PRE-OPERATIVE INFORMATION NURSES COMMUNICATE TO PATIENTS UNDERGOING GENERAL SURGERY

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DECLARATION

I hereby declare that to the best of my knowledge the work presented in this study has not been presented for any other project or being submitted for any other diploma or degree.

SIGNED........................................
CANDIDATE

APPROVED BY................................
SUPERVISING LECTURER
STATEMENT

I hereby certify that the work presented in this study is entirely a result of my own independent work. The various sources to which I am indebted are acknowledged in the text and in the bibliography.

SIGNED

CANDIDATE
DEDICATION

Dedicated to my children Mulumba, Tikambenji and Chisanga for what they have gone through during the most crucial period of their growth and development.
ABSTRACT

The study was conducted at the University Teaching Hospital, Department of Surgery. The main aim of the study was to determine the extent to which nurses communicate pre-operative information to patients undergoing general surgery.

The public in general have expressed dissatisfaction with the nursing care rendered in most health institutions through conversations with friends and relatives or through the press. It seems these complaints are often associated with lack of information. In view of the foregoing statement it was found imperative to carry out this study in order to examine communication patterns between nursing personnel and their clients with regard to information giving to general surgical patients.

Literature reviewed was based on communication in nursing particularly information giving and nurse-patient interaction. This is descriptive research. Data were collected from forty (40) patients who had undergone general surgery through interviews.

The results of the study revealed that nurse-patient interaction especially sharing of information was lacking. The majority of patients are given very little or no information at all in relation to their illnesses, pre-operative procedures/investigations and post-operative experiences. Very few patients were given the opportunity to ask questions about their illnesses and treatments. It was also found that in most instances the doctor provided information, which highlights how nurses keep a low profile in terms of providing patients with information.
In fact much of the information obtained makes the study important to the nurses, therefore suggested readings have been selected to provide the reader with sources as indicated in the bibliography. It is hoped that the reader will be provided with an insight into the role of the nurse in information giving which enhances psychological preparation of the surgical patient. Lastly, the nurse should realise that information-giving is an integral part of comprehensive nursing care.
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CHAPTER 1

INTRODUCTION AND OPERATIONAL DEFINITIONS

1. INTRODUCTION TO THE STUDY

Communication is imperative to all human interaction in whatever setting it might be. In nursing the subject is so important that without it the accomplishment of nursing duties and responsibilities would not be effected. Nurse-patient communication is not an area of great concern only to the nurse alone but also to the patient and indeed the public at large from which patients are drawn.

McLain and Gragg (1966, p.37) define communication as "the process by which knowledge, emotions, attitudes and information are transmitted." Communicating with patients through information-giving is one way of developing rapport with the patient. This should start immediately the patient comes to the hospital. Rapport is a kind of interpersonal relationship that has been defined by McLain and Gragg (1966, p.37) as "the therapeutic mechanism which makes possible all further communication." It can be said that first impressions form the basis for developing rapport upon which the patient may be made to feel comfortable or uncomfortable.

Patients are admitted to hospital under varying circumstances. There are those admitted for the first time while others have been in more than once. Some come in critically ill probably facing the threat of death when others are admitted for diagnostic or surgical procedures. These patients will have varying worries about their immediate strange environment, illnesses and its consequences including all the nursing and diagnostic procedures that may be performed on them. Surgical patients are even under more
stressful moments due to worry about impending surgical operation, indications for surgery, effects of anaesthesia, outcome of surgery, post-operative pain and discomforts and how they would cope with the outcome of surgery. Unfortunately most nurses do not seem to realise the agony or suffering patients go through by these aspects of their desire to get well. At times nurses may be heard saying "they do not know anything about the patient's illness," or they may refer the patient or his or her relative to the doctor for any information regarding the patient's illness, diagnostic/preparatory procedures for surgery or even the type of surgery the patient will undergo. Such referrals to the doctor without simple explanations may make the patient and his relatives become anxious about the illness. He may think of the condition to be of a very serious nature and may refrain from asking the doctor, thus prolonging his anxiety. Such patients tend to feel insecure and they do not have confidence in the nurse resulting in loss of trust in the nurse. In any case even though such references are made to the doctor, he spends far less time with the patient compared to the nurse who is there twenty-four hours a day, which puts her in a better position to get to know the patient well.

Hospitalisation has been said to cause a lot of dehumanization to patients (Travelbee, 1971) through loss of individuality and self identity because in practice, patients are referred to by their bed numbers, diagnoses and in cases of surgical patients by the type of operation they had. To emphasize the magnitude of the problem in surgical patients other than experiencing the above, these
their personal belongings such as clothes, jewellery, as well as the embarrassment they endure with procedures such as sharing which invade their privacy especially when the most intimate parts of their bodies have to be shaved. The stress is compounded by very little or no explanations given for different procedures done for or on the patients. Patients may also get disappointed with the care given which quite often is expressed through the press, to colleagues and even by writing to higher levels in health care services. Patients seem to be getting aware of their right to know what they are suffering from (illnesses), the treatments they are given including the effects of both. By explaining all events to take place, the surgical patient will be made aware of what to expect, and thus, prepare himself to try and cope with the situation.

Throughout the operative period, the nurse is expected to give psychological support to the patient by showing that she cares about him. 'Caring' can be shown through effective nurse-patient communication based on rapport. A nurse who cares also gives the patient reassurance. Boylan (1982, p.1523) says reassurance is:

"Giving patients specific information rather than platitudes to try and allay anxiety, and by directing the patients' thoughts to the positive rewards which will result from facing this challenge such as loss of chronic pain or illness."

One can therefore say that reassurance cannot be given to the patient without effective nurse-patient communication. Siren more contact with the patient without verbal communication can offer reassurance in a patient because feelings and emotions can be transmitted effectively through the non-verbal communication (Sundeen et al., 1976).
However, in most instances patients go through hospitals and other health institutions without receiving this reassurance as most of them may not even know what is wrong with them, the treatment they are receiving let alone the implications of having the illness and how to cope with it especially after discharge from hospital. When patients are deprived of this reassurance by not being given adequate information, they either reject the treatment of choice or accept it with mixed feelings that they have no choice. The former will be placed in the 'discharge against medical advice' group of patients only to come back a few days later in a critical condition or even too late for any surgical intervention to be carried out in order to save their lives. The latter group of patients may be possible candidates to develop complications as they have not been well prepared to cope with the operation. Some of the complications would be pneumonia, retention of urine, wound infection and thrombosis.

It is quite common for nurses in practice to say they allay patient's anxiety by giving reassurance which if they were asked to name the components of this reassurance, most of them would be able to spell them out. The components of reassurance are effective, nurse-patient communication, information-giving and good nurse-patient interaction (Boylan, 1982). Nurses talk about reassurance quite a lot but without delineating what it actually is and how it can be given to the patient.

In conclusion nurses generally know that patients can be put at ease through giving them reassurance, but it seems this reassurance is only given by 'lip service' because
nurses do not seem to clearly define what reassurance is. This failure by the nurses to define and offer reassurance to the patient is expressed through complaints from the patient, relatives and the general public which are often linked with lack of information. Information-giving is the most effective way of providing reassurance to the patient and his relatives as it forms the basis for the provision of comprehensive nursing care. Above all patients feel secure when information regarding their own care is given and thus feel they are partners with nurses in providing their own care.

2. **OPERATIONAL DEFINITIONS**

**BLUE COLLAR JOB**
Any job that requires expenditure of physical effort.

**COMMUNICATION**
The act of sharing information between the nurse and the patient.

**COMPREHENSIVE NURSING CARE**
Nursing care that includes the physical, social, cultural, psychological and spiritual aspects of clients.

**EXTENT**
Refers to the depth of knowledge and explanations given to the patient.

**GENERAL SURGERY**
Manual or instrumental operations performed on body structures other than the eyes, ear, nose, throat, heart and bones.

**INFORMATION**
Explanations or knowledge that a patient may need to know about his illness and treatment.
NURSE
Any individual who has undergone a 2 or 3 year training programme in nursing and is licenced to practice nursing.

NURSE-PATIENT INTERACTION
An encounter between the nurse and the patient during which verbal or non-verbal communication takes place.

PATIENT
Any person that is admitted to the hospital for treatment, investigations or observations.

PRE-OPERATIVE INFORMATION
Refers to knowledge and/or explanations the nurse shares with the patient on procedures and experiences anticipated before and after the operation and how to cope with the outcome.

PRE-OPERATIVE PERIOD
Period between doctors' decision about surgery and the time when the patient is anaesthetised.

SURGERY
Treatment of disease, injury or deformity by manual or instrumental operation.

WHITE COLLAR JOB
Any job that requires expenditure of mental effort.
CHAPTER 2

LITERATURE REVIEW

Today, effective communication in nursing is one of the most important and inevitable aspects in the provision of comprehensive nursing care. Hospitalised patients can benefit from the nurse who communicates effectively with them, because communication can serve as a means for maximising nurse-patient contact. In other words, effective communication can be said to be a means to an end and not an end itself in caring for the surgical patient; the end being the provision of quality care. This goal can be accomplished by the nurse who takes a lead in exercising her information-giving role.

1. COMMUNICATION IN NURSING

The actions and reactions that occur between two or more people is what forms interpersonal relationships. The type of interpersonal relationship expected to exist between the nurse and the patient has been described by Robinson (1977) as the "therapeutic relationship," because it aims at bringing about desirable results for both the patient and the nurse. Such a relationship is accomplished through effective communication which Robinson (1977 p.12) refers to as a "major component of the working relationship." The working relationship can also be facilitated by the type of interaction that takes place between the patient and the nurse. The desired type of interaction can be achieved through avoiding hurriedness and giving the patient time within which to ask questions and verbalise his problems. In so doing, the nurse will also be demonstrating patience and that she cares for the patient. It is through showing patience,
caring and interest in the patient that he will learn to trust the nurse. According to Robinson (1977 p.15), "the work of the nurse-patient relationship cannot commence until the element of trust has been established because it is only then that the patient can safely divulge himself." Because the nurse inevitably interacts with the patient for varying reasons, it is vital that she strives toward establishing a meaningful nurse-patient relationship through the use of effective communication.

Communication is a two-way process which constitutes four main elements: the sender, the message, the receiver and feedback or response to the message (Sundeen et al, 1976) and it occurs in verbal or non-verbal forms. Most communication that takes place in daily encounters is expressed verbally, but the nurse must recognize the non-verbal communication expressed through facial expression, wriggling, gestures, the way one sits or walks (Sundeen et al, 1976, Knop, 1972). However, observation in clinical settings has shown that this aspect of communication seems to be ignored and neglected by most nurse practitioners.

The scope of patient care is directed toward providing comprehensive nursing care which can be accomplished through effective nurse-patient communication. In providing comprehensive nursing care the nurse does not only interact with the patient but also with his relatives, doctors and other hospital personnel in other hospital departments (Robinson 1972) thus, making the nurse the central figure of all this interaction process which is intended to meet the patient's needs. In all these interactions the nurse comes in contact with people during "times of stress, concern, joy and grief" (Burton, 1979, p.17) during which communication
may be made easier or difficult. It is true that all illnesses cause stress and concern and that the results may be that of joy if the patient benefits from the treatment or result into grief if treatment is not successful and results in loss of life. These factors may affect the nurse's involvement with the patient and his relatives depending on how the nurse perceives the situation. Involvement can be "minimal, moderate or great" (Burton 1979 p. 17). It is only with the nurse's realisation that communication forms an essential component of all activities in her life and work that she will facilitate providing an atmosphere that may make living or illness easier for the patient to bear (O'Brien, 1974).

One shortcoming that has evidently been identified in hospitals is the lack of communication (Knon, 1972, Bluestone 1977, Boylan, 1982) which obviously makes the patient suffer. In order to provide a conducive atmosphere for effective nurse-patient communication, the nurse must leave open channels for communication by allowing the patient to verbalise his concerns to which she must listen and try to understand the problem from the patient's point of view (Gruendemann et al, 1977). This can be achieved through empathy which according to Robinson (1977 p.16) "involves skill in reaching out and trying to understand the thoughts and feelings of others. Stated in simple terms it is the ability to feel with the patient" by putting oneself in the patient's position." In empathizing with the patient the nurse must by all means avoid bringing in her own feelings that may be based on previous personal experiences as these may ruin and defeat the purpose of empathy in any
given situation. It is not uncommon to see nurses trying to comprehend patient's problems from their point of view. This often results in failure to comprehend the patient's problems as he or she perceives them. This can be referred to as the projection of one's feelings, which may hamper the nurse's effort toward establishing effective nurse-patient communication. Interpersonal relationship and delivery of factual information are two main aspects in staff-patient communication in which patients have expressed dissatisfaction. (Pascoe et al, 1978). Other studies that reflect upon the problems of nurse-patient communication are those done by Faulkner (1979) on nurse-patient conversation in a ward, Ashworth (1980) who investigated the problems of communication between nurses and patients in intensive therapy units, Weinwright's (1982) investigation of the relation of post-operative pain to the amount of information given to the patient pre-operatively and Syacumpi (1983) in her study on assessment of nurse-patient interaction. The results of the four studies showed that nurse-patient communication was inadequate in that patients were given little or no information at all regarding their illnesses and the care they received. This demonstrates that patients are neither considered as independent individuals nor are they treated as partners in planning their care (Abdeillah and Levine, 1957). This may cause the patient to feel that he is only valued by the hospital because of his illness in other words, "he is a case". Hence treatment is often directed toward relieving or curing physical symptoms, while completely ignoring the patient's psychosocial problems. It is therefore not
surprising that nurses often encounter patients who respond to such type of interactions by saying "go on nurse, you know what is best for me." It is because of the way patients are treated that lead them to adopt such a passive attitude. If patients were given adequate information and made aware that they are partners in their own care, they would take an interest in being involved in their care.

The aims of nurse-patient communication according to Ashworth (1980, p.75) are fourfold:

1. To establish a friendly, helpful, competent and reliable relationship which recognizes the patient's worthy and individuality.

2. To determine patients' needs as they are perceived by him and to assist him identify those needs that are perceived by the nurse.

3. To provide factual information on which the patient can base his expectations.

4. To assist the patient use his own resources and those offered to him such as information to meet his own needs.

These aims of nurse-patient communication clearly indicate that the nurse must develop a kind of interpersonal relationship that is therapeutic as stated earlier which will facilitate a holistic approach to patient care. Nurse-patient communication can therefore be facilitated if there is maximum contact between the patient and the nurse; an aspect which Uuskalio (1970) identifies to be universally deficient in most hospitals. This lack of or little contact between the nurse and the patient may be viewed as a deliberate avoidance of nurse-patient communication. Nurses do not seem to recognize that effective nurse-patient communication can be very rewarding to both as it serves as a medium through which the patient can verbalise his fears and thus satisfy his needs to express himself. The nurse will also have the
opportunity to gather information that will facilitate planning nursing care as well as get a guideline on what type of information the patient needs, also information on the patient's actual needs. Surgical patients particularly need to be given a chance in order to help reduce anxiety during the pre and post-operative periods. These are the periods when surgical patients wonder about the "why", "what" and "how" aspects of surgery. The more the nurse interacts with the patient the more she may get to talk and even get ease on identification of ques and pros in the patient's conversation.

Hospitalisation causes a certain kind of social isolation from everybody, social relations (Bluestone, 1977) which causes the patients to have an increased emotional sensibility that make them vulnerable to small details concerning their care. During such periods the patient looks at the nurse as " surrogate significant other" as she is expected to perform some of the roles that are performed by family members (Gruendemann et al, 1977). The nurse must therefore recognize her role and strive toward establishing the therapeutic nurse-patient relationship upon which effective communication is dependent. The patient probably appears to appreciate a nurse who spends a little more time with him because conversing with the patient may assist him divert his thoughts from the obvious experiences of surgery such as pain and other related discomforts.

Nurses must develop skill in recognizing the patient's need for communication while appreciating that all individuals are unique, having different needs and that these needs are expressed differently by each individual. When patients come to hospital they expect relief which, in most
instances, should be facilitated by the nurse. (Brunner and Suddarth, 1980), through effective nurse-patient communication. Effective nurse-patient communication can be enhanced by the nurse by providing a warm and receptive atmosphere which makes the patient experience minimal levels of stress and anxiety during hospitalisation and surgery. Communication in nursing may thus be viewed as the core of all activities in the provision of nursing care without which it would be impossible to achieve the goals of nursing.

2. THE SURGICAL PATIENT AND THE NURSE'S ROLE IN PROVIDING INFORMATION

Earlier in this chapter the effects of hospitalisation on an individual were explored together with the place of nurse-patient communication in the provision of comprehensive nursing care. Indeed the effects of hospitalisation equally affect the patient. He is not only apprehensive of the strange and possibly, frightening environment he finds himself in which the people and language are strange to him, (Bluestone, 1977) but also about the impending surgical operation. This worry about surgery commences with the doctor's decision that surgery is the treatment of choice for the patient. Such worries may be caused by the thought of anaesthesia, the operation and its outcome which are all unknown to the patient. Some operations according to Hayward (1981 p.40) "may involve actual probable loss of a body part or cause permanent physical disability such as colostomy and radical mastectomy." Such operations may be perceived as life threatening situations by both the patient and his family because they carry a lot of repercussions for the future. These situations bring a lot of torment to the
patient so much so that if nothing is done about his fears and anxieties about the unknown, may cause a lot of unwarranted suffering than the effects of the operation itself. Information provision can go a long way in assisting the patient cope with such a threatening situation. One outstanding complaint of surgical patients is that they are given inadequate information in terms of the disease, surgical procedure, its implications, post-operative discomforts and ways of dealing with them (Bridge and Mclead-Clark, 1981). Information-giving is beneficial to the surgical patient as it is said to minimise the worry and anxiety of surgery by enabling the patient to carry out the 'work of worrying' (Weisener, 1976). This mechanism can be said to work through providing the patient with a realistic basis on which to base his expectations of events ahead of him, because most worries of surgical patients may be caused by their unrealistic assumptions based on personal values and beliefs. Wilson-Barnette and Osborne (1983) have demonstrated how altered perception of a "threatening" situation could be brought about through information-giving. This was done through an appraisal of what to expect and rehearsal of coping methods and the results were that patients had a more rapid mobilisation, discharge from hospital and fewer post-operative complications. As a rule explanations of any kind must be repeated several times if it is intended to bring about desired behaviour. Surgical patients need time in which to deal with the life threatening procedure, of course not without the family from whom the patient can derive a lot of satisfaction if explanations were made to them. The nurse must exercise flexibility in her approach to each patient in order to assist him see the
threatening aspects of surgery in a new and better perspective.

The trauma of surgery does not end with gaining of consciousness, but it goes a long way up to complete healing of the wound and resuming normal daily activities without discomfort. This implies that explanations given to the surgical patient should be detailed enough to enable him accept the challenge of having to undergo surgery and all the discomforts that follow. Wainwright, (1982) states that information giving on patients' experiences and sensations during and after surgery are more effective in reducing anxiety rather than procedural details, because it involves appraisal of what to expect and rehearsal of coping methods. Studies such as those done by Hayward (1975), Boore (1978) and Wilson-Barnette (1978) establish that pain, anxiety, stress and other discomforts can be reduced through giving the patient adequate information and explanations prior to surgery and investigations. But in most instances it seems patients are taken unaware as they are not told what to expect post-operatively, hence this may be thought to be the reason for many patients seen screaming and shouting due to fright from the immediate post-operative effects of surgery. Nurses are expected to be competent in teaching and demonstrating coping methods such as breathing, coughing and leg exercises to name a few as well as the teaching and explaining of post-operative experiences.

Although it is the doctor's responsibility to explain the diagnosis and the nature of operation to be performed on the patient, he does so to fulfill his responsibility towards obtaining an "informed consent" to operation.
The nurse plays a very important role in reinforcing the information as well as assisting the patient and his family adjust psychologically (Clough, 1982). In most cases patients do not seem to understand their illnesses and treatments due to the hurried manner in which the doctor gives explanations (Boylan, 1982). Such a situation can be corrected by the nurse who by virtue of her continued contact with the patient can get an opportunity to assess the patient's status and mental state and give explanations accordingly. As stated earlier in this Chapter that patients are less concerned about procedural details of the operation, nurses must develop competence in providing the patient with explanations on various procedures to be performed prior to surgery which might place the patient in turmoil if not explained. This turmoil may cause some patients to opt not to go for surgery because they are uncertain of everything that is happening to them.

The role of the nurse in information giving is one of her professional functions (Boylan, 1982) though she finds herself in a dilemma, as regards to the type of information to communicate to the patient. Nurses seem uncertain about their information giving role, a matter that is resolved by referring the patient and his relatives to the doctor. Unfortunately, this is not brought to the doctor's attention thus leaving the patient and his relatives in more worries and anxieties. Clough (1982) attributes this uncertainty about the type of information to be shared with patients to lack of knowledge and confidence on the part of the nurse. To cover up for her inabilities the nurse refrains from involving herself in conversations with the patient by minimising nurse-patient contact. This kind of cover
up was referred to by Mclead-Clark (1981) as the "blocking technique," in which the nurse avoids responding to the patients' questions or puts a barrier to a question not asked. Boylan (1982) further explains that junior nurses often get into the trap of being asked awkward questions because they lack skills in the blocking technique and that their open-minded approach seem to encourage patients to ask questions. To support the above assertion Hart (1981) demonstrated the junior nurses position in regard to this by sharing his experience as a student nurse with an elderly woman who was to undergo a mastectomy. The patient demanded to be told the indications for a mastectomy to which she had convinced herself it was cancer and it had caused her a lot of worry and anxiety. This is a clear indication that the patient had not been furnished with information in relation to her illness and the indications for the surgical operation that she was to undergo. At the same time one is inclined to suggest that the nurse had failed to recognize the patient's need for information or had simply avoided to talk about the patient's condition. Otherwise if the nurse had taken a lead and realised her role in information giving, the junior nurse could have been served the embarrassment and also the patient from unnecessary worry and anxiety. Perhaps in these instances where information about the diagnosis and prognosis is not given to the patient, there are times when such information is given to the relatives (Rabkin, 1973). Such a shift of responsibility may make the situation intolerable for both the patient and his relatives because the patient is bound to sense this sooner or later through the manner in which relatives
and other people around him interact. Such an interaction may complicate the aims of treatment as the patient lives in suspicion and thus may not be forthcoming in sharing information with the nurse. No matter how bad the news is, the patient, must be told the truth (Reynolds, 1978) for it is the only way the patient can be helped to cope with the crisis psychologically. Rabkin (1973) states that patient often judge their hospital experiences less from the medical-technical point of diagnosis and treatment than from satisfaction for their psychological needs to which information-giving is a major component. The nurse who shares information with the patient does not only satisfy the patient's need for reassurance and comfort but also displays respect for personal dignity by making the patient aware of events to expect. It is time the nurse recognized and assumed her role in information giving in her attempt to provide comprehensive nursing care and indeed in surgical patients it is the only way the nurse can facilitate uncomplicated recovery.

In conclusion, effective nurse-patient communication is fundamental to the practice of nursing (Bridge and Mcleod Clark, 1981). The patient can derive a lot of relief through the therapeutic interpersonal relationship that may emerge between the patient and the nurse upon which nurse-patient communication depends. Surgical patients need both physical and mental preparation, both of these may be effectively accomplished through sharing information. The importance of nurse-patient communication cannot be over-emphasized, because it forms the core of all interpersonal interactions. While the nurse is making efforts in effecting nurse-patient communication she must realise that contact
with the patient has its own place, therefore, she must give the patient as much time as she can afford in conversations.

In realisation of her professional function in information giving, the nurse must develop skill and competence if she has to execute her duties effectively. This calls for recognition of patients who are in particular need for information as well as those who feel lost and lonely, so that the nurse can draw all her resources in an attempt to try and provide the patient with the opportunity to converse and express his fears and concerns. Surgical patients need to be understood by the nurse and the nurse must try by all means to minimise the psychological strain that the patient may be subjected to if something was not clearly explained. For a nurse who has acquired adequate skill and experience it may be less cumbersome and hazardous to determine the type of information required by the patient. By giving adequate information to the surgical patient the nurse will not only attempt to minimise the trauma of surgery and aiding recovery but also preserving self image and upholding self respect (Wessner, 1976). If nurses are to achieve the aims of patient care it is then time they critically examined their role in information-giving particularly when nursing patients who are undergoing surgery and other procedures.
CHAPTER 3

STATEMENT OF THE PROBLEM

Observation and experience have shown that patients complain to hospital staff, relatives or friends and through the press that they are not given adequate information regarding their illnesses, treatments and procedures done on them or for them. This means patients are not told in simple terms what is wrong with them, the names of drugs they are given, possible unexpected feelings resulting from drugs and why and how certain procedures are done. This results in anxiety because the patient has not been told what to expect which Wilson-Barnette (1981) refers to as "the face of the unknown." Anxiety according to Travelbee (1971, p. 190) is defined as a subjective experience characterised by tension, restlessness and apprehension prompted by real or imagined threats." In most instances this unpleasant emotion can cause the patient a lot of anguish and unnecessary expenditure of energy especially when the patient’s fears are unrealistic or fantasised and unrealistic thoughts may be based on an individual’s socio-cultural beliefs about the illness. A step that the nurse can take to reduce such anxiety may be done through giving the patient adequate and appropriate information and explanations of all events called for on his behalf.

The task of information-giving cannot be achieved without the necessary skill and experience. Nurses must therefore, firstly, recognize the gap that can exist between the patient and themselves in terms of knowledge that nurses possess about procedures and illnesses and the knowledge the patient possesses. (Wilson-Barnette, 1981). If this gap is not patched up through sharing information with the
patient, how then can the nurse say she is achieving her professional function in the provision of comprehensive care? A patient who lacks information on the decisions taken on his care cannot be said to be included in his care. Information-giving forms a very important aspect in providing comprehensive care and yet it is an area in which a lot of inadequacies have been identified (Faulkner, 1979, Wilson-Barnette, 1981, Syacumpi, 1983). What is observed in practical settings is that nurses do not seem to be interacting much with patients unless when they have procedures to perform on patients. On the other hand, one may be inclined to say nurses seem busy attending to (perhaps to them) more pressing problems, for example, administrative work. At the same time another observation that has been made is that nurses seem to direct their energy and time towards tasks for which they are accountable such as carrying out doctors orders and giving medicines. Travelbee (1971) refers to such nurses as the ones that are perceived as “good nurses” by nursing administrators and are probably the ones that are promoted to supervisory positions. In this case it only puts the patients in a more tormenting situation because such a nurse manager may not recognize the inefficiencies in nurse-patient interaction and communication. One may even wonder whether such nurses do greet or orient their patients to the ward environment at all, because patients do seem to undergo a lot of stressful moments upon admission to hospital caused by strangeness of the environment and the people. The result is that patients feel insecure and also find it difficult to be the ones taking a lead in generating a conversation with the nurse or even with other patients, that are already in the ward.
If such a situation is not recognized by the nurse it can cause a barrier which may produce negative results of the care being provided because the patient will not feel free to express his fears and feelings thereby concealing vital information that would positively contribute to his well being.

It is common practice for nurses on the wards to leave patients wondering about what will happen next after their admission to hospital. This makes the patients apprehensive in expectation of what is little known or not known. When patients are denied information they are also being denied their right to make decisions concerning their care; a situation which they resolve by either refusing the treatment, abscond or leave the hospital against medical advice. This is because they have not been given a basis on which to base their decision, even though they may realise that they are not taking the correct decision. These patients who leave the hospital prematurely are a hurtful reminder of the neglect of communication as an aspect of patient care in most hospitals" (Bluestone, 1977 p. 139). Furthermore, a situation in which patients are given very little or no information at all may hamper, complicate or nullify institutional efforts (Bluestone, 1977) in that these patients who decide to leave the hospital prematurely always come back, but either as dead persons or when it is too late to do anything for them. In the case of surgical patients they may refuse to have surgery performed on them or endure to undergo the surgical operation without being prepared psychologically. Such ill-prepared patients will not understand the post-operative discomforts including
ways of coping with these discomforts. The result may be exposure of the patient to complications as the patient will not reinforce what is being done for him because he lacks knowledge which is followed by a prolonged stay and unnecessary suffering to the patient and his family. At the same time it is expensive for the hospital to maintain long stay patients.

The patients' need for information must therefore be seriously considered by all nurses in whatever capacity in order to improve patient care. Due to this lack of recognition of the importance of effective nurse-patient communication on the part of the nurse, nurses seem to regard it less as a reflection of poor nursing care than if a patient was left to endure physical pain (Boylan, 1981).

The main aim of this study therefore is to determine the extent to which nurses communicate pre-operative information to patients undergoing general surgery and also to assess nurse-patient interaction in general. The study attempts to answer the research question: To what extent do nurses communicate pre-operative information to patients undergoing general surgery? It is hoped that the findings will assist the practicing nurse in her effort to improve patient care through information-giving.

To conclude it can be said that developing rapport with the patient is one way of establishing effective nurse-patient communication. Rapport serves as a basis for further communication as it does affect the overall interactions that occur between the patient and the nurse. If there is consistent and continuous communication between the two, both will feel free to share information that directly affects patient care. When effective nurse-patient
communication is affected the nurse could succeed in providing comprehensive nursing care which embraces the bio-psycho-social dimensions of patient care.
CHAPTER 4

METHODOLOGY

1. RESEARCH DESIGN

The purpose of the study is to find out the extent to which nurses communicate pre-operative information to patients undergoing general surgery. Therefore a descriptive research design was thought to be more appropriate to the study. Treece and Treece (1973) define a descriptive study as any research that does not involve experiments but rather aims at describing the existing interrelationship between nurses and patients as an attempt to answer questions and satisfy curiosity. The aim of descriptive studies is to provide an accurate picture of characteristics of persons, situations or groups and frequency with which certain events occur (Oppenhein, 1966, Polit and Hunger, 1983).

The descriptive research design was chosen for this study because the nature of data required for the study will be in descriptive form in order to determine the extent to which patients going for general surgery are given the necessary information that will allay their anxiety about the operation itself and the outcome of the operation. "Descriptive designs are closely oriented to observation, thus affords the investigator chance to observe in order to know the 'what' and 'why' of a phenomena. This offers the basis for explaining how events are closely interrelated to one another" (Seaman and Verhonick, 1982, p.2). Gathering of data in descriptive research design is done in a natural setting thereby providing quantitative descriptions of relationships. It was therefore hoped that the descriptive design would offer
chance to observe the nurse-patient interaction in general and the effects of lack or little information given to the patients. Lastly, descriptive designs are less expensive as respondents remain in their natural setting, which eliminates subjecting respondents to unpleasant conditions, hence cooperation is easily obtained (Abdellah and Levine, 1979).

2. RESEARCH SETTING

The study was conducted at the University Teaching Hospital which is located in Lusaka the Capital City of Zambia. The University Teaching Hospital is the largest health institution in the Country. It has a bed capacity of one thousand five hundred (1,500) distributed among six departments namely; Paediatrics, obstetrics and gynaecology, medical, surgical, administration wards and the paediatric and neonatal surgical Departments. Most of the specialists are found at the University Teaching Hospital and it also serves as a referral hospital for the Country.

The Hospital offers training facilities for registered nurses and midwives, theatre nurses, doctors, Physiotherapists, radiographers as well as post graduate courses in various fields of medicine including medical research.

The study was conducted in the Surgical Department of the Hospital. This department caters for general surgical patients. The Department is made up of six wards out of which two are being used for septic or unclean orthopaedic cases including condition with complications of a septic nature. The remaining four wards cater for general surgical patients. These are divided into two female wards and two male wards. The two female wards also cater for children with general surgical conditions.
The actual bed capacity per ward is thirty-two (32) but due to congestion and high turnover of patients the bed numbers are increased to forty (40) or more. The average number of nurses per ward is ten with four registered nurses and six enrolled nurses split into morning, afternoon and night shifts. Morning shift lasts five and a half hours, the afternoon shift takes six hours and night duty is a twelve hour span of duty. On average there are three nurses per shift apart from night shift when there is one nurse or two especially in busy wards. The approximate nurse-patient ratio during the day shifts is one nurse to thirteen patients. This is a very high nurse patient ratio which implies an increase on nurses' responsibilities, thereby reducing the amount of time spent with each patient. Nurses may be inclined to focus attention on tasks to be performed hence completely forget about nurse-patient communication.

Nurse learner numbers fluctuate during different times, and these are normally regarded as supernumery to ward staff except for the finalist students in their last six months of training. On average there are approximately ten nurse learners of different levels assigned to a ward at a time.

3. PILOT STUDY

The pilot study is that "Study which is done preliminarily to the main study with the aim of testing elements of the research proposal and correcting any inconsistencies" (Seaman and Verhorick, 1982, p.45) or to test the validity and reliability of the instrument to be used in collecting data.

The pilot study was not done due to limited time in which the study had to be conducted, compiled and submitted.
to the school of medicine, Department of Post-Basic Nursing.

Also pilot studies are "more extensive...and are most useful in the preliminary planning stages of large scale projects" (Sweeney and Olivieri, 1981, p. 39). Since a study of this kind has not been conducted in this Country before, the study can be said to be a pilot study in itself, and it is a small-scale study. In order to ensure validity and reliability of the instrument used for data collection, the charity and sequence of questions were checked by colleagues and the supervising lecturer several times until a consensus was reached. Another reason why the pilot study was not conducted is that it was not possible for one person to interview a large number of respondents as no other researchers were employed to collect data.

4. THE SAMPLE: SELECTION AND APPROACH

The target population were the general surgical patients because they comprised the larger population of all surgical patients in the hospital. These patients were nursed in one department in the Surgical Department, whereas patients requiring specialised surgery are nursed in designated departments. It was also felt necessary to confine the sample to one department in an effort to achieve uniformity in terms of the kind of information patients may be given, the quality of nursing care given and that patients' needs for information may not be the same.

Patients who had had emergency operations were excluded from the sample because these patients may not have had enough time to interact with nurses before surgery as most of them are basically not in a position to comprehend what may be said to them. Others are either in severe pain or in unconscious states. Orthopaedic
patients too were excluded as most of them were non-ambulant, hence unable to walk over to the place (room) where interviews were done.

It was intended to obtain a sample of fifty (5) general surgical patients. The sample size was for convenience due to the time limit in which the study had to be completed and submitted to the Department of Post-Basic Nursing of the University of Zambia. In addition, the data collecting instrument (interview) is time consuming. This size of the sample was thought to be manageable within the time available.

The sample comprised of patients only because they were the consumers of nursing care and are therefore the best people to give the kind of information nurses shared with them prior to surgery. (Uuskallio 1970) states that patients are the best people to evaluate the type of care given to them.

Permission to interview patients in the surgical department was sought for by letter to the Acting Nursing Officer of the Department (Appendix 1). A written reply granting permission was received (appendix 2). The Acting Nursing Officer took the responsibility of informing the sisters in-charge about the request to interview patients on the wards concerned. The ward sisters and charge nurses were met personally for self introduction and to explain the purpose of the study.

Sample selection was done by systematic sampling. Systematic sampling is a method that involves selection of subjects using already existing lists with the first subject being chosen randomly or by chance then proceeding to find the interval by dividing the total population by the number of subjects required. Every third patient on the ward was
the sample (50) could not be obtained due to the exclusion of two orthopaedic wards, emergency operations and children on female wards. Each patient included in the sample was approached individually. Self introduction was done and the purpose of the interview was explained. The subject was then asked if he/she was willing to participate in the study. It was ensured that all the volunteers were ambulant because they were required to walk to the sisters office for the interview on days and times agreed upon. Forty-nine (49) patients agreed to participate in the study.

5. **INSTRUMENT USED TO COLLECT DATA**

Data were collected using the structured interview schedules because it allows for collection of fairly consistent data (Sweeney and Olivieri, 1981). The structured interview schedule also allows for uniformity of questions asked, type of responses given and their options as well as the maintenance of question sequence. Comparison of responses is made easier and thus offers a basis for validity of responses (Polit and Hungler, 1983). Processing of data is eased in the structured interview schedule in that there is uniformity of information obtained. Other reasons for using the interview schedule were that the sample was going to include both the literate and illiterate patients. It was also hoped that the method would cut down on paper expenses since only the required number of schedules for the sample size prepared, and that all data obtained from interview schedules were relevant to the study. Lastly, it was hoped that an opportunity would be afforded to observe in general the nurse-patient interaction during interviews.
The advantages of the interview technique are:

1. It is flexible because it offers chance for repetition and clarification of questions.

2. The interviewer is able to build and maintain rapport throughout the interview (Oppenheim, 1966, p. 31).

3. The response rate is high because of the face to face interaction.

4. All questions are given the appropriate response.

5. The interviewer maintains strict control over question sequence.

6. Interviews minimise ambiguity and confusion of questions which may lead to erroneous conclusions if not detected.

7. People who hate composing and writing are served the trouble of having to do so especially in open-ended questions.

8. Interviews maintain control over the sample in that the respondents are the intended participants (Polit and Hungler, 1983, pp. 320-321).

9. Interviews cater for people who cannot read and write such as the elderly, blind, uneducated and children.

10. Interviews offer chance to ask probing questions whenever particular responses are encountered, thereby increasing the depth of data collected.

11. Interviews provide opportunities for asking questions as well as observing (Seaman and Verhonick, 1982, p. 217).

12. Interviews serve time for the interviewer in terms of writing and returning the instrument.

13. In interview technique all data obtained are usable.

14. Interviews offer chance for revealing about emotional topics or emotions that underlie a response. (Treece and Treece, 1982, p. 246)

The disadvantages of the interview technique are:

1. It is time consuming.

2. It is costly.

3. It does not enable the researcher to cover a more diverse geographical sample.

4. Personal and sensitive questions may not be given the correct responses because of the face to face interaction (Polit and Hungler, 1983, p. 320).
5. It is subject to interviewer bias influenced by the interviewers' expectations and selectivity in understanding and recording responses.

6. The face to face interaction decreases the respondents' feeling of anonymity.

7. Interviewers personal characteristics may reflect his or her own opinion to the respondent.

8. When more than one interviewer are used it may not be easy to achieve uniformity in terms of personal characteristics (Seaman and Verhonick, 1982, p. 217-218).

9. Subjects awareness that their responses are being recorded may make them nervous and bias their responses.

10. Interviewers pre-occupation with the techniques of an interview schedule may cause them to overlook the non-verbal ones that may take place (Treece and Treece, 1982).

Some of the disadvantages were minimised by assuring respondents anonymity, confidentiality and no names were recorded on interview forms. No other interviewers were employed and the sample size was even reduced from fifty (50) to forty (40). Interviews were as informal as possible in order to make respondents feel at ease by having a general discussion with them on their families, their health and other general subjects that appealed to them. Rapport was established this way so that respondents felt free to answer and ask questions. Verbatim problems encountered during the recording of responses especially when the respondents were unable to speak English were minimised by asking respondents to repeat the responses whenever the interviewer felt uncertain about the response given.

The interview technique was chosen in favour of the questionnaire due to the following reasons:-

1. The sample included people who were unable to read or write.

2. Questionnaires would not have afforded chance to observe the nurse-patient interaction.
3. In the questionnaire the investigator would not have had chance to interact with the respondents.

4. Questionnaires do not afford chance to assess respondents level of understanding.

5. It is not uncommon for respondents to misunderstand some items on questionnaires, as there may not be chance to clarify such items to respondents.

6. It may not be possible to obtain a representative sample because of the subjects who do not return the questionnaires.

6. QUESTION SEQUENCE

The interview schedule constituted 39 questions. The first five questions were constructed to elicit respondents' demographic date such as sex, age, educational attainment and occupation. The following four questions (6, 7, 8 and 9) sought information about previous admissions, diagnosis and length of stay in hospital. Questions ten to twelve asked for date relating to the type of information the respondent received about the ward and persons who gave him the information.

Information regarding the respondents' knowledge of names of nurses caring for them and how they got to know the names was elicited from questions thirteen (13) and fourteen (14). Respondents' knowledge of their illnesses and their opinion on explanations given to them was obtained from questions fifteen (15) to eighteen (18).

Succeeding questions, nineteen (19) to twenty-three (23) sought information about time lapse between the decision about surgery and the day of operation, the kind of information subjects were given about the operation and how they felt about the explanations. Information relating to pre-operative procedures or investigations including explanations of reasons for performing these procedures was sought from questions twenty-four (24) to twenty-nine (29).
Questions thirty (30) to thirty-four (34) asked for information about explanations the kind of post-operative experiences and whether or not these explanations were helpful to the respondents. The following questions thirty-five (35) to thirty-seven (37) were constructed to elicit information regarding other aspects of the operation that respondents wished to know before surgery. The last two questions requested respondents to comment on their hospital experience.

7. **DATA COLLECTION.**

Data were collected between the last week of March, 1984, and last week of April, 1984. Interviews were conducted over a period of five weeks in order to allow the investigator and respondents ample time during each interview so as to avoid rushing through the interview.

The times found suitable to conduct interviews were evenings after visiting hours and during weekends because there was less activity on the ward in regard to doctors' rounds, nursing and diagnostic procedures. Patients were also found to be more relaxed during these times. The time was also found to be convenient to the investigator because there were no formal lectures to attend during the evenings and weekends.

To ensure privacy to the respondents interviews were conducted in Sisters' office. This also enabled respondents to feel free to express their feelings freely. During the first four interviews, a few disturbances were encountered for example, nurses wanting to wash their hands and maids wanting to get items from the office. However, such disturbances did not persist during subsequent interviews because all items needed for immediate use were removed prior to beginning the interviews. Ward Sisters'
or Staff Nurses in charge were also very helpful in alerting everybody on duty about the interviews in order to avoid further disturbances by people entering the interview room.

One respondent could not speak English fluently, therefore clarity of all questions and responses was achieved by repeating sentences and questions. Three respondents were interviewed for more than forty-minutes because they asked questions about their conditions and nursing care but they had to be stopped because they would have gone on talking indefinitely. One of them expressed loneliness and this seemed a chance for him to talk to someone to express himself.

8. DATA ANALYSIS

Data collected are not useful unless arranged in a meaningful manner so that it is possible to derive patterns of relationships (Polit and Hungler, 1983). All data were handled manually with the aid of a pocket calculator.

Quantification of data is possible through the use of statistical procedures. It is necessary to quantify data so that information may be easily interpreted to give meaning as well as to reduce the bulk of information by using numerals (Polit and Hungler, 1983). Descriptive statistics using frequency distributions and percentages were used in tabulating data that were collected.

Responses to open-ended questions were processed and categorised. Sweeney and Olivieri (1981, p. 391) state that "The researcher should set up categories by sorting out the answers according to the major themes present in the responses". Accuracy in setting up categories is a major problem if done by "individuals". Help in setting up categories was sought from colleagues in order to get a consensus and be as objective as possible.
CHAPTER 5

PRESENTATION OF FINDINGS

The purpose of the study was to find out the extent to which nurses communicate pre-operative information to patients undergoing general surgery. The findings are presented in table form. It was found suitable to use tables because they offer ease to the reader in finding out the relationships between variables and also they help to summarise the findings. (Sweeney and Oh’vieri 1981)

Tables have been arranged according to the question sequence. The first set of tables show demographic data and succeeding tables show data relating to the kind of information respondents received pertaining to the ward, their illnesses, preparatory procedures or investigations and the post-operative experiences respectively. The tables also reflect the designations of persons giving information and the respondents’ feelings about the information given. The last two tables give information on the other aspects that respondents wished to be informed about and their comments on their hospital experience.
TABLE 1: SEX OF RESPONDENTS

<table>
<thead>
<tr>
<th>SEX</th>
<th>NUMBER OF RESPONDENTS</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>MALE</td>
<td>22</td>
<td>55</td>
</tr>
<tr>
<td>FEMALE</td>
<td>18</td>
<td>45</td>
</tr>
<tr>
<td>TOTAL</td>
<td>40</td>
<td>100</td>
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TABLE 2: AGE OF RESPONDENTS

<table>
<thead>
<tr>
<th>NUMBER OF RESPONDENTS</th>
<th>AGE-RANGE</th>
<th>PERCENT</th>
</tr>
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<tbody>
<tr>
<td>10</td>
<td>51-60</td>
<td>25</td>
</tr>
<tr>
<td>10</td>
<td>31-40</td>
<td>25</td>
</tr>
<tr>
<td>9</td>
<td>20-30</td>
<td>22</td>
</tr>
<tr>
<td>6</td>
<td>41-50</td>
<td>15</td>
</tr>
<tr>
<td>4</td>
<td>61-70</td>
<td>10</td>
</tr>
<tr>
<td>1</td>
<td>ABOVE 70</td>
<td>3</td>
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<tr>
<td>40</td>
<td>TOTAL</td>
<td>100</td>
</tr>
</tbody>
</table>

TABLE 3: EDUCATIONAL LEVEL OF RESPONDENTS

<table>
<thead>
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<th>EDUCATIONAL LEVEL</th>
<th>NUMBER OF RESPONDENTS</th>
<th>PERCENT</th>
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<tr>
<td>PRIMARY SCHOOL LEVEL</td>
<td>16</td>
<td>40</td>
</tr>
<tr>
<td>NEVER BEEN TO SCHOOL</td>
<td>15</td>
<td>38</td>
</tr>
<tr>
<td>SECONDARY SCHOOL LEVEL</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>UNIVERSITY LEVEL</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>COLLEGE LEVEL</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>
### TABLE 4: NUMBER OF RESPONDENTS IN EMPLOYMENT AND THEIR OCCUPATIONS

<table>
<thead>
<tr>
<th></th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
<th>OCCUPATION</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNEMPLOYED</td>
<td>22</td>
<td>55</td>
<td>WHITE COLLAR JOB</td>
<td>8</td>
<td>44</td>
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<tr>
<td>EMPLOYED</td>
<td>18</td>
<td>45</td>
<td>SELF EMPLOYED</td>
<td>7</td>
<td>39</td>
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<td></td>
<td></td>
<td></td>
<td>BLUE COLLAR</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>TOTAL</td>
<td>40</td>
<td>100</td>
<td></td>
<td>18</td>
<td>100</td>
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### TABLE 5: NUMBER OF PREVIOUS ADMISSIONS AND DISEASES RESPONDENTS SUFFERED FROM

<table>
<thead>
<tr>
<th>ADMISSIONS</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
<th>DISEASES</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIRST TIME</td>
<td>16</td>
<td>40</td>
<td>ACCIDENTAL INJURIES</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td>2ND TIME</td>
<td>14</td>
<td>35</td>
<td>GASTRO INTESTINAL TRACT</td>
<td>5</td>
<td>17</td>
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<tr>
<td>3RD TIME</td>
<td>7</td>
<td>17</td>
<td>FEBRILE CONDITIONS</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>4TH TIME</td>
<td>3</td>
<td>8</td>
<td>GENITAL URINARY TRACT</td>
<td>5</td>
<td>17</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>RESPIRATORY TRACT</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DID NOT KNOW</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>OBSTETRIC REASONS</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>40</td>
<td>100</td>
<td></td>
<td>30</td>
<td>100</td>
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</table>
### Table 6: Length of Time Respondents Had Been in Hospital

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Number of Responses</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5</td>
<td>14</td>
<td>35</td>
</tr>
<tr>
<td>6-10</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>11-15</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td>Over 30</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>16-20</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>21-25</td>
<td>1</td>
<td>3</td>
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<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

### Table 7: Number of Respondents Who Were Given Information About the Ward and the Type of Information Given

<table>
<thead>
<tr>
<th>Responses</th>
<th>Number of Responses</th>
<th>Percent</th>
<th>Type of Information</th>
<th>Number of Responses</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>5</td>
<td>12</td>
<td>Shown Bath and Toilet</td>
<td>3</td>
<td>60</td>
</tr>
<tr>
<td>No</td>
<td>35</td>
<td>88</td>
<td>Told About Visiting Times</td>
<td>1</td>
<td>20</td>
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<td></td>
<td></td>
<td></td>
<td>Told About Oxygen and Smoking</td>
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<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>100</td>
<td></td>
<td>5</td>
<td>100</td>
</tr>
</tbody>
</table>

### Table 8: Designations of People Who Gave Respondents Information About the Ward

<table>
<thead>
<tr>
<th>Designation</th>
<th>Number of Responses</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Nurse</td>
<td>2</td>
<td>40</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>Sister</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>Patient</td>
<td>1</td>
<td>20</td>
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</tbody>
</table>
TABLE 9: NUMBER OF RESPONDENTS WHO KNEW THE NAMES OF NURSES WHO RENDERED CARE TO THEM AND HOW THEY GOT TO KNOW THE NAMES

<table>
<thead>
<tr>
<th>RESPONSES</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
<th>WAYS PATIENTS KNEW NURSES' NAMES</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>9</td>
<td>22</td>
<td>OVER HEARING</td>
<td>4</td>
<td>44</td>
</tr>
<tr>
<td>NO</td>
<td>31</td>
<td>78</td>
<td>THROUGH READING</td>
<td>3</td>
<td>34</td>
</tr>
<tr>
<td>TOTAL</td>
<td>40</td>
<td>100</td>
<td>PATIENT ASKED</td>
<td>9</td>
<td>100</td>
</tr>
</tbody>
</table>

TABLE 10: NUMBER OF RESPONDENTS WHO WERE INFORMED ABOUT THE NATURE OF THEIR ILLNESSES AND PERSONS WHO GAVE THEM INFORMATION.

<table>
<thead>
<tr>
<th>RESPONSES</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
<th>DESIGNATION</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>20</td>
<td>50</td>
<td>DOCTOR</td>
<td>20</td>
<td>100</td>
</tr>
<tr>
<td>NO</td>
<td>20</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>40</td>
<td>100</td>
<td></td>
<td>20</td>
<td>100</td>
</tr>
</tbody>
</table>

TABLE 11: NUMBER OF RESPONDENTS WHO WERE SATISFIED WITH INFORMATION GIVEN AND THOSE WHO WERE GIVEN CHANCE TO ASK QUESTIONS ABOUT THEIR ILLNESSES

<table>
<thead>
<tr>
<th>RESPONSES</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
<th>RESPONSES</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>17</td>
<td>65</td>
<td>YES</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>NO</td>
<td>3</td>
<td>15</td>
<td>NO</td>
<td>17</td>
<td>85</td>
</tr>
<tr>
<td>TOTAL</td>
<td>20</td>
<td>100</td>
<td>20</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>
### Table 12: Period at Which Surgery Was Planned For

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Number of Responses</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - 7</td>
<td>18</td>
<td>45</td>
</tr>
<tr>
<td>22 - 28</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>8 - 14</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>15 - 21</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Over 21 Days</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>40</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

### Table 13: Number of Respondents Who Received Details About the Operation and Title of Persons Who Gave Them Details

<table>
<thead>
<tr>
<th>Responses</th>
<th>Number of Responses</th>
<th>Percent</th>
<th>Title</th>
<th>Number of Responses</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>9</td>
<td>22</td>
<td>Doctor</td>
<td>9</td>
<td>100</td>
</tr>
<tr>
<td>No</td>
<td>31</td>
<td>88</td>
<td></td>
<td>9</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>40</strong></td>
<td><strong>100</strong></td>
<td><strong>9</strong></td>
<td><strong>100</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Table 14: Number of Respondents Who Were Satisfied With Details Given and Reasons for Feeling Satisfied

<table>
<thead>
<tr>
<th>Responses</th>
<th>Number of Responses</th>
<th>Percent</th>
<th>Reasons</th>
<th>Number of Responses</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>7</td>
<td>78</td>
<td>Doctor Has Expertise</td>
<td>6</td>
<td>66</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>22</td>
<td>Given Positive Aspects About Operation</td>
<td>3</td>
<td>34</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>100</strong></td>
<td></td>
<td><strong>9</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

### Table 15: Respondents' Reasons for Not Feeling Satisfied With Information Given

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Number of Responses</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Given Platitude</td>
<td>2</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
### Table 16: Number of Respondents who had preparatory procedures/investigations done for or on them and the types of procedures

<table>
<thead>
<tr>
<th>RESPONSES</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
<th>PROCEDURES/INVESTIGATIONS</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>31</td>
<td>88</td>
<td>GASTRO-INTESTINAL TRACT</td>
<td>31</td>
<td>29</td>
</tr>
<tr>
<td>NO</td>
<td>9</td>
<td>22</td>
<td>SKIN PREPARATION</td>
<td>26</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HAEMATOLOGICAL TESTS</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PHYSICAL EXAMINATION</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>X-RAY EXAMINATION</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>HAD NONE</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>INTRAVENOUS INFUSION</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>40</td>
<td>100</td>
<td></td>
<td>107</td>
<td>100</td>
</tr>
</tbody>
</table>

### Table 17: Number of respondents who were informed about the procedure/investigations and title of persons who informed them

<table>
<thead>
<tr>
<th>RESPONSES</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
<th>TITLE</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>12</td>
<td>39</td>
<td>STAFF NURSE</td>
<td>5</td>
<td>41</td>
</tr>
<tr>
<td>NO</td>
<td>19</td>
<td>61</td>
<td>ENROLLED NURSE</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>DOCTOR</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>STUDENT NURSE</td>
<td>2</td>
<td>17</td>
</tr>
<tr>
<td>TOTAL</td>
<td>31</td>
<td>100</td>
<td></td>
<td>12</td>
<td>100</td>
</tr>
</tbody>
</table>
TABLE 18: NUMBER OF RESPONDENTS WHO WERE GIVEN REASONS FOR PROCEDURES DONE FOR OR ON THEM AND THEIR FEELINGS ABOUT THE EXPLANATIONS

<table>
<thead>
<tr>
<th>RESPONSES</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
<th>FEELINGS</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>12</td>
<td>39</td>
<td>SATISFIED</td>
<td>9</td>
<td>75</td>
</tr>
<tr>
<td>NO</td>
<td>19</td>
<td>61</td>
<td>INADEQUATE</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>TOTAL</td>
<td>31</td>
<td>100</td>
<td></td>
<td>12</td>
<td>100</td>
</tr>
</tbody>
</table>

TABLE 19: NUMBER OF RESPONDENTS WHO WERE INFORMED ABOUT THE LIKELY POST-OPERATIVE EXPERIENCES AND THE TYPE OF EXPERIENCES

<table>
<thead>
<tr>
<th>RESPONSES</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
<th>POST-OPERATIVE EXPERIENCES</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>2</td>
<td>5</td>
<td>PAIN</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td>NO</td>
<td>38</td>
<td>95</td>
<td>UNCONSCIOUSNESS</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>OUTCOME OF SURGERY</td>
<td>1</td>
<td>34</td>
</tr>
<tr>
<td>TOTAL</td>
<td>40</td>
<td>100</td>
<td></td>
<td>3</td>
<td>100</td>
</tr>
</tbody>
</table>

TABLE 20: DESIGNATIONS OF PERSONS WHO INFORMED THE RESPONDENTS ABOUT POST-OPERATIVE EXPERIENCES

<table>
<thead>
<tr>
<th>DESIGNATION</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR</td>
<td>2</td>
<td>66</td>
</tr>
<tr>
<td>STAFF NURSE</td>
<td>1</td>
<td>34</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3</td>
<td>100</td>
</tr>
</tbody>
</table>
### TABLE 21: NUMBER OF RESPONDENTS WHO FOUND INFORMATION GIVEN HELPFUL AND REASONS FOR FINDING INFORMATION HELPFUL

<table>
<thead>
<tr>
<th>RESPONSES</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
<th>REASONS</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>3</td>
<td>100</td>
<td>PREPARED ON WHAT TO EXPECT</td>
<td>2</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>GOT CURED</td>
<td>1</td>
<td>34</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3</td>
<td>100</td>
<td></td>
<td>3</td>
<td>100</td>
</tr>
</tbody>
</table>

### TABLE 22: NUMBER OF RESPONDENTS SEEKING OTHER PRE-OPERATIVE INFORMATION AND THE TYPE OF INFORMATION SOUGHT

<table>
<thead>
<tr>
<th>RESPONSES</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
<th>INFORMATION SOUGHT</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>25</td>
<td>63</td>
<td>INDICATIONS FOR SURGERY</td>
<td>16</td>
<td>52</td>
</tr>
<tr>
<td>NO</td>
<td>15</td>
<td>37</td>
<td>OUTCOME OF SURGERY</td>
<td>10</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>TYPE OF ANAESTHETIC</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PREPARATORY PROCEDURES</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>40</td>
<td>100</td>
<td></td>
<td>31</td>
<td>100</td>
</tr>
</tbody>
</table>

### TABLE 23: RESPONDENTS' REASONS FOR INFORMATION SOUGHT

<table>
<thead>
<tr>
<th>REASONS FOR INFORMATION SOUGHT</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAVE THE RIGHT TO KNOW</td>
<td>10</td>
<td>33</td>
</tr>
<tr>
<td>PSYCHOLOGICAL PREPARATION</td>
<td>9</td>
<td>30</td>
</tr>
<tr>
<td>CHANCE TO DECIDE TYPE OF TREATMENT</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>PLAN FOR CONVALESCENCE</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>AVOID EMBARRASSMENT</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>
### Table 24: Number of Respondents Who Commented on Their Hospital Experience and the Types of Comments

<table>
<thead>
<tr>
<th>RESPONSES</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
<th>COMMENTS</th>
<th>NUMBER OF RESPONSES</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>24</td>
<td>60</td>
<td>NEGLIGENCE</td>
<td>10</td>
<td>33</td>
</tr>
<tr>
<td>NO</td>
<td>16</td>
<td>40</td>
<td>LACK OF INFORMATION</td>
<td>9</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NURSES ARE OVERWORKED</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>LACK GOOD INTERPERSONAL RELATIONSHIP</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NEPOTISM</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>40</td>
<td>100</td>
<td></td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>
1. DISCUSSION OF FINDINGS

Nursing care of surgical patients is incomplete without sharing information because information shared is not only useful during the time the patient is in hospital but also after discharge from hospital. Effective nurse-patient communication also provides a medium for reassurance to the patient.

The sample consisted of twenty-two (22) males and eighteen (18) females. The ages of respondents were varied (table 2). It appears there were more patients in the age groups above fifty (50) years, probably this could be due to the fact that they suffer from conditions as a result of degenerative processes due to age.

Sixteen (16) respondents had only attained primary school level of education closely followed by those who had never been to school (14) while nine (9) had attained secondary school level and above. The reason why there is a large number of respondents who had not been to school or had attained up to primary school level of education may be attributed to the fact that Zambia is a developing country and that free education and more schools were only made available since the attainment of independence. Therefore illiteracy in the country is very high.

Twenty-two (22) respondents were unemployed and the other eighteen (18) were in employment. Among the subjects in employment eight (8) were engaged in white collar jobs, seven (7) were self employed and three (3) had been engaged in blue collar jobs.
The majority of patients (16) were admitted for the first time, fourteen (14) were coming in for the second time, seven (7) for the third time and three (3) had been in for the fourth time. Respondents had suffered from various conditions which warranted admission to the hospital as tabulated in table 5. The conditions were accidental injuries, gastrointestinal tract diseases, febrile conditions, diseases of the genitourinary tract, respiratory tract and for obstetric reasons.

The length of period that respondents had been in hospital varied. A large number of respondents (14) had been in hospital for 1 to 5 days, twelve (12) had been in for 6 to 10 days, nine (9) had been in for 11 to 15 days and only three (3) had been in hospital for 30 days or more. The variations in length of stay in hospital depend on the type of surgical intervention the patient had had. Those who stayed longer than a fortnight might have had extensive surgery requiring long term management and rehabilitation.

Most of the respondents stated that they were not given any information about the ward. Only five (5) were given information out of which three (3) indicated they were shown the bathroom and toilet, one (1) was told about visiting times and one (1) was warned about smoking in presence of oxygen. Two respondents were given the above information by student nurses. Probably this is a demonstration of the learners' effort in showing what an ideal nurse should be and also that this is a chance to apply theory to practice.

The majority of respondents (31) did not know the names of nurses caring for them and only nine (9) knew the
names, out of which four (4) overhead the nurses' names, three (3) of them read from name tags or consent form and two (2) asked for the nurses' names. Nurses do not seem keen to identify themselves to patients, perhaps this is a way of avoiding being called upon to provide care when patients want to call for them, because it was observed that nurses rather prefer to be addressed to as "Sister". This is a common term used by patients to refer to any person rendering nursing care on the ward such as student nurses, enrolled nurses, staff nurses and charge nurses. One respondent commented to say; "When I asked the nurse for her name she seemed reluctant to tell me, but she asked for my name why should I not know her name? I do not think it is right to address every nurse on the ward as sister because it is not specific". Another respondent said; "Why are nurses afraid of identifying themselves by name, is it a sin for a patient to ask for the nurses' name?". A third respondent's comment was; "I seem to get confused with the categories of nursing personnel on the ward because everybody is referred to as "Sister", I find this difficult particularly when I want to call for help." This finding corresponds to that of Ergbert et al's (1964) study on doctor-patient rapport in which they found that patients did not differentiate the different categories of hospital personnel hence this caused anxiety due to uncertainty about who to approach when need arose. At the same time, it can be said that this could be one way of how nurses avoid nurse-patient conversation as well as being called upon to render care (McLeod-Clark, 1981).

Half of the respondents (20) were informed about their illnesses and all of them indicated that the doctor
gave them this information. Probably this is because most patients are admitted via the Surgical Clinic and therefore the Doctor has had a chance to explain to the patient about the nature of their illnesses and the planned surgical intervention. It is also the Doctor's responsibility to give the patient such information for the purpose of 'informed consent' (Gragg and Rees, 1970, Wainwright, 1982).

Out of the twenty (20) respondents who were given information about their illnesses, seventeen (17) were satisfied with the information given and only three (3) were not satisfied. The Majority were satisfied because many patients seen to have faith in Doctors than nurses due to the fact that may be whenever nurses gave information it may have been unsatisfactory. Hayward (1981) cited Kutner (1958) who said that nurses' uncertainty as to what areas of professional responsibility can be legitimately covered by the nurse in regard to information given causes "fluster and hedging reactions which are perceived by the patient."

Out of the twenty (20) respondents who were given information about their illnesses, only three (3) were given chance to ask questions whereas seventeen (17) were not given the chance. Probably this could be attributed to the fact that Doctors only spend brief moments with the patient (Roper, 1973, Boylan, 1982) therefore deny patients a chance to ask questions.

The majority of the sample (18) had their surgical interventions planned for within 7 days. The period in which surgery is planned for may have an effect on the patients' perception of information given, as patients tend to learn better at the time when they are in need because
of their concerns about their health (Bartlett, 1973).

Thirty-one (31) respondents did not receive details of the operation procedure while nine (9) were given the details by the Doctor because he is the appropriate person as he is the one who performs the operation. Out of those respondents given procedural details seven (7) of them were satisfied with the information because they felt that the Doctor had expertise and were adequately enlightened about positive aspects of the operation. Two respondents were not satisfied with the information because they developed complications post-operatively as such they thought that the Doctor did not tell them the truth.

Most of the respondents (31) had pre-operative procedures done on/for them as outlined in table 16. All of them had gastro-intestinal preparations, others (26) had skin preparations, fifteen (15) had haematological tests, eleven (11) underwent a physical examination, ten (10) had X-rays and five (5) were given intravenous infusions. These procedures are necessary prior to undergoing major surgery.

Only nine (9) out of thirty-one (31) respondents who had preparatory procedures performed on them were given reasons for performing the procedures. Five (5) indicated they were informed by the staff nurse, three (3) by the enrolled nurse, two (2) were informed by the Doctor and two (2) by the student nurse. Probably the staff nurse realised the importance of information giving as part of their function due to the level of training they had attained and the emphasis they got during training on the
importance of sharing information with the patient. Also they may have been more comfortable with sharing this type of information. Nine (9) respondents were satisfied with the information given and three (3) were dissatisfied.

Most of the respondents (38) were not informed about the post-operative experiences, while the other two (2) were informed about pain, unconsciousness and the outcome of surgery. In the course of the study most respondents felt that nurses were not considerate because they asked patients to get out of bed as early as the first and second day post-operatively and this they found most disturbing. This could be an indication that patients have not been enlightened about early ambulation depending on the type of surgery they had undergone. This also could be an indication of non-compliance because patients who generally know what they are going to experience do become more co-operative with medical personnel (Bartlett, 1973). Again, the doctor seemed to take a lead in informing the patients of the post-operative experiences as shown in table 20. All the respondents who were given information on post-operative experiences found it helpful because they felt prepared on what to expect and that they believed they would get cured.

Twenty-five (25) respondents sought for other pre-operative information as indicated in table 22. Sixteen (16) respondents wanted to know about indications for surgery, three (3) about the type of anaesthetic and two (2) wanted to be enlightened on pre-operative procedures. The reasons given for seeking more information are outlined in table 23. Ten (10) of the respondents felt they had the right to know because after all it was their bodies that were being subjected
to surgery. This is true as patients are becoming more aware of their rights to information regarding their illnesses and treatments. Nine (9) indicated that they wanted to be prepared psychologically. Psychological preparation enables patients to cope with anxiety, uncertainty and fears about the operation (Gragg and Rees, 1970, Robinson, 1972). Six (6) respondents wanted to be given information because this afforded them a chance to decide on the type of treatment. This could be important especially if surgery was extensive or disfiguring, and one respondent particularly indicated that; "If Doctor was going to cut off my 'organ' I would have opted for traditional medicine, because I cannot imagine living without it." Three (3) respondents felt it was necessary to seek for information so that they could plan for convalescence. The importance of this is that patients often need to plan how long they would stay away from work. If one is a mother she needs to plan for someone to look after the home and children and also it is necessary for patients to know the limitations as a result of surgery. Two (2) respondents felt that such information could avoid embarrassment because they want to be prepared to talk about their illnesses to others. This helps the patient and those around him to accept the situation as it is.

The last table (24) shows that twenty-four (24) respondents commented on their hospital experience while sixteen (16) of them did not. Fifteen (15) respondents felt there was negligence because nurses did not seem to respond to patients calls in good time. The comments were:

"Nurses sit in sisters office and chart, when you call them they just do not respond at all."

"Night nurses sleep at the nurse's station (desk) and..."
never respond to our calls."

"When nurses are called upon to help a patient they have a tendency of saying 'I am coming' and would be the last you see of that nurse".

Ten (10) respondents said they were not given information about their illnesses and treatments. Six (6) sympathised with nurses that they were overworked probably due to the high turnover of patients on these wards. Five (5) respondents expressed that there was lack of good interpersonal relationships because some nurses quarrel with patients, one respondent said; "as patients we are like children and as such nurses should not get upset with what we say. We come here to be helped." This is true of hospitalisation and illness that it makes people vulnerable and sensitive to small details (Bluestone, 1977). Four (4) respondents felt nepotism was practiced in the hospital because it seemed nurses treated their fellow tribesmen, the educated and the well to do better than other patients on the ward.

In conclusion the findings revealed that nurses do not actively exercise their role in information-giving especially in relation to the ward, preparatory procedures and post-operative experiences. The nurses are adequately prepared during training to share such information with the patient. Perhaps this is the reason why some patients end up with complications even if the surgical intervention had been successful. The patient has also lost confidence in the nurse and there is no mutual trust between the two, hence there seems to be a general outcry from the public about falling standards of nursing care.
2. **NURSING IMPLICATIONS**

It appears from the results of the study that there exists problems in communication which affects the delivery of comprehensive nursing care in that nurses do not seem to be actively participating in providing information to patients and that this has led to patients being dissatisfied with the nursing care services being rendered.

Teachers of Nursing should lay more emphasis on the importance of nurse-patient communication to the learners. When providing clinical experience, teachers should organize adequate learning experiences in communication so as to enable the learners acquire and develop skills in communication. Also there is need to develop evaluation tools in communication to ensure that learning has taken place. Adequate supervision of learners too when they are in the respective clinical areas is important to reinforce the learning process.

For the practicing nurse, she may find difficulties in appreciating the patients' problems which mainly stems from either lack of or little information given on the importance of communication and interpersonal relationship in nursing during training. The practice of task oriented nursing care which causes fragmentation of nursing care can be viewed as a barrier to development of rapport with patients, which is a basis for effective nurse-patient communication. The introduction of the nursing process can help to maximise nurse-patient contact, appreciation of patients problems, increase nurse-patient interaction and predict behaviour patterns of patients as well as identification of specific areas of need for information.

Staff development may be another method of minimising communication. These could...
be provided to nurses already in the clinical areas and those in administrative positions through in-service education, seminars and workshops organized by respective health institutions. In addition, patients would benefit from printed orientation information booklets especially the ones who can read. Nurses should feel responsible to give information to patients as a way of providing psychological care.

Nurses should make attempts for more investigations into problems of communication in the hospital particularly those affecting quality of nursing care. It is only through research that problems can be identified and solutions sought.
1. CONCLUSION

'Caring' means 'Sharing' (Hart, 1982). A patient who is starved of information feels neglected and uncared for by the nurse. Information sharing with surgical patients is an important aspect in providing total patient care. The results of the study give evidence that nurses do not give patients relevant information regarding their immediate environment, illnesses and treatments. A few who attempted to do so, gave inadequate and unsatisfactory information and this caused the patients to lose confidence in the nurse. This lack of confidence makes patients not to trust nurses and thus they do not feel free to verbalise their concerns.

It was observed that nurses did not seem to interact much with patients other than when carrying out different nursing tasks such as bedbaths, dressings and medications. This finding is similar to that of Syacumpi (1983) who said that patients do not get a chance to interact with nurses other than when carrying out nursing tasks. In view of this it can be said that the type of nursing care rendered is task oriented which causes fragmentation of nursing care (Marks-Maram, 1978).

To surgical patients, 'safety of the mind' is equally important as 'physical safety' and this can be achieved through sharing information with the patient. It has been shown that patients who are given relevant information have reduced anxiety and increased control over their lives because they are treated as partners in their own care.
The provision of comprehensive nursing care is incomplete without sharing information with patients.

Nurses spend more time with patients than Doctors and thus can afford a chance to assess patients' need for information and also provide such information. Nurses must also realise that they are accountable for the care rendered to patients and that information giving is one of their professional functions, otherwise patients will continue to endure the psychological torment caused by lack of information. Above all sharing information with surgical patients can result in improved patient welfare and could also reduce post-operative nursing workload. Lastly communicating with clients may lead to improvement of client understanding and retention of health information.

2. RECOMMENDATIONS

1. A study of this kind should be conducted on a large scale to include other designated departments that cater for surgical patients in the hospital.

2. Emphasis should be laid on skills in communication in the schools of nursing so that nurse learners and nurses in the clinical areas can appreciate their role of information-giving.

3. In-service education department to hold workshops, seminars and in-service education to nurses on skills in communication.

4. All hospital personnel to put on name badges clearly showing their designations so that it is easy for the public to identify them.

5. Patients could be given questionnaires to fill when they leave the hospital to comment on their hospital experience. This can serve as a means to evaluate the care rendered in health institutions.

6. The sponsors of the programme should make available adequate financial assistance in order to enable future candidates meet the costs of stationery and typing services.

7. Findings of this study to be communicated to the area where the sample was drawn so as to enlighten the nurse in the area about the existing problems.
of communication.

3. LIMITATIONS OF THE STUDY

The time within which the study was to be conducted was limited therefore affected the sample size and also the study was limited to one department hence results cannot be used for generalising to the total population of surgical patients. Also if nurses were included in the study perhaps results could have been more revealing.
The University of Zambia,
School of Medicine,
Department of Post-Basic Nursing,
P.O. Box 50110,
LUSAKA.


The Chief Medical Superintendent,
University Teaching Hospital,
P.O. Box 50001,
LUSAKA.

Attention: Mrs. Thewo, Acting Nursing Officer

Dear Madam,

Re: STUDY PROJECT.

I am a student at the University of Zambia in the Department of Post-Basic Nursing, currently pursuing a course for the Bachelor of Science in Nursing.

I am required to submit a research paper in any selected area as part of course requirement. My area of interest is the pre-operative information nurses communicate to patients undergoing general surgery. Therefore, I am asking for permission to interview patients in the Surgical Department to enable me gather the information required for the study.

Thanking you in anticipation.

Yours faithfully,

Lastina Tembo Lwatula (Mrs)
Mrs. Lastina Tembo Lwatula,
University of Zambia,
School of Medicine,
Department of Post Basic Nursing,
P.O. Box 50110,
LUSAKA.

Dear Mrs. Lwatula,

Re: STUDY PROJECT

In reply to your letter dated 13th March, 1984 in which you asked us to allow you carry out a research in our unit.

We appreciate the good work that you are looking for. I am pleased to inform you that (this is a go ahead) you can go ahead and I hope you will be able to meet the co-operation from the Department.

Yours faithfully,

ACTING NURSING OFFICER - G BLOCK
APPENDIX 3.

INTERVIEW SCHEDULE

1. SEX
   FEMALE/MALE

2. HOW OLD ARE YOU?

3. DID YOU HAVE A CHANCE TO GO TO SCHOOL
   YES/NO

4. WHAT IS YOUR EDUCATIONAL ATTAINMENT

5. WHAT DO YOU DO FOR A LIVING?

6. HAVE YOU BEEN HOSPITALISED BEFORE
   YES/NO

7. HOW MANY TIMES HAVE YOU BEEN ADMITTED
   TO HOSPITAL?

8. WHAT WERE YOU SUFFERING FROM AT THAT
   TIME(S)

9. HOW MANY DAYS HAVE YOU BEEN IN
   HOSPITAL?

10. WERE YOU GIVEN ANY INFORMATION ABOUT
    THE WARD ON ADMISSION?
    YES/NO

11. WHAT WERE YOU TOLD?

12. WHO GAVE YOU THIS INFORMATION?

13. DO YOU KNOW THE NAMES OF THE NURSE(S)
    CARING FOR YOU?
    YES/NO

14. HOW DID YOU KNOW THEIR NAMES?
15. WAS THE NATURE OF YOUR ILLNESS EXPLAINED TO YOU?  
YES/NO

16. WHO EXPLAINED IT TO YOU?

17. WERE YOU SATISFIED WITH THE INFORMATION GIVEN TO YOU?  
YES/NO

18. WERE YOU GIVEN ANY CHANCE TO ASK QUESTIONS ABOUT YOUR ILLNESS?  
YES/NO

19. HOW LONG AGO WAS THE DECISION TO HAVE AN OPERATION MADE?

20. WAS INFORMATION ABOUT THE ACTUAL OPERATION GIVEN TO YOU?  
YES/NO

21. WHO GAVE YOU THIS INFORMATION?

22. WERE YOU SATISFIED WITH WHAT YOU WERE TOLD?  
YES/NO

23. WHY DO YOU SAY YOU WERE NOT SATISFIED (a) WITH THE INFORMATION YOU WERE GIVEN?

24. WHY DO YOU SAY YOU WERE SATISFIED WITH (b) THE INFORMATION YOU WERE GIVEN?
24. DID YOU HAVE ANY PROCEDURE(S)/INVESTIGATION(S) DONE BEFORE THE OPERATION?  
   YES/NO

25. WHAT PROCEDURE(S)/INVESTIGATION(S) WERE DONE?

26. WERE YOU TOLD ABOUT THE PROCEDURE(S)/INVESTIGATION(S) BEFORE THEY WERE DONE  
   YES/NO

27. WHO INFORMED YOU ABOUT THEM?

28. WERE THE REASONS FOR THE PROCEDURE(S)/INVESTIGATION(S) EXPLAINED TO YOU?  
   YES/NO

29. HOW DID YOU FEEL ABOUT THE EXPLANATION?

30. WERE YOU INFORMED ABOUT THE LIKELY POST-OPERATIVE EXPERIENCES?  
   YES/NO

31. CAN YOU TELL ME WHAT THESE EXPERIENCES ARE?

32. WHO INFORMED YOU ABOUT THEM?

33. WAS THE INFORMATION HELPFUL TO YOU?  
   YES/NO

34. IN WHAT WAY(S) WOULD YOU SAY THIS INFORMATION WAS HELPFUL TO YOU?
IN WHAT UAV(S) WOULD YOU SAY THE INFORMATION WAS NOT HELPFUL TO YOU?

IS THERE ANYTHING ELSE THAT YOU WOULD HAVE WANTED TO KNOW BEFORE THE OPERATION?

WHAT DID YOU WANT TO KNOW?

WHY DID YOU WANT TO KNOW WHAT YOU HAVE JUST MENTIONED?

HAVE YOU ANY COMMENT TO MAKE ABOUT YOUR HOSPITAL EXPERIENCE?

WHAT ARE YOUR COMMENTS?


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