type: none"> <li>• Unapproachable</li> <li>• Negativity</li> <li>• Bullying</li> <li>• Defense mechanism</li> <li>• Undermining</li> <li>• Passive</li> </ul>
D. Communication skills	<ul style="list-style-type: none"> <li>• Non verbal</li> <li>• Listening skills</li> <li>• Mannerism</li> <li>• High pitch voice</li> </ul>
E. Competence	<ul style="list-style-type: none"> <li>• Incompetence</li> <li>• Interpretation</li> </ul>
F. Professionalism	<ul style="list-style-type: none"> <li>• Privacy</li> <li>• Confidentiality</li> <li>• Gossiping</li> </ul>
G. Consequences/Effects	<ul style="list-style-type: none"> <li>• Lazy</li> <li>• Grudge</li> <li>• Conflicts</li> <li>• Absenteeism</li> <li>• Resignation</li> <li>• Quitting nursing</li> </ul>

#### 4.5.1 Theme A: Meaning

The communication meaning is widely described by different authors and communication gurus. This put emphasis on this world-wide concept which needs to be given attention for the smooth running of the businesses and improving the interpersonal, intrapersonal and mass communication. Communication means a two-way process during which information is transmitted in a specific code and by means of a specific channel from sender to a receiver, who respond to the stimulus by means of feedback (Van Schalkwyk 2013:3).

It is a tool for survival and it occurs everywhere and all the time thus its importance is greatly increasing in the workplace. Nurse managers need communication skills to enable them to acquire and apply knowledge covering a wide range of activities and subjects of nurses concerns. Meaning of communication in the context of this study is the real importance of a feeling or experience (Oxford Advanced Learner's Dictionary 2010:914). They need to know how to maintain sound interpersonal relationships and how to communicate effectively so that they can influence the perceptions of nurses

with regard to communication. The hospital as an organisation will benefit greatly from members who have developed effective communication skills.

The meaning of communication was described differently by different nurse categories although the context was still maintained. The nurses described communication as a tool for human interaction, an exchange of information among shifts and other members of the multidisciplinary team, the passing of messages among nurses even during the changing of shifts.

#### **4.5.1.1 Sub-theme 1: Tool**

Communication as a tool binds all activities together and enhances service delivery. The description of the perceptions during the interview was that it is a tool for human interaction and furthermore it was said it promote nurse-nurse-patient relationship and if well applied it moulds the professionalism. Communication as a tool means ability to communicate intended message to the target audience. The tools which were commonly cited were circulars, memorandums, organogram and notice boards, s from the employer and of focus were human resources related circulars (Muller 2011:207).

(NP/A) "Communication is a tool used for human interaction and to pass on the message, it could be verbally or non-verbally."

#### **4.5.1.2 Sub-theme 2: Exchange**

Exchange means involvement or an argument of two or more peoples in a conversation. The exchange of communication in this study was explored as giving information and feed backing at the same time. This during the interview was also sharing information until all staff members are informed (Oxford English Dictionary 2007:159). Exchange also meant an act of giving something to somebody and receiving something in return. The context of exchange in the study was giving and receiving information as well as feedback.

(NP/M) "Communication is the exchange of information between two parties."

#### **4.5.1.3 Sub-theme 3: Passing of message**

Passing of message was perceived as sharing information even if it means using the notice boards, communication book so that everyone in all shifts in the ward can be updated with current information. Passing of message meant one nurse receiving the message and giving or forwarding to others (Oxford Advanced Learner's Dictionary 2010:978).

(NP/F) "Communication is the passing of message to each other or among shifts in the ward."

#### **4.5.1.4 Sub-theme 4: Meaningless**

The manner in which communication is problematic is such that nurses perceived it as meaningless. The most prevalent comment about this sub-theme was that if one gets communication and it is not explicit and if the nurse manager cannot clarify then it was regarded as having less meaning. It is in this sense that it complicates the working relations. In addition to meaningless communication was the attitude they get, seeing it becoming manifested from nurse managers. This makes everything communicated to them to be of little or no meaning. Thus meaningless meant communication without purpose and not worth doing as described in the study.

(NP/B) "I do not listen to what my manager tries to communicate across because he/she say things he/she cannot clarify hence if I do not get the meaning I do not consider it."

(NP/C) "Communication is a meaning less subject between me and my manager, actually I regard it as null and void it has less meaning."

#### **4.5.2 Theme B: Feelings**

Feelings are a physical sensation of touch through either experience or perception. In Psychology it is a conscious subjective experience of emotions. Perceptions of feelings do not necessarily result in a universal reaction among receivers whom in the context of this study are nurses of other categories, but it varies depending on tendencies to

handle situations. There is a variation of feelings which can be grouped into positive and negative feelings. The negative feelings commonly describe some form of uneasiness and positive feelings describes trust (Kaplan & Sadock 2010:508).

Many people in the workplace have challenges in expressing their feelings or sharing them when faced with communication misunderstandings especially with their managers. It has been a culture of business to respect the managers and they, in turn, do not give back the respect to co-workers. The importance of expression of feelings is a right and not a privilege (South Africa 1996); thus nurses, before being employees, professionals are also human beings and they are not exempted to this right.

Feelings are communicated less by words a person uses than certain non-verbal means, e.g., facial expressions. There was a variety of negative feelings explored from nurses and that included mistrust, hopelessness, helplessness, despondency, inferiority complex, mood fluctuations, pain, hurt, fear and anger.

The nurse participants experienced mixed feelings while they were interviewed. During the interviews, some of the participants cried as they expressed their difficult experiences of communication with their nurse managers. Some of the participants viewed these feelings negatively but made themselves strong; they were also feeling despondent, lacked morale because they weren't listened to by other members of the health team management, experienced Professional nurses, nurses who have been long allocated in the same unit.

Feelings are senses of awareness. In relation to communication nurses described their feelings in a very broad spectrum and this was also an indication that the manner in which they communicate with their nurse managers evokes emotional feelings. The explored feelings from nurse participants were also observed during the interview and again, with the use of the voice recorder, there were instances where the pausing of responses was experienced and in view it displayed mixed feelings and some element of uneasiness (Kaplan & Sadock 2010:507-545).

#### **4.5.2.1 Sub-theme 1: Mistrust**

Trust in communication plays a major role and if it is compromised, it breaks the working relationships among nurses and nurse managers. Mistrust can be psychologically impairing as it will aggravates conflicts (Kaplan & Sadock, 2009:173).

(NP/D) "I cannot trust my manager with my personal information because when he/she is not in good mood nor have an outburst everyone may know."

(NP/B) "I had an experience where I heard her telling a colleague on the corridor about a nurse 'challenges, so whom I'm I to trust her?'"

#### **4.5.2.2 Sub-theme 2: Hopelessness**

A sense of hopelessness was expressed by nurses because what is communicated to them by nurse managers does not does not give hope. this included asking questions and they do not receive answers (Muller 2011:205).

(NP/A) "I feel so hopeless because I am a human being and have so many challenges but my manager cannot help me solve them. I mean even work related challenges."

#### **4.5.2.3 Sub-theme 3: Helplessness**

Helplessness in communication is a feeling of not being able to take care of self or do things without the help of others (Oxford Advanced Learner's Dictionary 2010:698). Some of the nurse participants experienced negative feelings but they believed that maybe it was a way of making them strong. There were also feelings of despondency, lack of morale because they are not listened to by other members of the health team management.

(NP/E) "My manager is never helpful even when it involves giving information to affirm what must be done. It is really sad and very demoralising being around such a nurse professional."

#### **4.5.2.4 Sub-theme 4: Despondency**

Despondency means a feeling of lack of hope and no expectation of improvement and it clouds one with uncertainties. The nurses were not certain if the communication can improve because their managers lack communication skills (Muller 2011:206).

(NP/F) “When the manager is around there is a lot of despondency, I mean everyone is sad and do not want to show up next to him/her because of the attitude he/ she has displayed to us and lack of sense of change. What kind of a leader is he/she without leadership skills.”

Nurses reflected sadness during the interview and they were offended that communicating with the nurse managers leaves them sad and very frustrated after deliberations that impact on their work.

#### **4.5.2.5 Sub-theme 5: Inferiority complex**

The inferiority complex means nurses did not feel as good as nurse managers hence issues of ranks were repeatedly mentioned during the interview because they perceived that they are not viewed as important members of the health team and yet they are always hands on when managers are regarded as absent but present (Muller 2011:206).

(NP/G) “I feel not listened to just because I am a nurse of lower category. Even if when you express yourself you could see that whatever you are saying is not taken into consideration.”

#### **4.5.2.6 Sub-theme 6: Mood fluctuation**

The mood fluctuation is the feeling of nurses at some point in time. visa-versa the nurses experience the same moods from the nurse managers. Moods are feelings of at times being angry or unhappy without warning (Kaplan & Sadock 2010:508). These moods may often hamper with communication and thus service delivery will be affected.

(NP/D) “You do not know exactly when to approach the manager, sometimes when you want to talk to her you can see he/she is not in the mood. At times when you greet her you do not know if he/she responded or not.”

(NP/E) “When my manager is happy everyone must be happy but when she’s not in the mood shouting and screaming even in front of patient or visitors is what we experience”.

#### **4.5.2.7 Sub-theme 7: Pain**

Pain is some form of discomfort and in communicatio it is exhibited by psychological harm. Pain is more often accompanied by sadness and it leads to a degree of discomfort and empathy should be demonstrated (Muller 2011:210).

(NP/C) “The pain that I am experiencing is so intense that I am even uncomfortable to be around her.”

#### **4.5.2.8 Sub-theme 8: Hurt**

Hurt is a form fo pain as described in the dictionary (Oxford English Dictionary 2007:222). In the context of the study hurt was expressed by the participants as a way how their nurse managers addressed them when in a conversations.

(NP/A) “It hurt so much to see that nurses of lower category are receiving more attention just because the nurse has been allocated in the ward for too long. The worst discomfort is when the nurse manager screams and shouts at you and doesn’t listen to your side of the story”.

Nurses also cited that the fact that nurse managers do not engage them in ward activities and communication but when they need action it becomes demanded on them. They acknowledged their role as team leaders but they complained that they treatment they receive from nurse managers is hurting them (Armstrong et al 2013:264).

#### **4.5.2.9 Sub-theme 9: Fear**

Fear is an alerting signal, it is a response to the known external non-conflictual threat. It is caused by consciously recognised and realistic danger. Fear in communication is an obstacle and it affects assertiveness in communication. The fact that nurses are not comfortable to face managers it clearly shows that they are afraid of them (Kaplan & Sadock 2010:281, 591-592).

(NP/C) "I am afraid to talk to my manager because at times I am not sure what or how he/she may respond. Honestly I'm afraid to embarrass myself."

(NP/L) "The way my manager looks at me and other staff members when communicating in the ward at times we are afraid to confront issues though they impair our duties, if you can see that look it's scary."

#### **4.5.2.10 Sub-theme 10: Anger**

Anger is an emotion and feeling that affects communication and may affect the interpersonal relationship in the hospital (Kaplan & Sadock 2010:506).

(NP/E) "Honestly, mam every time when I think of coming to work I get angry, it is as much as when I'm at home reflecting at what good I did at work I find myself filled with anger more than you can imagine. Sometimes I feel like using physical force and I will leave the ward and go out and smoke just to make myself feel better."

The nurses said they use a lot of defences because if not they would find themselves doing wrong things unintentionally. They cited that because of the frustrations that they experience they resort to unwanted behaviours like smoking or even leaving the ward without permission.

#### **4.5.3 Theme C: Behaviour**

The nurses elicited some of the behaviours displayed by nurse managers during the interview. They cited that because they are from different backgrounds both professionally and culturally, that impairs them psychologically. It was clear that more of

non-verbal communication was experienced and it had different meaning to them but, above all, they viewed it as insubordination (Muller 2011:212).

#### **4.5.3.1 Sub-theme 1: Isolation**

The nurses said they experience isolation in terms of ranks from the nurse managers and other professional nurses. Isolation meant operating an idea from the affect that accompanies it but is repressed. In communication isolation is social and meant the absence of object relationship (Oxford Advanced Learner's Dictionary 2010:208). This has also involved communication of service delivery which affects them but they do not receive relevant and/or enabling information. The pattern was explained to be worsened by managers discussing them with other managers and other staff members of lower category. It was also cited that the managers do not come to the ward to check how the operations of the unit flow and that symbolised a non-caring attitude for the nurses. They said only when they come to the wards everyone does not want to be around them because everything my turns sour from nowhere.

The communication isolation that is practiced by nurse managers appeared barbaric to the nurses such that they responded by saying they feel unattached to managers though they thought that they are like parents at the workplace.

(NP/A) "I used to think that my manager is a mother but after some experiences I do not want to see myself around him/her."

(NP/C) "Uh my nurse manager is absent though present on duty, after hearing what she said about me I am unable to share the same room with her. Even during tea time or lunch time I wait for her to go first just not to be with her in the same room."

(NP/E) "When my manager comes to the ward everyone looks for a corner to hide because we know he/she will scream at us like we are not human-beings. I mean even senior nurses in the ward are afraid of them and yet we depend on them to pave a communication platform."

(NP/G) "I always peep in the ward to check if the manager is around so that I can get out of his/her sight, that's how bad it is. This is because there is no peace

when the manager is in the ward, we do not enjoy her company we hardly greet even when we meet after work or on weekends.”

#### **4.5.3.2 Sub-theme 2: Unapproachable**

Unapproachable meant unfriendly and not easy to talk to (Oxford Advanced Learner’s Dictionary 2010:1599), this also the experience of nurses. The experience of approach was broadly explored and found to be a barrier for communication. It became clear that although managers were senior leaders it became difficult for nurses to verbalise their challenges in and outside the work environment.

(NP/K) “My nurse manager is not approachable because he/she doesn’t display a friendly face so that I can easily lay off my challenges.”

(NP/B) “ I’m not sure how to describe my nurse manager because sometimes he/she is easy going at times she comes to the ward wearing a serious face which offends me and I end up giving up and starting to confront my challenges my own way.”

(NP/M) “I am afraid to talk to my nurse manager as he/she is a moody person.”

(NP/N) “I am unable to approach my nurse manager because he/she doesn’t seem considerate and caring.”

(NP/O) “Believe me seeing my manager is like being in the wild forest without anyone to rescue me or to ask help from and yet I’m having a leader who is supposed to guide me through this journey, just imagine.”

#### **4.5.3.3 Sub-theme 3: Aggressive**

Aggressive is a form of violent action against others. it meant an intent to harm in a form of verbal communication. Verbal aggression was a managerial style that causes psychological harm (Kaplan & Sadock 2010:150). Aggressive behaviour in human being is associated with violent actions. In the nursing profession this can be associated with non-verbal cues and less of verbal cues which, when exhibited, are offensive to the recipient. Aggression as interpreted by psychiatrists and psychologists implies the intent

to harm others. These professionals further emphasises that aggressive behaviour is learned and difficult to rationalise in terms of benefit to others. They further said persons without mental disorders who exhibit aggressive behaviour are to hurt people they know or who they work closely with (Kaplan & Sadock 2010:150).

In the context of this study, nurses' explored perception was that they experience aggression to some extent, such that communication becomes a null and void matter. It was further explained by enrolled nursing auxiliary nurses that when communicating with the nurse manager they lose control and feel abused psychologically and emotionally. The nurses said because of their lower ranking in the profession, managers project their chronic anger on them and the treatment they receive from the nurse managers is unacceptable. The following was cited:

(NP/B) "My nurse manager is very rude when talking to us, he/she doesn't respect us at all."

(NP/C) "The nurse manager when entering the ward regardless of the time of the day he/she looks like someone ready to fight with us. I am very frustrated that the drama that the managers display in front of staff and patient at times it becomes unbearable."

(NP/G) "When I ask questions about what is discussed in the ward the manager becomes irritable and answer very rude and at times you could see that if it was not for being a nurse a fight was a solution. I mean a physical fight ... ."

(NP/I) "I have never seen a person who is so aggressive, I do not understand that why should a simple question make one to feel as if I have insulted him/her. Come to confronting issues or just talking about dissatisfactions it seems as if one could dig a hole and hide in it because the outburst will last for the entire shift or even more."

#### **4.5.3.4 Sub-theme 4: Avoidance**

Avoidance behaviour is a personality disorder and both concerned nurses and nurse managers show extreme sensitivity to rejection, hence nurses became socially withdrawn and confirmed that they are always timid. There was also an expression of

uncertainty, and there was also lack of self-confidence in nurses and they said it was because of their lower ranking in the profession (Kaplan 2009:195).

The pattern of avoidance behaviour from nurse managers was perceived to be poor visibility in the ward. Nurses also said they avoid managers at times because all they want is a peaceful working environment. Psychiatrists say negative reinforcements are related to avoidance behaviour. They further explained that for avoidance behaviour to be well noticeable it is always accompanied by a response and it symbolises inferiority complex.

It was also found that the avoidance behaviour experienced by nurse managers from nurses was that in most cases they run away from them or when engaging in a conversation nurses do not communicate with them.

(NP/H) "When I see my manager coming into the ward I vanish because I know that things may turn sour."

(NP/N) "Our nurse manager never shows up in the ward, especially when there are problems. You will see him/her on the corridor but cannot hardly come in and ask how we are coping."

(NP/O) "At times we hardly talk on face to face, or hardly greet. Even when you greet in the morning you are not sure if there was a response or not, that's the kind of my manager."

The nurses during the interview also revealed how they are avoided by their nurse managers when they ask question about Human Resources issues. They expressed a degree of dissatisfaction and could not hesitate to say managers do not care about them.

#### **4.5.3.5 Sub-theme 5: Poor communication**

Poor communication was perceived as continuous use of gestures, and less communication at all by the nurse manager (Muller 2011:209). In addition to what was perceived as poor communication by nurses, was lack of communication skills demonstrated by managers. The major findings were that there is always a clash of

personalities which was believed to be aggravated by professional differences even in opinions and approaches. Nurses were bold enough to say that managers are unable to separate personal and professional issues.

Working with others is a broad approach because it necessitates the consideration of professional identities and that included nursing professionals who work as a team. Working with people we sometimes do not gel or like them nor even stand them. This was cited by nurses that the least the managers can do was at least to treat them as human being than the judgement they experienced from their leaders.

The professional nurses who participated in this study managed to show that the extent of poor communication is such that they themselves are disrespected by their co-workers and other categories of nurses because of the poor treatment they receive from nurse managers. The interview also yielded that communication is not taken seriously, although it has an impact on them. Other categories of nurses said communication is so poor that the chain of respect is broken, and when the manager address them it feels better when there's a second person so that they can ask questions.

The following qualify the poor communication as stated by nurses during the interview:

(NP/N) "In the ward there is poor communication."

(NP/Q) "My nurse manager lacks communication skills and also every time insensitive, insensible things are communicated."

(NP/S) "My manager is a bad communicator."

(NP/T) "Communication in our ward is poor, I mean very poor such that I do not have interest in listening even when serious things are discussed."

(NP/L) "What is good communication? I do not know it, actually I have not seen or experienced it."

#### **4.5.3.6 Sub-theme 6: Bullying**

Bullying is a negative form of stroking and it is when a person uses strength or power and position to frighten or hurt weaker people (Webb 2011:35). Bullying as a negative stroke communicates disapproval and dislike, and it gives rise to a person avoiding further contacts and communication. The majority of nurses in explored data of the perception towards bullying said maybe that is how the nurse manager get rid of them when they want to confront challenges that affect them directly and indirectly.

Bullying as described by (Webb 2011:53) leads to losing confidence and a development of low self-esteem. Nurses said they have low self-esteem because they are shouted at in front of patients and, as for Professional nurses, they said they are shouted and screamed at even in front of nurses whom they are expected to lead and mentor and that lead to a disrespectful

The bullying that was explored from the nurse participants was described in different forms. The explored bullying behaviour was as follows:

(NP/Q) "This is my ward no one will tell me how to run it."

(NP/D) "My word is final I do not expect anyone to say anything because that will demonstrate disrespect."

(NP/G) "I am the leader everything that is happening in this ward must come to my attention. Do you understand"

(NP/I) "I am sick and tired of people who want to control me and tell me what to do. People must go to school so that they can come back and have a say in their wards not here."

The nurses experienced intimidation and autocracy. This was even frustrating because, on several occasions during the interview, there were times when this subject was explored when a nurse participant would talk louder or harder so that you could feel the discomfort it brings to the individual. Additionally was the repetition of anger and defense mechanisms which were used to avoid the bad communication they experience in the ward.

#### **4.5.3.7 Sub-theme 7: Inaction**

Inaction is a state of doing nothing about a situation or a problem (Oxford Advanced Learner's Dictionary 2010:752). In the context of inaction the explored features were that managers do not act all they is talking negative things but when they are to correct they become passive. The citation of passivity was that when a challenge is communicated to them in the ward they do not take the leader role.

(NP/F) "The extent to which communication is a challenge even when I report issues to my manager there is no action."

(NP/U) "The nurse manager is always in the office, does not help us to solve problems that families often challenge us with. All what he/she do is to judge us but doesn't know how to solve problems."

#### **4.5.3.8 Sub-theme 8: Defense mechanism**

Defense mechanism is a behaviour used to protect the mechanism to attack or criticise (Kaplan & Sadock 2010:383). The explored perceptions on the use of defense mechanism were mostly described by all nurse categories according to what they experience in the wards. A lot of statements were clear that managers when they find themselves in awkward situation they use defensive language to bail themselves from the situations.

The other category further intimated that we are so hopeless and helpless because there are no satisfying answers to allay our anxieties.

(NP/V) "We do not find solutions instead there a lot of complexities which we are facing even on this day. There is a lot of standing information which they receive in their meetings and yet when we question all we get is exclamations like 'shuh! you asking too many questions.'"

(NP/X) "I have too many things in my head, and you raising my blood pressure."

(NP/Y) "I have problems at home, now it's at work I think you must find solutions on your own and leave me alone."

(NP/Z) "I am not feeling well today my blood pressure is high and so are my stressors today. I am not in the mood to talk."

#### **4.5.3.9 Sub-theme 9: Negativity**

Negativity meant motiveless resistance to all attempts to be moved or all instructions (Kaplan & Sadock 2010:281). The nurses explained that a lot of negativity is displayed by the nurse manager. They were frustrated and felt that even if they do well it is not recognised. They also expressed feelings of negativity because they never receive positive feedback from managers.

(NP/B) "My manager does not appreciate."

(NP/H) "My manager always looks for faults and says negative things, he/she doesn't understand that sometimes I want to hear of the good that I do in the ward. A negative statement kills my morale.'

#### **4.5.4 Theme D: Communication skills**

Communication is an interactive behaviour between people and it involves the transmission of a message from one person to the other. It is the ability to convey ideas and views in an understandable way (Armstrong et al 2013:261-262). In a hospital, which is a health care setting communication, is central to the nurse-nurse relationship and other members of the multidisciplinary team. The positive relationship is built on trust which can be achieved only when the nurse feels listened to, respected by colleagues and managers involved.

Communication skills entail having insight about your own values, anticipating how people might feel when engaged in a communication. It also includes being sensitive and empowering people to meet their own needs and make choices. The most important competencies are taking person centred personalised approach to care and making communication to reach heights of satisfaction.

During the interview nurses expressed clear perceptions that nurse managers lack communication skills. Some nurses did not exclude themselves and pleaded that all of them should undertake training on communication. They said they experience interference from managers during conversation. To them it demonstrated disrespect just because of their low rank. Some of the managers were reported to use the language that other nurses do not understand and that created a barrier in communication.

#### **4.5.4.1 Sub-theme 1: Non-verbal communication**

Non-verbal communication is communication without words and that involves body language, facial expressions, hand movements, stance and eye contact. To be a good communicator you have to be aware of your own non-verbal signs and what they say (Armstrong et al 2013:268). Non-verbal communication has a limited range because it is used to communicate feelings, likings and personal preferences and mostly it contradicts verbal communication. A great deal of non-verbal behaviour and verbal communication constitutes touching, mannerism, tone of voice, relaxation of posture and rate of speech.

Use of non-verbal cues when communicating creates a barrier and to some degree nurses cited how offended they felt to see a manager using non-verbal cues when they least expect from the senior professional.

Non-verbal communication was perceived by nurses as a way that it is the nurse manager does not want to see them or barely communicate with them. The professionals perceived the unavailability of the nurse manager as a non-verbal that says "I do not want to see". Inconclusive comments were made and mixed feelings emerged in a way that the researcher concluded that the absence of the manager means non-verbal communication and was unacceptable to the nursing personnel under the leadership of the manager.

The following was explored:

(NP/T) "When I communicate with my nurse manager mostly I have observed body language and at times it doesn't give meaning".

(NP/S) “The facial expressions that we observe always tell us that the manager is not interested in what we are discussing, I think it’s only the body that is in the ward but the mind is far away.”

(NP/U) “The communication sometimes get to be too tense that there’s often use of hand movements which signify ‘I do not care attitude’ and it puts one under the impression that the nurse manager is lacking leadership skills.”

(NP/V) “My nurse manager likes using facial expressions, like when you talking the face are sulky, also one can note that the questions asked rises tension and then the attitude from the response follow.”

The sub-themes above constitute components of the communication skill that demonstrated that there was never congruency in what has been said verbally with what was said non-verbally. Poor eye contact also gave doubts to nurses if what is being said is it reality or it serves as a way to end the discussion.

#### **4.5.4.2 Sub-theme 2: Listening skills**

The use of listening skill is part of effective communication. This listening skill can either be active, selective or passive in nature and there are advantages and disadvantages to that. Using a skill of active listening should be one of the attributes demonstrated by the nurse manager. Whether communication is in the form of reporting, or assessment there should be an establishment of a good relationship (Webb 2011:52-54).

Active listening encourages nurses to give information and, most importantly, to express their concerns when conversing with their nurse managers. Active listening involves hearing, attending, understanding and remembering which nurse managers need to employ to enhance their professional standing. The nurse managers should be able to create a suitable environment for nurses and provide non-judgemental support and concern.

Active listening encompasses appropriate eye contact, which shows that you are interested in what is being communicated and appropriate response to cues. This was

identified to be a challenge that nurses face when communicating with manager because they said in most cases there is no listening.

(NP/I) “When I try to explain my manager will just talk in between without letting me finish saying what I wanted to put across.”

(NP/K) “My manager is not a good listener, and it frustrates me.”

(NP/L) “My nurse manager doesn’t listen; hence I keep my work related challenges to myself.”

(NP/O) “One day I proposed a method that would work for monitoring of patients vitals (Haemoglucotest) as I have seen it working in one of the hospitals when I was a student I was told that this hospital is not that hospital. I was crushed and told not to copy things that are done somewhere and bring them here.”

#### **4.5.4.3 Sub-theme 3: Mannerisms**

These were explored and found to be part of non-verbal communication. The Professional nurses explain mannerisms as a habit that they always have post their dissatisfaction that if they challenge the nurse manager the high chances of using such habits is very high. Inclusive was the tendency demonstrating short temper or irritability when engaging to sensitive issues including involuntary movement (Kaplan & Sadock 2010:281).

On probing further about sensitive issues it was said that “PMDS (Performance Management Developmental System) is the most issue that mostly disables the communication with the nurse manager. They said because it involves money it is awarded in a nepotism way. The main issue which influenced the perceptions of nurses was that if your manager does not like you the risk is you may never get the incentive bonus as long as you are working in that particular unit. The following sentiments were shared and discussed as below:

(NP/W) “Every time we talk she frowns and I have taken for granted that it’s always her habit, though it intimidates me.”

(NP/Z) “The habits displayed by the nurse manager during meetings are offending.”

(NP/X) “I cannot stand the manner in which she addresses us ... its shocking.”

(NP/V) “I’m embarrassed how my manager looks at me when I talk burning issues that affect the service delivery in the ward. I have never seen my manager wearing a friendly face.”

#### **4.5.4.4 Sub-theme 4: High pitched voice**

The tone of voice that is often used when communicating with people is very important because it sets the platform to enhance communication. It is thus important to be aware of own attitude when communicating regardless of the environment or the situation that one is facing. Commonly for other people, when your tone is high it is considered as rudeness or intimidation. High pitched voice meant vocal noises responses made rather than what is said and is commonly what nurses experience from nurse managers (Webb 2011:59).

The use of high pitched voice was reported by nurses as their experience from the nurse managers. Nurses perceived that as being rude to them and this was said because it is always accompanied by interference during a conversation or when engaging in sensitive matters. In probing further nurses said they feel threatened and intimidated because afterwards there is friction in the ward.

(NP/V) “My nurse manager always shouts and screams.”

(NP/W) “Why does he/she has to scream when talking to us?”

(NP/C) “My manager like raising his/her voice when talking as if he/she is angry at something. Why in the morning especially?”

#### **4.5.5 Theme E: Competence**

Competence in the nursing profession is based on the comprehensiveness of nurses’ knowledge and their ability to perform skills in an efficient and effective manner.

Competence entails high levels of commitment in the nursing unit. Competence is encompassed by compassion and is demonstrated by cognitive, affective and psychomotor ability required for the performance of specific activities and, in the context of this study, communication is that activity (Kaplan 2009:138).

Competence in this study is the ability to demonstrate effective communication skills. The competence of a nurse official is a way to understand the reasons for hospital communication and the nature of any treatment that nurses get from the nurse manager during communication. The attribute of competency in communication involves understanding the consequences, benefits and risks of miscommunication in the ward or unit (Webb 2011:248)

Competency involves theory and practical aspects and is complemented by the incorporation of sub-themes such as support and improved communication within the environment. The findings of this study indicated that nurse participants felt that nurse managers lack competency when supposed to interpret circulars or memos.

Lack of communication skills and knowledge based was a greatly emphasised point. They said nursing training has not equipped managers with knowledge, skills or confidence for independent practice so that they can be able to enter into a decent conversation with the colleagues and other category of nurses. The nurses felt that the support of experienced professional nurses was critical in this regard but it was said to be difficult because they themselves are victims of the very same circumstance. One of the informants indicated that it would be better for the nursing education unit in the hospital to support through teaching communication skills.

#### **4.5.5.1 Sub-theme 1: Incompetence**

Incompetence is defined as the lack of skill or ability to do your duty as it should be done (Oxford Advanced Learner's Dictionary 2010:755), this is applicable in this study because communication is a managerial function. The most explored aspect of incompetence was based on the presentation of the nurse manager with regard to the communication. They further said the years of experience was another offending statement because managers do not want to be challenged, and change was noted to

be a difficult process when it comes to improvement plans. The following were narrated by some nurses during the interview:

(NP/Q) "Sometimes I am not too sure if my manager clearly understands what she says to us".

(NP/A) "My manager is not able to interpret circulars or memos". Sometimes when you ask the manager about a circular you can see that actually you are telling a new story and then I have to explain to the manager about the content of the circular."

#### **4.5.5.2 Sub-theme 2: Poor interpretation**

The explored perception in poor interpretation symbolised frustration and stress as expressed by nurses during the interview. Aggravating this was the expression of anger. When listening to the narration in the voice recorder the tone of voices were shaky and went flat (Webb 2011:121-122).

The poor interpretation was based on circulars and memos for which nurses needed simplification from the nurse managers and could not get help. There were episodes of frustrations as nurses relied a lot on managers and yet all they get were dissatisfying answers. Nurses were questioning the level of understanding of managers.

(NP/A) "One day we had a circular from human resources and when we needed clarity from our manager, you could pick up that he/she doesn't know what to clarify and how to make it that everyone in the ward can understand."

(NP/B) "When I ask my manager about clarity on read circulars read that morning the answer I got was that what should be clarified because English is straight forward. I do not remember receiving clarification."

(NP/F) "There is poor interpretation of documents and it is frustrating."

#### **4.5.6 Theme F: Professionalism**

Nurse managers and nurses are responsible for maintaining professional communication in the ward and extend it to the entire hospital. Different professions have different traditions and cultures of communication. The protective practices of professional identity may involve information withholding, disengagement from communication role and that entails communicating effectively to meet the needs of nurses. Additionally, professional communication focuses on providing comprehensive and accurate written and verbal reports or feedback from meetings based on best available evidence (Webb 2011:182).

Communication takes verbal and non-verbal forms. This means to achieve professional communication nurse managers should demonstrate good written and verbal skills. This includes knowing how to communicate as a team member because nurses work as teams lead by nurse managers. The highest demand of facilitating team work needs intense communication. In this study nurses during the interview perceived nurse managers as having some shortfalls when coming to professionalism.

Nurse managers too can exclude other nurses from simply the way communication is facilitated in the wards. Nurses of other categories felt threatened by nurse managers who seemed to disrespect them and talk to them as they wish when they are regarded as professions of high standard. It became a question of is this person a professional or what?

Professional communication should also focus on the demands of nurses as human beings. This implies that nurses' communication should be under strict rules of the hospital in communication and those of the constitution of the country to ensure equality e.g. using a low tone of voice and treating people with sensitivity. A professional is never rude or using defense mechanism even though it compels unwanted behaviour from either of the nurses.

The findings yielded insufficiency but it was superseded by disrespect during communication which made nurse participants to question the professional status and maturity of their managers. The findings also on the voice recordings were relating well to the observed behaviour and that clearly demonstrated some degree of complexities

that were subjected to fear of sharing their personal or social information with the nurse managers.

In qualifying the above findings, below is what was narrated by nurses during the interview and in addition to observations made.

#### **4.5.6.1 Sub-theme 1: Privacy**

Privacy in the nursing profession is one of the fundamental principles which enhance professional secrecy (Webb 2011:121). During the interview nurses demonstrated anxiety saying managers often communicate unwelcome information and that breaks the privacy of the concerned professional. When communication goes wrong we often see a crossed transaction where the nurse manager has misinterpreted the ego state of the other nurses, this was especially binding the Professional nurses. They had challenges in opening up for the sharing of information with managers and live with the possibility that it will be known by others.

(NP/O) "I was frustrated to hear what I discussed with my manager being said by nurses who are not working in my ward."

(NP/L) "Surprisingly you talk to the manager and people in the ward start presenting with sorrowful faces and others goes to an extent of comforting you, and yet it was only the two of you in the room when you were talking."

(NP/E) "There is no privacy in this ward with regard to information communicated with the nurse manager."

(NP/S) "I thought for a second that what type of a manager is she who when I verbalised my sensitive information and the manager next door is well informed and has a nerve to confront me."

The lack of privacy as an explored perception of nurses was intense such that they said they prefer to heap up with their issues though they know that they need someone senior for advice. In an angry response one of the nurses said: "I was so embarrassed because I took my manager as a mother and yet I was wrong, now I am the talk of the ward."

#### **4.5.6.2 Sub-theme 2: Confidentiality**

Confidentiality is the principle of protection of information. It emphasises that information must be used for the purpose which is intended (Webb 2011:121).

The code of standards of conduct requires that confidentiality be maintained as much as possible. This has been one of the principles which the nursing profession is believed to be strong in upholding. This principle encourages respect for people's right to professional secrecy. The nurses were able to say that their private information is never kept confidential and that frustrates them because some of the challenges they experience are work related.

In exploring further this was said by nurses:

(NP/J) "Confidentiality is zero, it does not exist."

(NP/K) "There is no confidentiality here hence it's better to keep quiet."

#### **4.5.6.3 Sub-theme 3: Gossiping**

On exploring the gossiping, nurses were able to tell that nurse managers gossip a lot and that compromises professionalism. Gossiping is an act of talking about personal or private matters (Oxford Advanced Learner's Dictionary 2010:617). The gossiping was experienced in the context of manager to manager and manager to nurses of a lower category than the one of the nurse who is being gossiped.

(NP/O) "It feels so bad when the nurse manager gossip about you with an Auxiliary nurse."

(NP/M) "My nurse manager gossips a lot with other nurses and colleagues next door."

(NP/A) "Instead of being told were you went wrong you will hear it being said by other people, why cannot you be faced unless something was discussed about you in front of people who later come and tell you as if they were sent to do so."

(NP/F) “The way people in the ward look at you may suspect that something bad was discussed and now they want to see for themselves.”

(NP/B) “I fail to understand that why I’m I not confronted rather than be gossiped?”

The extent of gossiping in this study was noted to be overshadowing professionalism and it also had an impact on effective communication in the wards. The attribute that the researcher picked up was that rather than nurses being paranoid about gossiping, their self-esteem was the most affected. Nurses were able to come out clearly on how they also fear to talk or debrief to other nurses because they befriend nurse managers and will tell them.

The professional nurses based the effects of gossiping as a way of losing professionalism. They further said conflicts also arise in the ward and the very managers become unable to solve them.

#### **4.5.7 Theme G: Effects/consequences**

Although communication is a tool that is health care intense and binds all nursing activities together can at times becomes a barrier. It is a way people behave or interact among each other and if it is regarded as absent it may impair the smooth running of the ward. In the context of this study findings have shown that communication has implications which effect on the success of the service delivery in different forms.

The nurse participants were fair to express their feelings and behaviour because they do not receive attention from the nurse managers. Critical to their version of the story was that it was to their conscious mind that what they do is wrong but they cannot help it as they experience a lot of pressure in the respective wards. In mostly the exhibited effects were perceived as a way to relieve the self.

The effects conveyed by nurses were more of symbolic communication. In this type of communication the message is sent consciously in moderation and mostly unconsciously. These effects were explored and found to be the results of interpersonal

conflicts in the nursing unit or ward and resulted in calling changes that nurses had to choose or quit the stressful workplace (Oxford Advanced Learner's Dictionary 2010:465). These effects gave rise to resistance to adhering to the demands of the employer which include working of forty hours per week as legislated. The responses from nurses from nurses showed that because the attitude they receive from nurse managers was a results of being demoralised and that takes away the urge to come to work.

#### **4.5.7.1 Sub-theme 1: Laziness**

The nurses said just the thought of coming to work they deem it unnecessary to wake up. It has impacted to the extent that all that came to their mind is play a hide and seek (Oxford Advanced Learner's Dictionary 2010:817). Two of the nurses verbalised that having a challenge in the ward makes them to think twice, and in affirming to that they said:

(NP/P) "Just the thought of coming to work I lose interest and stay at home."

(NP/M) "I never have interest of coming to work, coz I know I will be down for the rest of the day."

#### **4.5.7.2 Sub-theme 2: Grudges**

The other explored issue which is a consequence of the communication challenge is holding of grudges. In most cases there is a reminder of how miserable one can be because when entering the hospital or ward the mood changes (Webb 2011:40).

(NP/P) "My manager keeps grudges against me and other nurses in the ward."

(NP/R) "When I have forgotten about what was previously discussed and there was misunderstanding you will be reminded about it."

#### **4.5.7.3 Sub-theme 3: Conflicts**

A conflict is a situation of unrest and is commonly occurring because of the communication challenges experienced by nurses who are looked by nurse managers.

They explained that the key cause of conflicts due to favouritism that is practiced by the managers (Armstrong et al 2013:271).

Nurses perceived favouritism as the main cause of conflict in the wards and they said it has been aggravated by inconsistencies when the staff is facing crisis. The worst was an experience of this type of behaviour being practiced by nurses who have been allocated in the same ward and have no respect for other nurses. The reason behind was they befriend managers.

In exploring further the following was said:

(NP/J) "I do not understand why I am taken for granted by a junior nurse who is a friend to the ward manager."

(NP/O) "We fight most of the time and yet solutions are not easy to find."

(NP/M) "There are lot of arguments in this ward; we do not communicate like adults or professionals."

#### **4.5.7.4 Sub-theme 4: Absenteeism**

Absenteeism is an act or practice of staying away from work frequently without good reason. At some point it develops into a habitual pattern which impairs the duty obligations of the employee and the employer. This is because the employer has the duty to apply strict control measures by reporting staff not on duty and to follow the necessary procedures. Traditionally absenteeism has been viewed as an indicator of poor performance as well as a breach of an implicit rule (Huber 2010:5). It breaches the contract between the employee and the employer and to some degree it affects working relationships. It is a managerial problem as viewed by management authors and if not well-managed it may yield unfavourable results in the workplace. It is related to i conflicts. In this study it arises as a result of managerial communication deficits.

High absenteeism in the workplace was found to be indicative of poor morale and its major impact is on the economic factor on the employer site. The major problem about it is that it is not budgeted for as it is not anticipated. The reality was that when nurses

absent themselves at work no one could distinguish the genuineness between illness and absence for inappropriate reasons. In this study, the findings showed that the response of being absent brings a relief from strenuous work environment though they said they do not get professional fulfilment.

According to the findings in this study absenteeism was more of a psychological indicator for social adjustment to work. It was a form of withdrawing the self because of dissatisfying working conditions. It was explained that sometimes it was the only way to have peace of mind. The nurses explained the consequences of being absent because some of them said they had experiences of signing leave without pay. In further exploring about the leave without pay they said they do need money but they rather lose it than being miserable at the workplace.

The exploration of absenteeism in this study was found to be a measure of nurses removing themselves from the vicinity of their nurse managers. The nurses had a long narration about the attitude they receive from the managers that makes them to become reluctant to report on duty. This was a point emphasising the demotivation which was prompted by the nurse managers in communication with the nurses. The nurse's perception towards the absenteeism matter clearly showed how ineffective communication can disable the balance between normal work balance and the ethics of the profession. It was also contravening with the agreement of the employer of working under pressure. One of the nurses explained that "the pressure we agreed to serve under was of workload, according to my understanding, not the one that is inflicted by my manager."

The nurses were able to tell that they are aware of the consequences of absenteeism that it has a negative impact on patient care but there's nothing they can do. On further clarification they said they would rather bring a medical certificate to make it look genuine, though deep down there's an element of guilt feeling. They also said that the acuity of patients in the wards is demanding and if they were to face that alone it could have been better, but instead they found themselves compelled to nurse managers' irritable moods and attitude.

(NP/D) "My nurse manager is very moody and when I think of coming to work and have to face him/her I phone and tell them that I am sick."

(NP/F) “When I think of coming to work after my day off I make up a story so that I do not report at work.”

(NP/G) “All I do is call and say I’m sick and when I feel relieved I bring a medical certificate from my doctor.”

(NP/K) “I know that patients are the ones to suffer, but what can I do? Sometimes it becomes difficult to make a decision about coming to work but when I put my manager on the fore front of the picture I am able to make a decision without hesitating.”

(NP/M) “I abuse sick leave though I’m not really sick and my days are exhausted before the cycle as allocated.”

(NP/P) “I usually do not phone and stay at home and when I come to work I do not have a medical certificate or an evidence to provide as proof. You will hear how my manager will haul at me, but because I know I am wrong I keep quiet and avoid the situation.”

(NP/T) “One day I was up to the thought of absconding at work after a long overhaul with my nurse manager, but I awarded myself with a full week leave which was not approved when I resumed duty.”

(NP/U) “What can I do if I am not happy? I stay at home and absent myself at work because it is not wise for me to face my manager by then.”

It was clear that nurses had different ways of absenting themselves at work. Included in absenteeism was the utilisation of leave without pay, personal problems like a child faling sick or “my child’s teacher wants to see me”. The nurses were aware and they verbalised that their absenteeism is greatly impacting on patient care. It was also came to the attention of the researcher that absenteeism in the wards was a platform that the nurse manager can use to do self-introspection and put things in perspective so that they can influence the perceptions of nurses of other categories.

#### **4.5.7.5 Sub-theme 5: Resignation**

Resignation is an act of giving up a position or a job for a variety of reasons (Oxford Advanced Learner's Dictionary 2010:817). It occurs when a person decides to leave the occupational position and may be due to internal or external pressures. Resigning from work is a challenge on the management site because there is a lot of demand to restructure staff in the ward. Currently the nursing profession is facing a lot of challenges which leads to resignations in high numbers.

The democratising of the South African government also demanded restructuring of health services systems and that brought a burden of staffing. The current trend is that the resignations are in the form of draining out expert nurses who because of attitudes of managers think of getting better work opportunities elsewhere. As in the context of this study nurses who opt for resignation said it is because they cannot take it anymore. They had bad communication issues with nurse managers which were unresolved, and that pushed them in taking harsh decision as they believed that they cannot change the nurse managers.

The effect that resignation carries in the wards is detrimental as workload surpasses patient care and replacement of resigned staff was difficult.

Further in the exploration the following was told by nurses during the interview:

(NP/A) "After all the treatment I have received from my nurse manager I am left with no option but to resign. I am waiting for a moment where they will say I must take a stand and act on behalf of my manager I am going to resign with immediate effect."

(NP/D) "I am spending most of my time surfing job opportunities on the internet; I am still young so the sooner I get a better work the better. I am aware that it is not as easy but as long as I get a manager who is different as the current. My frustration is that when I challenge managers I'm removed from that ward and in the new ward the new manager is being fed with information about me, so my only way out here is to resign."

(NP/F) “The option in this situation is to resign because even the problem solving skill is zero.”

(NP/I) “Resigning is the only option here, it will open the eyes of the managers of this ward and hospital because when you talk nobody takes an action and the situation became worse and worse.”

(NP/K) “There is too much work to do, too little sense of appreciation all we get is threats from managers so it’s better to resign than be threatened.”

(NP/R) “The working environment is frustrating me, the ward is frustrating me what is left is to make a decision and resign.”

(NP/X) “I have not stayed longer than I planned only because of communication with my nurse manager, I am serving the last month as I have resigned that how severe the situation has put me under stress.”

(NP/Z) “The only thing to resolve your frustrations here is to resign and you will look for another work. I know nurses are in demand.”

There were a variety of reasons for resigning but the majority of nurses were planning to leave but the most common was related to communication with the nurse managers. The perceptions of nurses who resigned were that they know they are looking forward to leaving as it will bring relief. Resignations were also symbolising an impulsive because they narrated that they have not secured jobs but were hoping to get some soon.

Part of the findings was that nurses who were assertive were rotated too soon and in the new ward the managers make them understand that they have information from previous managers. The nurses also made it clear that wherever they are going they do not expect ‘gravy train’ but if it can at least be better than where they come from.

#### **4.5.7.6 Sub-theme 6: Quitting nursing**

In the context of this study, ‘quitting’ meant giving up (Oxford Advanced Learner’s Dictionary 2010:1192). It means leaving the nursing profession completely and pursuing

another career which has been an option all along. The nurse professionals quitting the profession impact on the existing schema of shortage of nurses' world-wide. The reasons leading to quitting the nursing career needs attention and should be mitigated if possible.

Quitting the nursing profession was also part of the findings during the interview. Upon further probing, further few nurses said being abused verbally, psychologically and emotionally have pushed them that far. The nurses told the researcher that prior to the nursing they were pursuing other careers but for the love of nursing they chose it but they did not achieve fulfilment.

In exploring further individual nurses said:

(NP/P) "My managers are two in the ward, but their attitude has taken away the love of nursing in me. I have decided to go back and complete my Psychology and become a psychologist."

(NP/Q) "I have loved nursing all my life and now I'm quitting and will be staying at home I will decide later what to do but it will not be nursing again."

(NP/V) "I may think again but for now I consider quitting the nursing career though I loved it."

#### **4.6 CONCLUSION**

This chapter discussed interpretation under themes and subthemes and findings were done based on information obtained from the participants and also with reference to the literature review of other studies. Different categories verbalised different perceptions of communication with nurse managers. The emphasis was more on cultural issues rather than professional issues.

## **CHAPTER 5**

### **DISCUSSIONS, LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS**

#### **5.1 INTRODUCTION**

This chapter entails discussions, limitations, conclusions and recommendations that can be utilised to enhance communication. The discussions are mainly the facts which were established and achieved during the interview as some questions were encouraging probing in, so that the root of communication challenges can be identified. This has led to exploring responses from nurse participants of different categories in depth so that coding process could be at its best in terms of giving feedback.

There have been studies on communication challenges, perception and behaviour that have been conducted but focus was more on problems relating to specific categories; hence this study's focus is on perceptions of all nurse categories so that similarities and differences can be identified. Also, the previous studies were mostly conducted internationally and only a few were local but not in the Westrand region of Gauteng. This explains why this study is focused on this area.

The limitations of the study are restrictions that withhold the success of the study and they involve time, resources and participants' availability, including that of student nurses. The limitations mainly focused on aspects that lead to poor time management, and the delay in collection of data specifically. The limitations were expected as a contingency but not anticipated to drag to such an extent (Polit & Beck 2008:73-74).

Communication entails behaviour in it, regardless of it being verbal or non-verbal. Behaviour emotions are the product of the mind (Kaplan & Sadock 1998:135). This simply emphasises that before communicating one must think. I mean thinking about how to put the message across, when to do so and who is the relevant recipient of the message. The different categories of nurses defined perceptions of communication differently and it made sense because that is how they perceive it. One of the nurses

from one category said communication is one directional and it influences them in dealing with the complexities of the work environment. The interpretation of circulars also appeared to be a challenge as other categories are not familiar with the clauses that are quoted therein.

Behaviour in communication is important because it demonstrates professional maturity. In the interview conducted, aggressiveness accompanied by antisocial acts, shouting, avoidance was mostly cited. The behavioural theorist talks about types of behaviours in a clinical setting and that includes operant behaviour and respondent behaviour. Operant behaviour is the resultant of unknown or independent stimulus and the question is: do nurse managers comply with that instead of using defense mechanism when addressing nurses? The effects of operant behaviour predisposes nurses to perceive and identify lack of empathy, lack of attachment, emotionless, lack of social smile and lack of social competence skills. Respondent behaviour encompasses responding from known stimuli. This also necessitates introspection in the context of "Am I relevant and concise? The grimacing mannerism may give a different picture when trying to substitute, and that is simply because communication is a social skill in the first place.

## **5.2 DISCUSSIONS**

The health care environment is communication and information intensive and in hospitals which are a nursing practice environment, nurses are in constant care and communication with one another to deliver effective nursing care. Communication is essential for co-ordination of nursing activities, allowing nurses to work together in addressing new challenges in the health care environment, to promote quality nursing care.

Continuous communication in a nursing service improves ongoing working relationships among nurses. Nurses are responsible for communication among each other on how to enhance the delivery of nursing care. According to Muller (2011) there are various communication structures like management information systems. These systems include electronic mailing, distributing of internal circulars, intranet, policies and procedures.

Communication in the nursing environment is one of the most important interactions that take place every moment of the day. It is one of the basic, yet important life skills. Effective communication is thus vital for adequate management of the hospital environment. Communication is the interactive behavior between nurse managers and nursing personnel (Muller 2011:201-202).

The researcher was propelled by their own concern and observation to find out more about the perceptions of nurses of all categories with regard to communication with their nurse managers as there has been a high rate of resignations in the institution. The research findings revealed that regardless of the rank or category nurses shared experiences of same impact in communication and that is in the same way as summarised in the themes and sub-themes in chapter 4. The themes and sub-themes complemented each other throughout the conduction of the study.

Communication is a form of interaction among nurses regardless of the ranking level. The perceptions in this context referred to the way nurses perceive nurse managers in the context of day-day interaction, the influences, what happens in the interaction and the outcome of the interaction. It is difficult to define communication looking at different models and listening to what the nurse participants narrated during the interview (McCabe & Timmins 2006:9). The context of communication was differently defined by different nurse categories.

The findings from this study point to several notable issues related to perceptions of nurses regarding communication with nurse managers. The nurses anticipated staff turnover for quality care and reduction of being overworked because of high rate of resignations and absenteeism. Firstly, nurse managers and other nurse categories are not on the same page and also (from the nurses who were interviewed) there was a difference between perceptions explored from professional nurses, enrolled nurses and enrolled nursing auxiliary nurses. The professional nurses viewed communication as less threatening and the other categories viewed the same communication as a threat and they assumed that it could be rank related as they are of lower rank in the wards and hospital (Gormley 2011:37-38).

The discussions follow a wide variety of communication perceptions and meaning as different categories of nurses put it across during the interview. Individuality was

important because a lot of uniqueness was picked up. It clearly revealed that different nurses had different needs when it comes to communication. It is still a challenge to expect that all the needs are met but at least the nurses acknowledged that if they can be met half-way probably it would make things better but unfortunately the situation is not like that. They had an understanding that the work pressures also are a contributing factor to communication problem.

Despite the role of the nurse manager in a hospital setting being to facilitate the execution of the nursing regimen, remarkably little attention was been paid to communication. Findings from international research sources have proven that communication is a world-wide problem in different forms and it also applies in the hospital in the Westrand region. The objective of this research study was to explore the perceptions of nurses regarding communication with nurse managers. It was found that there were dynamics which make communication problematic.

### **5.3 LIMITATIONS**

The limitations of the study were that only one hospital was studied because of lack of financial resources to include other nearby hospitals though it was always premised on the thought that communication is a universal problem. The advantage of the studied hospital was accessibility in terms of distance, authorised permission from the hospital management and easy access of nurse participants.

The time frame for data collection process also had limitations in terms of awaiting permission from the Gauteng Protocol Review Committee. The Review Committee also had inputs of value which were employed to allow the smooth running of conducting the research study though that had an impact on time management of the study.

The availability of research participants was anticipated but the category of nurses which were thought to pose a threat were Professional nurses because they are always busy and in demand in the wards. Surprisingly, the challenge was with enrolled nursing auxiliary nurses. This category of nurses were not easy to access for various reasons that include escorting of patients to other hospitals, changing of off duties unintentionally and being too busy in the ward at scheduled times of the interview. This had a negative

impact on data collection for this category but it was also an opportunity to analyse the readily data collected from other nurse categories.

Included in limitations was the availability of a resource, in terms of venue to conduct interview. The interview room was identified and a letter of request was handed to the relevant officer after receiving permission to conduct the research study from the Chief Executive Officer of the hospital. The response from the logistics manager for a venue to conduct interviews was delayed and it hampered collecting data in distracting venues which were exposed to noise pollution and that led to collection of extra sounds on the voice recorder during the interview. It was unfortunate that regardless of making follow-up, all was in vain and because of time pressure I had to opt for using working environment when not busy.

The target population was also a part of limitations in the context that student nurses are allocated in the hospital for their clinical experience and they were not inclusive to participate during the data collection. It was noticeable and without exception that they also experience communication challenges with nurse managers. They also showed concern as to why were they not involved and an explanation was given to them that this was subjected to their availability.

#### **5.4 CONCLUSIONS**

The conduct of the study demonstrated a full picture of reflection on responses to questions. This was an experience during data collection where the nurse participants requested the skipping of some of the questions and responded later. It indicated that a lot of thinking was employed and the nurses paid undivided attention so that they may be able to give honest responses. Along with the data collection in the interview room there was also a demonstration of emotions which were exhibited unintentionally. The responses of such nature also indicated withholding of grudges and nurses hiding behind the professionalism which they wanted to protect rather than fighting with their nurses managers.

Communication requires certain skills in order to be successful for all those who are involved in the interaction. These skills include communication skills, listening skills and interpreting skills which are in simple form so that even a nurse of another category can

be able to understand. It can be concluded that communication is not a simple process and the problem is that often nurse manager's intrapersonal communication is evident in facial expression and a message is sent to the outside and is observed and interpreted by other nurses as a negative message or response. The reason behind may be the dimension of training taken by nurses as a contributing factor, e.g., Professional nurses experience difficulties less than nurses if other categories. This means that mature officers finds a way to deal with communication challenges

In conclusion, nurse managers should bear in mind that nurses regardless of their professional ranking are human beings who, apart from being employees, are also family members. The element of cultural sensitivity should also not be ignored because the profession also has its own culture to some level to counter affect the belief system of nurses. This clearly suggests that the personal and professional culture should be intertwined so that staff retention can be achieved. In this regard being humble and showing respect will never harm anybody. The most sincere is to show gratitude because, despite other challenges in the workplace, nurses need to be happy at work because that is where they spent most of their time.

The mandate of the employer about service delivery should be upheld and this will be capacitated by the contributions that nurse managers invest through improved communication with nurses so that production reaches its maximum and satisfactorily levels. This could also help to retain staff and curb absenteeism that is currently high and impacting on the service delivery.

## **5.5 RECOMMENDATIONS**

The foci on recommendations were made with view to overcome negative perceptions perceived by nurses with regard to communication with nurse managers. These recommendations were based on findings of the study pertaining to themes and sub-themes focused on data which was accrued during the data collection process.

The recommendations in this study were purely selected carefully from the interviews which were conducted. Noting that the communication problem needs to be minimised by proper management planning and correct implementation of work schedules, the researcher should come up with suggestions on how to approach this. The workshop

and in-service training on communication could be of help in mitigating the problem so that best practices and effective communication can be achieved.

The recommendations that were identified are based on findings during the data collection and data analysis and could serve as suggestions and a point of entry so that communication comfort can be established. These recommendations that may assist in improving communication between nurses and nurse managers as they work collaboratively will include employing the following approaches as basic strategies as they include education, practice and research.

### **5.5.1 Education**

Continuing education and training on communication will help to provide improved communication skills. The institutional management and training department should consult with communication experts from external sources to conduct training in communication. The expert communication trainers may be able to diagnose problems and assist in recommending suitable strategies that the institution will adopt and benefit the employees

Communication is a basic need for both social and professional advancement. This necessitates nursing educational institutions, e.g., universities, nursing colleges and nursing schools emphasising communication to nursing students so that on completion of the course they are better communicators. These institutions will also have to revisit the student curriculum and identify the gaps and correct them. This is because on producing these professionals their skills on communication will serve as basis to both professional and personal matured communicators.

In advancing the education to the next level in hospitals departments, clinics there should be in service education provided by nurse managers in help of support from the training department in the hospital, this may be a step in assisting the employer in strengthening communication and curbing absenteeism and resignations. Additionally, the following may be put on place to enhance communication:

- Training from external provider should be considered
- Training from internal provider may be used

- Workshops on communication may be organised

### **5.5.2 Practice**

Nursing practice requires specialised knowledge, skills and independent decision making. Nursing practice takes divergent paths because the practice focus varies by setting: in this study a hospital is where the practice takes place and communication is expected to be at its peak. The practice is both focused on the nursing actions and the environment where the practices are carried out. It is therefore critical to have professionals who are excellent in communication.

The following recommendations may assist in improving the practice on basis of communication as identified in the findings of the study:

- Nursing departments should conduct departmental workshops.
- In-services training should be conducted.
- Nurses should be encouraged to participate in daily talks.
- Nurses should be engaged in dialogues.
- Nurse Managers should treat nurses with respect at all times and bear in mind that nurses are cultural beings in both personal and professional point of view.
- Nurse managers should listen actively to nurses and attend to concerns because listening is a communication skill.
- Nurse managers should avoid favouritism at all costs to mitigate conflicts that are precipitating the miscommunication in the workplace.
- Nurse managers are to maintain professionalism and avoid befriending nurses of lower categories as it aggravates communication problem.
- The rotation of nurses is another recommendation as it will reduce neurosis and the social relation may improve as cultural sensitivity will be a lesson from the rotation of nurses.

### **5.5.3 Research**

Research means an investigation which can be done by a researcher or novice researcher under a supervision of a mentor. It is imperative that when conducting

research there should be adherence to prescribed ethical conduct pertaining to the phenomenon under study. As such it is related to the nursing practice and the ethical consideration for conducting this study was maintained throughout.

The recommendations which are related to research are that:

- A follow up study should be conducted after workshops and in service training to ascertain if there are any communication changes and development.
- A further study should be conducted on a larger scale e.g. in other provinces.
- Mixed method of qualitative and quantitative study should be conducted.

## **5.6 CONCLUDING REMARKS**

Communication may mean different concepts from different nurse categories but it should be clarified according to its application in different settings. The types of communication which are used by nurse managers should signify sensitivity and demonstrate respect among nurses. This is because during the interview conducted nurses of other categories verbalised that they are not taken seriously because of their low ranking status. The most of it all is the emerging attitude, poor listening skill, bullying which is an act of misconduct and insubordination. Nurse managers should consider their role in communication in order to facilitate the smooth running of the institution and their specific discipline allocation.

## REFERENCES

- Allsop, J & Saks, M. 2013. *Researching health. Qualitative, quantitative and mixed methods*. 2<sup>nd</sup> edition. London: Sage.
- Armstrong, S, Bhengu, B, Kotze, W, Nkonzo-Mthembu, L, Ricks, Stellenberg, E, Van Rooyen, D & Vasuthevan, S. 2013. *A new approach to professional practice*. Cape Town: Juta.
- Benedict, C. 2014. *Assertiveness and four styles of communication*. Available from <http://serenityonlinetherapy.com> (access 01 April 2014).
- Botma, Y, Greeff, M, Mulaudzi, FM & Wright, SCD. 2010. *Research in health sciences*. Cape Town: Heinemann.
- Brink, HI, Van der Walt, C & Van Rensburg, G. 2012. *Fundamentals of research methodology for health care professionals*. 3<sup>rd</sup> edition. Cape Town: Juta.
- Brinkert, R. 2010. A literature review of conflict communication causes, costs, benefits and interventions in nursing. *Journal of Nursing Management* 18:146-156.
- Brinkert, R. 2011. Conflict coaching training for nurse managers: a case study of a two-hospital health system. *Journal of Nursing Management* 19:80-91.
- Burns, N & Grove, SK. 2005. *The practice of nursing research. Conduct, critiquing and utilization*. 5<sup>th</sup> edition. USA: Elsevier Saunders.
- Brown, JM. 2012. *Evidence-based practised for nurses. Appraisal and application*. 2<sup>nd</sup> edition. Canada: Jones & Bartlett.
- Ceravolo, DJ, Schwartz, DG, Foltz-Ramos, KM & Castner, J. 2012. Strengthening communication to overcome lateral violence. *Journal of Nursing Management* 20(5):599-606.

Chan, EA, Jones, A & Wong, K. 2012. The relationships between communication, care and time are intertwined: a narrative inquiry exploring the impact of time on registered nurses work. *Journal of Advanced Nursing* 69 (9):2020-2029.

Cherry, B & Jacob, SR. 2014. *Contemporary nursing. Issues, trends and management*. 6<sup>th</sup> edition. USA: Elsevier.

Creswell, JW. 2013. *Research design. Qualitative inquiry and research design. choosing among five approaches*. 3<sup>rd</sup> edition. United Kingdom: Sage.

David, M & Sutton, CD. 2004. *Social research. The basics*. London: Sage.

Denzin, NK & Lincoln, YS. 2000. *Handbook of qualitative research*. 2<sup>nd</sup> edition. London: Sage.

De Vos, AS, Strydom, H, Fouche, CB & Delport, CSL. 2003. *Research at grass roots*. 2<sup>nd</sup> edition. Pretoria. Van Schaik.

De Vos, AS, Strydom, H, Fouche, CB & Delport, CSL. 2005. *Research at grass roots*. 3<sup>rd</sup> edition. Pretoria. Van Schaik

Dickson, GL & Flynn, L. 2009. *Nursing policy research. Turning evidence-based research into health policy*. New York. Springer.

Dr Phil. *You teach people how to treat you*. Oprah magazine. April 2014.

Ellis, JR & Hartley, CL. 2009. *Managing and coordinating nursing care*. 5<sup>th</sup> edition. Philadelphia: Lippincott Williams & Wilkins.

Garon, M. 2012. Speaking up, being heard: registered nurses 'perceptions of workplace communication. *Journal of Nursing Management* 20(3):361-371.

Gerrish, K & Lacey, A. 2010. *The research process in nursing*. 6<sup>th</sup> edition. USA: John Wiley & Sons.

Gomm, R. 2008. *Social research methodology. A critical introduction*. 2<sup>nd</sup> edition. New York: Palgrave Macmillan.

Gormley, DK. 2011. Are we on the same page? Staff nurse and manager perceptions of work environment, quality of care and anticipated nurse turnover. *Journal of Nursing Management* (19):37-38.

Griffiths, P & Bridges, J. 2010. *Nursing research methods. Fundamentals of applied research*. 2<sup>nd</sup> edition. London: Sage.

Grobler, PA. 2012. *Human resources in South Africa*. 2<sup>nd</sup> edition. Cape Town: Juta.

Jolley, J. 2012. *Introducing research and evidence-based practice for nurses*. England: Pearson Education.

Hedges, C & Williams, B. 2014. *Anatomy of research for nurses*. USA: Renee Wilmeth.

Holland, K & Rees, C. 2010. *Evidence-based practice skills*. Great Britain: Ashford Colour Press.

Houser, J. 2013. *Nursing research. Reading, using and creating evidence*. 3<sup>rd</sup> edition. Burlington: Jones & Bartlett.

Huber, D. 2010. *Leadership and nursing care management*. 4<sup>th</sup> edition. US: Saunders Elsevier.

Kaplan, HI & Sadock, BJ. 1998. *Synopsis of psychiatry. Behavioural sciences*. 8<sup>th</sup> edition. New York: Lippincott Williams & Wilkins.

Kaplan, HI & Sadock, BJ. 2010. *Synopsis of psychiatry*. 10<sup>th</sup> edition. New York: Lippincott Williams & Wilkins.

Keyton, J. 2011. *Communication and organizational culture. A key to understanding work experiences*. 2<sup>nd</sup> edition: Los Angeles: Sage.

Keyton, J, Caputo, JM, Ford, EA, Fu, R, Leibowitz, SA, Liu, T, Polasik, SS, Ghosh, P & Wu, C. 2013. Investigating verbal workplace communication behaviours. *Journal of Nursing* 50(2):152-169.

Koch-Weser, S, Rudd, RE & De Jong, W. 2010. Quantifying word use to study health literacy in doctor-patient communication. Boston. *Journal of Health Communication* 15(6):590-602.

Kvale, S & Brinkmann, S. 2009. *Interviews. Learning the craft of qualitative research interviewing*. 2<sup>nd</sup> edition. Los Angeles: Sage.

Lessem, R & Schieffer, A. 2010. *Integral research and innovation. Transforming enterprise and society*. England: Gower.

Lincoln, Y & Guba, E. 1985. *Naturalistic inquiry*. Beverly Hills: Sage.

LoBiondo-Wood, G & Haber, J. 2010. *Methods and critical appraisal for evidence-based practice*. 7<sup>th</sup> edition. USA: Mosby Elsevier.

Martin, AM, O'Connor-Fenelon, M & Lyons, R. 2010. Non-verbal communication between nurses and people with an intellectual disability: a review of literature. *Journal of Intellectual Disabilities* 14(4):303-314.

Maseko, T. 2014. *Extremists are finding more secretive ways of communication online*. Sunday Times, 31 December 2014.

McCabe, C & Timmins, F. 2006. *Communication skills for nursing practice*. New York: Palgrave MacMillan.

Mellish, JM, Oosthuizen, A & Paton, F. 2011. *An introduction to the ethos of nursing*. 3<sup>rd</sup> edition. South Africa: Heinemann.

Muller, M. 2009. *Nursing dynamics*. South Africa: Heinemann.

Muller, M. 2011. *Nursing Dynamics*. South Africa: Heinemann.

Mcintosh-Scott, A, Mason, T, Mason-Whitehead, E & Coyle, D. 2014. *Key concepts in nursing and health care research*. Los Angeles: Sage.

Moule, P & Goodman, M. 2014. *Nursing research. An introduction*. 2<sup>nd</sup> edition. Los Angeles: Sage.

Oxford English Dictionary. 2007. Sv "context". 2<sup>nd</sup> edition. Oxford: Oxford University Press.

Oxford English Dictionary. 2012. 5<sup>th</sup> edition. Oxford: Oxford University Press.

Oxford Advanced Learner's Dictionary. 2010. Sv "context". 7<sup>th</sup> edition. Oxford University Press.

Polit, DF, Beck, CT & Hungler, B. 2004. *Essentials of nursing research methods: appraisal and utilization*. Philadelphia: Lippincott.

Polit, DF & Beck, CT. 2008. *Nursing research. Generating and assessing evidence for nursing practice*. 8<sup>th</sup> edition: Wolters: Lippincott.

Rowlands, S & Callen, J. 2012. A qualitative analysis of communication between members of a hospital-based multidisciplinary lung cancer team. *Journal of Cancer Care* (22) 20-31.

Ruane, MJ. 2008. *Essentials of research methods. A guide to social science research*. Australia: Blackwell.

Rubin, A & Bellamy, J. 2012. *Using research for evidence-based practice*. 2<sup>nd</sup> edition. Canada: Wiley & Sons.

South Africa. 1996. *Constitution of the Republic of South Africa, Act no. 108, 1996*. Pretoria. Government Printers.

South Africa. 1997. *White paper for the transformation of the health system in South Africa (No 17910)*. Pretoria: Government Printers.

South Africa (Republic). Department of Health. 2008. *Nursing strategy*. Pretoria: Government Printers.

South African Nursing Council. 1984. *Regulation relating to the scope of practice of persons who are registered or enrolled under the Nursing Act. Regulation R.2598, in terms of the Nursing Act, 1978 (Act no 50, 1978, as amended)*. Pretoria: Government Printers.

Sullivan, EJ & Decker, PJ. 2012. *Effective leadership and management in nursing*. 7<sup>th</sup> edition. Boston: Pearson.

Taub, N, Douiri, A & Walker, DM. 2014. *Health service research*. London: Sage.

Sully, P & Dallas, J. 2010. *Essential communication skills for nursing and midwifery*. 2<sup>nd</sup> edition. China: Elsevier.

Van Schalkwyk, MJ. 2013. *Communication for management and secretarial students*. 6<sup>th</sup> edition. Parow: Creda Communications.

Waldeck, J, Durante, C, Helmuth, B & Marcia, B. 2012. Communication in a changing world. *Contemporary Perspectives on Business Communication Competence* (87):230-240.

Waltz, CF, Strickland, OL & Lenz, RE. 2010. *Measurement in nursing and health research*. 4<sup>th</sup> edition. New York: Springer.

Webb, L. 2011. *Nursing: Communication skills in practice*. Oxford New York: Oxford University Press.

Westphal, JA. 2012. Characteristics of nurse leaders in hospitals in the USA from 1992 to 2008. *Journal of Nursing Management* (20):928-937.

# ANNEXURE A

## ETHICAL CLEARANCE CERTIFICATE FROM UNISA



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

**HS HDC/300/2014**

Date: 30 January 2014 Student No: 4796-235-6  
Project Title: The views/perceptions of nurses regarding communication with nurse managers in a public hospital in Westrand, Gauteng Province.  
Researcher: Mananiso Nyaku Elizabeth  
Degree: MA in Nursing Science Code: MPCHS94  
Supervisor: Prof ZZ Nkosi  
Qualification: PhD  
Joint Supervisor: -

**DECISION OF COMMITTEE**

Approved

Conditionally Approved

**Prof L Roets  
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE**

**Prof MM Moleki  
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

## **ANNEXURE B**

### **LETTER OF REQUEST TO DEPARTMENT OF HEALTH IN GAUTENG TO CONDUCT RESEARCH STUDY**

The HOD: MR Gosnell

Gauteng Provincial Department of Health

37 Sauer Street

Bank of Lisbon

Marshall Town

2147

Request: Permission to conduct research study.

My name is Mananiso Nyaku Elizabeth, employed by Department of Health based at a specific public hospital in the Westrand in Gauteng Province. I am currently studying with University of South Africa doing MA Cur (Health Studies). The research study is done under the supervision of Professor Z.Z. Nkosi (012-429 6758), in the Department of Health Studies.

I hereby forward a letter of request to conduct a research study on “The views of nurses regarding communication with nurse managers in a public hospital in Westrand, Gauteng Province”. The study will benefit you through the findings and recommendations that will be described to address verbal and non-verbal communication in the hospital.

Your written permission will be highly appreciated. The researcher will adhere to your right to privacy and confidentiality, meaning your names will not appear on the research report. Also be assured that anonymity will be sustained throughout the study.

I hope and trusts that you will stretch you're helping hand in knowledge generation.

Sincerely

Ms Mananiso N.E

Contact no: 073 376 3908

## ANNEXURE C

### PERMISSION LETTER FROM GAUTENG DEPARTMENT OF HEALTH TO CONDUCT A RESEARCH STUDY

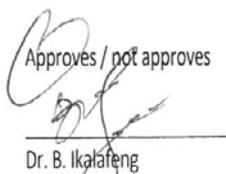


#### OUTCOME OF PROVINCIAL PROTOCOL REVIEW COMMITTEE (PPRC)

Researcher's Name (Principal investigator)	Mananiso Nyaku Elizabeth
Organization / Institution	Department of Health, Leratong Hospital
Research Title	The perceptions of nurses regarding communication with the nurse manager in a public hospital in Westrand, Gauteng Province.
Protocol number	P150214
Date submitted	12/05/2014
Date reviewed	23/07/2014
Outcome	APPROVED
Date resubmitted	N/A
Date of second review	N/A
Final outcome	N/A

It is a pleasure to inform that the Gauteng Health Department has approved your research on "The perceptions of nurses regarding communication with the nurse manager in a public hospital in Westrand, Gauteng Province".

The Provincial Protocol Review Committee kindly requests that you to submit a report after completion of your study and present your findings to the Gauteng Health Department.

Approves / not approves  
  
Dr. B. Ikalafeng  
Research and Epidemiology Manager  
Date 22/08/2014

## **ANNEXURE D**

### **LETTER OF REQUEST TO THE HOSPITAL MANAGEMENT**

The Hospital

Private Bag x 2078

Chamdor

1744

The Nursing Service Manager/ Chief Executive Officer

Request: Permission to conduct research study.

My name is Mananiso Nyaku Elizabeth, employed by Department of Health based at a specific public hospital in Westrand in Gauteng Province. I am currently studying with University of South Africa doing Master's Degree in management. The research study is done under the supervision of Professor Z. Nkosi, of the College of Nursing.

I hereby forward a letter of request to conduct a research study on "Verbal communication problem between nurses and nurse managers in a public hospital in Gauteng. The study will benefit you through the guidelines that will be described to address verbal communication in the hospital.

Your written permission will be highly appreciated. The researcher will adhere to your right to privacy and confidentiality, meaning your names will not appear on the research report. Also be assured that anonymity will be sustained throughout the study.

I hope and trusts that you will stretch you're helping hand in knowledge generation.

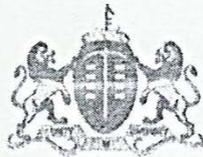
Yours in writing

Ms Mananiso N.E

Contact no: 073 376 3908

## ANNEXURE E

### PERMISSION FROM THE HOSPITAL MANAGEMENT (CEO AND NURSING SERVICE MANAGER)



**GAUTENG PROVINCE**  
HEALTH  
REPUBLIC OF SOUTH AFRICA

Private Bag X 75  
Krugersdorp  
1740

Enquiries: Mr G J Dube  
Tel: (011) 411-3531  
Fax: (011) 410-8421  
Email: [GreyD@npg.gov.za](mailto:GreyD@npg.gov.za)

Ms N E Mananiso  
Leratong Hospital Nursing Services

#### REQUEST TO DO RESEARCH – THE PERCEPTIONS OF COMMUNICATION BETWEEN NURSES AND NURSE MANAGER IN PUBLIC HOSPITAL IN WESTRAND, GAUTENG PROVINCE

Your letter of request refers.

Permission has been granted for the abovementioned request based on the conditions indicated from policy planning and research department. Please contact Mrs M Khoza for further arrangements (011)411-3506/3834

It would be appreciated if you could share your results of the research with the Management of Leratong Hospital.

Thank you for showing interest in our institution.

  
CHIEF EXECUTIVE OFFICER

011  
20140609



## ANNEXURE F

### LETTER OF REQUEST AND INFORMED CONSENT TO PARTICIPANTS

Private Bag x 2078

Chamdor

Krugersdorp

1744

Dear Nursing Officer

Invitation for consent to participate in research project.

You are invited to voluntarily participate in the research study entitled "Verbal communication between nurses and nurse managers in a public hospital in Gauteng" as part of the requirement for acquisition of my M.Cur Degree in Nursing Management. The study will be done under the supervision of Prof. Z.Z. Nkosi of the Department of Nursing, University of South Africa.

Your voluntary written consent will be highly appreciated or your signature on the space provided below. You will benefit from the study through guidelines that will be described to address verbal communication problem.

You are requested to complete a questionnaire that will take about 20 minutes of your time. There will be a box in the ward to mail the questionnaire and the researcher will come and collect the questionnaire every day in your departments. The questionnaire will be mailed in the provided envelope. Kindly note that, for the sake of privacy and confidentiality you are allowed to remain anonymous.

The researcher will adhere to your right to privacy, confidentiality and anonymity. Your identity will be protected, as a code number will be allocated to the questionnaire. You will not be coerced to participate in the study and should you wish to withdraw your opinion will be respected. The research results will be made available to you on request.

Should you have any questions with regard to this research, I will be pleased to answer.

Contact number: 073 376 3908

Yours truly

Ms Mananiso N.E

#### **Consent from participant.**

I, ..... hereby give written consent to participate in the research titled "Verbal communication problem between nurses and nurse managers in a public hospital in Gauteng.

Signature :-----

## ANNEXURE G

### THE INTERVIEW GUIDE

This interview guide is the important tool to collect and collate responses of the participant. Please be advised that confidentiality and privacy are maintained at the most high level.

1. What is the meaning of communication according to your understanding?
2. What is the communication structure that you use in your institution?
3. On personal level what is your perception of communication between you and your nurse manager?
4. On social level, what is your view of communication between you and your nurse manager?
5. How can communication be improved between you and your nurse manager?
6. What are the effects of delayed communication documents? How does it impacts on you?
7. Is there any information related to this topic that you would like to share?

The “**grand tour**” question that was used to all the participants was as follows: **Kindly share with me your views and perceptions on communicating with your nurse manager?**

## ANNEXURE H

### TRANSCRIPTION

Voice A

1. What is your rank or category?

*Professional nurse*

2. What is the meaning of communication according to your understanding?

*Communication it is the way in which people communicate like.... Talking to reach a certain level in order to understand each other.*

3. What is the communication structure that you use in your institution or ward?

*It is either verbal or paper, verbal by talking to each other and paper like in circulars.*

4. In your view, what is the meaning of communication between you and your nurse manager?

*The meaning of communication between me and my manager...Uhh... its sort of distance*

In which sense?

*In a sense that our managers [**generalising**] sometimes don't want to engage them in our view [**neglected**]. They took it for granted like when we talk to them they don't want to intervene as they don't want to intervene as they are. They don't want to be involved in certain issues.*

Issues which are what? Work related or what?

*Issues that are work related.... (Nodding head) especially issues that concerning issues from HR.*

5. On personal level what is your perception of communication between you and your nurse manager?

*I think they are ignorant.*

Ignorant in which way?

*In a way that they take our issues like they don't weigh them they don't view them as is being urgent or being serious?*

6. On social level what is your view of communication between you and your nurse manager?

*On social level there is social distance because some of the issues they know what the answer would be like. You may be talking to the matron about certain issues and she will be like distance herself, she don't want to get involved, and she know what might be the answer to the problem. [**Poor interpretation**]*

How does that make you feel?

*Mmmm ..... That one like, it creates a burnout and brings out a lot of frustrations?*

Like what tell me more?

*Like you become miserable, and helpless and hopeless* [**helplessness, hopelessness**]

To you as an individual?

*To me and my colleagues.*

7. What information do you normally communicate with your nurse manager?

*Uhh.... I communicate with my manager through verbal communication like talking and in paper or ink* [**deviation**]

Verbally what do you communicate?

*In verbal we talk about issues relating to work, like sometimes there is a barrier. There are things that you are supposed to do and the manager (matron) will take you for granted. You will see to finish and when you ask she will say "oh I've forgotten".* [**Defense mechanism, Inaction**]

In relation to paper (ink) communication?

*Circulars at times comes late and they expect us to be knowing and at times managers themselves are not aware of the circulars whereby we ourselves workers inform the matron of the circular especially from HR.* [**lack of knowledge**]

8. How is the delaying of information impacting on you? Especially like you talking about circulars that come late.

*Uhh... can we skip that one?* [**Not ready to respond to the question**]

9. How the changing of information on documents is affecting you?

*Ahh... This one, I don't think it affects so much because we have to do ... like to move along with the time and when it is changed there's nothing you can do.*

So, how does it make you feel? On you as a professional

*Well you will be angry, but there's nothing else that you can do because most of the time our circulars are not brought in time. They are late that is the only thing that is a problem. Others they will be dated a week before but they will be coming on this day like this.* [**Frustrated**]

10. How can communication be improved between you and your nurse manager?

*I think there should be transparency. If there can be transparency, we will definitely improve the wont be a barrier and what we do will be effective. The only thing I have noticed is that there is no transparency in our hospital.* [**Mistrust**]

By transparency can you explain further what do you mean?

*By transparency I mean things are not said on due time and some information you have to dig it up before you are being explained what it is, you have to find your own way how to deal with it and there is no honesty.* [**Mistrust**]

How does that make you feel?

*Is like.... you look cross to your manager and whenever you are about to ask, you lose hope or because next time you ask it's I don't know, I don't know, then you just keep quiet... you don't get further to that.*

**[Unapproachable]**

11. Can you share your experiences on communication with your nurse manager?

*Ok like this one personally...I don't know if it is going to be relevant. I had an issue whereby when I communicated with my area manager I was referred to my senior manager. I was running the ward for a year our in charge was at school by then. I ran the ward effectively and for the whole year there was no death. Then, I didn't receive the PMDS. When I asked about it, I was demoted in away. I think it was a demotion, then the CEO brought in the circular saying pensioners are going to be hired but they will be hired as new Professional nurses. When I questioned about the issue of PMDS, I was demoted and the pensioner was put on the position of the deputy. **[Emotional]***

How has that make you feel?

*I have decided that I have to quit the institution because of that **[quitting nursing/resigning]**. I'm waiting for the minute when they will say you will be the deputy of the unit because they will have to pick another one. **[Angry]***

12. Grand tour question

Kindly share with me the perceptions and the effects of communication with your nurse manager? Meaning when you talk to her/him are you free to do it or not and what are the reasons.

*In a way I am free to talk, but I know I've got limitations. I have noticed that she got favouritism in the ward. At the same instances I just keep quiet even if I want to say something knowing I just kept quiet cos I won't be taken to consideration. **[Hopeless]***

In your perception/view what is it that is limiting you to communicate with her?

*It is not always but at times I do have limitations. When you tell her something she will take it for granted.*

What are the things you have seen her doing so that you can say she is having favouritism?

*I have noticed that you at time like.... (Uhh) You cannot say when you are a manager like for instance, I am here with a Professional nurse and an Auxiliary nurse and you want to get the report from the Auxiliary nurse. The Auxiliary nurse also did this because she is being for longer in the unit and they tend to be friends with the unit managers. It creates a real conflict in the ward **[conflict]**. And if there's a conflict I believe that I don't know if it makes me happy**[emotional]** we should be consulted and not being gossiped, because the problem is not going to be solved if you being gossiped **[lack of Professionalism]***

When you communicate with your manager and see that she is not considering you what do you do or how do you feel?

Well, I take it her way like that and you know when I have a problem I normally consult.

Can we go to that question? Yes

How does the delaying of information to be communicated impact on you?

Uhh.... that one? It causes to work haphazardly because there should be time frame and our duties should be done accordingly. If issues come now, if the information come late you have to leave other things and do that is common in our ward.

So that is common Practice?

Mhhh.... [Nodding with the head]

So when you say your work becomes haphazard how does it impact on you?

Oh! It means you have to miss some of the things you have to do for the patient. At times we are short staffed, well shortage is everywhere but like at times we don't go for tea or lunch time and no one say anything about it like on Thursdays and Fridays we are only four on remaining on duty and we work two each thus no tea or lunch and no one sees that is normal and we not rewarded for that. **[Not appreciated]**

Thank you for participating in the interview. In closing how do you feel?

*I feel better because at least I've managed to open up cos I've been holding in because like in the ward we don't trust each other **[mistrust]**. If you say something about the manager the next thing you will hear from her saying she is aware of what you have been saying hence it's better to keep quiet.*

Remember all you said is between me and you and only my supervisor and few of the research team will access the information. Your real name is protected together with the ward you're allocated in.

Thank you again