Examining Barriers and Facilitators to Effective Nurse-Patient Communication Within a Saudi Arabic Cultural Context

A thesis submitted in total fulfilment of the requirement for the degree of

Doctor of Philosophy

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Declaration

I certify that except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program; any editorial work, paid or unpaid, carried out by a third party is acknowledged; and, ethics procedures and guidelines have been followed.

Signature:

Bander Saad Albagawi

Date:
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<tr>
<td>ANOVA</td>
<td>Analysis of Variance</td>
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<tr>
<td>CHEAN</td>
<td>College Human Ethics Advisory Network</td>
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<tr>
<td>CLT</td>
<td>Central Limit Theorem</td>
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<tr>
<td>ER</td>
<td>Emergency Room</td>
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<td>FG</td>
<td>Focus groups</td>
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<tr>
<td>HBM</td>
<td>Health Belief Model</td>
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<tr>
<td>KKUH</td>
<td>King Khalid University Hospital</td>
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<td>KSA</td>
<td>Kingdom of Saudi Arabia</td>
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<td>MANOVA</td>
<td>Multivariate Analysis of Variance</td>
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<td>NSACS</td>
<td>Nurses' Self-Administered Communication Survey</td>
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<td>RNS</td>
<td>Registered Nurse</td>
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<tr>
<td>SCT</td>
<td>Sociocultural Theory</td>
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<tr>
<td>SMCR</td>
<td>Source Message Channel Receiver</td>
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<tr>
<td>SPSS</td>
<td>Statistical Package for the Social Sciences</td>
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<tr>
<td>UAE</td>
<td>United Arab Emirates</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>US</td>
<td>United States</td>
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<td>ZPD</td>
<td>Zone of Proximal Development</td>
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Abstract

Study background

Nurses with effective communication skills have a critical role in minimising the stress associated with hospitalisation for both patients and their families. Effective communication has become increasingly documented as a key component in effective healthcare outcomes. Effective nurse-patient communication is of paramount importance in countries with large foreign healthcare workforces such as the Middle East and in particular Saudi Arabia. The presence of a large expatriate population with a different language from the host society and the ensuing complexity of sociocultural linguistic and health belief systems require a sound knowledge of communication and associated skills, which have been poorly practiced and researched. In Saudi Arabia, the health workforce is mainly staffed by international nurses who comprise 67.7% of the total population of registered nurses. This study highlights specific personal, professional, organisational and contextual barriers in order to provide a baseline for developing strategies and protocols for the delivery of effective nurse-to-patient communication.

Objectives

This research project focused on communication by nurses towards patients within a Saudi Arabian cultural context. The research was founded on the following objectives: (a) to identify the nature of current communication practices; (b) to critically examine the barriers to effective communication; (c) to identify the nature of an appropriate support system needed for effective communication; and (d) to make recommendations for improving the effectiveness of nursing communication towards patients within the context of a subset of patient safety protocols.
Aim of the study

This study aimed to investigate barriers and facilitators of nurses’ communication towards Arabic patients in Kingdom of Saudi Arabia (KSA) health organisations. This study explored the personal, professional and organisational factors influencing nurse-patient communication in light of experiences of local and international nurses within Saudi Arabian health settings.

Study methodology

Mixed-methods were utilised an exploratory descriptive research design conducted in two phases. The first phase, quantitative, delivered a Nurses’ Self-Administered Communication Survey (NSACS) (Anoosheh et al., 2009) to a random sample of 291 nurses in surgical and medical departments at five hospitals in Saudi Arabia. There was a return of 91% (n =267). For the second (qualitative) phase, a total of four focus group interviews (employing purposive sampling to identify five to six nurses in each group) were selected based on the NSACS scores, participants’ age, nationalities and gender. A total sample of 23 nurses participated in phase 2. The data were analysed using a thematic analysis approach.

Study results

The quantitative component showed that nurses’ specific nationality was found to be statistically significant, with Filipino nurses scoring higher communication skills than other nurses nationalities on the personal/Social (NSACS) Scale. This means that Arabic patients preferred to be cared for international nurses more than Saudi nurses as the international nurses have high quality of nursing skills and able to communicate effectively. Moreover, another critical finding was the significant difference between the participants’ years of experience and their communication skills towards patients in a Saudi Arabian context. An additional empirical finding
was that the nurses who had not attended specialist courses perceived greater barriers to communication with respect to personal characteristic and job specification (NSACS) subscales than the nurses who had attended such courses.

In phase 2, personal factors that influenced effective nurse-patient communication were testified by the local and international nurses interviewed. These included perceived language barriers between overseas trained nurses and patients who could not converse in English. Additionally, Arabic cultural taboos, such as expressing pain and other concerns related to the use of traditional medicine, featured in the focus group discussions. The service delivery of caring for patients from another gender to the nurses was also seen to increase nurses’ discomfort and inform communication breakdown. Conversely, professional factors facilitate effective communication, as seen in the statements of professionalism fostering acceptance and trust. Further, an improved salary has a positive influence on nurses’ communication styles and care effectiveness. Uniquely to Saudi Arabia, the senior nursing colleagues were seen as having valuable previous experience with the language and culture, and were seen to serve as role models. Nursing workload also affected the effectiveness of nursing communication. The higher the perceived workload of the nurses, the less time they had to communicate with their patients and, correspondingly, the less time for other responsibilities. In the Middle East, the timing and duration of shift work also affects the nature of nurse-patient communication. A particular problem attributed to high workload, as an organisational management concern, was tiredness and poor mood negatively affecting the nurses’ communication styles and patterns.
Recommendations

Achieving effective communication between nurses and their patients in the Saudi Arabian context requires a complex understanding of the Middle Eastern and Saudi Arabian social and cultural environment. Also of importance are the personal factors of individual nurses’ self-awareness of their own personal and cultural constraints in order to achieve effective and competent communication. It is recommended that nurses are professionally educated on cultural beliefs to be able to conduct cultural assessments. The study recommends training programs for all new graduate nurses in how to provide culturally competent Arabic-targeted nursing. In addition, simple language learning of key phrases and meanings of key service delivery areas, such as pain, within an Arabic context would be useful.

The nurses interviewed stated that their basic nursing education had not prepared them to be culturally sensitive or enabled them to provide care to patients of various cultures. Clearly, registered nurses in a KSA context need targeted orientation and ongoing education to improve their understanding of communication processes and receive culturally and linguistically targeted education and skills training. Further recommended is programmatic research examining Arabic patients’ perception of the nature and extent of communication barriers in order to inform more effective healthcare delivery.

**Key words:** nurse-patient, Saudi Arabia, Arabic culture, communication barriers and facilitators, mixed-methods research design
Chapter 1: Introduction

This study outlines communication issues arising from the multicultural nature of the nursing workforce in Saudi Arabia, where nurses come from different cultural and linguistic backgrounds to care for a primarily indigenous and elderly Arabic client population. This chapter provides the context and structural outline of the thesis. Finally, an overall rationale for the study is provided, together with an overview of the setting of the study.

1.1 Communication

Communication between nurses and patients is critical to providing and delivering quality healthcare outcomes. Difficulties in communication between nurse and patient arise due to a complex number of personal, cultural, gendered, professional and organisational management factors. A common theme in the definition of communication ‘is the use of words and behaviors to construct, send and interpret messages’ (Dewolf Bosek, 2002, p. 93). Communication involves an interaction between the speaker, the subject and environment determining the effectiveness of communication. Structural, personal and environmental barriers can all contribute to ineffective communication processes (Park & Song, 2005). In the nursing profession, communication has the added complexity of being rendered in a situation of high acuity, emergency, pain, altered states of consciousness, disabilities and emotional and stressed situations, increasing the likelihood of sending or receiving incorrect and incomplete messages. For instance, nurses dealing with patients with special needs might need to have some proficiency in sign language so that they can communicate effectively (Aboul-Enein, 2002). Therefore, communication is the primary medium of healthcare delivery whereby the onus is on
the healthcare professionals to provide an optimal environment for building trust and empathy, promoting effective healthcare outcomes.

Key factors to promote communication documented to date include an appropriate environment such as private, comfortable, sufficient time and inclusion of the patient’s identified support system. Implied also is the importance of tone of voice and choice of vocabulary (Von Gunten et al., 2000). Quality communication is a subset of patient satisfaction and safety; however, a number of structural and organisational factors contribute to effective professional communication, including staff shortages, complexity of work decisions and increasingly emphasis on physiological needs at the expense of psychological and communication needs. Further, nursing staff from different cultures commonly experience communication incongruence that could lead to misdiagnosis, misunderstanding and resultant inability to anticipate and articulate needs of patients, resulting in a breakdown in care delivery (Tucker & Spear, 2006). Further, cultural differences are significant since international nurses bring a different set of cultural norms than Arabic norms in a Saudi Arabian setting in respect to psychological healthcare, which further influence communication patterns.

1.2 Aim of the Study

The aim of this study was to examine the barriers and facilitators of nursing communication towards patients that local Saudi nurses as well as international nurses currently face within a Saudi Arabian cultural context. An explorative approach was used in order to develop first-time baseline data from which to recommend standardised nurse communication guidelines in order to improve patient safety and resultant healthcare outcomes in Saudi hospitals.
1.3 Research Objectives

The current study focuses on communication by nurses towards patients within a Saudi Arabian cultural context. The research objectives are:

- to identify the nature of current communication practices
- to critically examine the barriers to effective communication
- to identify the nature of an appropriate support system needed for effective communication
- to make recommendations based on study results for improving the effectiveness of nursing communication towards patients as a subset of patient safety protocols.

1.4 Significance of the Study

The significance of this study is that it provides for the first time, using multiple methods, a critical understanding of the factors informing nurse-patient communication within a Saudi Arabian context. This study also provides an initial empirical foundation for baseline data on nurse-patient communication. Moreover, the current research raises awareness of multiculturalism and the challenges for international nurses in providing effective and safe care for patients, in Saudi Arabian hospitals regionally and for similar populations internationally. In addition, this study provides recommendations that could enhance the ability of Saudi Arabian hospitals to manage cultural differences in the healthcare workforce and maintain safe and effective nurses-patient communication protocols. Moreover, it is recommended that Arabic health organisations draw on the findings in respect to raising nurses’ awareness of language and communication issues that assist to mitigate the extent of the complications that result from cultural and linguistic differences between nurses and patients.
CHAPTER 1: INTRODUCTION

1.5 Research Questions

The research questions for this study in respect to the Saudi cultural context were:

1- What are the nursing demographic factors that influence the delivery of effective nursing communication towards patients?

2- What are the cultural factors that influence the delivery of effective nursing communication towards patients?

3- What are the religious factors that influence the delivery of effective nursing communication towards patients?

4- What are the organisational factors that influence the delivery of effective nursing communication towards patients?

5- What are the current barriers to effective nursing communication with patients?

6- What are the current facilitators of effective nursing communication with patients?

1.6 Methodology and Data Collection

A mixed-method study, two-phase descriptive and explorative design comprising both quantitative and qualitative research methods was employed. Phase 1 utilised the Nurses’ Self-Administered Communication Survey (NSACS), which was randomly distributed—to 291 with a return of 91% (n = 267)—to nurses working in surgical and medical departments at five hospitals in Saudi Arabia. In phase 2, 23 nurses were purposively selected with the four focus groups recruited on the basis of heterogeneity, in order to stimulate discussion, diversity and to allow comparison and clusters of data to be collected from different groups. Selection for focus groups participants were based on the questionnaire scores, participants’ age, nationalities
and gender. The data were analysed using NVivo technology and a thematic analysis approach.

1.7 Overview of the Saudi Arabia

This section discusses the important aspects of cultural context and religion in Saudi Arabia in order to provide context for the study. In addition, an overview of the health system, nursing workforce and nursing education is provided. The Kingdom of Saudi Arabia (KSA) is one of the biggest countries in the Middle East. The neighbouring countries are Iraq to the north east, Jordan to the north, Kuwait to the north east, Oman to the south east, Qatar to the east and both the United Arab Emirates (UAE) and Yemen to the south east. The KSA borders the Red Sea to the west and the Arabic Gulf to the east. It had a population of 27 million in 2006, with an estimated population growth rate of 1.536% (Central Department of Statistics and Information, 2009).

Islam is the religion of 100% of the Saudi Arabian citizens. Saudi Arabia was founded on Arabic culture with an Islamic influence spanning more than 1400 years since the first emergence of Islam (Al-Shahri, 2002). Saudi Arabian culture is a unique mixture of Arabic tribal traditions and customs and the Islamic faith that shapes and directs the attitude and behaviour of Saudi society. Islam encourages optimistic and constructive practices that promote health and wellbeing, including meditation, ablution and bathing, fasting and breast feeding (Almutairi, McCarthy & Gardner, 2012). Further, Islam inhibits influences that could be deleterious to the person’s body and health status, including excessive eating, eating carrion, drinking alcohol, consuming blood and intoxicants, homosexuality and sexual promiscuity. Muslims do not view illness as a punishment from Allah (God), but see it as atonement for sins. Islam encourages Muslims to seek medical consultation and
treatment when required. In addition, Islam encourages patients to ask for help from Allah and forgiveness by exercising patience and saying prayers.

The centrality of family life is an important component in Saudi Arabian culture, where generally each person has an extended family network that includes parents, grandparents, siblings, aunts and uncles and cousins. In Saudi Arabia, family is considered as the basis of an individual’s identity. According to Saudi culture, grandparents are held in high esteem and have holistic authority in relation to decisions concerning family matters. In big cities such as Riyadh, Jeddah and Dammam, relatives tend to live near each other, facilitating family interaction and socialisation (Achoui, 2006). This demonstrates the strong ties and bonds that exist between extended and immediate family members.

In high-context societies, such as Saudi Arabia, people tend to be indirect in their personal communication and use implicit messages, with the meaning being embedded in the sociocultural context (Almutairi, McCarthy & Gardner, 2012). Moreover, Saudi citizens use a combination of verbal and non-verbal communication in order to convey the right meaning (McDaniel, Samovar & Porter, 2009). Particularly, people often use indirect messages aimed to avoid direct interactions that may involve conflict or make another person angry. It is still very common in Saudi society to cope with personal conflict by exercising passive resistance by using a third party ‘wise man’ to convey the message or discussing the issues privately (Gupta, 2007). In contrast, in low-context cultures such as Western countries people tend to be more direct in their personal interaction, preferring to use more explicit communication styles. In such societies, words are commonly used to convey the entire meaning of the message, with people often using direct
communication styles to discuss conflicts honestly, usually through face-to-face encounters, in the belief that such discussions will resolve the problem.

In Saudi Arabia, gender segregation is endorsed by the society and imposed through country government and local authorities. For instance, there is no mixing between the genders and there are different physical areas assigned for men, women and families. Females are not permitted to work with unrelated males in most locations, unless out of necessity. Currently, Saudi females are dependent on their male relatives such as fathers, brothers and husbands to drive them for transportation to work or shopping malls (Winter & Chevrier, 2008). In addition, Saudi men are responsible for their family’s financial support even if their wives are working, unless joint decisions are made on alternatives and the wives make concessions.

In regards to the nursing workforce, Tumulty (2001) stated that in Saudi Arabia about 25% of Saudi nurses are men. The education system in Saudi Arabia separates genders, which means that there is a special education system designed for female students and another designed for male students. As a result, this leads to limited male and female interaction. Accordingly, this affects nurses’ interaction with their patients based on cultural values. For example, some Saudi female nurses prefer to deal with female patients only with no male involvement. Based on the customs and traditions of Saudi Arabia, there is a gender separation in nursing care, which means that male nurses look after male patients and female nurses look after female patients. However, in emergency situations when a shortage of nursing staff occurs, the male and female nurses commonly need to care for both genders.

The following section discusses the history and development of the health system in Saudi Arabia.
1.8 Saudi Arabia Health System

Health matters in Saudi Arabia are handled by the Ministry of Health. The healthcare system in Saudi Arabia was first initiated through a declaration made by King Abdulaziz Al-Saud in 1926 (Albejaidi, 2010). This declaration facilitated the development of clinics and hospitals in major urban centres. Healthcare was hence not accessible to the entire population. In 1954, the Ministry of Health was set up in the KSA and was charged with the responsibility of supervising and managing the healthcare facilities. At this time, Saudi Arabia had not fully developed oil as a natural resource. When Saudi Arabia started to benefit from its main natural resource, more of its financial resources were allocated to improving its healthcare system. The Saudi Arabian government implemented this through the setting up of primary healthcare facilities, hospitals and research facilities.

The Ministry of Health manages both the public and private hospitals. According to the Ministry’s official website, the Ministry is made up of 22 departments. Saudi Arabia is divided into 18 health regions (see Figure 1.1), each with a regional director who is attached to the Ministry of Health (Aboul-Enein, 2002).
The Saudi constitution in Article 31 states that citizens can access healthcare facilities and services without making any payment (Athar, 2008). Saudi Arabia has also made great efforts in getting the right personnel to work in its hospitals, sourcing its workforce from across the world. Saudi Arabia, as of 2009, had 56 tertiary care hospitals, 244 general hospitals that are described as secondary care facilities and 2037 primary healthcare centres to serve the citizens and residents of Saudi Arabia Albejaidi (2010) (see Figure 1.2).
The government of Saudi Arabia has taken the initiative of improving the healthcare system and has been increasing its expenditure on healthcare over the years. As a result of this, the Saudi Arabian healthcare system was ranked 26th in the world, outweighing other major economic countries like Canada and the United States (US), according to statistics cited from the World Health Report (Albejaidi, 2010). The total number of Saudi nurses working at Ministry of Health hospitals in 2007 was 22,590, which represents 44%. In addition, the international nurse workforce was 28,598, representing 56% of the total nursing workforce (Ministry of Health, 2009). The number of Saudi nurses working at the Ministry of Health clinics was 11,872. In the Ministry of Health hospitals, poly clinics and corporate hospitals, the number of Saudi male nurses is 10,469 or 48.3%, whereas female nurses accounted for 11,083 or 51.7% of the total Saudi nursing workforce population at Ministry of Health. Clearly, these data indicate that the nursing career for local Saudi
nurses is distributed almost equally across gender, and this is true for both large or small hospital types in Saudi Arabia.

In the next section, an overview of nursing workforce in Saudi Arabia is provided.

1.9 Nursing Workforce in Saudi Arabia

The following outlines the status of the nursing workforce in Saudi Arabia. Nursing in Saudi Arabia has traditionally been dependent on expatriates. The history of the expatriate nursing workforce can be traced back to the 1800s when doctors and nurses from Bahrain were invited to the KSA to take care of King Saud and his family. However, this trend has changed to some extent in recent years, following the issue of a royal decree for Saudisation of nursing in the country (Al-Hosis, 2010). Another reason (Tumulty, 2001) for the rise in the number of Saudi nationals employed as nurses and doctors is the ever rising cost of medical services due to high dependency on expatriates.

The international nurse workforce makes a considerable contribution to the healthcare system in Saudi Arabia. However, there are difficulties associated with such a high dependence on the expatriate workforce, most significant being the very high rate of attribution (Baumann, 2010). There are two forms of nurse exodus: internal and external (Al-Hosis, 2010). Internal turnover rate is whereby the nurses leave the nursing department and head to work in another department or division in the same hospital, organisation or institution. The external turnover rate is the rate at which the nurses leave working for the hospital to work in other institutions or organisations. This loss of nursing staff has been attributed to a variety of factors (Tumulty, 2001) that can be categorised under work-related attitudes, personal characteristics or external environmental factors. This is partly a result of economic
considerations: qualified nurses from sub-Saharan countries, after accumulation of reasonable savings, migrate back home to undertake other economic activities.

As far as the international nurses are concerned, problems with cultural adaptation rank very high as a cause of nurses opting to leave (Almutairi, McCarthy & Gardner, 2012). Medical care in Saudi Arabia is strongly rooted in its religious and cultural traditions (El-Islam, 1995), creating a cultural gap that needs to be bridged. Though some of the workforce (Tumulty, 2001) may have limited background information on Islamic culture, challenges still remain since it is difficult to draw a line between Saudi culture and Islamic culture.

Saudi Arabian hospitals have a reputation as providers of high salaries to staff, compared to many developed countries (Kline, 2003). It is likely therefore that other factors relating to high turnover are more important. One of the major factors that affects the attitude of staff in the nursing profession has to do with hospital administration. As noted earlier, the organisational valuing of the workforce is at the core of the efficiency and effectiveness of the operations of a hospital. The leadership style utilised by the hospital administration should contribute towards job satisfaction of the staff nurses. Typically, hospital administration manages the staff nurses through the nurse manager or administrator. The actions and decisions made by the nurse managers or administrators directly and indirectly affect the actions and behaviour of the staff nurses. A poor administrative strategy adopted by a nurse manager can lead to frustration among the nursing staff to the point that they choose to leave (El-Islam, 1995). El-Gilany and Al-Wehady (2002) showed evidence of this in a study involving nurses working in hospitals in KSA.

Other contributory factors to high turnover include dissatisfaction of the nursing profession, the challenging nature of the work because of obligations and
tasks and overwhelming duties. The lack of opportunities to participate in making decisions, some of which may adversely affect the nursing staff, is another often cited reason for dissatisfaction and as such results in feelings of alienation, unappreciation and demoralisation (Hammoud & Siblani, 2003). All these factors contribute to the low level of job satisfaction among nurses, regardless of whether they are local or international. Hospital administrations need to employ staff retention strategies and thereby effectively and efficiently manage the staff turnover rates in their respective hospitals.

Al-Ahmadi (2002) conducted a study at a number of hospitals in the Ministry of Health in the capital city of Saudi Arabia (Riyadh), finding that the nursing profession in Saudi Arabia was unable to attract adequate numbers of Saudi men and women due to challenges arising from salaries, shift schedules and social perception of nurses. Additionally, hospital administration and leaders in health settings were found to be one of the most stressful factors for nurses. Al-Ahmadi contended that these problems were exacerbated by the small number of Saudi nurses willing to accept difficult and unsatisfactory working conditions.

A high nurse turnover rate in the nursing workforce is not exceptional to Saudi Arabia. Hayajneh et al. (2009) indicated a 36.6% turnover rate of nurses working in hospitals in Jordan. Similarly, Carter and Rashidi (2003) presented data that indicated a high rate of turnover among nurses in Lebanon. These authors indicated these Middle Eastern-based turnover rates are attributable to weak administrative policies and practices.

Conversely, it has been argued that high nurse turnover rates can also be beneficial to a hospital administration (Tucker & Spear, 2006), as a continuous flow of new suggestions and ideas brought in by the newly employed staff can be utilised
by hospital administration in improving the operations of the hospital and thereby bringing a positive change. In support of this, Aldossary, While and Barriball (2008) further argued that hospitals stand to benefit from the exit of nurses who may have had poor performance, traits and attributes. In so doing, the operations of these hospitals will become better in terms of efficiency and effectiveness. However, these suggestions have to be evaluated against the costs of losing experienced staff and those of training new staff.

The following section examines the nursing education organisations and the current status of nursing colleges and institutes in Saudi Arabia.

1.10 Nursing Education in Saudi Arabia

Nursing education was first initiated in KSA in 1959 when the first health institute were established by the Ministry of Health. Small colleges were established in order to cover the need for health professionals in 1992. Currently, due to fast development, there are 24 health institutes and 19 small health colleges undertaking nursing education. These colleges teach both genders and employ different health professionals from diverse countries such as Jordan, the Philippines and India. Graduate students from the health institutes and junior colleges are awarded diplomas in different health specialties.

In KSA, the first Bachelor of Nursing program was established in 1976 in addition to other health education programs to expand the number of highly qualified nurses in the health professions. All these programs and courses were monitored under the supervision of the Ministry of Higher Education. Further, in 1987, a Master degree program in health was established, limited to female nurses only. In 1994, the first Doctor of Philosophy program was established in collaboration with one of the United Kingdom’s (UK) university’s. The aim of this program was to
facilitate career advancement for Saudi women who are unable to study abroad. Currently, nursing institutes and Saudi universities offer nursing accredited certificates for Saudi men at a diploma, an associated diploma and a Bachelor level, whereas the Master degree for nurses in Saudi Arabia is limited only to female Saudis (Al-Ahmadi, 2002). The gendered rationale relates to the convenience for female Saudis to continue education in Saudi Arabia due to cultural and religious imperatives. However, the Doctor of Philosophy in Nursing is pending to be offered for both genders within Saudi universities in the near future.

Currently, only 23 health institutes are managed and supervised by the Ministry of Health. These health institutes were upgraded to be intermediate health colleges, and nurses who graduate are considered to be technicians with a nursing diploma (Ministry of Health, 2009). The number of nursing universities increased dramatically into five nursing colleges attached to the Higher Ministry of Education (Ministry of Health, 2009). However, only three private colleges are available to meet the demands in public healthcare or other private healthcare settings. Shukri (2005), an author with a well-established background on professional issues in nursing in the Middle East, has proposed that over the past decade in Saudi Arabia, several issues relating to nurses’ job satisfaction and the nursing profession have encouraged a more positive approach by health leaders to the retention and education of Saudi nurses.

1.11 Summary and Thesis Structure

This dissertation is comprised of seven chapters. This chapter presented the background of the current research. The context of Saudi Arabia, the research questions as well as the significance of the study were outlined. Chapter 2 critically discusses the literature relevant to the research topic. A systematic literature search
strategy was adopted to critically identify and evaluate the studies related to nursing communication towards patients in healthcare settings. In addition, Chapter 2 includes a summary of the previous research and identifies the gaps in the literature for future research. It concludes with an explanation of the theoretical framework that underpins this study. Chapter 3 addresses the mixed-methodology of the current study design and gives justification for using exploratory descriptive research. It also provides a detailed description and rationale for the methods used to conduct this research and analysis plan. The ethical considerations of this research are also discussed.

Chapter 4 presents the results of phase 1 of the NSACS. It addresses in detail the demographic data of the study sample, the response rate, descriptive statistics and non-parametric tests as appropriate statistical tests. Chapter 5 reports the results of the qualitative component of this study (phase 2) that were obtained by semi-structured focus group (focus group) interviews. It outlines the demographic profile of the participants. Chapter 6 critically presents, compares, contrasts and matches the main findings of the two phases of the current study against the research questions. This chapter also discusses the findings from each phase in light of the prior research. It concludes by highlighting the limitations of the study. Chapter 7 outlines the major conclusions derived from the two-phase findings of the current study. It summarises the utility of the theoretical model and provides recommendations for practice, continuing professional development and future research with a Middle Eastern, specifically KSA, context aimed at improving nursing communication outcomes.
Chapter 2: Literature Review

2.1 Introduction

Communication is a two-way process that primarily involves both sending information and receiving messages through a variety of means. The significance of effective nurse-patient communication has been demonstrated frequently in the literature. Effective nurse communication is a skill that can be learned and continually improved (McGilton, Robinson, Boscart & Spanjevic, 2006). Communication is a vital component of quality healthcare in diverse health settings. In nursing, effective nursing interventions require high proficiency in communication skills. Nonetheless, communication between nurses and patients from different cultural backgrounds, languages and dialects poses considerable challenges.

The present chapter critically reviews the empirical literature that focuses on communication within the healthcare service context. A literature search was conducted to critically identify and evaluate related studies that focused on nurses’ effective communication towards patients in cultural and linguistic diversity of healthcare settings. The majority of reviewed studies were qualitative in design and included exploratory, phenomenological, qualitative descriptive and interpretive-descriptive designs. The studies varied in terms of settings and were conducted primarily in the US, the UK, Australia and available Middle Eastern studies. The studies included in the current literature are organised to consider personal, professional and organisational barriers and facilitators to communication that in turn affect the quality and delivery of patient care in KSA hospital settings. In addition, a process of study design, settings, key findings and limitations are also reviewed.
2.2 Description of Literature Review Search Method

A review of the literature on nurse-patient communication was undertaken to provide background to the study. The search strategy included studies with dates ranging from 2000 to 2013. The searches used the Nursing Resources, Academic Search and Nursing Full Text databases. The search terms considered were related to the aims and objectives of the study. Initially, the concept of communication was represented by terms such as ‘communication barriers, communication facilitators, communication skills, communication theory and interpersonal communication’. The search terms were used to identify potential studies for use in quantitative and qualitative synthesis.

The current literature review was conducted using resources from several reliable databases comprising the following: Academic Search Premier, CINAHL, Pre-CINAHL, EMBASE, Ovid’s Medline, PubMed and PsychInfo and related (dissertations/thesis) from the RMIT University Library, Melbourne, Australia. The researcher further screened the articles that referred to effectiveness of communication in Middle Eastern culture. Articles were included in this literature review if they: (a) contained relevant data relating to nurse-patient communication; (b) were published in peer-reviewed professional journals; and (c) used empirical studies to elucidate attitudes of Arabic and international staff regarding communication in the Arabic or rest of the world. All the literature resources drawn on for the study were published in English.

The subsequent section critically outlines the concept of communication skills within the cultural and social context of specific healthcare settings.
CHAPTER 2: LITERATURE REVIEW

2.3 Definitions and Key Concepts in Communication

Human communication is a complex process that revolves around exchange of ideas, thoughts and feelings being both verbal and/or a non-verbal process (Heater, 2003). Difficulties in communication between nurse and patient arise due to a complex number of personal, cultural, gendered, professional and organisational management factors. A common definition of communication ‘is the use of words and behaviors to construct, send and interpret messages’ (Dewolf Bosek, 2002, p. 93).

Therapeutic communication in nursing is a process in which the nurse consciously influences a patient or helps the patient to a better understanding through verbal or non-verbal communication. A key component includes non-verbal communications such as body language, facial expressions and active listening. Consequently, the communication is a dynamic process that is understood as the means of passing information from one person to another, whether both sender and receiver are in close proximity or separated by distance. This process involves three entities: the sender, information and the receiver. In relation to the message, a content analysis study in Iran identified that the context within which it is sent as well as the verbal and non-verbal components of communication form the foundation from which the listener gets the information (Vaismoradi et al., 2011). The same study found that effective nursing communication was not only based on the personal awareness of the nurse but also promoted an understanding of the cultural milieu of the patients’ circumstances and sensitivities.

In healthcare outcomes, effective communication requires nurses to have key roles such as providing physical care, emotional support and exchange of information with patients in critical conditions. In Europe, White (2003) studied the
interactions between nurses and male patients admitted with chest pain, showing effective care cannot be provided unless nurses are able to communicate effectively with their patients. Another study examined nurses’ difficulties with communication, suggesting that communication is a central aspect of nursing practice (Sheldon et al., 2006). The study indicated that the quality of nursing care is improved through effective communication skills in a nurse-patient relationship.

Nurses from different cultures to the patients’ cultural background may experience communication incongruence that could lead to misdiagnosis, misunderstanding and, above all, the inability of the nurse to articulate the needs of patients, resulting in breakdown of patient care (Hammoud & Siblani, 2003). Moreover, nurses need to practice effective communication skills during patient care to inform the competent delivery of biomedical as well as psychosocial information. Constructive communication between nurses and patients influences patients’ satisfaction and their adherence to therapeutic regimes (Gilbert & Hayes 2009), and leads to a reduction of patients’ and families’ anxiety during hospitalisation (Back et al. 2005). Correspondingly, poor communication may lead to failure to understand the psychosocial and emotional needs (Reynolds & Scott 2000) and therefore increase distress in patients.

The next section presents and examines the recent literature on nurse-to-patient communication in the context of patient safety.

2.4 Communication and Patient Safety

From a patient safety perspective, patients’ harmful experiences have been directly and indirectly influenced by patient protocols in a clinical environment. The environment within which communication occurs, past experiences, personal perceptions of the sender or the recipient and the nature of the message are critical
determinants of whether communication and corresponding safety is effective or not (Divi et al., 2007). In the US, a study exploring nursing communication as a product of patient safety revealed that communication failures were a common cause of inadvertent patient harm (Leonard et al., 2004). For instance, in the scenario of a patient having a fall during a night shift, when the in-coming nurse on the morning shifts is not informed of the incident, this could potentially endanger the patient’s life. Such adverse patient outcomes can effectively be managed if communication between nurses with patients is effective.

In the current study situated in the Middle East, as elsewhere, nursing communication draws upon complex personal, professional and organisational interactions among numerous stakeholders (nurses, patients, doctors, allied health professionals supervisors and support staff) (Aboul-Enein, 2002). In relation to patient safety, one study in the Middle East utilised a convenience sample of 262 female Muslim-Arabs to compare the attitudes of female students towards mental health treatment (Al-Krenawi et al., 2004). Key results indicated that clarity of information was paramount in the effect of nursing care. In addition, an Australian study interviewed 15 hospital nurses. Hemsley, Balandin and Worrall (2012) revealed that often sending or receiving messages was done within very tight time constraints or under conditions of emergency, making the process highly vulnerable to patient medical error and corresponding serious concerns and medical errors. This indicates the importance of communication knowledge and skills in the nursing profession.

The following section highlights research that illustrates the barriers to effective communication between the nurse and the patient in order to provide efficient patient care and overcome communication barriers.
2.5 Barriers to Effective Nursing Communication

This section outlines the potential barriers to effective nurse-patient communication in healthcare settings. Barriers to nursing communication may occur at three levels: personal, professional and organisational level. Personal barriers are those resulting from the personality of the nurse. Professional related barriers gender age cultural religious’ background and personality in the individual of the nurse. Professional berries are those that arise from the nursing profession practice in hospital. The latter affect nursing in terms of the knowledge acquired. Organisational related barriers usually result from the regulatory regimen. These barriers will be captured under the following headings of personal, professional and organisational. The cultural contexts of these key domains are also critiqued in a later section within a Saudi context.

Communication barriers can be complex and overlapping. An Iranian study used the NSACS (Anoosheh et al., 2009) and concluded that heavy nursing workload, hard nursing tasks and lack of welfare facilities for nurses were the main communication barriers. The same study findings revealed that shared communication barriers were age difference, social class difference and having contagious diseases. It was concluded that nurse managers and policy makers should focus on eliminating or modifying the barriers stated by patients and nurses. The current study adopted this same survey, NSACS (Anoosheh et al., 2009), for the first phase to explore barriers and facilitators between nurses and patients in Saudi Arabia.

2.7.1 Personal barriers

This section clarifies the personal barriers of nurses’ communication towards patients. These personal barriers involve gender, psychological status, age and
language, and face local and international nurses during nursing communication with patients. Individuals differ significantly in terms of values, expectations and even how they interpret information, thus the variances in the nursing workplace. The nurses’ individual evaluations of situations associated with the workplace may not always be in-line with their expectations. Nurse communication barriers are further influenced by the specific characteristics of the patients. This may include sensory impairment and environment issues, with psychological barriers including personality or disability (Finke, Light & Kitko, 2008).

### 2.7.2 Gender and nursing communication

This section outlines the way in which gender facilitates or inhibits communication. In different cultural groupings, gender bias and gender-based norms may prevent the staff from being assertive or challenging opinions openly. In Iceland, a phenomenological study that sampled 11 registered nurses from seven countries showed the centrality of language to personal and professional wellbeing and how language and culture were inseparable entities (Magnusdottir, 2005). This European based study concluded that gender was experienced as a communication concern.

In the Middle East, a study by Bowen and Early (2002) highlighted that a male nurse does not have the authority to treat a female patient, though female nurses may attend to men. Further, the fact that most doctors were men, whereas most nurses are women, had a very negative impact on effective communication, leading to a subtle gender-based tension (Bowen & Early, 2002). A systemic review examined the impact of gender dyads on clinician-patient communication between (2005–2007) with 10 studies included (Sandhu et al., 2009). The meta-analysis represented numerous differences in communication patterns across health providers,
healthcare settings and clinical specialties and possible impacts on health outcomes. The meta-analysis concluded that the increase of woman health providers in the medical profession in Arabic countries implied that health authorities should improve the organisational and financial conditions of nurses, taking into consideration the cultural characteristics of the community.

2.7.3 Psychological barriers

Barriers to communication arise from the nurses’ perceptions, beliefs, attitudes and cognitions described as psychological barriers to communication. Attributes such as resilience in communication styles are seen to be critical for nursing to face the extreme challenges of the healthcare environment. Psychological barriers to communication are difficult to resolve since they are innate to an individual. Dovidio, Hebl, Richeson and Shelton (2006) contended the importance of nurses to effectively counter any stereotyping.

2.7.4 Age-related barriers

Generation gaps hinder effective communication, such as in a situation when a younger nurse is attending to an elderly patient. Even if the two come from the same ethnic background, they may not communicate effectively due to their social orientations and circumstances (Cortis, 2000). A study exploring new young graduate nurses’ critical care orientation retention and financial impact concluded that failure of newly employed nurses to develop professional relationships with their patients negatively affected professional growth, nursing satisfaction and ultimately job retention (Friedman, Cooper, Click & Fitzpatrick, 2011).

In Saudi Arabia, a mixed-method study by Mitchell (2009) explored job satisfaction and burn-out among foreign-trained nurses, pointing out that the average age of actively engaged nurses was 40 years. Younger nurses both international and
in Saudi Arabia were not interested in pursuing nursing as a career, which may have serious workforce implications both short and long term. As result, most young Saudi nurses face frequent emotional and physical difficulties within the Saudi community that stresses nurses’ communication with Saudi patients.

### 2.7.5 Language barriers

In Saudi Arabia, international nurses’ language may differ from that of the local Saudi patients for which they care, jeopardising their ability to communicate effectively. The possibility of passing the wrong message increases when the nurse and the patient speak different languages. This was affirmed by a focused ethnography study (del Pino, Soriano & Higginbottom, 2013) conducted with semi-structured interviews of 32 nurses in three public hospitals in southern Spain. It concluded that incorrect pronunciation and use of figurative language implied different things in different cultures and can mislead the patient or the nurse alike. Further, patients with poor literacy levels and skills may also face challenges to understand the information and care by nurses. Correspondingly, the use of slang by patients may breakdown communication especially in acute care communication.

In relation to nursing communication in settings such as oncology departments, Jarrett and Payne (2000) interviewed nurses and patients about their communication experiences with cancer. The study concluded that patients with language difficulties expressed less satisfaction with medical services and lack of understanding of feelings by nurses compared with those patients without language difficulties. A study by Wilson and Reisfield (2003) investigated patients with metastatic testicular cancer and intractable pain, finding that providing complex care with easily understood language was important. The study revealed that nurses’ frequent use of medical terminologies and technical language led to ambiguities in
communication and patient dissatisfaction. The report concluded that health practitioners such as doctors and nurses commonly use such language, ignoring the fact that patients and families may not easily understand what they are saying and that it can distance the healthcare professional from the patient.

2.6 Communication Barriers Related to the Profession

This section critically discusses the relevant professional barriers related to international and Middle Eastern-based studies on effective nurse healthcare communication. This section outlines nurse’ educational background, responsibilities and leadership effects on nurse-patient communication.

2.7.1 Nurse education and communication barriers

Nursing education is intended to inform proficient nursing skills and effective interpersonal communication. Nurse education has often neglected skills in communication with patients with special needs, such as those with speech, hearing or vision impairments. A study in Australia explored the patients’ experience with cerebral palsy and complex communication needs, finding considerable miscommunication, concluding that a lack of education and skill-based education impair effective communication and leads to ineffective care (Balandin, Hemsley, Sigafoos & Green, 2007).

In relation to the communication barriers and nursing education, a study in Japan used a survey method and measured communication effectiveness of nurses working on a selection of clinical departments within a large university hospital (Lambert, Lambert, Itano, Inouye, Kim, Kuniviktikul & Ito, 2004). The effectiveness of communication was measured with an instrument named ‘how well do you communicate’. The study concluded that nurses did not communicate in a high proficiency manner due to a lack of education regarding Japanese culture.
2.7.2 Professional responsibilities

In relation to nurse-patient communication and professional responsibilities, a qualitative study utilising face-to-face interviews with first-line nurse managers at two US hospitals noted ineffective communication due to the overlapping nature of tasks that the nursing or clinical staff undertook (Marx, 2013). In most cases, response to a crisis at the hospitals requires a joint action by the physicians as well as the nursing providers. However, this does not imply that what is stipulated is done. In the implementation, the doctor carries out the task to some extent and leaves the rest for the nurse. Decisions about nursing care need to be made in a timely manner in order to respond to emergencies, allowing little or no time to communicate with patients, and may lead to medical errors.

In the Middle East, communication is rendered difficult due to a complex dynamic of multicultural workforce interacting with local patients. A study in Iran used a thematic analysis to explore nurses’ communication and parents’ experiences in a paediatric ward (Aein et al., 2009). The study findings revealed that factors such as nurses’ lack of time, high workload and nurses’ inadequate communication skills reduced the efficacy of nurse-parent communication. They concluded that nurses’ lack of time due to staff shortages led to ineffective communication and not meeting parents’ supportive and information needs. Similarly, in Iran, Bakhtiari and Moshtagh (2008), in a survey on communication barriers between nurses and elderly patients, affirmed that nurses’ tiredness, patients’ forgetfulness and weak memory were the shared barriers to communication. The same study concluded that nurses should be supported to be able to offer the nursing care with sufficient time and energy.
Similarly, a large mixed-method study addressed nursing communication barriers at the professional level (Tjia, Mazor, Field, Meterko, Spenard & Gurwitz, 2009). They study used a self-administered questionnaire and qualitative semi-structured telephone interviews with nurses seeking to examine nurse-doctor communication in the long-term care setting. It was found to be imperative that nurses were flexible and maintained positive communication and transmitted their professional concerns.

2.7.3 Leadership and nurse-patient communication

A comprehensive understanding of the professional leadership barriers that inhibit nurse-patient communication can lead to an opportunity to eliminate and provide optimal nursing care. For example, a descriptive study conducted in Saudi Arabia representing 52 nationalities examined leadership styles of nurse managers in a multinational environment (Suliman, 2009). The study concluded that in order to promote effective communication and empowerment of patient needs, a nurse needed to be aware of the patient’s physical, psychological or social barriers.

2.7.4 Organisational related barriers

The current section highlights organisational barriers that influence effective communication between health providers and patients. A recent systematic review analysed 12 papers to examine the effectiveness of nurse communication with patients with complex communication needs (Finke, Light & Kitko, 2008). The meta-analyses focused on the use of augmentative and alternative communication and noted it was a less of a problem between nurses of similar ranks than between nurses and patients. The review also reported that all staff members interacted daily, with different perceptions of their roles. Organisational hierarchies that place some healthcare workers in authority over their fellows were seen to worsen effective
communication and contributed to upward control and struggles for interpersonal power and conflict.

The following section critically reviews the enabling factors that facilitate communication between nurses and patients.

2.7 Nursing Communication Facilitators

Developing communication skills is regarded as the most effective method to overcome the barriers that inhibit nurses from building patient-nurse relationships. The promoting factors documented to date include competency and learning in effective communication skills (Stiefel, Barth, Bensing, Fallowfield, Jost, Razavi & Kiss, 2010). In Scotland, a study utilised semi-structured interviews to examine joint working and facilitating factors from the perspectives of health and social care professionals (Hubbard & Themessl-Huber, 2005). The study concluded that clear strategic vision and planning is sensitive to different requirements of health and social care systems and healthcare providers. The same study cited that annual planning at healthcare settings led to better communication strategies. These strategies included regular informal and formal meetings across providers and between health agencies.

Effective therapeutic communication skills gather or transmit information successfully and promote recovery. An Australian study by Robinson and Street (2004) highlighted that therapeutic communication skills can be attained and improved through persistent nursing practice. Also, the study indicated that continuous education increase the knowledge of ward nurses about what is available and how to access services in effective ways. Increased knowledge of therapeutic communication led to improved confidence to participate in referral and discharge
planning more actively and effectively, plus quality of referrals of patients
(Robinson & Street, 2004).

An additional increasingly documented communication skill for nurses is
exploration (Shattell, 2004), which involves the use of effective questioning
techniques to probe deeper into the issues concerning a patient. Exploration uses
open-ended questions that can assist the patient to discuss and clarify what the
patient is thinking, concerning and feeling. In addition, the nurses may practice
assertive communication styles (Shattell, 2004) and quick responses in order to
provide the patients’ needs and productive nursing care. Patient-centred
communication allows the patient to have an influence over and input into the
patient’s own healthcare, encouraging two-way communication as opposed to the
one-way process of telling the patient what to do and expecting compliance. In this
form of nursing care, the focus shifts from task-oriented nursing to the values and
needs of each patient.

In relation to Islam and health practice, Fluehr-Lobban (2004) found that
quality nursing should focus on strengths rather than weaknesses of the nurse or the
patient. Nurses should utilise a patient-centred communication approach in order to
provide efficient nursing care, as seen in a content analysis study conducted on nurse
practitioners and patients in the US (Berry, 2009). The study found that few nurses
used patient-centred communication style and that most nurses (69.8%) followed a
provider-centred style in such situations or activities, for example, meeting the
provider schedule, restricting patients’ comments, giving directions and using close-
ended questions. The study concluded that further research should involve
examining communication styles with nursing care outcomes, using open-ended
questions style and patient-centred communication.
The following section reveals the significance of nurses being competent in communication when providing nursing care towards patients.

2.8 Nurses with Competent Communication Skills

Communication competency plays a major role in patient safety. Perception of international and local nurses’ competence as viewed by patients is negatively affected by communication barriers, which in turn can affect job satisfaction and retention of nurses in the workforce. A nurse with impeccable nursing communication competence in palliative care will not automatically be competent in communication at a mental health clinic. Nurses need such skills as nursing therapeutic and even palliative care among other forms of nursing competence. For instance, in establishing the pain levels of a patient, the nurse needs to grasp the main contention of the patient and interpret it effectively (Harrison, Edwards, Koenig, Bosworth, Decastro & Wood, 2005). In other instances, nurses need to establish the patient’s readiness or ability to understand information and respond effectively. In some instances, the patients could, due to their illness, lack the ability or fail to respond correctly.

In view of communication competency, a Singaporean study interviewed 10 registered nurses from the oncology wards of a major teaching hospital and found that communication helps in creating the necessary functional relationship between the nurses and the patients (Tay, Ang & Hegney, 2012). This study found that nurses were competent to understand a patient’s experiences of the illness, able to relay meaningful information to the patients to improve their welfare and to enable patients, whenever possible, to actively participate in their own care. Correspondingly, expressions of empathy have been found to be the most effective
way of stimulating a patient’s engagement when being cared for and ensures patient rights are respected.

Patient engagement and understanding enables nursing communication and directions. Nurse understanding of the patient needs to be recognised as another communication competency. A study conducted in Lebanon reported that effective nursing communication can aid the nurse in judging the information provided and in filtering it when a patient recovers (Skalla, Bakitas, Furstenberg, Ahles & Henderson, 2004). The nurse may need to read the patient’s level of interest to engage in a discussion before initiating it. Moreover, it was imperative for nurses to be able to understand patients’ medical conditions and carefully choose their words, appropriately and accurately.

Likewise, communication competency is essential for every nurse employed in Saudi Arabia. For instance, a study conducted to investigate critical care nurses’ experiences in Saudi Arabia showed that communication competency was needed for those nurses who worked in different clinical environments (Halligan, 2006). A qualitative study by Tucker et al. (2003) in the US conducted 20 focus group interviews with 135 patients from three different ethnic/cultural groups (African American, European American and Latino American). The study identified cultural sensitivity to healthcare delivery and the impact on patient satisfaction and treatment adherence. The study suggested that perhaps more nurse-patient contact time may be a significant factor required for increased comprehension, particularly in areas where low literacy levels are significant.

The next section reviews nurses’ communication barriers in relation to patients suffering from critical or chronic diseases.
2.9 Critical and Chronic Care Context of Nurse-patient Communication

This section outlines nurses’ communication techniques with critically ill patients or those suffering chronic diseases. Some communication barriers arise as a result of inappropriate organisational regulations or due to patient disease severity. Emergency medical care is a critical episode when patients and their families need to communicate quickly and effectively with rapid response from the nursing staff. An emergency care study in Korea by Park and Song (2005) focused on communication barriers between patients and nurses. It indicated that communication was hindered by noise interruptions, anxiety and confusion. Moreover, in Canada, another study explored the context of healthcare communication from patients’ perspectives in chronic illnesses using a grounded theory (Thorne, Harris, Mahoney, Con & McGuinness, 2004). The study analysis revealed that the concepts of courtesy, respect and engagement were inherent in communication priorities across chronic conditions. This study concluded that nurses who provided a balance communication to the patient from discrete clinical settings were the most helpful to and supportive for those patients. From the patients’ view, the nurses’ attitude was the central standard of healthcare communication.

Certain communication strategies can be utilised during nursing care for chronic cases. A systematic review of literature cited 97 articles aimed to illustrate a definition of communication and interaction between the nurses and patients (Fleischer, Berg, Zimmermann, Wüste & Behrens, 2009). The meta-analysis strongly recommended that nurses’ chronic care should be personalised through the use of effective communication strategies. For example, nurses should talk directly to the critically ill patient and use touch to enhance communication and convey
emotional support. Nursing care can be achieved by addressing ill patients by their name, encouraging family and friends to contribute to the sound of familiar voices and discussing subjects of interest to the patient. The same study indicated that this type of communication could improve sensory input to the patient in serious conditions.

The next section covers related literature critiquing the cultural impact of nurses’ communication towards patients.

2.10 Culture and the Nurses Communication

Studies of key communication barriers to providing culturally and linguistically appropriate care found that language and cultural differences remain the greatest impediments to effective communication. Nurses need to interact sensitively, effectively and professionally when communicating with patients from diverse racial and ethnic backgrounds (Anderson, Scrimshaw, Fullilove, Fielding & Normand, 2003). The concepts of cultural competence, cultural knowledge, cultural understanding, cultural skills, cultural awareness as well as cultural sensitivity are buttressed by the attributes of nurses’ ability openness, flexibility and capability. Cultural knowledge on nursing involves understanding one’s own world-view, while accommodating the views of the clientele or patients. Cultural competence of a nursing provider is the nurse’s ability to provide acceptable healthcare services to the patients, while accepting and appreciating the differences that patients may have with regard to their belief systems (Cortis, 2000).

Cultural consciousness enables nurses to plan, communicate and implement individualised care that is tailored and acceptable to patients of different cultural backgrounds. As such, cultural competence is not a state of the nurses’ mental preparedness but an ongoing process with the nurses continually striving to be
culturally competent. The nurse, therefore, aims to achieve the ability to work effectively communicate with native patients within a new culture. Multiculturalism is a reference to societies where there is a mixture of people of different cultures because of their original ancestry (Brach & Fraserirector, 2000). Australian society illustrates the complexity of multiculturalism, with the population being representative of many cultures such as British, Greek, Italian, Arabic, Asian and others (Cameron-Traub & Stewart, 1994). There is an undeniable relevance of multiculturalism to communication issues in the clinical context. Nurses and the patients of differing religions and different cultures need understanding before they communicate effectively (Cameron-Traub & Stewart, 1994). In this respect, communication in nursing is an activity that is undertaken by individuals whose attitudes, beliefs and values are shaped by the culture in which they were raised.

Scholars have argued that some communication aspects can trace people’s historical origins and may lead to difficulty interacting with each other as result of their initial social orientations (Amowitz & Iacopino, 2000; Fillion et al., 2009). Hence, the nurse must understand the social, political and cultural environment within which they work. Gottfried (2003) indicated that the aspect of culture is seen as severing the interaction between nurses and patients of different cultures in a multicultural society. For instance, cases of patients being mishandled by nurses have been reported frequently in Saudi Arabia. It thus behoves the nurse to understand the people’s temperaments to effectively deal with patient based on their culture.

Indeed, the interaction between nurses and patients who have originated from the two different cultures can face some communication difficulties because, while the one is focused fully on the religious aspect of life, the other may be focusing on
morals and ethics of a certain practice (Aldridge, 2004). What is most important to note is the fact that the aspect of work cannot be completely separated from the aspect of life. For example, nursing cannot be divorced from people’s way of life (Aldridge, 2004). This can be used to mean that nurses and patients carry their attitudes and values that have been shaped by the wider culture and also the society and this means that they play a very important part in the individual’s life (nurses or patients). Ethnic compatibility between the patient and the nurse influences the opinions and decisions that the nursing providers make about their clientele. It makes the nurse-patient conversation more participatory due to the cultural coherence in both verbal and non-verbal communication.

The next section illustrates the Arabic cultural considerations appreciated by nurses to practice effective communication during nursing care.

2.11 Nursing Communication Within the Arabic Context

Cultural considerations are essential in any discussion about communication as cultural incompatibility is a major hindrance to effective communication in all human interactions. The nursing profession in Saudi Arabia is a good case in point. Saudi Arabia, and indeed the whole of the Middle East, experienced an influx of nurses from all over the world in the last few decades, resulting in about two-thirds of the current nursing work force being foreign in origin (Halligan, 2006). The phenomenon is influenced by several push and pull factors. The pull factors in the destination countries include the shortage of nurse training facilities to meet the local demand. In Saudi Arabia, the decision to recruit nurses internationally is therefore a quick fix effort to meet the ever increasing demand for nurses (Stilwell, Diallo, Zurn, Vujicic, Adams & Dal Poz, 2004). The push factors include low pay, poor working conditions, lack of resources, limited career and educational opportunities, economic
instability and working environments experienced by these nurses in their respective
countries of origin. However, on arrival in their new workplaces, nurses face another
dilemma when faced with the cultural differences.

In the Middle East, where religion, especially Islam is a core pillar of the
society, the complexity of communication assumes even greater significance. The
Islamic culture influences virtually all spheres of people’s lives including matters
related to one’s profession (Hammoud, White & Fetters, 2005). The KSA is a highly
conservative nation that adheres to the code of morality based on Islamic traditions.
This code is imposed not only on the native Saudi population, but on foreigners
residing in the Kingdom as well (Halligan, 2006). The following illustrates the strict
nature of the code: the authorities have the power to arrest any men and women seen
socialising in public, unless they are married or blood-related. Such restrictions on
human interaction and others such as strict regulations on the female dress have the
potential to compromise the freedom to practice effective nursing (Amowitz &
Iacopino, 2000). Another noteworthy fact, which is relevant to the subject of this
thesis, is that while female nurses may attend to male patients, a male nurse can
never attend to a female patient. The nurses face the challenges of effectively
communicating with patients as a result of such culturally ingrained factors.

Language barriers between the immigrant nurses and Saudi patients are
another common barrier in Saudi Arabia. Arabic is the predominant language used
by the Saudis. Unless the migrant nurses are proficient in Arabic, therefore, the
nurse-patient communication becomes a major problem. The problem is
compounded by the extensive variation of local accents such as Saudi Arabian. Also,
according to Fluerhr-Lobban (2004), the failure by the nurses to understand what the
doctor is ordering or what someone is asking for, can have a negative impact on his/her self-belief, self-worth and work morale.

Cultural barriers have a negative impact on nursing communication and patient safety and may lead to serious medical errors. A cultural dichotomy occurs between Arabic speakers and others. In Saudi Arabia, it is a common practice for hospital patients to have family members or close friends (sitters) staying with them (Bosma, Apland & Kazanjian, 2008). This strong family connection adds another dimension to the nurses’ communication skills in that they need to communicate, not only with the patient, but also with the patient’s friends, family and sitters (Bosma, Apland & Kazanjian, 2008). For immigrant nurses from countries where confidentiality of issues relating to a patient is a major concern, this could be a big challenge.

In the Middle East, as elsewhere, non-verbal communication conveys feelings, especially the intensity of an emotion. However, in a culture in which women cover their head, face and body, it becomes difficult to depend on the non-verbal aspects of communication that may convey some information. For example, Almalki, Fitzgerald and Clark (2011) conducted a literature review on the nursing profession in Saudi Arabia, finding that aspects of communication such as eye contact, touch, space, distance and intimacy were restricted, making the therapeutic aspect of nursing inapplicable. An environment in which patients and nurses freely interact is considered therapeutic and essential in establishing the right rapport between the nurses and their patients (Almalki, Fitzgerald & Clark, 2011). It is clear from the above discussion that this is not always possible in Saudi Arabia or the Arabic states of the Middle East.
The next section highlights the gap in the literature and methodology examined in this thesis.

### 2.12 Gap in the Literature

The literature review identified, compared and contrasted the published work on nurse/patient communication. The majority of publications related to the experiences of nurse-patient communication in international clinical settings. Those in a Saudi Arabian context are relatively few. This gap in the knowledge base on the subject of communication skills of nurses in Saudi Arabia and the relevant issues raised by the nurses themselves constituted the reasons for undertaking the research described in this thesis. The sparsely available literature pertaining to Saudi Arabia has used a qualitative approach. The present research therefore utilises a mixed-methodology approach in order to investigate a collection of factors related to nurse-patient communication.

The following section will critically review the communication models that have been adopted in human research designs employed in the discipline of nursing. These models include: the telegraph model, interactional model, transactional model and convergence model of communication. It ends with examining sociocultural theories (SCT) that have been utilised as theoretical frameworks.

### 2.13 Studies’ Theoretical Frameworks

A review of the literature has demonstrated two elements consistently emerging with reference to communication between the nurses and patients. These elements can be synthesised as either cultural or interpersonal in context:

1. Cultural elements relate to challenges with cultural differences associated with lack of cultural knowledge. Expatriate nurses can bring cultural values, beliefs, behaviours and attitudes with them that
differ from those of their host country and from those of their patients. The widely varied cultural background of the Saudi Arabian health workforce has numerous healthcare contexts and potentially harbours a variety of communication misunderstandings or complications.

2. Interpersonal elements are personal, professional and organisational barriers and facilitators that impact on communication between nurses, patients and their families.

Communication on issues such as patient safety and understanding meaningful dialogues is a complex process that revolves around the exchange of ideas, thoughts and feelings (Hattar-Pollara, 2003). This complicated communication process is augmented by effective non-verbal communication, including body language, facial expressions and active listening.

Several theoretical frameworks have been developed to inform the communication process and functions that have application to healthcare in diverse healthcare setting/s. These frameworks are primarily of Western origin, being primarily developed in the US, UK and New Zealand (Jirwe, Gerrish & Emami, 2006). The frameworks have been influenced by the contexts and period of history within which they were developed; hence, they tend to reflect these distinctly unique sociocultural, historical and political dimensions.

This section provides an overview of the conceptual frameworks with possible application to nurses’ communication that have been dominant in historical periods in the literature. The key theoretical assumptions, historical development and empirical support for each concept will be examined and critiqued as to their
relevance to the current study, with an emphasis on how this might affect the quality of nurse-patient communication.

2.7.1 Communication models

There are several theories and models of communication that could provide an explanatory framework for nurse communication in the context of Saudi Arabian healthcare. A critical review of related communication theories and models includes the:

1. Telegraphic model (Shannon & Weaver, 1949)
2. Interactional model (Schramm, 1954)
3. Source message channel receiver (SMCR) model (Berlo, 1960)
4. Transactional model (Barnlund, 1970)

2.13.1.1 The telegraphic model of communication

The telegraphic model is recognised as the fundamental foundation out of which contemporary communication studies have grown. The telegraphic model was developed during the Second World War in the Bell Telephone laboratories in the US with the central tenant to identify the way in which the channels of communication could be used most efficiently and effectively (Hollnagel & Woods, 2005). Critics of the telegraphic model of communication assert that it tends to lengthen the communication channels. For example, in the hospital environment, it is argued by Leape, Woods, Hatlie, Kizer, Schroeder and Lundberg (1998) that as decisions within medical interventions need to be taken swiftly and promptly with the seriousness they deserves, a process that calls for a convergence in understanding between the information sender and the receiver.
2.13.1.2 The interactional model of communication

The interactional model of communication was developed in the 1950s in the US, as a response to the perceived failures of the telegraph model in particular as it relates to the incorrect interpretation of information sent. The interaction model applies a ‘closed loop’ system for both the sender and the receiver of information (Brooke & Omeri, 1999; Adair-Hauck & Donato, 2002). Information is encoded and sent by the sender and received and decoded by the receiver. Both the sender and the receiver interpret the message. The process used by this model ensures that there are no limits to the process of communication. In the healthcare setting, the nurses act as switchboard centres, handling and rerouting the information. Sender and receiver participants in this model swap positions frequently, facilitating a two-way communication process. The cycle is therefore not complete until the nurse receives the information from the patient and responds accordingly (Bowers, Lauring & Jacobson, 2001). Such an interactive model attempts to strengthen nurses’ communication by application of transparent communication channels; however, it does not account for other factors that influence nurse-patient communication within a Saudi Arabian context.

The interactive model has limited application in the current investigation as nurse-patient communication needs a holistic approach that covers social, political and spiritual dynamic interaction between nurse-patient relationships. For instance, this model only allows for verbal communication and does not take into account the Arabic context and non-verbal communication overlays.

2.13.1.3 The source message channel receiver communication model

The source message channel receiver communication model (SMCR) was developed by Berlo in 1960 as a more advanced version of the telegraph model.
According to Berlo, the sender encodes the message through his/her speaking and writing skills, while the receiver decodes the message through his/her listening and reading skills (Kreuter & McClure, 2004). In some organisational cultures, direct communication is valued more than indirect communication to reduce uncertainties (Ting-Toomey, 2005). Typically, direct communicators tend to say what people think and their message is conveyed primarily by the words they use and completely depend on the literal interpretation of these words. In contrast, in indirect communication, common in high-context cultures such as KSA, the meaning is conveyed not just by the words used but by non-verbal behaviours, for example, facial expression, pauses, silence and tone of voice. Within the nursing practice, the nurses will assess the patient based on his/her own understanding of certain phenomena, while the patient will respond based on his/her own interpretation of the nurse’s questions.

2.13.1.4 The transactional model of communication

The transactional model of communication, developed in the US, is based on the premise that communication only occurs when the sender receives feedback from the recipient. The feedback could be verbal, non-verbal or even silence (Foulger, 2004). This model borrows from the interactive model, in that the sender and the receiver could swap positions. In this model, emphasis is on whether the intended meanings of the message are properly received and comprehended. The model therefore gives little regard to who is the source or who is the receiver, but rather emphasises whether communication has taken place successfully (Foulger, 2004). All models discussed to date have been developed from a Western-based perspective and do not provide the requisite reference to religion and social collaboration among nurses, patients and their relatives required within the Saudi Arabian context.
2.13.1.5 The convergence model of communication

In the US, Lawrence Kincaid (1979) proposed the convergence model of communication as a more holistic form of the communication process. The convergence model of communication is premised on the assertion that communication is the agreement in terms of meaning and not merely an exchange of information. The basic assumption of the convergence theory of communication is that ‘the communication process results in a change in the statistical distribution of the beliefs, values and behaviors of a culture’ (Kincaid, 1987, p. 212). Convergence in this case implies that the reality of the nurse and the reality of the patient must meet at some point (Al-Krenawi & Graham, 1999). According to the convergence model, the communication process has no beginning or end. Also, only the mutually expressed relationship between the two parts gives comprehensive meaning (Tudge & Scrimsher, 2003).

This model represents individual and group communication as a dynamic, cyclical process over time. The model identifies ‘mutual causation’ or more than a one-way mechanistic causation, and emphasises the interdependent relationship of the participants, rather than a bias towards either the ‘source’ or the ‘receiver’ of a message (Tudge & Scrimsher, 2003). The current convergence model comprehends mutual understanding of words, actions between individuals or groups and interaction as the primary goal of the communication process.

The aim of communication within the context of the convergence model is to maximise coherence, reduce uncertainty and enhance predictability, while at the same time helping co-ordinate events for achievement of a common goal (Hammoud & Siblani, 2003). Both the sender and recipient of information have to maximise their mutual understanding of the information being passed. In this sense, the nurse
and the patient must acknowledge their relationship overlap and take accountability for their part in achieving the optimal nursing care. The model identifies the principle of communication as the dynamic elements that make up the whole. The elements must interact and influence each other within the environment that they exist in and result in better patient care outcome (Wood, 2012).

The limitation of this model, as it is a symbolic representation, is that only very important elements are represented while elements such as personal cognition and context are not represented. It thus becomes very difficult to form an idea about complex messages between the nurses and their patients with a model that does not include such important elements as cognition and context. The convergence model does not incorporate religious, emotional and environmental variables that are central to achieve effective communication between nurses and patients in a Middle Eastern context.

As outlined, the communication models presented have various limitations that make them unable to completely answer the current study questions and objectives. The research thus utilised the sociocultural theory as a base form of cultural communication that aims to share information between diverse international and local nurses with Arabic patients in KSA health organisations. Moreover, the sociocultural theory explains the wide range of communication processes and problems that naturally appear within an organisation made up of individuals from different religious, social, ethnic and educational backgrounds.

2.7.2 The sociocultural theory

This section will provide an inclusive critical description of the (SCT) as a proposed theoretical framework for the current study. In addition, this section will outline SCT’s application for nurses’ communication towards patients in an Arabic
context. In relation to the proposed study, the influence of culture on one’s thinking, beliefs and their extension to professional conduct needs to be further examined.

The SCT originated in the 1920s and 1930s from the work of Vygotsky, a Soviet psychologist. Vygotsky observed that human cognition is embedded in the social, cultural, institutional and historical context of the individual life (see Figure 2.1). Vygotsky argued that in order to understand an individual and his/her actions, one must understand his/her historical, social and cultural background, as well as the context in which s/he is situated. Vygotsky described the six concepts of the SCT (Herrenkohl & Wertsch, 1999; Vygotsky, 1978) which include:

1. Zone of proximal development (ZPD), which refers to the distance between what one can achieve alone and what one can achieve with help.
2. Internalisation, which is known as the process whereby individuals’ social interaction generates ZPDs in order to foster skilfulness and capacities that originally are accomplished with support or collaboration with others.
3. Scaffolding, which refers to the teaching method that provides the learner/person with guidance to complete a task or to solve a problem that would not have been successfully completed without assistance.
4. Inter-subjectivity, which refers to the idea that learning can take place as a result of shared meaning or understanding of the way learners/individuals think about the world within their social contexts.
5. Cognitive apprenticeship, which uses real-world learning experiences that are shared between the mentor/instructor and the apprentice (or
learner/person), which utilises both scaffolding and inter-subjectivity.

6. Assisted learning, which usually takes place when activities and forms of assistance between educators/instructors and learner/person result in co-construction of new meanings and knowledge.

*Figure 2.1 Basic process of the SCT (Spouse, 2001).*

These sociocultural techniques can help and enable a learner/person practice their duties with a high conceptual understanding and effective progress. During the 1920s, Vygotsky focused on a unit of activity, mediated by signs used as tools or instruments to control personal behaviour. During this epoch, he claimed that the stimulus-response unit provided the common foundation for learning. A decade later, Vygotsky shifted the focus and talked about physiological systems (analytic unit) in which the focus also should be placed on the development of new relationships.
between mental functions. Subsequently, a third phase was developed that emphasised a system of psychological constructs (Lantolf, 2000) that would simplify the analysis of psychological processes regarding the concrete interactions.

SCT aims to understand the cultural concepts and belief systems embedded in the signs and symbols of a language and the speech of a defined culture, which are essential for communicating successfully in another language (Spouse, 2001). This particular construct is important in the context of increasing dependence on an expatriate nursing workforce, particularly significant in Saudi Arabia because of multicultural workforces in KSA hospitals. Without such comprehension, creating a shared social reality becomes problematic.

Significant in the theory is the emphasis on the need to harmonise nursing care with the immediate environment within which care is given. Indeed, Florence Nightingale strived to harmonise nursing care with religion in a manner that would foster greater order, meaning, purpose and dignity of both the nursing personnel and the patients (Whitehead, 2001). According to the precedents of the Nightingale model, the SCT seeks to retain diversity of nursing while at the same time providing a contextual base for communication between the nurses and patients and among the nurses (McVee, Dunsmore & Gavelek, 2005).

From a healthcare perspective, numerous shared similarities in regards to communication learning are found in most health providers. A Canadian study recruited family doctors to increase the quality of doctor-patient communications in the Aboriginal community (Towle, Godolphin & Alexander, 2006). In addition, Polednak (2007) found that Hispanics in the US were receiving poorer healthcare treatments because of language barriers with the health providers. Communication barriers in healthcare still exist as they do in personal and social situations.
(Polednak, 2007). In a study in South Korea on communication barriers perceived by older (>60) hospitalised patients and nurses, three elements of communication barriers were identified—the nurse, the patient and the hospital environment (Park & Song, 2005). The above summary would be a way to understand one another’s social background that influence the language and understanding of languages and at same time learn what is meant to be learnt.

Effective communication is the tangible evidence of respect for individuals and is necessary for autonomous decision-making (Spouse, 2001). Application of appropriate decision-making harmonised with valid communication should include the following:

7- communicating the benefits and the risks of undergoing a certain medical processes along with all the necessary information about the outcomes in writing and/or verbally
8- the participant understanding all the information
9- the participant, after considering the information, arriving at a decision without coercion or undue influence (Tudge & Scrimsher, 2003).

Within SCT theory, Lin and Mackay (2004) argued that nurses should not pre-empt what the patient wants to communicate but should let them communicate. An awareness of the social cultural dimensions is needed to inform the provision of best case healthcare that supports cultural beliefs, values and religion, as well as developing effective communication between patient and nurse. In particular, social cultural awareness enhances professional and personal values, communication abilities and nurses’ satisfaction with their practice (Suh, 2004). SCT potentially provides an explanatory framework for healthcare outcomes as it provides a framework for improved quality of nursing performance, the facilitation of good
patient-provider relationships, improves treatment efficiency and effectiveness and can result in cost savings (Betancourt et al., 2003). From a philosophical perspective, SCT informs the elimination of the health disparities among different cultural groups (Betancourt, Green & Carrillo, 2002).

Sociocultural theory (see Figure 2.1) provides a new way of addressing sociocultural issues. The model assists in identifying relevant sociocultural factors that can be used in nurse-patient communication, as well as offering strategies of how international and Saudi nurses can be integrated in high quality nursing care for Arabic patients. This ultimately leads to secure medical interventions with low risk events. The model has addressed the gap in the literature and acknowledged the importance of culture in nursing. This model is transferable to other domains such as social workers, pharmacists, labourites and international doctors. Given the range of elements embedded in notions of culture, language, communication and health, Vygotsky’s SCT can underpin the key objectives formative for this study. This conceptual framework will therefore form the basis for this study, providing a structure for data collection and analysis.

2.14 Summary

The literature reviewed in this chapter related to the nurse, the patient and the environment in which their interaction takes place. In the context of the nursing profession in Saudi Arabia, the contrast between the country’s culture and the large number of international nurses who have a limited knowledge of Saudi culture presents a unique set of problems with regard to nurse-patient communication. Patient-centred communication is central to informing positive nurse-patient relationships, which, along with other organisational factors, play a major role in the delivery of quality nursing care and patient outcomes. Sociocultural theory guided
the research as it emphasises the communication and related interactions between social, cultural and personal factors, elements that weave together to create a suitable environment that is as unique as the individual. However, achieving effective communication between nurses and patients, between nursing colleagues as well as nurses and doctors, requires an understanding of the patients’ social and cultural environment as well as that of the personal, professional and organisational context. Both parties should improve comprehension, information transfer and wellbeing of the patients.

This study’s methodologies including research design, study settings and participant recruitment will be discussed in the following chapter.
Chapter 3: Methodology

3.1 Introduction

Methodology is a system of explicit rules and procedures on which research is based and against which claims of knowledge are evaluated (Ojo, 2003). This section describes the research techniques adopted for this study for the purpose of achieving the research objectives. The study utilised an explorative descriptive two-phase study design using both a survey and focus groups method research strategy.

This chapter provides an overview of the research methodology, rationale, approaches sampling and the development, testing and evaluation of research instruments. First, the key problem and aims of the research are introduced, followed by the research design, with the justification for the research and instrumentation. This is followed by a description of the study population and the sampling for the two phases used. The data collection methods, piloting data analysis, rigor and ethical considerations are then discussed.

3.2 Research Design

A research design constitutes a framework for the collection and analysis of data. It is designed for generating evidence, suited both to a certain set of criteria and to a research question and, thus, is defensible (Bryman, 2004). The exploratory and descriptive research used in this study employed a two-phase approach to capture the process of organisation structures, professional reasoning, interaction and communications with lay people (patients for the purposes of this study) (Huberman & Miles, 2002).

A mixed-method design enables quantitative and qualitative methods to complement each other and allow for a more complete analysis of the research problem (Creswell & Creswell, 2005). The current study utilised mixed-method
research, meaning that both quantitative and qualitative techniques were combined sequentially in a single study. This approach constitutes the third major research paradigm, providing an alternative (when it is appropriate) to either quantitative or qualitative research. In the social sciences, a mixed-method approach provides triangulation both in terms of needed rigor and to provide social and cultural context of a given survey approach (Huberman & Miles, 2002). Moreover, through both the application of a survey and follow-up focus group sessions, the researcher was able to examine the conceptual framework more fully and the cultural perspective of the Saudi hospital administrations’ organisation, as well as the socially embedded processes of nurse-patient interactions.

Phase 1 of the current study utilised the survey method; this method is widely used in descriptive studies. This data collection instrument is suitable for obtaining information about phenomena such as the beliefs, attitudes, points of view and behaviour of various groups of people (Thomas, Nelson & Silverman, 2011). Moreover, the strength of the survey is identified as its ability to collect a large amount of responses over a short or specific period of time and its commonly representing the target population. Further, the survey is a useful and effective data collection technique when the researcher is seeking participants’ responses for specific items that answer the research question (McNabb, 2012). Thus, in this study, a reliable and validated instrument (phase 1) was used and combined with focus groups session to examine the barriers and facilitators (phase 2) of nurse-patient communication in Saudi Arabian culture.

Commonly, the second component of mixed-method research is a semi-structured open-ended interview, as they are critical for developing an in depth understanding of qualitative issues in particular. For the purpose of this thesis, a
focus group was used for collecting information from the nurses’ perspectives. It allows for in depth discussion and probing on an issue. A focus group discussion is an ‘interview [that] taps into human tendencies, where attitudes and perceptions related to concepts, products and services are developed in part by interaction with other people’ (Huberman & Miles, 2002, p. 27). According to Kitzinger (1994), the researcher’s main role in a focus group discussion is to encourage the participants to get more involved in the interaction, thus encouraging them to elaborate on the topic under investigation. In addition, the use of the focus group provides a high level of face validity, because participants’ ideas and discussions can be confirmed, reinforced or contradicted during the discussion process (Webb & Kevern, 2001). Barbour (2005) emphasised that using a focus group can help in planning for developing health policies and practice. Moreover, this thesis used a triangulation method as it is advocated as a strategy to achieve more comprehensive understandings of phenomena.

Triangulation through mixed-methods facilitates validation of data from more than two sources, through cross-verification. In an applied social sciences research such as the topic under investigation, triangulation is often used to indicate that more than two methods are used in a study, with a view to double (or triple) checking results (Creswell & Creswell, 2005). Such an approach enables the application and combination of several research methodologies in the study of the same phenomenon (Onwuegbuzie & Leech, 2006). Triangulation was used in this study to enable the combining of multiple theoretical models and empirical materials, as an attempt to overcoming intrinsic biases and the problems inherent to single method, single-observer or single-theory studies.
3.3 Research Aim

The aim of this study is to examine barriers and facilitators of nursing communication towards patients that local Saudi nurses as well as international nurses currently face within a Saudi Arabian cultural context. An explorative approach was used as outlined in Section 3.2 to develop first-time baseline data from which to develop standardised nurse communication guidelines in order to improve current communication and patient safety in Saudi hospitals. This study is intended to contribute to promoting awareness and the importance of recognising the multicultural diversity among nursing staff in order to provide more effective communication and improved healthcare outcomes for patients in the Hail region of Saudi Arabia. Also, this project informs effective orientation and ongoing educational packages for newly employed Saudi and expatriate nurses. See sections 1.3 and 1.5 for research objectives and questions.

3.4 Study Setting

The district chosen for setting the study was the Hail district. Hail is located in northern Saudi Arabia and has five general hospitals and a total population of 1000 general nurses employed full-time (Ministry of Health, 2009). These public hospitals offer free healthcare services to local Saudi nationals and international patients. The sampled hospitals provide healthcare services to patients from Hail city and rural and remote areas in the Hail province, being funded by the Ministry of Health. The two major hospitals, namely the King Khalid hospital and the Hail General Hospital, also provide clinical experience and training to medical and nursing students, whereas others hospitals provide only standard medical services due to insufficient hospital staff and facilities. In addition, each hospital has
outpatient clinics, minor/major surgery departments and internal ward admission procedures.

The current study was conducted with a total sample of five Saudi Arabian general hospitals in the northern region of Hail. The invited hospitals represented different affiliations and were in general representative of those in Saudi Arabia nationally. Nursing services at each hospital varied based on the availability of resources, amount of support, strategic planning by the hospitals’ administration and policies on nursing administration. The five sampled hospitals (for phase 1 and phase 2 samples) had a total population of approximately 1000 full-time registered nurses.

3.5 Population Sample

This section outlines the targeted population identified for inclusion purposes in order to maximise result accuracy. In most survey research, appropriate determination of the required sample size or participants is crucial so that the resulting outcome will produce valid results (Dantzker & Hunter, 2006). The determination of the appropriate number of respondents can be influenced by the population size, the risks of selecting the inappropriate sample and the sampling error. Additionally, there are three criteria which usually need to be specified to determine the appropriate sample size. First, the level of precision, second, the level of confidence or risk and the third is the degree of variability in the attributes being measured (Thomas, Nelson & Silverman, 2011). The level of precision, also known as sampling error, is defined as the range in which the true value of the population is estimated to be (Dantzker & Hunter, 2006). This range is often expressed in percentage points, in the same way that the results for political opinion polls are reported by the media (Smith, 2004). The confidence or risk level is based on ideas encompassed under the central limit theorem. The key idea encompassed in the
central limit theorem is that when a population is repeatedly sampled, the average value of the attribute obtained by those samples is equal to the true population value.

Further, the values obtained by these samples are distributed normally about the true value, with some samples having a higher value and some obtaining a lower score than the true population value. In a normal distribution, approximately 95% of the sample values are within two standard deviations of the true population value (for example, mean). In other words, this means that if a 95% confidence level is selected, 95 out of 100 samples will have the true population value within the range of precision (Smith, 2004). There is always a chance that the sample you obtain does not represent the true population value. The third criterion, the degree of variability in the attributes being measured, refers to the distribution of attributes in the population. The more heterogeneous a population, the larger the sample size required to obtain a given level of precision (Magidson & Vermunt, 2004). The less variable (more homogeneous) a population, the smaller the sample size. Note that a proportion of 50% indicates a greater level of variability than either 20% or 80%. This is because 20% and 80% indicate that a large majority do not or do, respectively, have the attribute of interest. Because a proportion of .5 indicates the maximum variability in a population, it is often used in determining a more conservative sample size, that is, the sample size may be larger than if the true variability of the population attribute were used (Smith, 2004).

The two sampling phases (phase 1 and 2) for the study are as follows.

3.7.1 Phase I

The target population for this study was registered nurses assigned to the total available adult medical and surgical departments, including both local nurses and international nurses working at Hail public hospitals. Simple random sampling
(Ojo, 2003) was utilised. Simple random sampling is the most basic form of probability sample. With it, each unit in the population has an equal probability of inclusion in the sample. A probability sampling method was used, specifically simple random sampling, to recruit 291 nurses who met the eligibility criteria in order to be representative of the population. The researcher used simple random sample by randomly generated numbers utilising computer software. This is based on a confidence level of 95%; the confidence interval will be set at 5% and the population of 1,000 (Creative Research Systems, 2007). However, it was acknowledged, based on published literature, that response rates were generally high in surveys previously conducted in Saudi Arabia. So, expected attrition rate was from 5–10 % (Smith, 2004). Therefore, the researcher took precaution to distribute an additional 10 % extra printed copies to eligible participants in order to reach representative sample (Creswell & Clark, 2007). The study participants’ response rate was about 91%. The researcher applied the attrition rate in order to determine the number of nurses at Hail hospitals who must be sampled and obtained the sample that represented generalisability to the original population.

3.5.1.1 Inclusion criteria

The inclusion criteria for the selection of participants (phase 1) were: registered nurses between 20 to 60 years old, employed full-time and having worked for four or more months in Ministry of Health hospitals and able to read and comprehend English.

3.5.1.2 Exclusion criteria

Excluded were nurses who worked in emergency, critical care, as these patients are frequently unconscious, and nurses who worked in the paediatric departments because they have unique and special communication needs.
Data from phase 1 provided information useful in formulating the approach to the data collection in phase 2.

3.5.1.3 Effect size

Inferential statistics determine if the data possibly deviate from random variation, as a function of the sample size; however, the data deviated from randomness did not necessarily imply that the results of multivariate analysis of variance (MANOVA) were meaningful or important in the context of this study. This is emphasised by Thomas et al. (1991, p. 344), while Vacha-Haase (2001, p. 219) claimed that ‘statistical significance should not be considered as one of life’s guarantees. Effect sizes are needed’. Effect sizes are provided in the SPSS output for MANOVA as eta squared (\(\eta^2\)). The \(\eta^2\) values, equivalent to \(R^2\) values in regression analysis, indicated the proportions of the variance in the dependent variables that were explained by the independent variables (Field, 2009). The criteria defined by Ferguson (2009) and Kraemer et al. (2003) were used to interpret the effect sizes. Practical/clinical significance was assumed to be negligible if \(\eta^2 < .04\); low if \(\eta^2 = .16\), moderate if \(\eta^2 = .25\) and high if \(\eta^2 > .64\).

3.7.2 Phase 2

Recruitment to each focus group was based on consent obtained on completion of the quantitative component of the survey and then further selecting a purposive sampling from the analysis of phase 1 data. Although the heterogeneous groups could have a potentiality of gaining a wide range of views (Creswell & Clark, 2007), another purposive criterion was that of cultural representation of nationalities and religion of the sample population such as Arabic and Asian nurses along with Muslim and Christian nurses. A total of 34 consenting participants were invited from phase 1. They were from either Saudi Arabia, the Philippines, India or Indonesia.
Upon completion of the focus groups, 23 participants engaged in four independent focus groups sessions.

This phase allowed the researcher to identify and cluster the participants for the focus group based on an analysis of the questionnaire scores from phase 1 (for example, younger and older age clusters). Given that nurses work together in a naturalistic setting, focus group discussion produced results derived from various nurses’ personal experiences and thus more comprehensive and strong evidence could be reached. As result, the nature of interaction of the group allowed participants to comment and build on and judge emerging issues (Gillham, 2000).

The use of multiple focus groups increased the reliability of research data by detecting the consensus across the different groups (Huberman & Miles, 2002). Bloor (2001) indicated that an average number of three focus group discussions are adequate, particularly in triangulated research. In order to ensure more coverage of the identified problem, four focus group discussions were used with local and international nurses.

### 3.6 Approaches and Recruitment

This section covers the current study approaching and recruitment of participants under phase 1 and 2.

#### 3.7.1 Phase I

After obtaining an up-to-date register of all nurses employed in the target hospital wards, from the General Director of nursing, the nurses were randomised and invited to participate in the study. A special permission to conduct the study was previously approved by the Hail Region Health Affairs Directorate (see Appendix B) prior to collecting this information. Thus, all eligible nurses, after randomisation, were contacted to take part in this study. Each participant was asked to complete a
15–20 minute questionnaire (Anoosheh et al. 2009). Once completed, each participant was asked to return the survey in a stamped, addressed envelope provided or placed in the locked return box located at the nursing office. Informed consent was implied by submission of the completed survey. Each participant was encouraged prior to completion of the survey to examine the questionnaire carefully as it may aid in his/her decision to participate in the study. Nurses who were on leave at the time of data collection were contacted, by the researcher, via email to invite them to participate in the study. The survey then was sent electronically (email) or by returned mail (two-way paid).

The researcher ensured to followed-up this process in order to maximise the participation rate. The follow-up resulted in about half of the questionnaires being returned at a rate of 48%, and as the researcher expected, second (73%) and third follow-up rounds encouraged a high return rate of questionnaires and maximised the response rate (91%). Follow-up with nurses were very beneficial to get a high participation response rate, as nurses were very busy with patient interventions and had high workloads in their hospitals.

3.7.2 Phase 2

The aim of using focus groups was to explore in depth the key findings from phase 1 (the quantitative survey). The four focus groups were recruited on the basis of heterogeneity (Yin, 2003). These focus groups included participants from mixed ethnicity, different gender, religion and age as key factors from both the literature and phase 1 in order to stimulate discussion and diversity and to allow comparison and clustering of data collected from different groups. All participants in phase 1 were happy to be contacted and asked to provide their confidential contact details for the researcher to contact them and arrange the focus group. Four focus groups, with
five to six nurses in each, were held. The details were coded once contacted for focus groups to maintain anonymity. Recruitment to the group was based on consent from the survey and a purposive sample from the analysis of phase 1 data—gender, age and nationalities—for example, one group with older nurses, one with younger nurses and another group with local nurses and one with expatriates who agreed to take part in the focus groups.

At the commencement of each focus group, each participant was given an information sheet explaining the study (plain language statement, see Appendix G) and a brief demographic form to complete. At the end of each discussion, participants were asked for their feedback about the discussion in which they had participated and this feedback along with the concurrently analysed data was then incorporated into the interview guides and planning of the subsequent focus group discussions. In healthcare, focus group interviews enable the interpersonal aspects of care or help if the available evidence is limited (Yin, 2003). Focus group interviews have the advantage of being more time efficient as more people can be interviewed for the same amount of time and provide a richer source of data.

The current study’s participants were grouped into four heterogeneous focus groups, designed with the aim of diversifying responses based on cultural background and years of clinical experience. These focus groups were held with sufficient diversity within the groups to stimulate and maximise potential for active dialogue to facilitate comparisons between each focus group (Morse, 2003). A total of four focus group interviews (with purposive sampling to identify five to six nurses in each group) were selected based on the questionnaire scores, participants age, nationalities and gender. A total sample of 23 nurses participated in phase 2. The researcher took into consideration a cultural representation of nationality with
enough participants to facilitate group interaction and small enough to interact. All focus groups were conducted in English by the same moderator (the researcher) and audio tape-recorded (Huberman & Miles, 2002).

3.7 Data Collection Instruments

This two phases study employed two different instruments to answer the research questions. In phase 1, a questionnaire was used to examine barriers and facilitators of nurses’ communication towards patients in Saudi Arabia. In addition, a comprehensive explanation of questionnaire items was included. Phase 2 used a focus group interviews method to capture in depth key words from study participants.

3.7.1 Phase I

The main instrument in the study is an adopted instrument, which is composed of two parts: a demographic profile and the Nurses Self-Administered Communication Survey (Anoosheh et al., 2009). The primary tool for this project is based on a survey that assisted in the examination of personal experience and the basic perception of barriers and facilitators to communication from each participant. The researcher obtained permission from the authorised correspondents of the NSACS, prior to using it in this survey (see Appendix F). Further, the researcher adapted a proportion of the survey from a critical literature review.

Panels of experts have rated the individual relevance of each set of questionnaires used by Anoosheh et al. (2009) with different nurses’ communication as follows. According to nurses’ responses, heavy nursing workload, hard nursing tasks and lack of welfare facilities for nurses were the leading communication barriers in Iranian hospitals. The shared communication barriers for patients and nurses were age difference, social class difference and having contagious diseases.
CHAPTER 3: METHODOLOGY

This questionnaire uses a Likert scale (completely disagree = 1, disagree = 2, neutral = 3, agree = 4, completely agree = 5). The reliability of the core 30 items—including ‘personal and social characteristics’ (eight items), ‘job specifications’ (nine items), ‘clinical situation of patients’ (four items) and ‘environmental factors’ (nine items)—revealed overall consistency of 0.96 (calculated by using Cronbach’s alpha coefficient) (Anoosheh et al., 2009).

The NSACS used in this current study consisted of 41 items and five subscales. The first included some demographic details of the nurse, like age, gender and country of origin, hospital experience and marital status. The second section ‘personal and social characteristics’ focused on nurse-patient age difference, nurses’ religion, nurses’ nationality, nurses unfamiliarity with dialect and unfamiliarity with nursing job description. The third subscale of the questionnaire was ‘job specifications’, centred on and not limited to hard nursing tasks, nursing shift work, patient contact with different nurses and lack of information and skills in communication. The fourth subscale ‘clinical situation of patients’ consisted of history of hospitalisation, presence of a helper for providing care and patients disease severity. The final subscale ‘environmental factors’ sought information on lack of educational background in communication skills, lack of managerial appreciation from nurses and lack of nurses’ and nurses’ participation in decision-making. The approximate time to complete the survey was 15 to 20 minutes.

3.7.2 Phase 2

Phase 2 was conducted after performing basic analyses (descriptive analyses) of the phase 1 data. The semi-structured interview guide was utilised as the instrument to examine the barriers and facilitators of nurses’ communication towards patients in Saudi Arabia hospitals. From the critical review of the literature and
phase 1, the key issues identified were integrated into a focus group interview guide. This included questions about the nursing communication barriers with patients, nurses’ communication facilitators and effects of religion, culture and health organisations on nurses’ communication towards patients (see Appendix I). All focus group interviews were digitally recorded and then the data were transcribed.

Such an interview is characteristically based on a flexible topic guide that provides a loose structure of open-ended questions to explore experiences and attitudes. It has the advantage of great flexibility, enabling the researcher to enter new areas and produce richer data. In addition, it helps the researcher to develop a rapport with the informants. Semi-structured focus group interviews elicit people’s own views and descriptions and have the benefit of uncovering issues or concerns that have not been anticipated by the researcher (Yin, 2003).

3.8 Content Validity

The purpose of this section is to evaluate the content validity of the survey and focus group sessions. Validity demonstrates the relationship between the test and the behaviour as a measurement. Individual test questions may be drawn from a large pool of items that cover a broad range of topics (Kimberlin & Winterstein, 2008). Content validity of both phase 1 and 2 is explained as follows.

3.7.1 Phase 1

Content validity for questionnaire (phase 1) was secured by an expert panel and the related literature on barriers and facilitators of nurses’ communication with patients. The expert panel included three senior nurses and two academic nurses who were independent from the current study sample. The phase 1 instrument (NSACS) was circulated to experts in order to rate the relevance and clarity of the instrument items. Modifications on word choice—such as, replace ‘sex’ with ‘gender’—to the
instrument were done based on feedback from registered full-time nurses and qualified nursing lecturers who had insight into the standards of nursing.

3.7.2 Phase 2

In mixed-methods research, content validation involves consulting with experts or members of the target population. Indeed, consultation with members of the target population can—and should—be used to inform the initial identification and specification of key constructs (Morse, 2008). Moreover, it was acknowledged that the focus group methodology, an approach that involves moderator-facilitated discussions among multiple participants, may be especially helpful in this regard.

Content validity of the focus group interviews was established through the same expert panel that included three senior nurses and two academic nurses. The phase 2 interview guide was circulated to experts in order to rate the relevance and clarity of the interview guide questions. The process of content validation involved three primary components: a review of relevant literature, the ongoing refinement of definitions of key constructs and the conduct of focus groups with members of the target population. The expert’s panel suggested the expansion of the interviews’ timeframe into one hour and half. The interview guide required no modification as the questions were understood and answered satisfactorily.

3.9 Pilot Study

A pilot study is usually carried out on members of the relevant population, but independent of the main study sample. This section explains the approach and strategies used to conduct the pilot study for phases 1 and 2.

3.7.1 Phase I

To assess the validity of the instrument, certain measures were utilised such as pilot testing (Creswell & Creswell, 2005). Pilot testing is one way of ensuring the
validity of the instrument to see the potential misunderstandings and errors of the questions. A pilot study was conducted with seven nurses who met the inclusive criteria and who were independent of the main study. The pilot study provided an opportunity to determine appropriateness, but the data from the pilot project were not included in the main study. The participants generally had satisfactory English and writing skills. Moreover, the pilot study results helped the researcher make some modifications to some items, such as questions on religion and gender, to improve clarity.

3.7.2 Phase 2

A pilot focus group interview was carried out using a purposive sample of seven local and international nurses. It was found that the length of time was not enough to get in depth information in a group of seven participants. It was initially difficult to ensure equal contribution to the discussion in such a limited time. For that purpose, the moderator increased focus groups’ timeframe to one hour and half with five to six participants. The interview guide required no modification as the questions were understood and answered satisfactorily. The pilot interview provided rich descriptions and was much more successful than anticipated.

3.10 Data Analysis Process

Quantitative data was analysed with the use of a statistical programme. This section outlines phase 1 statistical data analysis strategies, data management and operational scales description.

3.7.1 Analytical strategy for the statistical analysis

The responses to the NSACS were transferred to the SPSS data editor for the purposes of statistical analysis using the methods described by Field (2009). The data matrix consisted of 267 cases in the rows and 41 variables in the columns.
Following the initial screening and cleaning of the data, the data analysis proceeded in three stages. The first stage was to define the demographic/contextual characteristics of the participants. The second stage was to analyse the responses to each item using frequency distributions (counts and percentages), summarise the responses to each item using descriptive statistics (median, mean and standard deviation) and determine the reliability of the item scores. The aim of the third stage was to explore the relationships between the reliably measured scales extracted from four sections of the instrument (dependent variables) and the demographic and contextual characteristics of the participants (independent variables) using inferential statistics.

3.7.2 Data Cleaning

Because the inclusion of missing values (for example, the items with no responses, initially recorded as blanks in the data matrix) could potentially bias the results of the statistical analysis, it was imperative to screen and clean the data. Missing values were found among eight of the 11 demographic/contextual characteristics, but this vital information could not be imputed and meant that the sample size was not consistent for each inferential statistical test. Missing values were found among 21 of the 30 item scores, representing 3.8% of the total number of responses. To avoid errors in the statistical analysis, the missing values were imputed with the mean score for the corresponding item. The mean is one of the most common ways of replacing questionnaire scores, so long as no consistent or regular patterns among the missing values can be identified (Hair et al., 2010).

3.7.3 Demographic and contextual profiles

The demographic and contextual profiles of the participants were constructed based upon the frequencies of the numerical codes or value labels used in the SPSS
data editor. The nominal categories (i.e., with codes that did not imply a rank or hierarchy) and the ordinal categories (with codes that implied a rank order) are defined in tables 3.1 and 3.2.

Table 3.1

<table>
<thead>
<tr>
<th>Variable</th>
<th>Level</th>
<th>Code</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (Years)</td>
<td>Ordinal</td>
<td>1</td>
<td>18–25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>26–30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>31–40</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>41–50</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td>50+</td>
</tr>
<tr>
<td>Gender</td>
<td>Nominal</td>
<td>1</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>Female</td>
</tr>
<tr>
<td>Religion</td>
<td>Nominal</td>
<td>1</td>
<td>Islam</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>Buddhist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>Hindu</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>Christian</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td>Other</td>
</tr>
<tr>
<td>Nationality</td>
<td>Nominal</td>
<td>1</td>
<td>Saudi</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>Filipino</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>Indian</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>South African</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td>Other</td>
</tr>
<tr>
<td>Racial/Ethnic Background</td>
<td>Nominal</td>
<td>1</td>
<td>Caucasian</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>Arabic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>American-Indian</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>Asian</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td>African</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Nominal</td>
<td>1</td>
<td>Never married</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>Married</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>Living with partner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>Separated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td>Divorced</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6</td>
<td>Widowed</td>
</tr>
<tr>
<td>Highest Educational Level</td>
<td>Ordinal</td>
<td>1</td>
<td>Primary school</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>Secondary school</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>Some college</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>Undergraduate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td>Postgraduate</td>
</tr>
</tbody>
</table>
Table 3.2 includes the contextual profiles of all variables used to define the contextual characteristics of the respondents.

Table 3.2

*Contextual Characteristics Variables*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Level</th>
<th>Code</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational status</td>
<td>Nominal</td>
<td>1</td>
<td>Full-time employed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>Part-time employed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>Other</td>
</tr>
<tr>
<td>Worked in KSA before</td>
<td>Nominal</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>No</td>
</tr>
<tr>
<td>Time working at hospital</td>
<td>Ordinal</td>
<td>1</td>
<td>1–4 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>4–8 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>8–12 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>12–24 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td>&gt; 24 months</td>
</tr>
<tr>
<td>Specialist courses undertaken</td>
<td>Nominal</td>
<td>1</td>
<td>Communication skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>Patient safety policies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>Culture program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>Arabic language</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td>Other</td>
</tr>
</tbody>
</table>

3.7.4 Item scores

The analysis of the scores for the 30 items concerned with barriers to communication was based on a five-point scale, specifically 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral: 4 = Agree: 5 = Strongly Agree. This scale was the opposite to that originally applied in the questionnaire, which used a negative ranking system, i.e., 1 = Strongly Agree and 5 = Strongly Disagree. The scores were reversed in order to create a positive relationship, where a high level of agreement corresponded to a high score and a low level of agreement corresponded to a low score. Such a positive ranking system is much more logical and intuitive to interpret and understand than a negative system (Zikmund et al., 2010). The reversal of scores
meant that higher scores > 3 resulted from the respondents agreeing with the item, implying that they perceived that the subject of the item was a barrier to communication. Low scores < 3 resulted from the respondents disagreeing with the item, implying that they perceived that the subject of the item was not a barrier to communication.

The statistical analysis of item scores based on an ordinal scale from 1 to 5 is problematic because: (a) it cannot be assumed that the respondents perceive that the interval between two adjacent categories (e.g., Strongly Agree and Agree) is exactly the same as the interval between two other adjacent categories (e.g., Strongly Disagree and Disagree); (b) it is theoretically impossible for integers ranging from 1 to 5 to be normally distributed; (c) it makes no sense to add up or subtract the scores for a single item, e.g., addition of 1 (Strongly Disagree) to 2 (Disagree) does not equal 3 (Neutral). The implications are that parametric statistical analysis of ordinal item scores, assuming that they represent normally distributed variables measured at the interval level, may lead to erroneous results (Cliff, 1996; Jamieson, 2004; Kahler et al., 2008). Because the scores were ordinal level variables, the interpretation of the distributions of responses to the individual items in the questionnaire required the use of non-parametric descriptive statistics, specifically the median and the mode (Agresti, 2010).

### 3.7.5 Operationalisation of scales

Operationalisation means converting concepts that lack clarity and precision into reliably measured composite variables or scales consisting of clusters of item scores (Creswell, 2009). Assuming that they were reliably measured, the four scales were operationalised by the addition of the item scores, specifically: Section 1: barriers to communication related to personal/social characteristics (10 items) called
the personal/social characteristics scale; Section 2: barriers to communication related to job specifications (nine items) called the job specifications scale; Section 3: barriers to communication related to the clinical situations of patients (four items) called the clinical situations of patients scale; and Section 4: barriers to communication related to environmental factors (seven items) called the environmental factors scale.

The four scales were operationally defined as dependent variables for purposes of inferential statistical analysis. The normality of the four scales was checked visually by observing their frequency distribution histograms and statistically by performing Kolmogorov-Smirnov (K-S) tests using the significance level of $\alpha = .01$. The decision rule was to assume that the scale departed significantly from normality if $p < .01$ for the K-S test statistic. The reason for prescribing $\alpha = .01$ (rather than $\alpha = .05$) for the normality test was that the sample size was relatively large ($N = 267$) so that even very small departures of the variables from normality could potentially result in $p < .05$ for the normality test. For this reason, a significance level of $\alpha = .01$ is recommended for testing normality when using large sample sizes (Shapiro, 1980; Bonett & Woodward, 1990).

3.7.6 Inferential statistics

Before inferential statistics can be conducted, hypotheses are usually formulated. Hypotheses are guesses, claims or propositions that have not yet been tested concerning the existence of specified relationships (e.g., differences, associations or effects) among observed sets of data. Although it may be possible to make confirmatory observations providing evidence to substantiate or support the truth of a hypothesis, this is not the universally accepted scientific method. Even a large number of confirmatory observations cannot prove that a hypothesis is true.
Falsification or the provision of scientific evidence to reject or turn down a hypothesis is generally considered to be logically more decisive (Sink & Mvududu, 2010). Inferential statistics are central to the scientific method because they conventionally involve the testing of null hypotheses proposing negative default situations among observed subsets (samples) of data assuming that the samples represent the whole set of data (the population) from which the samples were drawn. According to the Neyman-Pearson decision-making framework, which has dominated statistical inference for nearly a century, the null hypothesis can be rejected in favour of an alternative hypothesis only if the frequency probability (p-value) of the test statistic is less than a prescribed significance level, conventionally $\alpha = .05$ (Field, 2009). The testing of null hypotheses using the Neyman-Pearson rule has, however, been challenged in recent years, because it has been responsible for widespread confusion. Many researchers who are not experienced in inferential statistical analysis have misconceptions (Alderson, 2004; Kline, 2004; Hurlbert & Lombardi, 2009). For this reason, null hypotheses are avoided in this study and replaced by research questions, which are addressed in next chapter using inferential statistics.

Research question 1 was tested by correlation analysis. Scatterplots were constructed and Pearson’s correlation coefficients ($r$) were computed to determine the extent to which pairs of scales were linearly related to each other. A significant correlation was assumed if the probability (p-value) of Pearson’s $r$ was less than the significance level of $\alpha = .05$. Assuming that the four scales were positively intercorrelated, it was justified to perform MANOVA to address research question 2 to research question 6 using a linear combination of the personal/social characteristics
scale, the job specifications scale, the clinical situations of patients scale and the environmental factors scale as the multivariate dependent variables.

MANOVA is very sensitive to sample size. To obtain accurate results using MANOVA there must be an absolute minimum of 20 cases and preferably more in each cell of the sample design matrix (Hair et al., 2010). It was not possible to include all six of the demographic/contextual characteristics in one comprehensive MANOVA model because the number of cases in most cells of the sampling design matrix (gender x age x religion x nationality x time working at hospital x attending specialist courses) was less than 20 and many of the cells contained zero cases. Also, there were too many interactions between the demographic/contextual factors to include them all in one MANOVA model.

The categories of nurses had to be collapsed in order to ensure that the minimum sample size requirement of 20 cases per category was achieved with respect to addressing Research question 1 to Research question 4 using six MANOVA models. Because six consecutive MANOVAs were performed on one set of data, the statistical inferences could potentially be compromised by the inflation of Type I errors (i.e., the declaration of statistical significance at $\alpha = .05$ by chance, when there was, in fact, no significant difference between the means scores). The Bonferroni adjustment was therefore applied to correct the significance level (Abdi, 2007). The significance level was reduced from the conventional level of $\alpha = .05$ down to $\alpha = .05/6 = .01$. The decision rule was to assume that the MANOVA test statistics (Wilk’s $\lambda$ and multivariate $F$) were statistically significant if $p < .01$. Conversely, if $p \geq .01$, then the test statistics were declared to be not significant. Scheffé’s test was used for the post-hoc pairwise comparison between three or more mean values, because unlike other post-hoc tests, such as Tukey’s HSD, it does not
assume that the sample size in each group is equal (Field, 2009). The mean values were also compared visually using error bar charts, where the bars represented the mean values and vertical lines represented the 95% confidence intervals.

MANOVA assumed that the variances and the covariance matrices of the dependent variables were homogeneous across the groups of nurses classified according to their demographic/contextual characteristics. These assumptions were tested using Levene’s test and Box’s M respectively at the .01 level of significance. MANOVA is very sensitive to outliers (i.e., extremely large or small values, which are not contiguous with a multivariate normal distribution) because they distort the calculations of the sums of squares (Hair et al., 2010). Mahalanobis distance ($D^2$) values for each case were computed using the method in SPSS described by Field (2009). $D^2$ measures the distance of each case from the centroid (multidimensional mean) of a distribution, taking into account the covariance (multidimensional variance) of the distribution. All of the p-values for the computed $D^2$ values exceeded .001, providing evidence to conclude that the data did not include multivariate outliers.

3.7.7 Reliability analysis

Reliability analysis is essential when evaluating the responses to questionnaires. This is because the responses to single items contain inconsistencies due to the vagaries of the respondents and so they are not reliable. If the item scores collected in this study were not reliably measured then inferential statistical analysis might be meaningless (Thompson, 2003). So long as the clusters of items scores for sections 1, 2, 3 and 4 of the instrument were reliably measured, then it was justified to add up the scores to create summative scales for the purpose of inferential statistical analysis. When the ordinal scores for a number of inter-related items are
combined to create a summative scale, then an interval level variable is arguably created and parametric statistics may be justified, assuming that the scale is normally distributed (Creswell, 2009; Knapp, 1990; Long et al., 2003; Agresti, 2010). The advantage of summatating inter-correlated item scores to create a scale is that the systematic components are reinforced and the error components are reduced (Allen & Yen, 2002).

The internal consistency reliability of the item scores for Section 1 (items one to 10), Section 2 (items 11 to 19), Section 3 (items 20 to 23) and Section 4 (items 24 to 30) were estimated. Cronbach’s alpha was computed because it is the most commonly used estimate of internal consistency for questionnaire item scores (Thompson, 2003). Cronbach’s alpha potentially ranges from 0 (zero reliability) to 1 (perfect reliability), but values of alpha greater than .6 were assumed to indicate adequate reliability (Creswell, 2009).

Factor analysis was also used to confirm the four-dimensional structure of the questionnaire and to determine if four reliably measured scales could be extracted from the responses, specifically one factor for Section 1 (items one to 10), one factor for Section 2 (items 11 to 19), one factor for Section 3 (items 20 to 23) and one factor for Section 4 (items 24 to 30). Principal axis factoring with direct oblimin rotation was used to create a non-orthogonal factor solution, assuming that the factors were correlated with each other (Hair et al., 2010). The pattern matrix displaying the loadings of the items on the factors was interpreted. Because the loadings were correlation coefficients, reflecting the strength of the relationship between each factor and its constituent items, they could potentially range from -1 to +1. The eigenvalues and the proportions of the variance explained by each factor were also recorded.
3.11 Qualitative Data Analysis (Phase 2)

Focus group interview sessions were used in the second phase. This section illustrates the development of transcription, codes and themes emerging from participants’ focus group interviews. Qualitative research centred on understanding and interpretation of all participants’ information through categorising themes into meaningful categories and then translating them into a meaningful model. Before conducting the focus group interviews, the researcher developed an interview guide from the literature and phase 1 and protocol for the transcription of data: number of interviews and identification of participants.

The transcript of each focus group interview was read and re-read in order to gain an understanding of the whole situation and then re-read slowly to determine its significant features. All focus group interviews were audio-taped and transcribed verbatim by the researcher. Each tape was listened to at least twice, once before the audiotaped transcription and then later on to check the typed text with the data transcribed. The collated focus group interviews were analysed using the NVivo qualitative research software (Morse, 2002). At the beginning, all ideas were identified and coded under free nodes. By the final coding structure, the researcher and two expert researchers reviewed all completed transcripts again. There was total agreement between the researcher and supervisor of the codes applied, indicating good reliability in qualitative research. During the coding process, each significant feature of every focus groups interview was analysed and formulated into a statement that expressed the implicit and explicit meanings of the statement. Each new statement was clustered together to formulate common content that reflected the totality of the picture, a process called open coding. After the themes emerged they were organised into categories.
Saturation of data collected is a commonly used criterion for when sampling should cease in qualitative research studies (Morse, 2002). The data saturation occurred by the end of the fourth focus group session, data saturation meaning no new information emerges or is considered critical in ensuring data applicability in qualitative research. Category saturation occurs when one category is saturated while theoretical saturation occurs when all categories are saturated. Once the fourth focus group recruitment ended by the researcher and during the progress of the current study when new categories and explanations stopped emerging, both category and theoretical saturation occurred. In the current study, the final stage of thematic analysis revealed a general summary of the enclosing main themes and related subthemes. This was member checked by the researcher’s PhD student and principle supervisor.

The next section details the application of focus group interview rigor.

3.12 Phase 2 (Rigor)

In the qualitative portion of the mixed-methods research, measures need to be identified to establish and ensure credibility, confirmability and transferability (Hoskins, 2004). The accuracy of data was based on sample selection and the fact that participants were given the choice to express what they think is true without any risk of bias or threat. This section covered rigor methods such as: triangulation, credibility, confirmability and transferability that applied by the researcher in order to maintain the high quality of qualitative data.

3.7.1 Triangulation

Several procedures have been described to increase rigor in mixed-method research. For example, triangulation is commonly used as a way of validating data (Creswell & Miller, 2000). Triangulation postulates varied techniques of looking at
the same phenomenon and adds credibility and confidence in the conclusions drawn from the study. There are two styles of triangulation, triangulation of sources and analyst triangulation. Triangulations ‘attempt to map out or explain more fully, the richness and complexity of human behaviour by studying it from more than one standpoint’ Creswell (2005, p. 23). According to O’Donoghue and Punch (2003, p. 76), triangulation is a ‘method of cross-checking data from multiple sources to search for regularities in the research data’.

Triangulation is defined by Patton (2001) as ways of checking the consistency of various data sources within a similar method. The researcher used triangulation in order to compare the quantitative and qualitative results in the current study. The triangulation of quantitative and qualitative methods is highly useful both for the research process and the research question. Both methods have different angles, the results complement each other and yield a comprehensive picture of the barriers and facilitators of nurse patient communication. Several studies have used this method of verification to study the accounts of doctors, patients and managers in order to identify similarities and differences in views (Davies & Dodd, 2002; Seale, 1999; Stenbacka, 2001).

3.7.2 Credibility

Credibility was established by careful consideration of ethical, religious and cultural issues, as well as by logically establishing a research method. The researcher aimed to interpret the participant’s or informant’s meaning in the fullest possible sense. Credibility of data is defined by Morse (2002) as confidence in the qualitative data and interpretation of them. The aim of the researcher was to obtain and discover what is needed for the study from the respondents. This was achieved through the truth of the research data and the way the researcher interprets the data (Morse,
In addition, Hoskins (2004) described credibility as assurance of reasonable and persuasive interpretation and conclusions. Within the cultural context, international and Saudi nurses were able to use their own words to explain their opinion about current barriers and facilitators while communicating with patients in Saudi Arabian health settings.

During the initial part of the focus group interviews sessions, the researcher informally discussed whatever issues the nurses raised and gained some understanding of how the nurses felt, what their needs were and what their experience of nursing was. Focus group interview sessions were based around prepared questions that stemmed from the primary research aims.

**3.7.3 Confirmability**

Confirmability refers to the evidence of a research’s goals and objectivity. The researcher ensured that research results accurately represented the current study’s participants’ points of view in phase 1 and 2. Hoskins (2004) indicated that confirmability is the confirmation of findings, conclusions and recommendations by the data obtained. This implies agreement between the researcher’s interpretation and the actual evidence and outcomes. All focus groups were conducted by the same researcher and audio tape-recorded (Huberman & Miles, 2002). The audio recording of the participants’ views facilitated credibility and confirmability of the data collection process. To this end, the researcher’s audit trials and member checking allows other researchers to duplicate the current study and compare their ideas.

**3.7.4 Transferability**

Transferability refers to the extent to which the research results can be applied in other settings or groups as part of the trustworthiness of the research (Morse, 2003). Transferability represents the amount of information that has been
provided within the framework of the research, for instance, describing research respondents and research background and setting (Morse, 2002). Moreover, transferability refers to how the findings are generalised from samples to the whole group (Holloway & Wheeler, 1996), which in this case were both international and Saudi nurses. The researcher drew data from nurses representing a variety of different circumstances. The researcher can be fairly certain of the similarities in rich contextual data on nurses’ communication towards patients regardless of their religion, gender, nationality or educational background. The transferability criterion also focuses on general similarities of findings under similar environmental conditions, contexts or circumstances (Morse, 2002). This means the transferability criterion is about other researchers doing further research along the same lines.

3.13 Ethical Considerations

Approval to recruit the participants was obtained from the Higher Research Ethics Committee of the Royal Melbourne Institute of Technology University (Ethics research number BSEHAPP 07 – 11 ALBAGAWI, see Appendix A). Also, the Hail Region Health Affairs Directorate (see Appendix B) approved special permission prior to collecting information at the selected hospitals. Once a participant was identified, the researcher provided adequate information about the significance and purposes of the study to them. Participants were informed that participation was voluntary. In addition, they were informed about their rights to withdraw from the study at any time or to refuse to answer any particular question. Further, the participants were instructed that their completion of the questionnaire would be considered as written consent for their participation and that the information would be used only for the purposes of this study. Participants were also assured that their responses would be treated confidentially by replacing their names...
with codes. Additionally, information that revealed their identity were not to be recorded and only aggregated data communicated. All completed study questionnaires and the software of the study were saved in locked files that no unauthorised persons could reach, except the researcher.

The researcher took every precaution to protect the participants’ identity by identifying individuals by numeric code rather than name and ensuring that participant names did not appear on any documentation. They also protected the confidentiality of the information that was provided. The researcher also restricted access to collected data to the researcher only, ensuring that transcribed data were checked for accuracy, validated by the participant and de-identified for anonymity prior to sharing results with others.

Each participant in the focus group discussions received the PLS and then signed a consent form. These documents explained to the participants the aim of the study and required participants to sign a provided consent (see Appendix H). The focus group discussions had the same moderator. The moderator, who guided the discussion in the focus groups, asked the participants to keep the names of participants and their contributions confidential. The moderator discussed any concerns with participants and suggested appropriate follow-up if necessary. Participants were informed that the research data would be kept secure at the researcher’s university for a period of five years before being destroyed. Cultural sensitivity (Morse, 2008) was maintained throughout the focus group interviews. The researcher is from Saudi Arabia and has had a lengthy experience in the nursing workforce practices of Saudi Arabia. Both current study phases have had a prior pilot study to predict any possible cultural incongruence posed by the questionnaire
or interview guide questions. Throughout the research, the researcher ensured that participants’ rights were upheld.

3.14 Summary

This chapter provided comprehensive justification for the mixed-method approach to strengthen the study design, and both quantitative and qualitative data were collected and analysed. This chapter provided an inclusive description of the design and methods used in the current study. A simple random and purposive sampling technique was chosen for data collection. The scale measurements and focus group interviews utilised in this study were described and reliability and validity trustworthiness methods outlined. The pilot study provided a valuable perspective regarding the practicalities of conducting the NSACS and focus group interviews with the participants. Ethical guidelines ensured that both privacy and anonymity were upheld.

The next chapter details the phase 1 results that emerged according to the study objectives and questions and theoretical framework.
Chapter 4: Quantitative Results

4.1 Introduction

This chapter presents the data analysis process and the results that form the empirical findings obtained from the quantitative method, namely, the NSACS. Data analysis, according to Brink, Van der Walt and Van Rensburg (2006), entails categorising, ordering, manipulating and summarising the data, whereafter it is described in meaningful terms. There are two main statistical approaches to the quantitative data: descriptive statistics and inferential statistics. This chapter addresses the descriptive statistics, including frequency, mean and standard deviation, and inferential statistics.

4.2 Abbreviations

The abbreviations for the statistics used in the subsequent tables and text are as follows: $\alpha$ = significance level; CI = confidence interval; $F$ = variance ratio; $\lambda$ = Wilk’s lambda statistic, K-S = Kolmogorov-Smirnov test statistic; $M$ = Mean; $Md$ = Median; $N$ = sample size; $n$ = group size; $N$ = sample size; $p$ = probability (p-value) of inferential test statistic; $\eta^2$ = effect size (eta squared); $r$ = Pearson’s correlation coefficient, SD = Standard Deviation, RQ= research question.

4.3 Demographic/Contextual Characteristics of the Nurses:

A total of 267 nurses provided valid responses to the NSACS. The demographic profile of the participants is summarised in Table 4.1. The majority ($n = 192$, 71.9%) were female and most ($n = 185$, 70.9%) were between the ages of 18 and 30 years old. Only about one-third ($n = 97$, 36.3%) of the participating nurses were expatriate, because they were Christians, whereas the majority ($n=161$, 60.3%) were Muslims. About one-half ($n = 138$, 52.5%) were from Saudi Arabia, while
about one-quarter \((n = 72, 27.4\%)\) were Filipino nurses (from the Philippines) and the remainder were Indian, South African or other nationalities. Accordingly, the ethnic/racial background of most of the nurses \((n = 151, 56.8\%)\) was Arabic but with a high proportion of Asians \((n = 112, 42.1\%)\). About half of the participants \((n = 128, 48.1\%)\) were married. About two-thirds \((n = 178, 66.9\%)\) had some college education and a relatively low proportion \((n = 70, 26.3\%)\) were university graduates.

Table 4.1

Demographic Profile of the Participants

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Category</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>75</td>
<td>28.1%</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>192</td>
<td>71.9%</td>
</tr>
<tr>
<td>Age (years)</td>
<td>18–25</td>
<td>83</td>
<td>31.8%</td>
</tr>
<tr>
<td></td>
<td>26–30</td>
<td>102</td>
<td>39.1%</td>
</tr>
<tr>
<td></td>
<td>31–40</td>
<td>54</td>
<td>20.7%</td>
</tr>
<tr>
<td></td>
<td>41–50</td>
<td>13</td>
<td>5.0%</td>
</tr>
<tr>
<td></td>
<td>50+</td>
<td>9</td>
<td>3.4%</td>
</tr>
<tr>
<td>Religion</td>
<td>Islam</td>
<td>161</td>
<td>60.3%</td>
</tr>
<tr>
<td></td>
<td>Buddhist</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td></td>
<td>Hindu</td>
<td>6</td>
<td>2.2%</td>
</tr>
<tr>
<td></td>
<td>Christian</td>
<td>97</td>
<td>36.3%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>2</td>
<td>0.7%</td>
</tr>
<tr>
<td>Nationality</td>
<td>Saudi</td>
<td>138</td>
<td>52.5%</td>
</tr>
<tr>
<td></td>
<td>Filipino</td>
<td>72</td>
<td>27.4%</td>
</tr>
<tr>
<td></td>
<td>Indian</td>
<td>44</td>
<td>16.7%</td>
</tr>
<tr>
<td></td>
<td>South African</td>
<td>2</td>
<td>0.8%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>7</td>
<td>2.7%</td>
</tr>
<tr>
<td>Racial/ethnic background</td>
<td>Caucasian</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td></td>
<td>Arabic</td>
<td>151</td>
<td>56.8%</td>
</tr>
<tr>
<td></td>
<td>American-Indian</td>
<td>2</td>
<td>0.8%</td>
</tr>
<tr>
<td></td>
<td>Asian</td>
<td>112</td>
<td>42.1%</td>
</tr>
<tr>
<td></td>
<td>African</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Marital status</td>
<td>Never married</td>
<td>113</td>
<td>42.5%</td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>128</td>
<td>48.1%</td>
</tr>
<tr>
<td></td>
<td>Living with partner</td>
<td>12</td>
<td>4.5%</td>
</tr>
<tr>
<td></td>
<td>Separated</td>
<td>6</td>
<td>2.3%</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>4</td>
<td>1.5%</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>3</td>
<td>1.1%</td>
</tr>
</tbody>
</table>
The contextual characteristics of the participants are summarised in Table 4.2. Nearly all (n = 250, 95.1%) were employed full-time and more than half (n = 149, 57.7%) had worked in Saudi Arabia before. Over half were experienced (n = 143, 74.4%), with more than 24 months working at the hospital, the remainder having worked there for one to 24 months. Relatively few (n = 30, 11.3%) were very inexperienced, having worked at the hospital for one to four months. Among the 267 participants, the majority (n = 224, 83.9%) had attended specialist courses, of which the most popular were concerned with patient safety policies (n = 72, 78.4%) and communication skills (n = 53, 22.6%).

Table 4.2

**Contextual Profile of the Participants**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Level</th>
<th>Category</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest educational level</td>
<td>Nominal</td>
<td>Primary school</td>
<td>8</td>
<td>3.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Secondary school</td>
<td>10</td>
<td>3.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Some college</td>
<td>178</td>
<td>66.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Undergraduate</td>
<td>36</td>
<td>13.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Postgraduate</td>
<td>34</td>
<td>12.8%</td>
</tr>
</tbody>
</table>

| Occupational status            | Nominal          | Full-time employed    | 250 | 95.1%|
|                                |                  | Part-time employed    | 8   | 3.0% |
|                                |                  | Other                 | 5   | 1.9% |
| Worked in KSA before           | Nominal          | Yes                   | 149 | 57.8%|
|                                |                  | No                    | 109 | 42.2%|
| Time working at hospital       | Ordinal          | 1–4 months            | 30  | 11.3%|
|                                |                  | 4–8 months            | 32  | 12.0%|
|                                |                  | 8–12 months           | 30  | 11.3%|
|                                |                  | 12–24 months          | 31  | 11.7%|
|                                |                  | > 24 months           | 143 | 53.8%|
| Specialist courses undertaken  | Nominal          | Communication skills  | 53  | 22.6%|
|                                |                  | Patient safety policies| 72  | 30.8%|
|                                |                  | Culture program       | 11  | 4.7% |
|                                |                  | Arabic language       | 12  | 5.1% |
|                                |                  | Other                 | 86  | 36.8%|
CHAPTER 4: QUANTITATIVE RESULTS

4.4 Responses to the Questionnaire Items

The frequency distributions of the responses are presented in Table 4.3 (Section 1 personal/social characteristics), Table 4.4 (Section 2, job specifications), Table 4.5 (Clinical situation of patients) and Table 4.6 (Environmental Factors). These data include the missing values, therefore the total number of responses to each item ranged from a minimum of 262 to a maximum of 267. The responses were not normally distributed, but tended to be skewed to the left (indicating disagreement) or to the right (indicating agreement), and therefore the mean and standard deviation were biased estimates of central tendency. The modes and medians were more appropriate to summarise each item. Each table will be discussed in detail as follows.
<table>
<thead>
<tr>
<th>Item</th>
<th>Completely Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Completely Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age difference</td>
<td>11</td>
<td>41</td>
<td>33</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td>Sex difference</td>
<td>2</td>
<td>14</td>
<td>70</td>
<td>25</td>
<td>30</td>
</tr>
<tr>
<td>Nurse's religion</td>
<td>8</td>
<td>41</td>
<td>65</td>
<td>55</td>
<td>22</td>
</tr>
<tr>
<td>Nurse's nationality</td>
<td>6</td>
<td>22</td>
<td>65</td>
<td>33</td>
<td>18</td>
</tr>
<tr>
<td>Unfamiliarity with dialect</td>
<td>4</td>
<td>21</td>
<td>65</td>
<td>25</td>
<td>18</td>
</tr>
<tr>
<td>Social class difference</td>
<td>2</td>
<td>14</td>
<td>65</td>
<td>33</td>
<td>18</td>
</tr>
<tr>
<td>Problems outside work environment</td>
<td>7</td>
<td>25</td>
<td>94</td>
<td>54</td>
<td>40</td>
</tr>
<tr>
<td>Language with patients</td>
<td>6</td>
<td>22</td>
<td>65</td>
<td>33</td>
<td>18</td>
</tr>
<tr>
<td>Opinion toward nursing profession</td>
<td>5</td>
<td>14</td>
<td>65</td>
<td>33</td>
<td>18</td>
</tr>
<tr>
<td>Age difference</td>
<td>1</td>
<td>41</td>
<td>65</td>
<td>55</td>
<td>22</td>
</tr>
</tbody>
</table>

Note: The modes (highest frequencies for each item) are underlined.
Table 4.4  Responses to Section 2, job specifications (Nine items)

<table>
<thead>
<tr>
<th>Item</th>
<th>Job Specifications</th>
<th>Completely Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Completely Disagree</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of welfare facilities for nurses</td>
<td>11</td>
<td>12.9</td>
<td>3.2</td>
<td>7.7</td>
<td>2.7</td>
<td>23.9</td>
<td>110</td>
<td>41.7</td>
<td>3.7</td>
</tr>
<tr>
<td>Low salary</td>
<td>19</td>
<td>7.1</td>
<td>15.7</td>
<td>23.2</td>
<td>24.7</td>
<td>3.49</td>
<td>66</td>
<td>24.7</td>
<td>2.62</td>
</tr>
<tr>
<td>Hard nursing tasks</td>
<td>11</td>
<td>4.1</td>
<td>20.6</td>
<td>25.8</td>
<td>17.6</td>
<td>2.62</td>
<td>47</td>
<td>17.6</td>
<td>3.61</td>
</tr>
<tr>
<td>Heavy nursing work</td>
<td>7</td>
<td>2.6</td>
<td>18.0</td>
<td>18.8</td>
<td>23.6</td>
<td>3.61</td>
<td>53</td>
<td>19.9</td>
<td>3.88</td>
</tr>
<tr>
<td>Patient contact with different nurses</td>
<td>6</td>
<td>2.3</td>
<td>14.0</td>
<td>28.7</td>
<td>28.8</td>
<td>1.04</td>
<td>36</td>
<td>13.6</td>
<td>0.77</td>
</tr>
<tr>
<td>Lack of information &amp; skills in communication</td>
<td>13</td>
<td>4.9</td>
<td>18.3</td>
<td>38.2</td>
<td>10.2</td>
<td>1.04</td>
<td>36</td>
<td>13.6</td>
<td>0.77</td>
</tr>
<tr>
<td>Nurse's burn-out</td>
<td>16</td>
<td>6.0</td>
<td>20.7</td>
<td>31.1</td>
<td>23.1</td>
<td>1.04</td>
<td>76</td>
<td>28.9</td>
<td>3.88</td>
</tr>
<tr>
<td>Low job satisfaction</td>
<td>16</td>
<td>6.0</td>
<td>20.7</td>
<td>31.1</td>
<td>23.1</td>
<td>1.04</td>
<td>76</td>
<td>28.9</td>
<td>3.88</td>
</tr>
<tr>
<td>LACK of interest in work</td>
<td>11</td>
<td>3.8</td>
<td>14.3</td>
<td>38.0</td>
<td>24.7</td>
<td>3.49</td>
<td>53</td>
<td>19.9</td>
<td>3.88</td>
</tr>
</tbody>
</table>

Note. The modes (highest frequencies for each item) are underlined.
Table 4.5

Responses to Section 3, clinical situation of patients (four items)

<table>
<thead>
<tr>
<th>Item</th>
<th>Clinic Situation of Patients</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>History of hospitalization</td>
<td>4</td>
<td>6</td>
<td>22</td>
<td>367</td>
</tr>
<tr>
<td>2</td>
<td>Presence of a helper for providing care</td>
<td>8</td>
<td>12</td>
<td>26</td>
<td>367</td>
</tr>
<tr>
<td>3</td>
<td>Disease severity</td>
<td>8</td>
<td>12</td>
<td>26</td>
<td>367</td>
</tr>
<tr>
<td>4</td>
<td>Having a contagious disease</td>
<td>4</td>
<td>1.15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The modes (highest frequencies for each item) are underlined.
Table 4.6

<table>
<thead>
<tr>
<th>Item</th>
<th>Completely Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Completely Agree</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>Median</th>
</tr>
</thead>
</table>
| 24 Lack of educational facilities                                    | 4 1 19 2 2 3 4       | 1 1 3 2 1 4 1 4 | 1 1 1 2 | 1 1 1 2 | 2 2 2 2 2 2 2 2 | 4 1 1 2 | 1 1 1 2 | 2 2 2 2 2 2 2 2 |...
Table 4.3 indicates that in general: (a) there was disagreement that age difference and problems outside work were a barrier to communication (Md = 2 or 3, Mode = 2); (b) the respondents tended towards neutral or agreement about issues concerned with religion, nationality, social class difference, unfamiliarity with job description and aggressiveness of nurses (Md = 3, Mode = 4); and (c) the respondents agreed that sex difference, unfamiliarity with dialect and too much expectation of patients were barriers to communication (Md = 4, Mode = 4). The reliability of the 10 items was adequate (Cronbach’s alpha = .719).

Table 4.4 indicates that in general: (a) there was disagreement that lack of interest to work was a barrier to communication (Md = 3, Mode = 2); (b) the respondents tended towards neutral or agreement about issues concerned with hard nursing tasks (Md = 3, Mode = 4); and (c) the respondents agreed that lack of welfare facilities for nurses, low salary, heavy workload, shift work, patient contact with different nurses and lack of information and skills in communication were barriers to communication (Md = 4, Mode = 4). The reliability of the nine items was good (Cronbach’s alpha = .781).

Table 4.5 indicates that there was general agreement among the nurses that history of hospitalisation, presence of a helper for providing care disease severity and having a contagious disease were barriers to communication (Md = 4, Mode = 4). The reliability of the four items was adequate (Cronbach’s alpha = .693).

Table 4.6 indicates that there was general agreement among the nurses that lack of educational background in communication skills, lack of continuing education in communication skills, lack of welfare and medical facilities for patients, poor sanitation in patients’ rooms, feeling of injustice at workplace, lack of managerial appreciation from nurses and lack of nurses’ participation in decision-
making were barriers to communication (Md = 4, Mode = 4). The reliability of the four items was good (Cronbach’s alpha = .875).

### 4.5 Factor Analysis

The solution to the factor analysis, copied from SPSS output, is presented in Table 4.7. This factor analysis condensed the 30 items into four factors, each consisting of subsets of inter-correlated items, reflecting the four sections of the questionnaire. The four factors had eigenvalues > 1.0. Factor 1 explained 24.2% of the variance, Factor 2 explained 10.6%, Factor 3 explained 6.5% and Factor 4 explained 5.6%. In combination, the four factors explained 46.9% of the variance.

The factor loadings were consistently positive and > .35, indicating that all the items contributed substantially to their respective factors and were measured in the same logical direction. There was no need to exclude any of the items because they had negative or negligible loadings.

A factor solution is unlikely to be valid if the constructs reflected by the factors are not realistic (Hair et al., 2010). Consequently, the content of the four factors is interpreted. Factor 1 was the most important factor, explaining the highest proportion of the variance. It represented a realistic construct incorporating seven items in Section 4 measuring the barriers to communication related to environmental factors, so it was called the environmental factors scale. Factor 2, explaining less variance was a realistic construct incorporated nine items measuring barriers to communication related to job specifications in Section 2 and so it was called the job specifications scale. Factor 3, explaining less variance, was also realistic. It included 10 items that measured barriers to communication related to personal/social characteristics in Section 1 and therefore it was called the personal/social characteristics scale. Factor 4 explained the least variance and contained the lowest
number of items, but it was also realistic. Factor 4 measured barriers to communication related to the clinical situations of patients using four items in Section 3 and it was therefore called the clinical situations of patients scale.

Table 4.7

*Factor Analysis Solution*

<table>
<thead>
<tr>
<th>Items</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>26 Lack of welfare and medical facilities for patients</td>
<td>.748</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 Lack of continuing education in communication skills</td>
<td>.740</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27 Poor sanitation in patients’ rooms</td>
<td>.738</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 Lack of managerial appreciation from nurses</td>
<td>.729</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 Lack of educational background in communication skills</td>
<td>.675</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Lack of nurses’ participation in decision-making</td>
<td>.671</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 Feeling of injustice at workplace</td>
<td>.662</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Heavy nursing workload</td>
<td>.678</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Hard nursing tasks</td>
<td>.639</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Nurses’ burn-out (physical and mental tiredness)</td>
<td>.635</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 Lack of interest to work</td>
<td>.556</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 Lack of information &amp; skills in communication</td>
<td>.544</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Low salary</td>
<td>.508</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Nursing shift work</td>
<td>.419</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Lack of welfare facilities for nurses</td>
<td>.414</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Patient contact with different nurses</td>
<td>.354</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Nurses religion</td>
<td>.701</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Social class difference</td>
<td>.638</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Sex difference</td>
<td>.605</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Nurses nationality</td>
<td>.590</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Problems outside work environment</td>
<td>.549</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Age difference</td>
<td>.541</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Too much expectation of patients</td>
<td>.510</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Unfamiliarity with nursing job description</td>
<td>.495</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Aggressiveness of nurses</td>
<td>.447</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Unfamiliarity with dialect</td>
<td>.423</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The four factors each contained closely inter-related items and they were sensible and realistic, reflecting their construct validity and reliability and confirmed the structure of the four sections of the questionnaire. The internal consistency reliability of each of the four factors was indicated by the Cronbach’s alpha values (.693 to .875), which were greater than the threshold of .6 conventionally applied to indicate adequate reliability.

4.6 Normality

Because the four factors were reliably measured, it was justified to add up the scores for each factor to create four scales and also to summate the scores for 30 items to create a total score. The frequency distributions of the summative scales for 267 participants approximated bell-shaped curves (see Figure 4.1) reflecting normality. The K-S tests provided no evidence of a statistically significant departure from normality at $\alpha = .01$ (see Table 4.8).
**Figure 4.1** Frequency distribution histograms for the four scales and total scores.

**Table 4.8**

Descriptive Statistics and Tests for Normality of the Four Scales and Total Score

<table>
<thead>
<tr>
<th>Statistics</th>
<th>Personal/Social Characteristics</th>
<th>Job Specifications</th>
<th>Clinical Situation of Patients</th>
<th>Environmental Factors</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>267</td>
<td>267</td>
<td>267</td>
<td>267</td>
<td>267</td>
</tr>
<tr>
<td>M</td>
<td>31.41</td>
<td>31.34</td>
<td>14.46</td>
<td>24.71</td>
<td>101.92</td>
</tr>
<tr>
<td>SD</td>
<td>6.00</td>
<td>6.04</td>
<td>2.66</td>
<td>6.07</td>
<td>15.52</td>
</tr>
<tr>
<td>K-S</td>
<td>1.179</td>
<td>.818</td>
<td>1.504</td>
<td>1.394</td>
<td>.607</td>
</tr>
<tr>
<td>p</td>
<td>.124&lt;sup&gt;ns&lt;/sup&gt;</td>
<td>.515&lt;sup&gt;ns&lt;/sup&gt;</td>
<td>.028&lt;sup&gt;ns&lt;/sup&gt;</td>
<td>.041&lt;sup&gt;ns&lt;/sup&gt;</td>
<td>.855&lt;sup&gt;ns&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

*Note.*<sup> ns</sup> No significant departure from normality at α = .01

Due to the large sample size used in this study, the central limit theorem (CLT) could also be applied for the purpose of parametric testing. The CLT states that the sampling distributions will be approximately normally distributed regardless of the underlying population distribution of data for large sample sizes (Allen & Yen, 2002). In other words, the assumption of normality of the population data need not necessarily be met for large sample sizes, such as N = 267 used in this study.
4.7 Nursing demographic factors that influence the delivery of effective nursing communication towards patients.

Statistical evidence was obtained to provide an affirmative answer to RQ1 (What are the nursing demographic factors that influence the delivery of effective nursing communication towards patients?). The test focused on: Is there a correlation between the personal/social characteristics scale the job specifications scale, the clinical situations of patients scale and the environmental factors scale? The matrix of Pearson’s coefficients based on N = 267 participants (r = .246 to .586) indicated statistically significant positive inter-correlations at α = .05 between the four scales (see Table 4.9). The linearity between the four scales is visualised in Figure 4.2.

Table 4.9

Matrix of Pearson’s Correlation Coefficients (R) between the Four Scales

<table>
<thead>
<tr>
<th></th>
<th>Personal/Social Characteristics</th>
<th>Job Specifications</th>
<th>Clinical Situation of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Specifications</td>
<td>.406*</td>
<td>.246*</td>
<td>.386*</td>
</tr>
<tr>
<td>Clinical Situation of Patients</td>
<td>.246*</td>
<td>.386*</td>
<td></td>
</tr>
<tr>
<td>Environmental Factors</td>
<td>.284*</td>
<td>.586*</td>
<td>.343*</td>
</tr>
</tbody>
</table>

* Statistically significant correlation at α = .05
4.8 nursing demographic factors that influence the delivery of effective nursing communication towards patients

Statistical evidence was obtained using MANOVA to address RQ1 (What are the nursing demographic factors that influence the delivery of effective nursing communication towards patients?). The test focused on: What is the effect of the gender of the nurses on a linear combination of the personal/social characteristics scale, the job specifications scale, the clinical situations of patients scale and the environmental factors scale?

The theoretical assumptions were not violated. Levene’s test indicated that the variances of the dependent variables across n = 75 males and n = 191 females did not deviate from homogeneity at $\alpha = .01$ with respect to personal/social characteristics ($F = .377, p = .540$), job specifications ($F = 4.897, p = .028$), clinical situation of patients ($F = 3.162, p = .077$) and environmental factors ($F = 1.589$, ...)
p = .209). The covariance matrix also did not deviate from homogeneity at \(\alpha = .01\), indicated by Box’s M = 14.907, p = .148. The effect of gender on a linear combination of four dependent variables was not statistically significant at \(\alpha = .01\) (Wilk’s \(\lambda = .981\), F = 1.271, p = .282) and the effect size was negligible (\(\eta^2 = .02\)). The lack of statistical significance is reflected by the strong overlaps between the 95% CIs within each scale in the error bar chart (see Figure 4.3). The mean score of the males (M = 31.65) was similar to the females (M = 31.34) for personal/social characteristics; the mean score of the females (M = 31.54) was similar to the males (M = 30.88) for job specification; the mean score of the females (M = 14.57) was similar to the males (M = 14.17) for clinical situations of patients; and the mean score of the females (M = 25.16) was similar to the males (M = 23.57) for environmental factors (see Table 4.10).

![Figure 4.3](image-url)  
*Figure 4.3 Mean ± 95% CI for the four scales with respect to gender.*
Table 4.10

Mean ± SD for the Four Scales with Respect to Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Personal/Social Characteristics</th>
<th>Job Specifications</th>
<th>Clinical Situation of Patients</th>
<th>Environmental Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>M 31.65</td>
<td>30.88</td>
<td>14.17</td>
<td>23.57</td>
</tr>
<tr>
<td></td>
<td>SD 5.755</td>
<td>6.891</td>
<td>2.896</td>
<td>6.541</td>
</tr>
<tr>
<td>Female</td>
<td>M 31.34</td>
<td>31.54</td>
<td>14.57</td>
<td>25.16</td>
</tr>
<tr>
<td></td>
<td>SD 6.110</td>
<td>5.686</td>
<td>2.570</td>
<td>5.847</td>
</tr>
</tbody>
</table>

Statistical evidence was obtained using MANOVA to address RQ1 (What are the nursing demographic factors that influence the delivery of effective nursing communication towards patients?). The test focus on: What is the effect of the age of the nurses on a linear combination of the personal/social characteristics scale, the job specifications scale, the clinical situations of patients scale and the environmental factors scale?

The theoretical assumptions were not violated. Levene’s test indicated that the variances of the dependent variables across the four age-groups (n = 83, age 18–25; n = 102, age 26–30; n = 54, age 31–40; and n = 22, age 40+) did not deviate from homogeneity at α = .01 with respect to personal/social characteristics (F = 2.501, p = .060), job specifications (F = 2.338, p = .074), clinical situation of patients (F = .697, p = .555) and environmental factors (F = .110, p = .954). The covariance matrix also did not deviate from homogeneity at α = .01, indicated by Box’s M = 29.999, p = .020.

The effect of age on a linear combination of four dependent variables was not statistically significant at α = .01 (Wilk’s λ = .943, F = 1.263, p = .236) and the effect size was negligible (η² = .02). The lack of statistical significance is reflected by the strong overlaps between the 95% CIs within each scale in the error bar chart (see Figure 4.4). The descriptive statistics (see Table 4.11) indicate the similarities
between the scores across the four age-groups with respect to: personal/social
c characteristics (M = 30.48 to 33.00), job specification (M = 30.94 to 31.59), clinical
 situations of patients (M = 13.64 to 14.83) and environmental factors (M = 23.41 to
25.58).

![Figure 4.4 Mean ± 95% CI for the four scales with respect to age.]

Table 4.11

*Mean ± SD for the Four Scales with Respect to Age*

<table>
<thead>
<tr>
<th>Age</th>
<th>Personal/Social Characteristics</th>
<th>Job Specifications</th>
<th>Clinical Situation of Patients</th>
<th>Environmental Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>18–25</td>
<td>M 31.66</td>
<td>31.02</td>
<td>14.83</td>
<td>25.58</td>
</tr>
<tr>
<td></td>
<td>SD 6.506</td>
<td>6.648</td>
<td>2.537</td>
<td>5.939</td>
</tr>
<tr>
<td>26–30</td>
<td>Mean 31.39</td>
<td>31.59</td>
<td>14.47</td>
<td>24.90</td>
</tr>
<tr>
<td></td>
<td>SD 5.194</td>
<td>6.024</td>
<td>2.597</td>
<td>6.070</td>
</tr>
<tr>
<td>31–40</td>
<td>Mean 30.48</td>
<td>30.94</td>
<td>14.06</td>
<td>23.70</td>
</tr>
<tr>
<td></td>
<td>SD 6.768</td>
<td>5.329</td>
<td>2.791</td>
<td>6.245</td>
</tr>
<tr>
<td>40+</td>
<td>Mean 33.00</td>
<td>31.09</td>
<td>13.64</td>
<td>23.41</td>
</tr>
<tr>
<td></td>
<td>SD 4.397</td>
<td>4.407</td>
<td>2.629</td>
<td>5.844</td>
</tr>
</tbody>
</table>
4.9 Cultural factors that influence the delivery of effective nursing communication towards patients.

Statistical evidence was obtained using MANOVA to address RQ2. The test focused on: What is the effect of the nationality of the nurses on a linear combination of the personal/social characteristics scale, the job specifications scale, the clinical situations of patients scale and the environmental factors scale?

The theoretical assumptions were not violated. Levene’s test indicated that the variances of the dependent variables across the three nationality groups (n = 138, Saudi, n = 72, Filipino and n = 53, other nationalities) did not deviate from homogeneity at α = .01 with respect to personal/social characteristics (F = .039, p = .961), job specifications (F = 2.894, p = .080), clinical situation of patients (F = 336, p = .715) and environmental factors (F = 1.974, p = .954). The covariance matrix also did not deviate from homogeneity at α = .01, indicated by Box’s M = 28.530, p = .012.

The effect of nationality on a linear combination of four dependent variables was found to be statistically significant at α = .01 (Wilk’s λ = .890; F = 3.843, p < .001) but the effect size was low (η² = .056). The significant differences between the mean scores across the two nationality groups are reflected by the limited extent of the overlaps between the 95% CIs within the scales in the error bar chart (see Figure 4.5). The descriptive statistics (see Table 4.12) and Scheffé’s pairwise post-hoc tests revealed significant differences between the mean scores of the nationality groups with respect to three scales. The Filipino nurses (M = 34.03) scored significantly higher than the Saudi nurses (M = 30.78) and the other nurses (M = 29.58) on the personal/social characteristics scale. The Filipino nurses (M = 32.11) and the Saudi nurses (M = 31.74) scored significantly higher than the other nurses (M = 29.17) on
the job specifications scale. There was no significant difference between the Filipino nurses ($M = 14.28$) the Saudi nurses ($M = 14.65$) and the other nurses ($M = 14.13$) on the clinical situations of patients scale. The Filipino nurses ($M = 25.00$) and the Saudi nurses ($M = 25.17$) scored significantly higher than the other nurses ($M = 22.89$) on the environmental factors scale.

*Figure 4.5* Mean ± 95% CI for the four scales with respect to nationality.

**Table 4.12**

*Mean ± SD for the Four Scales with Respect to Nationality*

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Personal/Social Characteristics</th>
<th>Job Specifications</th>
<th>Clinical Situation of Patients</th>
<th>Environmental Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saudi</td>
<td>$M = 30.78^{b}$</td>
<td>$31.74^{a}$</td>
<td>$14.65^{c}$</td>
<td>$25.17^{b}$</td>
</tr>
<tr>
<td></td>
<td>SD $5.405$</td>
<td>$6.548$</td>
<td>$2.690$</td>
<td>$6.365$</td>
</tr>
<tr>
<td>Filipino</td>
<td>$M = 34.03^{a}$</td>
<td>$32.11^{b}$</td>
<td>$14.28^{a}$</td>
<td>$25.00^{b}$</td>
</tr>
<tr>
<td></td>
<td>SD $6.459$</td>
<td>$5.242$</td>
<td>$2.759$</td>
<td>$5.363$</td>
</tr>
<tr>
<td>Other</td>
<td>$M = 29.58$</td>
<td>$29.17^{b}$</td>
<td>$14.13^{a}$</td>
<td>$22.89^{b}$</td>
</tr>
</tbody>
</table>
4.10 Religious factors that influence the delivery of effective nursing communication towards patients

Statistical evidence was obtained using MANOVA to address RQ3. The test focused on: What is the effect of the religion of the nurses on a linear combination of the personal/social characteristics scale, the job specifications scale, the clinical situations of patients scale and the environmental factors scale?

The theoretical assumptions were not violated. Levene’s test indicated that the variances of the dependent variables across the two religious groups (n = 161, Islam and n = 106, other religions) did not deviate from homogeneity at α = .01 with respect to personal/social characteristics (F = 1.347, p = .247), job specifications (F = 4.262, p = .030), clinical situation of patients (F = .395, p = .530) and environmental factors (F = 1.172, p = .280). The covariance matrix also did not deviate from homogeneity at α = .01, indicated by Box’s M = 17.716, p = .020.

The effect of religion on a linear combination of the four dependent variables was not statistically significant at α = .01 (Wilk’s λ = .971; F = 1.986, p = .097) and the effect size was negligible (η² = .029). The lack of statistical significance is reflected by the strong overlaps between the 95% CIs within the four scales in the error bar chart (see Figure 4.6). The descriptive statistics (see Table 4.13) indicate that the mean score of the Islamic nurses (M = 31.26) was similar to the other nurses (M = 31.63) for personal/social characteristics; the mean score of the Islamic nurses (M = 30.75) was similar to the other nurses (M = 31.74) for job specification; the mean score of the Islamic nurses (M = 14.74) was similar to the other nurses (M = 14.03) for clinical situations of patients; and the mean score of the Islamic nurses (M = 32.54) was similar to the other nurses (M = 33.01) for environmental factors.

<table>
<thead>
<tr>
<th></th>
<th>SD</th>
<th>5.979^b</th>
<th>5.334</th>
<th>2.504</th>
<th>6.072</th>
</tr>
</thead>
</table>

*Note: Means scores with different superscripts (a or b) are significantly different*
nurses (M = 25.26) was similar to the other nurses (M = 23.87) for environmental factors.

![Chart showing mean ± 95% CI for the four scales with respect to religion.](image)

*Figure 4.6 Mean ± 95% CI for the four scales with respect to religion.*

Table 4.13

**Mean ± SD for the Four Scales with Respect to Religion**

<table>
<thead>
<tr>
<th>Religion</th>
<th>Personal/Social Characteristics</th>
<th>Job Specifications</th>
<th>Clinical Situation of Patients</th>
<th>Environmental Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Islam</td>
<td>M 31.26</td>
<td>31.74</td>
<td>14.74</td>
<td>25.26</td>
</tr>
<tr>
<td></td>
<td>SD 5.575</td>
<td>6.591</td>
<td>2.694</td>
<td>6.248</td>
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<tr>
<td>Other</td>
<td>M 31.63</td>
<td>30.75</td>
<td>14.03</td>
<td>23.87</td>
</tr>
<tr>
<td></td>
<td>SD 6.616</td>
<td>5.050</td>
<td>2.565</td>
<td>5.717</td>
</tr>
</tbody>
</table>

4.11 Organisational factors that influence the delivery of effective nursing communication towards patients.

Statistical evidence was obtained using MANOVA to address RQ4. The test focused on: What is the effect of the time of hospital experience of the nurses on a
linear combination of the personal/social characteristics scale, the job specifications scale, the clinical situations of patients scale and the environmental factors scale?

The theoretical assumptions were not violated. Levene’s test indicated that the variances of the dependent variables across the three experience groups (n = 92, < 1 year, n = 31, 1–2 years and n = 143, > 2 years) were homogeneous at $\alpha = .01$ with respect to personal/social characteristics ($F = .904, p = .406$), job specifications ($F = .122, p = .885$), clinical situation of patients ($F = 1.228, p = .295$) and environmental factors ($F = 4.334, p = .012$). The covariance matrix was also homogeneous at $\alpha = .01$, indicated by Box’s $M = 29.707, p = .094$.

The effect of time of hospital experience on a linear combination of the four dependent variables statistically significant at $\alpha = .01$ (Wilk’s $\lambda = .907; F = 3.255, p = .001$) but the effect size was very low ($\eta^2 = .048$). The significant difference between the mean scores of the three groups is reflected by the limited extent of the overlaps between the 95% CIs in the error bar chart (see Figure 4.7). The descriptive statistics (see Table 4.14) and Scheffé’s pairwise post-hoc-tests revealed significant differences between the mean scores of the three groups with respect to two of the scales. On the clinical situation of patients scale, the nurses with < 1 year experience (M = 15.14) scored significantly higher than the nurses with 1–2 years of experience (M = 13.32) and the nurses with > 2 years of experience (M = 14.25). On the environmental factors scale, the nurses with < 1 year experience (M = 25.49) scored significantly higher than the nurses with > 2 years of experience (M = 24.23) and the nurses with 1–2 years of experience (M = 24.52). There were no significant differences between the mean scores of the three groups on the other two scales. The mean scores across the three groups ranged from 29.90 to 31.87 on the
personal/social characteristics scale and 30.89 to 31.77 on the job specifications scale.

Figure 4.7 Mean ± 95% CI for the four scales with respect to time of hospital experience.

Table 4.14

<table>
<thead>
<tr>
<th>Experience</th>
<th>Personal/Social Characteristics M</th>
<th>Job Specifications M</th>
<th>Clinical Situation of Patients M</th>
<th>Environmental Factors M</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 year</td>
<td>31.16(^a)</td>
<td>30.89(^a)</td>
<td>15.14(^a)</td>
<td>25.49(^a)</td>
</tr>
<tr>
<td></td>
<td>SD 5.824</td>
<td>6.261</td>
<td>2.402</td>
<td>4.943</td>
</tr>
<tr>
<td>1–2 years</td>
<td>29.90(^a)</td>
<td>30.71(^a)</td>
<td>13.32(^b)</td>
<td>24.52(^b)</td>
</tr>
<tr>
<td></td>
<td>SD 7.203</td>
<td>6.599</td>
<td>2.948</td>
<td>6.521</td>
</tr>
<tr>
<td>&gt;2 years</td>
<td>31.87(^a)</td>
<td>31.77(^a)</td>
<td>14.25(^b)</td>
<td>24.23(^b)</td>
</tr>
<tr>
<td></td>
<td>SD 5.824</td>
<td>5.791</td>
<td>2.663</td>
<td>6.612</td>
</tr>
</tbody>
</table>

*Note.* Means scores with different superscripts (a or b) are significantly different
4.12 Organisational factors that influence the delivery of effective nursing communication towards patients.

Statistical evidence was obtained using MANOVA to address RQ4. The test focused on: What is the effect of the nurses attending specialist courses on a linear combination of the personal/social characteristics scale, the job specifications scale, the clinical situations of patients scale and the environmental factors scale?

The theoretical assumptions were not violated. Levene’s test indicated that the variances of the dependent variables across the two groups (n = 33, nurses who had not attended specialist courses and n = 234 nurses who had attended specialist courses) did not deviate from homogeneity at α = .01 with respect to personal/social characteristics (F = 112, p = .738), job specifications (F = 1.558, p = .213), clinical situation of patients (F = 1.009, p = .316) and environmental factors (F = .007, p = .934). The covariance matrix also did not deviate from homogeneity at α = .01, indicated by Box’s M = 7.817, p = .682.

The effect of attending specialist courses on a linear combination of the four dependent variables was found to be statistically significant at α = .01 (Wilk’s λ = .955; F = 3.058, p = .017) but the effect size was very low (η^2 = .045). The significant difference between the mean scores across the two groups is reflected by the limited extent of the overlaps between the 95% CIs in the error bar chart (see Figure 4.8). The descriptive statistics (see Table 4.15) revealed significant differences between the mean scores of the two groups with respect to two of the scales. On the personal characteristics scale, the nurses who had not attended courses (M = 33.03) scored significantly higher than the nurses who had (M = 31.18). On the job specifications scale, the nurses who had not attended courses (M = 33.21) scored significantly higher than the nurses who had (M = 31.08).
No significant differences between the mean scores of the two groups were found for the other two scales. The mean scores for the two groups were 14.58 and 14.44 on the clinical situations of patients scale and 23.70 and 24.85 on the environmental factors scale.

Figure 4.8 Mean ± 95% CI for the four scales with respect to attending specialist courses.

Table 4.15

Mean ± SD for the Four Scales with Respect to Attending Specialist Courses

<table>
<thead>
<tr>
<th>Attending Specialist Courses</th>
<th>Personal/Social Characteristics</th>
<th>Job Specifications</th>
<th>Clinical Situation of Patients</th>
<th>Environmental Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>M 33.03&lt;sup&gt;a&lt;/sup&gt;</td>
<td>33.21&lt;sup&gt;a&lt;/sup&gt;</td>
<td>14.58&lt;sup&gt;a&lt;/sup&gt;</td>
<td>23.70&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>SD 6.028</td>
<td>5.067</td>
<td>2.359</td>
<td>5.950</td>
</tr>
<tr>
<td>Yes</td>
<td>M 31.18&lt;sup&gt;b&lt;/sup&gt;</td>
<td>31.08&lt;sup&gt;b&lt;/sup&gt;</td>
<td>14.44&lt;sup&gt;a&lt;/sup&gt;</td>
<td>24.85&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>SD 5.974</td>
<td>6.124</td>
<td>2.706</td>
<td>6.086</td>
</tr>
</tbody>
</table>
4.13 Summary

A total of (267) nurses participated in this study. The majority were female and most were Muslims from Saudi Arabia or Christians from the Philippines between the ages of 18 and 30. Consequently, the ethnic/racial background of most of the nurses was Arabic but with a high proportion of Asian background. About half of the participants were married, about two-thirds had some college education and a low proportion were university graduates. Nearly all were employed full-time and most had worked in Saudi Arabia before. Over half were experienced, with more than 24 months working at the hospital. Relatively few were very inexperienced. The majority had attended specialist courses.

The responses to the individual questionnaire items were not normally distributed, therefore the modes and medians were used to interpret the scores. In general: (a) there was disagreement that age differences, problems outside work and lack of interest to work were barriers to communication (Md = 2 or 3, Mode = 2); (b) the respondents tended towards neutral or agreement about issues concerned with religion, nationality, social class difference, unfamiliarity with job description and aggressiveness of nurses and hard nursing tasks (Md = 3, Mode = 4); and (c) the respondents agreed that sex difference, unfamiliarity with dialect and too much expectation of patients, lack of welfare facilities for nurses, low salary, heavy workload, shift work, patient contact with different nurses, lack of information, history of hospitalisation, presence of a helper for providing care disease severity and having a contagious disease were barriers to communication. In addition, lack of educational background in communication skills, lack of continuing education in communication skills, lack of welfare and medical facilities for patients, poor
sanitation in patients’ rooms, feeling of injustice at workplace and lack of managerial appreciation from nurses were also barriers to communication (Md = 4, Mode = 4).

Four reliably measured scales (Cronbach’s alpha ≥ .7) were extracted from the 30 items, specifically: Section 1: personal/social characteristics scale (10 items); Section 2: job specifications scale (9 items); Section 3: clinical situations of patients scale (4 items); and Section 4: the environmental factors scale (7 items). A factor analysis confirmed the four-dimensional structure of the questionnaire.

Evidence was provided using correlation analysis to support RQ1: The barriers to communication of the nurses relating to personal/Social characteristics, job specifications, clinical situations of patients and environmental factors were significantly and positively correlated with each other. A matrix of Pearson’s correlation coefficients and scatterplots indicated significant linear relationships at α = .05 between the four scales. The inter-correlation of the four scales justified the use of MANOVA to address RQ1 to RQ4.

Evidence was provided using MANOVA to address RQ1: What is the effect of the gender of the nurses on a linear combination of the personal/social characteristics scale, the job specifications scale, the clinical situations of patients scale and the environmental factors scale? The answer is that the effect of gender was found to be not statistically significant.

Evidence was provided to support RQ2: What is the effect of the nationality of the nurses on a linear combination of the personal/social characteristics scale, the job specifications scale, the clinical situations of patients scale and the environmental factors scale? The answer is that the effect of nationality was found to be statistically significant, although the effect size was low. The Filipino nurses scored higher than the nurses of other nationalities on the personal/social
characteristics scale. The Filipino nurses scored higher than the other nurses on the job specifications and environmental factors scales. There was no difference between the three groups of nurses on the clinical situations of patients scale. The implications are that Filipino nurses perceived greater barriers to communication with respect to personal/social characteristics, job specifications and environmental factors than the nurses of other nationalities; however, this effect was relatively small and may have limited practical/clinical significance.

Evidence was provided to address RQ3: What is the effect of the religion of the nurses on a linear combination of the personal/social characteristics scale, the job specifications scale, the clinical situations of patients scale and the environmental factors scale? The answer is that the effect of religion was found to be not statistically significant.

Evidence was provided to support RQ4: What is the effect of the time the nurses had worked at the hospital on a linear combination of the personal/social characteristics scale, the job specifications scale, the clinical situations of patients scale and the environmental factors scale? The answer is that the effect of experience was statistically significant, although the effect size was low. On the clinical situation of patients scale and the environmental factors scale, the nurses with less than one year experience scored higher than the nurses with longer experience. There were no differences between the mean scores of the three groups on the other two scales. The implications are that nurses with shorter experience perceived greater barriers to communication with respect to the clinical situation of patients and the environmental factors than the nurses with longer experience; however, this effect was relatively small and may have limited practical/clinical significance.
CHAPTER 4: QUANTITATIVE RESULTS

Evidence was provided to support RQ4: What is the effect of the nurses attending specialist courses on a linear combination of the personal/social characteristics scale, the job specifications scale, the clinical situations of patients scale and the environmental factors scale? The answer is that the effect of attending specialist courses was statistically significant, although the effect size was low. On the Personal Characteristics Scale and the job specifications scale, the nurses who had not attended courses scored higher than the nurses who had attended courses. No significant differences between the mean scores of the two groups were found for the other two scales. The implications are that nurses who had not attended specialist courses perceived greater barriers to communication with respect to personal characteristics and job specifications than the nurses who had attended courses; however, this effect was relatively small and may have limited practical/clinical significance.

The next chapter discusses the phase 2 results.
Chapter 5: Qualitative Results

5.1 Introduction

This chapter discusses the results of the second phase of data collection, phase 2 qualitative data, and provides an analysis. Using purposive sampling of focus group informants drawn from phase 1, the analysis enabled the cultural variation responses to be highlighted. Primary data were collected by way of four focus groups using semi-structured interviews. The interpretation of focus group interview data enabled concepts and relationships to be organised thematically. Textual and verbatim examples from the focus groups discussions served to provide and address research questions.

Data collected from the focus groups was coded systematically and thematic analysis was performed, allowing the categories to emerge freely from the combined focus groups data. Member checking and associated debate and concurrent agreement then took place to maintain rigor. Subsequently, the most contextually rich statements that were relevant to the identified thematic analysis were then selected to represent the participant’s experience and perceptions (Morse, 2003). This chapter concludes by outlining all research questions specifically (research questions 5 and 6) and how theses research questions were addressed by the qualitative results.

5.2 Description of Population and Sampling

The focus group sample population comprised a purposive sample of nurses, drawn from phase 1 results as outlined in Chapter 4, from the five hospitals in the Hail region of Saudi Arabia. These public hospitals offer free healthcare services for local Saudi nationals and international patients. The five sampled hospitals
encompass approximately 3000 nursing and non-nursing positions, employing personnel of over five different nationalities.

Recruitment to the focus groups was based on consent obtained on completion of the quantitative component of the survey and then further selecting a purposive sample of high and low scorers from the analysis of phase 1 data. Another purposive criterion was that of cultural representation of nationalities and religion of the sample population, such as Arabic and Asian nurses as well as Muslim and Christian nurses. The third purposive criterion was that of length of hospital service. The inclusion criteria for participants were: registered nurses between 20 to 60 years old, employed full-time for more than four months in Ministry of Health hospitals and able to read and understand English. A total of 34 consenting participants were invited from phase 1 and were from either Saudi Arabia, the Philippines, India or Indonesia. Upon completion of the focus groups, 23 participants were selected to engage in four independent focus groups sessions (see Section 3.5.2 and Table 5.1). The 23 participants that were selected as the final sample were registered nurses aged between the ages of 24–30 years and comprised 11 males and 12 females. The years of clinical practice, education and work settings also varied. Table 5.1 presents the demographical composition of the semi-structured focus groups.
Table 5.1

<table>
<thead>
<tr>
<th>Focus Group 1</th>
<th>Age</th>
<th>Gender</th>
<th>Background</th>
<th>Nationality</th>
<th>Religion</th>
<th>Hospital Experience (Years)</th>
<th>Continuing Education Courses 'If Any'</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29</td>
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<td>Arabic</td>
<td>Saudi Arabian</td>
<td>Islam</td>
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<td>Saudi Arabian</td>
<td>Islam</td>
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<td>Asian</td>
<td>Filipino</td>
<td>Christian</td>
<td>6</td>
<td>Arabic language</td>
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<td>Filipino</td>
<td>Christian</td>
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<td>Saudi Arabian culture program</td>
</tr>
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<td>Asian</td>
<td>Indonesian</td>
<td>Islam</td>
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</tr>
</tbody>
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<table>
<thead>
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<th>Background</th>
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<th>Religion</th>
<th>Hospital Experience (Years)</th>
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<td>Saudi Arabian</td>
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<td>Communication skills</td>
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<tr>
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<td>Filipino</td>
<td>Christian</td>
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<td></td>
<td>29</td>
<td>Female</td>
<td>Asian</td>
<td>Indian</td>
<td>Christian</td>
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<td>Saudi Arabian culture program</td>
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</table>

<table>
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<tr>
<th>Focus Group 3</th>
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<th>Gender</th>
<th>Background</th>
<th>Nationality</th>
<th>Religion</th>
<th>Hospital Experience (Years)</th>
<th>Continuing Education Courses 'If Any'</th>
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</thead>
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<tr>
<td></td>
<td>30</td>
<td>Male</td>
<td>Arabic</td>
<td>Saudi Arabian</td>
<td>Islam</td>
<td>4</td>
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<tr>
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<td>27</td>
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<td>Arabic</td>
<td>Saudi Arabian</td>
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</tr>
<tr>
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<td>Arabic</td>
<td>Saudi Arabian</td>
<td>Islam</td>
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<td>Asian</td>
<td>Filipino</td>
<td>Christian</td>
<td>1</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>30</td>
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<td>Asian</td>
<td>Filipino</td>
<td>Christian</td>
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<td>Indian</td>
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<table>
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<th>Gender</th>
<th>Background</th>
<th>Nationality</th>
<th>Religion</th>
<th>Hospital Experience (Years)</th>
<th>Continuing Education Courses 'If Any'</th>
</tr>
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<td>Communication skills</td>
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<td></td>
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<td>Arabic</td>
<td>Saudi Arabian</td>
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<td>N/A</td>
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<tr>
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<td>Saudi Arabian</td>
<td>Islam</td>
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<td>Islam</td>
<td>6</td>
<td>Communication skills</td>
</tr>
</tbody>
</table>
CHAPTER 5: QUALITATIVE RESULTS

The emerging themes were categorised into three macro themes: personal, professional and organisational communication barriers and facilitators (see Table 5.2). Each extracted code was matched to a related focus group by using the participant’s pseudonym and focus group number. For example: extracted codes by a participant from focus group 1 was matched as (Terry, FG 1). The results of the focus group discussions highlighted the necessity to suggest measures that could be implemented to counteract the communication barriers described above.

The table below summarises the categories, themes and subthemes arising during the various sessions, presenting the nurses’ perspective of communications barriers and suggested facilitators towards improving nursing communication with patients and their families (see Table 5.2).

Table 5.2

<table>
<thead>
<tr>
<th>Categories</th>
<th>Themes</th>
<th>Subthemes</th>
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<tbody>
<tr>
<td>Personal facilitators and barriers</td>
<td>Language barriers</td>
<td>Arabic is a difficult language to learn</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Different dialects</td>
</tr>
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<td>Cultural barriers</td>
<td>Religion differences</td>
</tr>
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<td></td>
<td></td>
<td>Ramadan and fasting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of traditional ‘Arabic medicine’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Influences of demographic characteristics on communications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Impact of pain on communication</td>
</tr>
<tr>
<td></td>
<td>Gender barriers</td>
<td>Refusing care from male nurses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Saudi female nurses preference not to work with male patients</td>
</tr>
<tr>
<td></td>
<td>Personal adaptation to facilitate communication</td>
<td>Acceptance and trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Influence of life events</td>
</tr>
<tr>
<td>Professional influences</td>
<td>Salary levels</td>
<td>Nurses salary and communication</td>
</tr>
<tr>
<td></td>
<td>Professional assistance from senior colleagues</td>
<td>Prior experience with language and culture</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Role modelling</td>
</tr>
<tr>
<td></td>
<td>Nursing workload</td>
<td>Nurses’ shortages and time limitations</td>
</tr>
</tbody>
</table>
### 5.3 Personal Facilitators and Barriers

This category related to the personal concerns that faced nurses while communicating with patients in KSA hospital settings. Language in particular was an important theme that presented a communication barrier. Additional barriers were where the cultural diversity of the workforce posed contradictions to communication capabilities. This theme of culture was also linked to gender and gender norms arising from the mixed ethnic background of the nurses when communicating with Saudi nationals.

#### 5.7.1 Language barriers

Language barriers identified included poor communication due to lack of a common language for the workforce in such a multicultural setting. Language barriers were attributed to three factors. First, Arabic was considered to be a complex language to learn and speak and therefore often too difficult for international workers to adopt (Habash & Sadat, 2006). Second, dialect, whereby the same language was being used but different regional areas used different dialects or where

---

| Influence of work shifts | Nurses shifts preference  
| Shift work influencing tiredness and poor moods |
| Organisational communication facilitators | Need for professional translators  
| Multilingual signs in the hospital |
| Suggestions for workforce policy | Insufficient knowledge of the culture of the new country  
| Hospital guidelines |
| Organisation Strategies | Multicultural teams and communication  
| Job descriptions |
| Need for educational orientation programs | Use of documentation  
| IPhone programs raise communication effectiveness |

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#### 5.7.1 Language barriers

Language barriers identified included poor communication due to lack of a common language for the workforce in such a multicultural setting. Language barriers were attributed to three factors. First, Arabic was considered to be a complex language to learn and speak and therefore often too difficult for international workers to adopt (Habash & Sadat, 2006). Second, dialect, whereby the same language was being used but different regional areas used different dialects or where
a word in one dialect meant a different thing in another dialect. Third, most local patients, being predominately elderly, did not speaking English, which compounded this situation for the non-Arabic workforce. English remains the most widely used language between staff in Saudi Arabian health sectors. All four focus groups frequently referred to language as a key barrier to effective communication depicted.

5.3.1.1 Arabic being a difficult language

There were regular testimonies that Arabic was a difficult language to learn and especially challenging especially among the international nurses. For example:

Arabic is not an easy language, as I was assuming. I have applied for many courses in order to understand the culture and deal with different situations that could face me here. (Terry, FG 1)

One female participant from India in focus group 2 described that most hospitals used Arabic only in patients’ files and documents, highlighting the negative consequences for nurses who were not conversant in Arabic phrases. She stated:

There is one more problem: if we are able to use writing with Arabic … always we are not able to read or write [Arabic] names … sometimes we ask somebody what is name [patients’ names] so they will tell us the patients name and the standard pronunciation. (Susan, FG 2)

This statement was affirmed by the majority of the participants, in particular international nurses, who reported numerous communication breakdowns due to language. For example:

Nurse language barriers is one of the barriers that face us as non-Saudi nurses because we are dealing with the majority of the patients being Saudi … from a different language … can’t easily understand what they say … they can’t
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also understand what we can say … also for Saudi nurses and how they can understand and communicate with non-Saudi patients. (Danny, FG 3)

These testimonies indicated that for nurses to communicate with Arabic patients an average Arabic language proficiency was required and Arabic courses or workshops for newly employed expatriates nurses were lacking.

5.3.1.2 Different dialects

It was commonly reported from all the focus group participants that language was the major barrier to communication, with the difference in dialect being very challenging, particularly among non-Saudi nurses. However, many Saudi participants acknowledged that dialect was a huge barrier for them as well when communicating with patients with unfamiliar dialects because these patients expressed their phrases differently. For example:

The Baqaa people have their own language and the Ashammari people have their own language: the manner on how they speak the Arabic language is different. (Rasna, FG 2)

Many senior international nurse participants faced similar communication problems while practicing the local dialect with patients. One participant from Philippines described her challenging experience when communicating with patients from rural areas:

Sometimes I need assistance from my colleagues, who are experienced in this field or who have much better knowledge … it’s not about the language itself but it’s sometimes even with the dialects. (Hass, FG 3)

There was also general agreement that even among Saudi nurses, the various dialects from different regions presented language communication difficulties:
I worked in a small hospital before and I had some problems with the local people even though I’m Saudi. They have their own expressions; they have their own words for describing the pain or describing the procedures. When I’m going to explain to them, they don’t understand, some of them. This affects my communication with them. (Hass, FG 3)

This statement acknowledged that the specific dialects were challenging for both international and local nurses. When international nurses commenced employment, they testified to needing extra effort to explain their nursing care in Arabic language for patients from rural areas. This was suggested to be both complex and imply communication breakdown not only in language but differing cultural values and norms between nurses and between nurses and patients from diverse cultural backgrounds, which caused further tensions. Different cultures held distinct views on various social issues such as gender norms, health beliefs, values, family life, perceptions of pain and matters of life and death; some practices appeared to be unacceptable to the nurses, while they were the norm in the Saudi culture.

Hence, discussions from focus group 2 highlighted an issue for international nurses, that it was a challenge to successfully commence a career in Saudi Arabian hospitals without an earlier educational and contextual exposure to the culture norms and languages and dialects:

We have our own culture, even Saudi people have their own culture … you cannot explain it properly by cultural things, you just perceive and accept.

(Susan, FG 2)

One participant from India described her experiences of cultural complexity as well as the complexity of engaging with different dialects:
If the patient is Bedouin, it is going to be too much [difficult] but most of the time with me it is easy with a Saudi … it was maybe difficult when I was new, but after that I had no problem. (Rasna, FG 2)

In this case, the nurse seemed to be well-versed in the Saudi culture, but at the same time, the initial difficulties experienced were still felt keenly.

5.7.2 Cultural barriers

The key element related to cultural barriers appeared to result from inexperience with Arabic culture. This included nurse communications with patients from different Saudi backgrounds as well as communications with local or foreign patients. In all the focus groups, it was common to have experienced cultural barriers arising from differences between the nurses and patients. One such example in Saudi hospitals’ organisation was the use of traditional ‘Arabic medicine’ among Arabic patients. This issue was a concern in that not all international nurses understood and were thus surprised. Focus group participants stated that Saudi patients used traditional medicine without permission or consulting of their assigned doctors and nurse. Further, the mode of communication used by the nurses for children and the older patients also posed a major challenge and may lead to medical errors.

5.3.2.1 Religious differences

In Saudi Arabia, the Arabic religious basis means the Saudi patients have created an environment that is poorly understood by the majority of foreign nationals. Therefore, it follows that non-Muslim nurses may have difficulties adapting to the centrality of religion and culture in the daily life and health practices of their patients. One powerful example of this divergence is the practice of Ramadan, which can be seen to violate standard healthcare treatment protocols. During the holy month of fasting, the focus group discussions reported patients
avoiding meals in order to observe religious laws and that this was not in-line with the medication regimen or treatment directions by doctors and nurses. Even though Islamic law says that sick people need not fast and that missed fasts can be compensated for by later fasting or fidyah, local or family traditions may prevent this, causing conflict with nursing staff that may place the patient’s treatment needs as a higher priority than their faith.

The holy month of the fast is strictly observed in Saudi Arabia and the religious belief frequently contradicts with health service protocols. Some patients wanted to observe the law of Ramadan, so they would fast and not take their medication. One participant in focus group 2 noted:

It is really hard because the first time I came here, I asked one mamma, ‘I need to do injection in your buttocks’. That time she was fasting and she told me, ‘I cannot take any injection while I am fasting’. (Mary, FG 2)

Another participant highlighted the same issue related to religious differences. She said she was untrained to guide the patients through appropriate medication procedures during fasting, especially in Ramadan:

Sometimes in fasting times they will ask us—we are not Muslim [nurses] and they are Muslims [patients]—whether they can take an injection or IV fluid, if it will break the fasting or not because of this religious problem. We don’t know the complete details about fasting. (Rasna, FG 2)

This lack of knowledge on the importance and nature of religious practices resulted in nurses testifying to feeling they were outside of their scope of practice when communicating with patients. Further, nurses saw these religious practices as having a potential negative impact on the health of a patient. This posed a conflict between best professional practice and the cultural belief systems of patients.
Likewise, patient background, life style and level of education were inhibiting to effective communication and high quality of healthcare. One female participant stated:

I think because most of the people are from rural areas here their language … I cannot understand what they are talking about … they told me this is not in the Arabic dictionary, some words. (Mary, FG 2)

This unfamiliarity and confusion with the language made it difficult for the international staff to establish the actual health concerns being experienced by their patients.

5.3.2.2 Use of traditional ‘Arabic medicine’

The focus group discussion also reported complexities of cultural health beliefs and treatment systems in their Arabic patients inherent cultural ‘norms’, which were seen to hinder cultural assimilation and healthcare outcomes. It was seen at times to affect the ability of the nurses to perform their role as well as they were capable of doing in their country of origin. An example is seen in the way in which traditional Arabic medicine is acceptable as a parallel treatment path in Saudi Arabia, alongside Western bio-medicine, for local KSA nationals, whereas commonly the nurses testified that they saw this as highly dangerous or ineffective. This conflict in beliefs between international nurses and local patients coupled with communication challenges was seen to add to the stress of treatment for both parties.

In particular, the older generation of Saudis have a different perception of the role of traditional medicine that is contradictory to the perceptions and training of modern health practitioners. One participant stated:
They are used to being treated using traditional medication and when we start to intervene with our ways in the treatment, the Western way, the Western medicine …. (Hamid, FG 4)

This suggests that these older patients do not appear to value the modern treatment methods because they perceive them as a negative influence from the West and prefer to adhere to their native ways of treatment to seek protection.

5.3.2.3 Influences of demographic characteristics on communications

The majority of participants affirmed that extra precautions were needed when delivering nursing care or communicating with both geriatric and paediatric patients in Saudi Arabia. Paediatric patients needed communicate through their parents and not directly. A participant in focus group 1 stated that:

I think a lot of the barrier is this developmental level of your patients, for example, if there is a child or if there are adults or even the elderly, then … the way you communicate is different … also with baby communication. (Terry, FG 1)

Another participant in focus group 1 confirmed that flexible nursing care delivery was vital in facilitating communication when providing nursing care to the Arabic paediatric patients: ‘because they need private care and support’ (Bader, FG 1). In focus group 2, the facilitator posed a question about the importance of following communication guidelines when administering nursing care to children. There was unanimous agreement from all the groups’ participants regarding the need for clear guidelines in paediatric activities.

Danny from the Philippines reported having faced many obstacles nursing geriatric patients. He reported:
I observe that, especially the old people, they are not explaining their pain clearly, they try to just keep it and are just trying to deal with it. (Danny, FG 3)

There was a suggestion from focus group 3 that it might be useful to utilise social workers as mediators between the patients and the nurses to enhance communication barriers.

5.3.2.4 Impact of pain on communication

Pain was a major hindrance to effective communication between the patients and the nurses, with the extremely ill patients further exacerbating the situation. It has been noted that it is taboo for the people of Saudi Arabia to complain about pain, making it difficult for nurses to establish what is wrong with the patient (Al-Sejari, 2005). Vague physical symptoms substitute for anxiety or depression because Middle Easterners lack concepts that distinguish mental states from physical states and their experience does not permit them to carefully describe signs and symptoms as they are associated with different parts of the body. From a discussion in focus group 3, it was noted that:

Saudi patients, they can’t explain their pain sometimes for religious reasons.

As a foreigner nurse, I didn’t know that about the Saudi culture and that could affect the patient and how they could explain their pain. (Fayez, FG 3)

In summary, many participants agreed that patients were not compliant with pain management regimes for religious reasons. One participant in focus group 3 reported:

I was waiting for the patient to complain to me when they feel pain but I found out later as my friend said I have to ask the patients because they don’t
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complain, this is based on their culture and their beliefs. They don’t complain so I have to ask in between whether they have pain or not. (Maryama, FG 3)

Thus the cultural tendency of patients to conceal their pain was an issue for both local and international nurses. One international nurse from the Philippines said:

Well, as a Filipino, we express the pain … Whether you are male or female, it’s the same. Here, I observe it’s different. I observe that especially the old people, they are not explaining their pain clearly. They try to just keep it [to themselves] and just try to deal with it. (Danny, FG 3)

This testimony highlights the ensuing cultural shock among the nurses and confusion between nurses and patients. Such tension poses major impediments to effective service delivery since the nurse may not fully be able to assess the patient’s condition, leading to under-medication.

It was further reported in the focus group that that there was a wide spread use of non-verbal styles of communication in the Saudi culture, increasing the difficulties experienced by international nurses who are not aware of or practiced in such non-verbal language. The ability of nurses and patients to share non-verbal information was critical during nursing care. Non-verbal commutation appeared frequently as a challenging issue in the focus group participants’ comments. Terry confirmed:

This non-verbal communication, these gestures, if you cannot explain it literally or you can’t explain it in their own dialect, at least in your action the way you act it, maybe you can relay what you mean with them. (Terry, FG 1)

Indeed, one participant confirmed that sign language and actions were useful tools during nursing care delivery:
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You cannot explain, but because of your gestures … by action, then that can help you come across with the patient … most of the patients are cooperating, they know that we don’t know their language, so they will come with us [and] they will ask somebody or by [our] actions, they can understand. It’s good. (Mary, FG 2)

5.7.3 Gender barriers

Gender constitutes a powerful category of social inclusion and exclusion in a cultural context of Islam and in particular in Saudi Arabia. From the perspective of the local nurses, the most common and contributing factors that influence Saudi female nurses were that the nature of their work requires mingling with men and that the resulting negative public perception may jeopardise their reputation and marriage prospects (Almutairi, Moradi, Idrus, 2002). Many Saudi families look upon the medical profession, whether as a doctor, nurse, technician or administrative staff, as an inappropriate place for women to work.

In the KSA, the medical employment sector is one of the few places of employment where unrelated men and women have to be in contact with one another. Many Saudi husbands, fathers and brothers are very wary of having their female relatives exposed to such an environment, regardless of their family member’s background, professional qualifications or the need for gainful employment. As a result, some Saudi female nurses have a preference to work with female patients and male patients tend to be uncomfortable being attended to by male nurses. Various studies reported the sensitive issue of favouring patients based on their race or gender is considered an important ethical issue by the majority of clinicians within a Middle Eastern context (Saeed, Mohammed, Magzoub & Al-Doghaither, 2001; Aboshaiqah, 2013; Manojlovich & DeCicco, 2007). Thus there
are two main issues: male patients refusing care from male nurses and the Saudi female nurse preference not to work with male patients.

5.3.3.1 Refusing care from male nurses

A commonly perceived barrier among the focus group participants reflected the cultural differences between nurses and patients related to gender roles and equality of the sexes. An additional difficulty experienced by participants was the way in which religious beliefs affected gender role expectations and behavioural protocols in clinical area rules. For example, participants noted that some Saudi nurses could not attend to male patients in various circumstances:

Some males here refuse injection, dressings … in ER they are refusing male nurses, even if they give IV cannula, dressings, IM injections. (Katrina, FG 1)

5.3.3.2 Saudi female nurses preferring not to work with male patients

The Saudi Arabian customs and culture have led to gender separation in nursing care in KSA hospitals. Some of these cultural separations affect gender relations and therefore become a factor when delivering healthcare. For example, male patients may not want to be cared for by a female nurse and or a Saudi female nurse.

They don’t want to do [procedure/care] with a Saudi female, even female staff. They are not interested to do [anything] with that Saudi nurse … for example, in the delivery room, all people know one female Saudi was assigned there, but the female delivery patients, they refused to be handled by a Saudi female nurse. Nobody accepts a Saudi nurse in the delivery room, [or] even in the ward, giving IV fluid. (Connie, FG 1)
5.7.4 Personal adaptations to facilitate communication

The need for nurses to consistently make personal adaptations in order to provide effective nursing communication with patients was noted frequently by focus group participants. This theme consisted of two main subthemes: professional acceptance and trust and another related to the individual nurses’ personal life experience.

5.3.4.1 Acceptance and trust

A notable aspect of the focus group discussions was a belief that many Saudi patients preferred the international nurses since they felt they could trust them more, as the international nurses were perceived to abide by more ethical and professional conduct. From the participant’s perspective, this had a positive effect on the Saudi patients, as they commented that the foreign nurses were very nice people with whom they could communicate freely.

Most expatriate nurses’ personal cultural adaptations were cited to arise from their professional orientation into the Saudi Arabia government rules and professional acceptance of health system regulations in their new country of employment. As noted by several participants in the second focus group, patients knew that the nurses had to observe the laws of the land and that consequently this helped them win the trust of the local people, which assisted with consistent communication:

We are here, the religion is Islam and we have to respect it. Accept and respect, it must be like that. We don’t neglect any rules here. We are obeying the rules … We should obey because this is not our country, this is the country of Saudis … We come here to work and we must obey what the rules and regulations they are implementing. (Susan, FG 2)
Similarly in respect to the building of trusting relationships, Connie, a nurse from the Philippines, expressed that Saudi patients trusted international nurses more than Saudi nurses. The nurses testified that this boosted their self-esteem and respect for their host country’s government and improving communication and service delivery.

5.3.4.2 Influence of life experiences

Nurses reported trying not to mix their social and their professional lives, mainly by focusing on the patients so as to disengage from any pressing personal emotional situation often exacerbated from living in a new and very foreign culture. At the same time, at one point or another, they all reported being affected at work by their home life, coupled with the complexity of living in a new country. One participant Mary, reported:

If the problem is so serious where that will already affect your thinking, you’re emotionally unstable. Because of the seriousness of the problem, then maybe that will affect you, but if not that serious we can always manage.

(Mary, FG 2)

The following section will critique the themes of professional barriers and facilitators to communications that emerged from the focus group.

5.4 Professional Influences

The second thematic category was related to the barriers in the profession’s requirements. This featured career motivation, nursing workload and the influence of shift work, which were seen to pose negative influences. In contrast, professional assistance and support from senior nursing colleagues was described as a positive communication facilitator.
5.7.1 Salary levels

Pay incentives were cited to provide important motivators to attract and retain nurses in long-term employment in the KSA. It was seen by the focus group as important to provide a desirable incentive system to attract and motivate Saudi and non-Saudi nurses to work in Saudi Arabian governmental hospitals. A recent study found that nurses in Saudi Arabia with low salaries had high levels of stress (Al-Ahmadi, 2009). Long-term nursing job-related stress factors can affect physical as well as mental health, which in turn impacts the quality of nursing care provided. However, this in itself does not necessarily mean that nurses on a higher salary were more motivated in terms of ensuring patient safety than patients on a lower salary, more that the stress of a low salaried position coupled with the stresses of nursing could have had a negative effect on patient care.

5.4.1.1 Nurses salary and communication

Several participants in the focus groups acknowledged that nurses’ communication may be indirectly affected by the salary earned. Both international and local focus group participants believed that salary was very important as it served as a motivation for them to work hard and acquire more professional knowledge:

We will be inspired to work more to deal more with the patient, it’s like inspiration to work. We should be honest to say that we are here to work only actually … my salary’s very low but when our salary becomes high of course we are more inspired to work. (Connie, FG 1)

In contrast, some participants felt that nurses’ salaries did not have an effect on communication with patients and the level of professional nursing care that was offered. Saudi nurses confirmed that salary increments would not necessarily
motivate them with regard to maintaining patient rights: ‘salary is important; however, I will deal with the patient as his position’ (Fatimah, FG 1).

5.7.2 Professional assistance from senior colleagues

The nurses generally reported that they could rely upon the senior nurses, doctors and social workers to help them, especially when communicating clearly with patients during busy shifts. This in turn motivated the junior nurses, who aspired to attain a senior position and to continue to attain higher levels of quality through training and experience, a finding in common with the work of Al-Ahmadi (2009). The nurses agreed that having a background knowledge of the Saudi culture and language handed down to them from the experienced nurses would be very helpful during their professional career.

Subthemes captured were prior experience with Saudi language and culture as well as the influence of role models.

5.4.2.1 Prior and ongoing knowledge of language and culture

Newly employed nurses should have prior knowledge about Arab society, particularly regarding specific routine healthcare and emergency care situations in which religion may impede effective communications. Maryama, an Indian nurse, affirmed that certain cultural and religious books provided by her hospital were really useful in helping her to understand the Muslim religion:

As an international nurse, I think it’s useful because they support us with booklets [religious books], which help us to work easily within a new culture or with a new patient [culture] … I think it’s easier to take care of the patient and improve our communication. (Maryama, FG 3)
Another participant from the Philippines, indicated that educational programs were helpful, especially for newly appointed international nurses in Saudi Arabia. She said:

I think to improve the communication with the patients and the nurses, we need to give them (the foreigner nurse) some knowledge about our culture, so I think the directors of the hospitals, they need to set up some educational programs to develop their [knowledge] to sort this matter. (Remy, FG 3)

Danny, however, argued that the training sessions he received were commonly concentrated on general facts about Saudi society. His reflection was:

It’s just about general phrases and general information about religion and these things, but it’s not relating to the communication or how to communicate with the patient. (Danny, FG 3).

It was further recommended in the ensuing focus group discussion that the training sessions should provide more details on specific health-related cultural elements.

5.4.2.2 Role modelling

Almost every participant was enthusiastic about the influence of the senior nurses’ role in facilitating nurse communications with local patients. Mary noted:

The senior nurses, you can ask help from them to explain it to the patient better, rather than the way the new nurses explain it without knowing Arabic too well. If the patient does not understand, you can grab this senior nurse from there or she can explain it. (Mary, FG 2)

This support from senior nurses was testified to facilitate communication due to the application of the mentorship skills and the ability of passing these skills to the junior nurses. This facilitated teamwork:
Teamwork within the area, not just in one area, they work within the hospital because if there is teamwork in the hospital, the work will go smoothly.

(Rasna, FG 2)

5.7.3 Nursing workload

The high volume of nursing workload was reported by the nurses to affect the way that they were able to deliver services. They reported frequently feeling overworked due to the limited patient time coupled with the need to attend to other responsibilities such as administration; this they felt influenced their quality of care. Most participants acknowledged that with a heavy workload, they had limited time to put into communicating with the patient effectively. This lack of time was sometime seen to cause patients to become frustrated or angry, as they felt neglected and under-informed.

The nurses in most of the focus groups mentioned their workloads as negatively impacting communications and sometimes the level and quality of care given to the patient:

Surely it [workload] affects our work because we have limited time to do many assignments and treatments and we have not enough time to talk with the patient and speak. If there are a few nurses in the shift and we have a lot of patients, we don’t have enough time. Numerous patients are frustrated from that because they need to discuss something [patient situation] but we have no time for that. (Bader, FG 1)

Several participants remarked that it was the shortage in number of nurses that caused the huge workload for the remaining available staff. For example, Maryama noted:
The case of the shortage [of nurses], it’s a worldwide phenomenon, so we have problems with the priorities, so we have to do a lot of things. We give a little time for the communication and we know it’s a mistake, but we don’t have enough time to communicate with the patients because we have to do treatments, dressings, medications and other things. (Maryama, FG 3)

Another participant confirmed the negative effect on nursing care due to the high workload:

It’s really affecting the care, which is provided from the nurses because if you have a shortage or lack of nurses, you can’t do everything … it’s really important, but there are some things more important than just communicating with the patient. So sometimes we have a shortage, but unfortunately, we don’t have time to communicate with the patients. (Chris, FG 4)

Numerous participants shared within the groups that Saudi patients become frustrated easily because of a lack of personalised attention. Various nursing interventions were needed to combat the limited work time allocation that may lead to patient inconvenience and substandard care. Fatimah said:

The nurse shortage and time limit, both of these are the main reasons. So, some patients get angry easily because we have no time to explain every nursing intervention for them. (Fatimah, FG 1)

5.7.4 Influence of work shifts

While some nurses reported preferring to work on less busy shifts to avoid communication difficulties, others testified to preferring that their other work demands, such as administration, were reduced to allow them the time they needed in order to communicate more effectively. Long working hours and harassment on certain shifts, predominantly the night shift, are associated with turnover among
Saudi nurses (Almutairi, Moradi Idrus, Emami & Alanazi, 2013). Reducing working hours and allowing Saudi female nurses to work morning shifts and male or foreign nurses to work the night shift may well help to retain local nurses. Busy shifts were seen by the participants to reduce the time available for effective communication, both with the patients and with their families.

The last key factor described by the focus group participants across the different groups was the effect of shift work. Participants from differing nationalities and differing languages had very different preferences for shift work. Some of the Saudi nurses felt communication was hindered during certain shifts, resulting in instances where there became a preference for night shift work as there was less demand for communication with the patients. For instance, nurses’ communication was seen as challenging on morning shifts due to the visitors and countless patient procedures.

5.4.4.1 Nurses selection of shifts

The differing perspectives to the shift work were further explored when participants said that they preferred the morning shift because they felt communication was easier than on other shifts. For instance:

I like morning shift because of the presence of doctors that help me to explain everything through them. (Terry, FG 1)

Others felt that the doctors offered an opportunity to speak with the patient:

So that time, I don’t have any problem because the doctor will communicate with the patient instead of me. I don’t have a problem with that but in the afternoon or in night times, when the doctor is not around, we have got a problem … how to communicate with the patient, especially [because] I am new and I don’t speak Arabic very well and I couldn’t understand it. So, I
international nurse] have a problem with communicating with the Saudi patients. (Celine, FG 4)

Overall, this subtheme revealed that nurses’ communication with patients varied according to their shifts assigned.

5.4.4.2 Shift work influencing tiredness and poor moods

It was reported by some participants that they felt tired and in low moods due to the demands of shift work leading to poor communication. When combined with increased responsibilities, this led to further distress. One participant said:

I think in the morning shift [because] most of the procedures are done in the morning. So, you will be very busy and this will also affect the time for communicating with the patients because of the procedures and you can be very busy in the morning, so you don’t have enough time to speak and to discuss the next event and elaborate on the patient. (Wafa, FG 4)

Additionally, some participants reported not wanting morning shifts due to the demands from patients’ family members, difficulties both with patient communication and handling their families’ requests. Remy, a participant from focus group 3, confirmed:

Sometimes, I’m in trouble on the morning shift because of the family and relatives. They want to know more information about the patients and I don’t know how to speak good fluent Arabic. I know some phrases and they keep questioning me about the patient; I’m just smiling at them. That’s why I prefer afternoon shift or night shift because there’s less visitors. (Remy, FG 3)
In contrast, another Saudi participant declared some advantages of morning shifts as conversation with patients usually went smoothly because patients were always in better moods:

When you talk to them in the morning, they slept well, this is based on their culture. They’re going early, they have more energy to talk and they can understand you. (Hass, FG 3)

However, some participants preferred night shifts as most patients were sleeping, reducing the need to communicate. Khailed, a participant from focus group 4, said: ‘During the night, patients will sleep, so you don’t need to speak with them’. However, this approach could have a long-term negative effect on communication as the nurse’s preference seems to be favouring avoiding communication, which poses a challenge to professional responsibilities, patient rapport and clinical skill development.

The final section of this chapter critiques the organisational themes originating from the focus groups. Three main subthemes were captured: organisational communication facilitators, suggestions for workforce policy and need for educational orientation programs.

5.5 Organisational Strategies

The final thematic category highlighted participants’ recommendations for organisational change and suggestions for new guidelines aimed at facilitating effective communication. Consistently, participants pointed to the need to establish both orientation and refresher educational classes for newly recruited international nurses focusing on communication skills, simple Arabic language acquisitions and Arabic cultural norms and values.
5.7.1 Organisational communication facilitators

The focus groups suggested that Arabic language translated material should be made available such as by way of hospital labels, signs and markers to facilitate orientation and communication processes in the hospitals.

5.5.1.1 Need for professional translators

In order to facilitate effective communication, it was noted in the focus groups that there was a need to have translators. The use of professional translators was seen by many participants as helpful, particularly in circumstances when effective and accurate communication is crucial such as informed consent request, surgery procedures and compliance with treatment issues. Another way of translation was utilising the patient themselves as translator during the nursing intervention. Local patient capability to speak English and Arabic made nurse communication more effective for both sides:

I find bilingual patients really help me to communicate with them easily and I find myself confident and happier to work with a patient that is bilingual.

(Hamid, FG 4).

However, this method of translation was unsafe way of translation and negatively affecting the level of patient satisfaction. In addition, utilisation of family and friends are not bound by any code of conduct. Therefor, the patient family and friends may interpret, editorialize, or deliberately withhold information that they feel is embarrassing or that may disappointed the patient or health care provider.

5.5.1.2 Multilingual signs in the hospital

Putting up multilingual signs around the hospital was suggested during all four focus group. These could be used to give directions to the patients, pre-empt certain standard queries and to guide patients, their families and hospital visitors.
There was general agreement between the participants on the importance and existence of signs and labels in the hospitals. A participant from focus group 3, Mohamed, said that they would enhance communication and allow more time to nurse the client. Another participant in group four affirmed the same belief: ‘signs to guide the patients in the hospital … it really helps’ (Celine, FG 4).

### 5.7.2 Suggestions for workforce policy

The participating nurses perceived a need for reference books, phone programs or applications or DVD/CDs of information to be provided on arrival to the international nurses in Saudi Arabia. There was a consensus formed in the focus group discussions that led to the realisation that a small book or booklet, DVD or file clip were needed to provide simple explanations. The nurses in general agreed that easily accessible and portable cultural and linguistic resources would serve to assist them, particularly in situations in which such factors impeded effective communication. A participant in focus group 1 noted:

> [All] of them will be really helpful for me, especially [because] I am still a new nurse and I have insufficient knowledge about Saudi Arabian culture and religion. (Terry, FG 1)

Remy from focus group 3 described her preference for using selected resources that educationally informed her of cultural barriers:

> It’s really important. I totally agree with that. We come from a different language totally and if we can’t communicate with the patients, we can’t give our full care for the patients. So the communication is number one priority in dealing with the patients. (Remy, FG 3)
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Additionally, Wafa from focus group 4 noted that the communication skill education routinely used before commencement of employment was ineffective because of the patient preference to have everything described in Arabic: Wafa said:

[These are useful because] you need Arabic because most of the patients don’t speak English. Just a few patients can speak English, but even though [they can speak English], they prefer to speak in Arabic because if the patient is in pain, he can describe his pain much better in Arabic. (Wafa, FG 4)

5.5.2.1 Hospital guidelines

Participants expressed a desire to be actively encouraged to speak of their experiences to their managers so as to improve the hospital working environment. Nasser, a participant form focus group 2, said:

If you were[able] to participate in making the policies, at least you own that you will be more encouraged to follow policies. (Nasser, FG 2)

Maryama emphasised the importance of hospital communication guidelines as an aid to accelerated communication processes:

As an international nurse … it’s useful because they support us with booklets that help us to work easily within a new culture or with a new patient with a new language so I think it’s easier to take care of the patient and improve our communication … it’s a good thing for the hospital to set these guidelines. (Maryama, FG 3)

However there were diverse perspectives from the focus groups on the opportunity to apply hospital guidelines between the Saudi and the international nurses. A Saudi local participant reported:

For us as local nurses … we don’t need any guidelines to speak with the patients because most of the patients are Saudis so it’s easy to communicate
and you don’t have to follow any guidelines to limit your communication.

(Wafa, FG 4)

In contrast, another international participant in the same group admitted that the hospital guidelines promoted communication with patients:

For us as a foreigner … we really need it because we don’t know about this new culture, we don’t know about this new religion so it’s helpful to have these guidelines.’ (Celine, FG 4)

5.5.2.2 Multicultural teams and communication

There was a preference for developing multi-health professional working cultural teams to promote cultural language acquisitions from almost all the participant nurses. The focus group participants highlighted the sharing of experiences and knowledge as part of the team learning process. From focus group 3, Danny stated:

I prefer to be in groups in order to share my ideas and exchange our knowledge about the communication and about the culture … Without my friends’ advice, I couldn’t improve my communication skills and I couldn’t know this new culture. (Danny, FG 3)

5.5.2.3 Job descriptions

The last key organisational subtheme is the utility of having a detailed nursing position description. Nurses described such a document as providing clarity in their work in terms of responsibilities and expectations. According to one participant:

It [job description] will be our reference about our scope of our responsibilities. We must know our limits, also our responsibility of our job and also these policies and procedures. We can use that as a guide for us to
make our responsibilities our own responsibilities, also for the good of the patient. (Connie, FG 1)

5.5.2.4 Use of documentation

One participant from the second focus group noted the difficulties with hospital documentation given that many nurses do not know how to read and write in Arabic. In particular, when notes were handwritten or in a shortened form, it may not be possible to decipher which patient the doctors (or other healthcare practitioners) were writing about. Susan stated:

In the file, they are writing this one, but we are not able to read this one, so we don’t know some names … We are not able to find out this patient, then after that they will come and fight with us … That is one of the policies the administration is trying to improve, the documentation, particularly the files, because we don’t know how to read and write in Arabic. (Susan, FG 2)

The process of centrally filing all the patient documentation in the hospital was appreciated by participants as promoting quality control. Rasna, a participant from group 2, explained the importance of a centralised Kardex in every shift in her hospital:

We have also our communication notebook especially in our delivery room every shift. Anything that happens or nothing happens, we will write it in one notebook. This serves as a communication with the other healthcare workers, this Kardex endorsement and documentation. (Rasna, FG 2)

5.5.2.5 iPhone programs raise communication effectiveness

A number of participants suggested the need to provide holistic nursing care through the utilisation of new portable technologies. From focus group 3:
I think it makes learning more easy using the DVD or the booklet or, because of the new technology, the iPhone program helps a lot and makes our profession more professional. We can give holistic care in the real meaning of care. (Remy, FG 3)

However, participants in focus group 4 mentioned the obstacle to the implementation of the use of iPhone technology being its expense. Khailed noted:

But not everyone can afford to buy an iPhone. The actual ward has a computer and they can access the internet. There is a good website that can help them with expressions. (Khailed, FG 4)

**5.7.3 Need for educational orientation programs**

One of the objectives of KSA hospitals administrating nursing orientation is to ensure that each local and international nurse receives consistent information regarding policies, procedures and standards to support practice and familiarise them with the health system and organisational structure. However, most participants reported not being able to effectively communicate with patients and so they proposed the need for educational courses and also the advantages of teamwork.

**5.5.3.1 Educational and orientation programs**

The focus group participants offered many suggestions for changes to enhance effective communication exchange between nurses and patients in Saudi Arabian hospital settings. One suggestion was to increase opportunities for education and cultural orientation so that the nurses could learn more about the Saudi language, culture and religion. However, many of the nurses noted a lack of availability of such courses, as stated by the following participant: ‘Unfortunately, we don’t have any course to improve … language courses’ (Danny, FG 3).
It was also suggested that each hospital should conduct a seminar or offer courses about the local culture and religion and how to improve communication with patients. This would be especially useful for foreign nurses as part of an orientation package. This was recommended by one participant as ‘the orientation would be helpful for one month or two month … to learn about communication skills’ (Fayez, FG 3). It was reported that there were educational departments available in hospitals, but that there was a need to restructure them to focus not only on acute care and how to care for patients but also on ways of improving communication with the patient.

5.5.3.2 Continuing professional educational courses

Arabic is not an easy language to learn or in which to acquire proficiency and so written resources in a range of languages was seen by focus group members to facilitate effective communication. A sample of simple and useful phrases and basic words was seen to be essential for the orientation of the newly recruited nurses. Focus group members stated that regular continuing courses can facilitate nursing communication for local and international nurses. For instance, Saudi and international nurses indicated that in-service educational workshops about styles of Arabic patients’ pain expression as well as online letters and emails sent by nursing education centres to target newly employed nurses would minimise communication breakdown.

5.6 Summary

This chapter presented and provided an analysis of the key themes raised from the qualitative analyses. The results in phase 2 showed three main categories: individual facilitators and barriers, professional influences and organisational strategies. A comprehensive review of each of the main emerging themes and subthemes led to an understanding of how each particular problem was perceived by
both local and international nurses and recommendations as to how these problems can potentially be overcome, particularly with regard to the primary research questions in this study. This study highlights the importance of nurses’ need to communicate effectively towards local patients thorough educational preparation and orientation and ongoing refresher education in new culture and language training.

In the following chapter, the significant findings of the quantitative and qualitative phases of the study are integrated, triangulated where possible, and critiqued in light of the set research questions.
Chapter 6: Discussion

6.1 Introduction

This chapter summarises key qualitative and quantitative results that inform the research questions supported by comparative and contrasting literature both regionally and internationally. Critical findings related to nurses’ communication towards patient in Arabic health settings are discussed in light of the research questions and compared and contrasted to address the research questions and research contributions. In addition, critiques of the application and utility of the conceptual framework to the results will also be applied. Lastly, the limitations of this study will be examined.

6.2 Population demography

The demographic pattern in this study (see Table 5.1) is similar to others on the nursing workforce in the Middle East (Albishi, 2004; Almutairi, 2012), with a diversity of nurses’ ages, nationalities and experience. A recent Saudi Arabian case study design incorporated multiple methods and examined the influence of cultural diversity in the multicultural nursing workforce on the quality of care and patient safety (Almutairi, 2012). The study recruited 25 different nationalities working in nursing services at large hospitals in Riyadh, Saudi Arabia. The most common background of the nurses (n = 98, 30.7%) was Asian. Eleven nurses were from European countries (3.4%), while 17 were from South Africa (5.3%) and 15 from Middle Eastern countries (4.7%). The study participants’ nursing experience was from less than 6 months to 21 years; the age of the study respondents ranged from less than 30 years to 45 years or over. This indicated the variety of nursing workforce employed in Saudi Arabia health settings.
Of the cohort in this study, 14 were taking certain forms of continuing education courses to improve themselves as nurses in Saudi Arabia. Two of the participants were taking lessons on Arabic language, four were taking classes on Saudi Arabian culture and eight were taking classes on improving their communication skills.

In the following section the nurses’ demographic characteristics will be examined as well as the working diversity that contributed to specific communications barriers associated with gender and culture background.

6.3 Demographic influences on nurses’ communication

This section highlights the ways in which gender influences posed communication barriers for international and local nurses within the Saudi Arabian context.

6.7.1 Gender and nursing communication

The majority of participants qualitatively claimed that demographic factors, particularly the nurses’ gender, affected how they communicated with their patients. From the perspective of the local nurses, the most common contributing factors that influenced Saudi female nurses was the nature of their work requiring them to liaise with men and that the resulting negative Saudi public perception may jeopardise their cultural reputation and marriage prospects. According to the focus groups, some Saudi male and female nurses were not able to attend to male patients in various circumstances such as administering intramuscular injections, wound dressings and ECG recordings. In addition, certain cultural differences affected gender relations and therefore informed a complex situation when caring for a patient in a nursing context. For example, in some situations, male patients felt culturally compromised when attended by a female Saudi nurse. This was affirmed...
by international researchers (Magnusdottir, 2005; Fatahi, Mattsson, Lundgren & Hellström, 2010), who have highlighted gender to be one of the critical factors in regards to the nurse-patient relationship.

Gender and social class differences have been well documented to pose communication barriers between nurses and patient. One study conducted in Iceland showed the centrality of language to personal and professional wellbeing and how language and culture were common communication barriers (Magnusdottir, 2005). Also, a Middle Eastern-based study presented variations such as age and gender in communication patterns across different clinician groups, healthcare settings and clinical specialties and possible impacts on health outcomes (Sandhu, Adams, Singleton, Clark-Carter & Kidd, 2009). The same researchers confirmed that the increased feminisation of the medical profession in the Middle East meant that health authorities facing difficulties in the organisation and remuneration of nurses should take into consideration the cultural characteristics of the community.

The focus group participants in the current study agreed that Saudi Arabian patients trusted and preferred the international female nurses as these nurses were seen to provide sympathetic and high quality nursing care. The gendered influences on nurses’ consultation processes is of paramount importance in the recent literature and particularly in terms of quality of nurse-patient communication (Sandhu, Adams, Singleton, Clark-Carter & Kidd, 2009). In Sweden, female health providers involve patients in decision-making and gather information about psychosocial issues more than their male colleagues. Male nurses, however, are more likely to direct consultations, to use medical jargon and to focus more discussion on medical conditions compared with female providers (Fatahi, Hellström, Skott & Mattsson, 2008). The same authors argued that although female providers offer a more
empathetic communication style and spent longer with patients, they also made more referrals to hospitals compared with male nurses.

In Europe, a Swedish study found that male patients in Saudi Arabia refuse to be cared for by male nurses (Sahlsten, Larsson, Sjöström, Lindencrona & Plos, 2007). Conversely, the Saudi female nurses preferred not to care for Saudi male patients. Gender difference affects patterns of communication when delivering care. The European study observed that male nurses’ communication has been identified as predominantly task-oriented. In addition, men were more likely to communicate in ways which were louder, more forceful, dominant and competitive and interrupted their patients more frequently. However, female nurses’ communication was more likely to exhibit emotional, subjective, polite and self-revealing aspects and to show more concern and awareness of the feelings of others (Sahlsten, Larsson, Sjöström, Lindencrona & Plos, 2007). Additionally, another European study also revealed that women’s verbal behaviours are reflected in non-verbal communication and there is evidence that women express and interpret emotions through non-verbal cues more accurately than men, by smiling more, for example (Fatahi, Hellström, Skott & Mattsson, 2008). A mix of gender in all hospital departments avoids any kinds of issues.

In the current study, a gendered concern qualitatively reported was that when patients or families were given bad news, nurses testified that they were not able to ‘touch’ or ‘comfort’ patients in the usual way. Men in Arabic culture are often observed walking hand in hand down the streets, whereas men and women cannot touch in public, as touching the opposite sex is considered offensive. Thus, modesty is an important virtue and is held in high regard by males and females in the Arabic culture. In addition, in the Middle East, usually patients prefer to have providers of
CHAPTER 6: DISCUSSION

the same sex, and husbands hence often requested to stay while their spouses were being examined in all situations (Porter & McDaniel, 2009). Commonly, traditional Arab women expected to see female providers only: trying to meet this need creates staffing difficulties. Consequently, to eliminate gender variation, the Ministry of Health in Saudi Arabia has constructed several maternity and women hospitals and isolated wards operate entirely staffed by females. However, the current study’s focus group findings indicate that male nurses felt rejected by male patients and many female nurses testified to not consider working with male patients. This could be attributed to culture of the country, as that affects the communication.

6.4 Cultural Influences

This section explains nurses’ diverse backgrounds as cultural informants that may pose communication barriers with Arabic patients when providing nursing care.

6.7.1 Cultural background and nurses’ communication patterns

In phase 1 of the current study, differing nationalities scored statistical significance on the personal/social NSACS subscale. Filipino nurses scored significantly higher in communication skills towards their patients when compared to Saudi nurses and other non-Filipino nurses. This means that Arabic patients preferred to be care by international nurses more than Saudi nurses as the international nurses have high quality of nursing skills and able to communicate effectively. In addition, the qualitative findings in the current study, the nurses’ responses indicated many concerns about gender, ethnicity and culture implications as well as language in the workplace.

The communication issues are clearly more prominent in populations of large expatriate health workforces in countries like Saudi Arabia and the UAE than in monocultural workforces. The presence of a large expatriate population with a
different language from the host society results in multiple languages as well as cultural differences in a healthcare setting. The differences exist in nursing staff dialects as well as in the multiple dialects of the patients. In the presence of such linguistic and cultural differences, local language speaking nurses also report barriers to communication when the patients belong to different dialectical language and ethnic group. For example, El-Amouri and O’Neill (2011) reported on cultural influences in the diverse nursing population in the UAE, which was recently 28% of Arabic, 63% Asian and 2% other nationalities (El-Amouri & O’Neill, 2011). Similarly to current study findings, the same authors indicated that the hospitals in the UAE were facing professional and managerial concerns due to wide ranging of linguistic and sociocultural backgrounds.

6.7.2 Patient safety and culture

The current study’s focus group data suggest nurses’ staff shortages and time limitations were notably a potential risk for safety because each nurse needed to explain fully to patients when performing nursing interventions and this took time and was complex. In regards to patient safety, two researchers from the US, Brach and Fraserirector (2007), indicated that the context of languages and cultural differences between international nurses and local patients decreased the patient satisfaction and increased risks of making medical errors. The sociocultural complexity including emotional and safety needs of the patients has not been well researched in the Middle Eastern literature.

Effective communication and nurse-patient relationships are necessary to deliver quality healthcare services and secure patient safety. However, female nurses were alluded to in the focus group as not keen to deliver services to patients with the same type of cultural beliefs in keeping with opposing gender complexity in
countries like Saudi Arabia, with an exception being emergency cases and specific urgent conditions (Almutairi, 2012). Thus shared beliefs and cultural competency are important aspects of nurse-patient relationships and highly influential on patient safety and outcomes.

6.7.3 Cultural norms

This section outlines specific cultural norms found in the qualitative data, specially the use of traditional ‘Arabic medicine’ and expression of pain, physical touch and patient modesty. The current study findings indicated that cultural norms arising from differences between the nurses’ and patients’ cultural belief systems was a concern primarily based on the fact that not all international nurses understood the use of traditional ‘Arabic medicine’ among patients. Again the study focus group results indicated that the mode of communication used by the nurses also posed a major challenge, along with local behavioural practices and cultural beliefs that deterred patients from fully communicating their pain levels. Effective communication between the patient and the healthcare providers is essential for accurate assessment, appropriate treatment and for obtaining optimal outcomes for the patient (Hudelson, 2005). Nurses in the current study also reported that patients may be very hesitant to seek clarifying information from their doctors or nurses and this could even result in non-adherence to treatment plans and even medication errors.

In relation to traditional Arabic medicine, the participants in the focus groups pointed out that patients’ preference for this style of treatment was considered by nurses as one of the critical communication barriers related to culture. Patients from some cultures may recourse to alternative or traditional medicines that may conflict with their main treatment plan, often without the knowledge of the medical care
CHAPTER 6: DISCUSSION

provider, resulting in a high risk for developing adverse complications (Ferguson & Candib, 2002). However, if the nurse and other healthcare providers understand the patient’s language, nurses will be able to communicate better with the patients and such complications can be prevented.

Physical touch and patient modesty data in Chapter 6 were seen as an integral part of the nurse-patient interaction, regardless of the cultural context. In regards to this issue, the Saudi Arabian and UAE hospital administrations attempted actively to recruit mixed genders from various ethnic groups to minimise these challenging conflicts with patients (El-Amouri & O’Neill, 2011; Almutairi, 2012). However, due to the current shortage of nurses, the possibility of achieving this gender distribution is unlikely.

Pain posed another important feature in nurses’ pattern of communication in the current study, with several focus group participants revealing that Saudi patients explain their pain differently to those in other countries. In addition, the patients even preferred to hide the pain because of religious or cultural prohibitions. Consequently, the cultural and linguistic differences imply the vital importance of developing culturally competent communication skills to inform pain. An extensive literature review (Narayan, 2010) critically reviewed 13 studies that focused on the effect of culture on pain assessment and management in clinical settings, examining why members of cultural minority groups frequently receive suboptimal pain management and how nurses can improve patients’ pain outcomes by using culturally sensitive assessments and providing culturally comfortable care. It concluded that in providing optimal pain care, nurses must understand how the patient thinks about pain and in turn cultural influences on pain perceptions and behaviours have to be properly discerned by nurses. To decrease nurses’ cultural
barriers towards communication, an emphasis on patient-centred communication enhanced reports of physical and emotional health, improved functioning and led to better pain control (Price & Cooper, 2003). In contrast, in qualitative results, the majority of participants in the current study faced difficulties with pain assessment due to patients’ cultural restrictions to express their pain to others.

In phase 1 of the current study, nurses identified that lack of professional educational backgrounds in communication skills and too much expectation of patients were communication barriers. In the US, a study that focused on nurses’ responses to transcultural exposure in their work reported a reliance on previous experience, education and training and friends (Cang-Wong Murphy & Adelman, 2009). Additionally, 71 (63%) subjects expressed the usefulness of interpretation services. As many as 86 (76%) nurses reported that they needed more culture-oriented education and continued training. Highlighted was the need for including culture-specific education and training for nurses to better equip them for culturally competent care delivery.

6.7.4 Personal factors influencing communications patterns

The participants of the current study stated that when they felt tired and in a low mood, this increased their responsibilities and personal distractions. An Iranian study affirmed that fatigue of nurses, patients’ forgetfulness and poor memory were the most common barriers to communication (Mohammadzadeh Bakhtiari, Moshtagh & Ebrahimi, 2007). The study concluded that nurses must be supported professionally to be able to dedicate their time and energy to relieve patients’ needs. Similarly, a another Middle Eastern qualitative study on nurses’ communication towards children showed that factors such as lack of time, work overload due to imbalance between human resources’ demand and supply and nurses’ insufficient
communication skills reduced the level of nurse-parent communication (Aein, Alhani, Mohammadi & Kazemnejad, 2009).

6.7.5 Religion and nurses’ communication patterns

Quantitative results of the current study found that religion did not produce a statistically significant effect, with the scores in the NSACS’s four subscales remaining similar across nurses with varying religious beliefs. Implied is the need to develop culturally and religiously appropriate questionnaires for Islamic societies in order to examine cultural and religious issues. However, most of the focus group participants from various religious beliefs identified family, friends and Islam as well as Christian ‘faith’ as facilitators to effective communication in hospital settings.

In the current study, the personal subscale of NSACS showed significance in the high score of Indian and Filipino nurses, specifically in empathy, respect and a willingness to make an effort in the communication process, while others showed an ethno-centric orientation to Islamic culture. In England, a study examined the issues specific to Islamic beliefs that were relevant to healthcare professionals (Rassool, 2000). It found a fundamental deficit of knowledge of the spiritual beliefs of Islamic people resulted in a cultural-blind approach to patient care. It contended that health professionals should be offered an overview of the tenets of Islamic spiritual beliefs, to enable an understanding of how the Islamic patient’s perspective on health and faith are intertwined. An Australian study described similar difficulties faced by international nurses in communicating with culturally and linguistically diverse patients in an acute care setting, services and the provision of support for nurses by healthcare workers (Cioffi, 2003).
In phase 1 of this study, the interviewed participants revealed various difficulties when communicating with patients during Ramadan in particular, bad news declarations and other faith-related concerns. Keeping religion’s effect on communication in mind, the ability to communicate in collaborative relationships is particularly highlighted in fostering peer and collegial relationships (Boyle & Kochinda, 2004). It is further contended that interaction patterns between nurses and patients with different culture norms need to be solutions-focused for effective communication (Bowles, Mackintosh & Torn, 2001). Physicians’ utilisation of open-ended questions has been shown to be positively related to patient satisfaction. A Japanese study reported that when patients asked frequent questions, this meant a significantly lower level of patient satisfaction (Ishikawa, Takayama, Yamazaki, Seki & Katsumata, 2002). In the US, a study highlighted that active listening was shown to be an essential interview skill for multicultural physicians because of many patients expressing their concerns and expectations not directly but instead through verbal or behavioural cues (Duldt-Battey, 2004). The current focus group findings had similar thematic findings with Wanzer, Wojtaszczyk and Kelly (2009), confirming that emerging characteristics of the communication interaction cannot solely be based on gender and culture alone.

In phase 2 of the current study, the Indian and Filipino nurses testified that healthcare providers needed to use a patient-centred approach in future. This approach centralises the patient as a main source of communication and requires the nurse to be a professional listener. Moreover, in the US, scripted behavioural counselling on safety habits failed to respond to individual needs that might influence behavioural change. Moreover, listening to the patients’ stories to learn patients’ needs and preferences and communicate accordingly is considered to be
vital part of patient-centred care (Vranceanu, Cooper & Ring, 2009). Consequently, the qualitative data in the current study found that consideration of both nurses’ and patients’ views appeared to be important in the Middle Eastern settings to deliver effective and successful communication in health sites.

Organisational factors of the Middle Eastern hospitals that influenced nurses’ communication delivery towards patients will be critiqued in the following section.

6.5 Organisational factors

This section examines the key finding of organisational factors including nursing high workload, career motivation and nurses’ time limitations, which were seen to inhibit communication towards patients within a Saudi Arabian context.

6.7.1 Nurse workload and career motivation

The focus group discussions identified local patients and workload career motivation acted as barriers to communication. However, the Saudi Arabian senior nurse participants claimed that the level of salary was a powerful motivator to justify working harder; other nurses agreed it was a factor that would inform how they communicated with their patients. Some participants felt that nurses’ salaries did not have an effect on communications with patients and the level of professional nursing care that was offered.

Heavy nursing workload and lack of welfare facilities for nurses were among the most important barriers to nurse-patient communication in a study by Kingma (2007), in keeping with the current study’s qualitative findings. In Iran, Anoosheh et al. (2009) concluded that nurse managers and policy makers should focus on eliminating or modifying the barriers stated by patients and nurses. Equally, the current study’s Saudi nurses confirmed requested salary increments, although they stated this would not necessarily motivate them with regard to maintaining patient
rights. Another study in Iran stated that tiredness of nurses, patients’ forgetfulness and poor memory of nurses were the most common barriers to effective communication (Mohammadzadeh, Bakhtiari, Moshtagh & Ebrahimi, 2007). Low salary, tiredness and time-work pressure of nurses may negatively influence nursing care and leads to ineffective communication. The current study revealed that time shortages due to understaffing and insufficient interpersonal competences led to deterioration of the communication between parents and nurses and consequently not meeting patients’ supportive and information needs.

**6.7.2 Time limitation and workload**

This section explores nurses’ lack of time as a significant communication barrier with patients in Saudi Arabian hospitals. The surveyed nurses stated that the lack of time and heavy workload were barriers to sound communication. Equally, the focus group participants acknowledged that with a heavy workload, they had limited time to put into communicating with the patient effectively. This lack of time was seen by the nurses to cause patients to become frustrated or angry as they felt neglected and under-informed. Moreover, busy shifts reduced the time available for effective communication, both with the patients and with their families.

The focus group showed that nurses must be organisationally supported to be able to dedicate their workload and time to meet patients’ needs. An Iranian study by Anoosheh et al. (2009) indicated that a high increase of the volume of nursing tasks and inappropriate ratio of nurses to patients were important conditions that affected quality of nursing care and duration of communication between nurses and patients. A heavy nursing workload and lack of time were identified as hindering factors to effective communication (Anoosheh et al., 2009). Further, Berry (2009) expressed that nurses preferred to use a nurse-centred communication style rather than patient-
centred approaches when they had time constraints and were pressured to care for a large number of patients, as seen similarly in the current study.

The phase 2 findings of the current study exposed the importance for policy makers to address high nursing workloads, further supported by the fact that commonly Saudi patients become frustrated because of a lack of personalised attention from hospital staff. Various nursing interventions were seen as needed to combat the limited work time allocation that may lead to patient inconvenience and substandard care. In contrast, in Australia, nurses were perceived to increase the effectiveness of communication with patients (Hemsley et al., 2001). The nurses’ willingness to take the time necessary to communicate with patients and their fortitude in persisting until the message was understood. The nurses were willing to ask for help (from family members, speech-language pathologists or other nurses) when communication barriers prevented effective communication with patients. In the same study, nurses’ willingness to share the information learnt from communicating with patients during shift changes was seen as supporting effective nurse-patient communication.

6.7.3 Continuing education courses and perceived effects on nurses communication

The current study’s quantitative findings indicated that there was significant need for education in communication skills. Similarly, in South Africa, researchers interviewing international nurses on their work experiences in Saudi Arabian hospitals found they faced stress when completing the mandatory core competencies, courses and workshops (van Rooyen et al., 2010). In the current study, many Indian and Filipino nurses spoke of being frustrated with the agencies for not preparing them adequately prior to their arrival to Saudi Arabia.
Most nurses interviewed in the current study testified to recognising that some existing educational packages and new educational programs enhanced their professional development. This may indicate that the participants were not ready to learn about communication and other staff development issues on entering Saudi Arabia, but later realised the worth of the information and became receptive enough to engage in the learning process (Morgan & Jones, 2009). Similarly, the focus group participants in the current study reported that there were educational departments available in hospitals to offer nursing classes, but that there was a need to restructure them to focus not only on acute care and how to care for patients but also on ways of improving communication with the patient. In Saudi Arabia, most international nurses receive little formal training prior to their arrival (Halligan, 2006). The current study’s focus group members suggested that without this training and experience, nurses found that caring for and communicating with local patients was extremely challenging.

Providing nurses with training on how to prevent communication breakdown with patients has been documented to be of crucial importance (Hemsley & Balandin, 2004). Also, participants in the current study indicated that improving effective communication between patients, staff and management is recommended. For example, Hegeman (2005) described short-term interventional nurse mentoring courses utilising peer mentoring systems, including management training, mentor training and serial newsletters. The participants from the current study indicated that training courses could enhance communication styles and problem solving with local patients and lead to facilitating nursing interventions.
6.7.4 Staff organisational hierarchy and nurse communication

This section outlines the influences of organisational collaboration between nursing staff and senior colleagues on nurses’ communication towards patients. The present study’s focus group themes indicated that professional assistance and support from senior colleagues was seen as a positive communication facilitator. An Australian study showed that the sources of miscommunication between Australian patients and nurses consisted of circumstances of interactions and senior nurse support to other staff (Cass et al., 2002). This is a frequent dilemma in acute care; the organisational complexity of acute hospitals contributes to difficulty communicating with the appropriate healthcare provider. In the US, nurses and physicians reported difficulty in contacting the correct healthcare provider (McKnight et al., 2002). One study found that only 23% of physicians could correctly recognise the assigned nurse responsible for their patient; however, 42% of nurses could identify the physician responsible for the patient in their care (Potter et al., 2005). The conclusion is that the senior nurses engaging in collaboration teamwork serve to minimise miscommunication and maintain patient safety. The focus group participants emphasised that expert nurses who had background knowledge of the Saudi culture and language handed down to new nurses various types of support and that this support expanded their professional experience within the new culture.

The current study affirmed the benefit of senior nurses’ support and nursing teamwork to facilitate junior nurses’ communication with Saudi patients. In the Middle East, in Iran, the importance of roles for senior or bilingual staff during communication with patients has been highlighted (Mohammadzadeh, Bakhtiari, Moshtagh & Ebrahimi, 2007). In Australia, hospitals supported and trained groups of senior and bilingual staff with varying communication skills in order to secure
patient safety and overcome miscommunication (Health in South Western Sydney, 2000). Likewise, the qualitative results from the current study showed that junior nurses were motivated and aspired to attain a senior position and consistently attain higher levels of nursing performance through training and experience.

The next section critiques the specific language difficulties in respect to the context when communicating with Middle Eastern patients.

### 6.6 Influence of Language and Dialects on Nurses’ Communication

This section explains nurse-patient differences in languages and dialects as crucial communication barriers within a Saudi Arabian context. Essentially, the choice of use and understanding of language was an important theme that presented a barrier between nurses and patients in terms of communication. The current study showed poor communication between nurses and patients because a lack of a common language in such a multicultural setting was common in Saudi hospitals. Two important themes emerged: the difference between nurse and patient dialects and fluent Arabic being a difficult language for international nurses.

Language barriers in the Saudi nurse-patient context can be explained by, first, dialect, whereby the same language is being used but different areas use different pronunciations or where a word in one dialect means a different thing in another dialect. Second, Arabic is considered a complex language to learn and speak and therefore often too difficult for non-indigenous workers to adopt. Third, most local patients not speaking English because they did not learn English at an early age in Saudi Arabian schools makes the situation harder for international nurses.

Commonly reported in the focus group was that Filipino participants lacked Arabic language proficiency, which many felt may be adversely affecting the quality of care received by the patient. Even in cases where the immediate relatives of the
patient acted as the interpreters, several studies have reported the problems involved in such an approach, ranging from incorrect translation from nurses into patients’ inhibitions pertaining to sharing certain sensitive information, preventing them from disclosing the information to the care providers in the presence of their relatives (Fatahi, Hellström, Skott & Mattsson, 2008).

In keeping with current study findings and nurse-patient language communication barriers, a Korean study (2005) found that individual difficulties such as having hearing problems, having a low educational level and having an accent or dialect were other barriers to nurse-patient communication (Park & Song, 2005). In the US, it was reported that patients felt that their doctor did not listen to everything they said and that they did not fully understand their doctor or they had questions for the doctor and were afraid to ask them. This communication problem was further compounded for the non-English speakers, as found in the current study findings (Cooper et al., 2003). Likewise, the current study qualitative data affirmed that nurses encountered problems such as dialect, accent and nurse-patient gender differences as significant communication barriers towards local patients.

The next section will discuss the facilitating influences on communication, which include the themes of professional experience, use of interpreters and translations that enhanced nurses’ communication with their patients.

6.7 Facilitators Towards Nurse-patient Communication in an Arabic Setting

This section critically discusses identified facilitators to nursing communication in Arabic settings and includes positive adaptation, quality of professional experience, cultural competency and personal adaptations to the complexity of the Saudi Arabian hospital environment as communication facilitators.
6.7.1 Professional experience

The nurses’ length of professional hospital experience produced a statistically significant effect on communication. Associated NSACS scores differed depending on how long the participants had been working the hospital. In particular, the nurses with less than a year experience scored significantly higher than the nurses with one to two years of experience and the nurses with more than two years of experience. In the literature, factors that were recognised to increase the effectiveness of communication with patients were the nurses’ prior training and experience working with people from different countries (Hemsley et al., 2001). The nurses in the focus group reported to be willing to take the time necessary to communicate with patients emphasised the importance of constant nursing care until the message was understood and (Balandin et al., 2007). The experienced nurses’ preferred to ask for assistance from patients’ family, speech-language technicians or other expert nurses when communication barriers prevented effective communication with patients (Hemsley et al., 2001). However, in the current study, international nurses need to employ nursing competency skills to fit into the new country and practice safe communication styles when providing nursing interventions.

6.7.2 Personal adaptation factors

Personal adaptation factors were noted frequently by the focus group participants to serve as facilitating effective nursing communication with patients. The nurses said that the patients were more likely to communicate effectively with the nurses based on the acceptance and trust they felt for their nurses and the extent of nurses’ life experience. In the current study, nurses stated that many local patients preferred the international nurses since they felt they could trust them more and that the international nurses were perceived to be more ethically and legally bound in
their practice. While the nurses reported to not mix their social and their professional lives, mainly by focusing on the patients so as to manage any emotional situation, they all reported being affected at work by issues in their personal lives, which further impeded communication between the nurses and the patients.

Indian participants in the current study affirmed that the absence from family led to depression and loneliness; however, they managed to overcome these difficulties by phone calls and utilisation of personal confidence. Another comparative study indicated that expatriates can be easily isolated and suffer from depression (van Rooyen, Telford-Smith & Strumpher, 2010). This was consistent with the current study’s participants’ statements as they used cultural adjustments and support systems in order to survive in the new culture.

In the focus groups, nurses’ paradigms of cultural awareness depended on their subjective beliefs and personal demographics. Additionally, the current study revealed that nursing training may provide for the establishment of evidence-based critical care practice by nurses towards people from other cultures. The research has suggested that communication and norms for experiencing emotions are different in collectivist and individualistic societies (Jain & Krieger, 2011). In Saudi Arabia, a collectivist society, the current study’s participants indicated that different backgrounds of nurses affected their communication and ability to adjust emotionally to the new culture, as well as what type of comforting a nurse should provide to patient.

As the current study’s demographic data have shown, various international nurses from the Philippines, India and Indonesia are employed in Saudi health settings. In this current study, the focus group nurses reported additional problems outside work that attributed to a lack of interest in work and that further posed
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barriers to communication. International nurses’ missing families was a common frustration that interrupted nurse-patient relationships during their stay in Saudi Arabia.

In the current study, communication in critical situations with terminally ill patients was reported as challenging. Testimonies from several nurses’ underlined that the cultural tendency of patients to conceal their pain was an issue for both local and international nurses. Moreover, the urgency and immediacy of emergency medical situations further presented as a key issue in regards to the communication process for international nurses adjustment. In the literature, a quantitative study surveyed 90 doctors from 20 countries and found that physicians from countries outside the US felt most comfortable communicating to patients when introducing a diagnosis of a life-threatening illness, for example, ‘cancer’, to the family members of the patient (Yun et al., 2004). As with other common communication difficulties doctors face, it is unknown to what extent they adjust to the various cultural norms of patients in the US.

6.7.3 Need for improved knowledge of cultural competency

The current study’s participants claimed that there was a need to provide educational classes for new nurses, focusing on communication skills and cultural awareness. To ensure cultural awareness and sensitivity, the participants said that there should be more reference books, phone applications or DVD/CDs of information that would be provided to them upon arrival in Saudi Arabia.

Middle Eastern patients are commonly reluctant to follow nursing or doctor guidelines because these are incompatible with their cultural beliefs. In these situations, an impasse is created between the nurse and the individual, as neither understands why each is asking for or acting in a certain way and therefore non-
compliance ensues (Heuberger, Gerber & Anderson, 1999). A simple linguistic communication without complex medical terms makes it easier for the patient to understand and follow instructions. If there is no avenue for the nurse to quickly communicate directly with the patient, the nurse and patient are left feeling as if they have no ability to act effectively to facilitate satisfactory patient outcomes, particularly in acute care settings.

In the current study, several focus group participants testified to the importance of the need to use bilingual medical staff or local nurses to overcome communication barriers, especially with monitory groups of patients, for example, geriatrics and Bedouins. Evidence suggests there are significant challenges to effective interpersonal communication with patient form vulnerable groups, such as the disabled or mentally ill (Collins, Clark, Petersen & Kressin, 2002). Public health and human service providers often contribute either consciously or unconsciously to racial/ethnic disparities in health outcomes by expressing cultural biases and inadequate communication with different racial and ethnic groups (Freeman, 2004).

The importance of having quality interpreter services is also a key component of caring for patients from diverse backgrounds (Fatahi, Hellström, Skott & Mattsson, 2008), and it is the responsibility of the health institutions to provide these services. A cross-cultural community leads nurses to utilise effective communication skills to enhance patient care outcome.

In the current study, the focus group nurses testified to considerable issues when communicating with patients during their early days of employment in Saudi Arabia. An American study similarly reported that nurses faced challenges in cross-cultural communities and that culturally sensitive health communication needed to develop cooperative healthcare relationships, which lead to significant influences on
the quality of healthcare and health promotion with vulnerable consumers (Kagawa-Singer & Kassim-Lakha, 2003). Development of dedicated training programs to promote communication for healthcare providers has shown great promise for improving health communication and reducing health inequities (Taylor & Lurie, 2004). Sensitive and adaptive health communication improves health literacy communication barriers that frequently limit holistic practices and understanding between patients and nurses.

In the current study, the focus group members identified that there was insufficient support from health organisations to minimise cultural sensitivity for new recruits via educational courses. In the literature, this aspect was critical for nurses to understand the cultural differences and healthcare issues when moving to another country (Marrone, 2007). A challenge has been posed to providers of healthcare to deliver rigorous education and facilitation related to cultural differences and cultural sensitivity. Until recently in Saudi Arabia, a limited effort has been made to provide culturally sensitive information and education to nurses and other who migrate to a new country with a view to pursuing a career in healthcare services. Obstacles that prevent ensuring these mechanisms are the lack of facilities to provide expertise and low levels of education in cultural competent nursing skills. The effectiveness of teaching interventions on the development of cultural competency has been noted by Jeffries (2005). A further problem is the absence of research to evaluate the utility of culturally competent education for nurses. This was clearly indicated by the current study’s participants, as international nurse called for educational courses in order to improve their nursing competency.
6.7.4 Need for interpreters and translation

The study findings highlighted the importance of professional translators in medical settings. Several focus group participants emphasised that medical translators were helpful, particularly in circumstances when effective and accurate communication is essential (Campbell, Sleath & Bosco, 2003). Also, the study participants recommended the use of alternatives such as social workers, Arabic physicians and Arabic nurses as translators during nursing care to facilitate the communication with Arabic patients. If translation was not available, the lack of bilingual nurses meant that communication failure occurred and resulted in conflict, fear and breakdown for both nurse and patient families (Campbell, Sleath & Bosco, 2003). Facilities must be aware of this need and answer. If this occurs, the culpability is evident and the development of care is lacking.

Research shows that there exists a wide gap in communication between patient and nursing staff due to multifarious factors such as language barriers and lack of cultural awareness (Campbell, Sleath & Bosco, 2003). Although the current study’s focus group nurses testified to sometimes learning a few Arabic words, it was not enough to communicate effectively in the other language (Al-Shahri, 2002). It has been said that ‘Knowing a smattering of a foreign language only allows one to make a fluent fool of oneself if the implicit meanings behind highly subtle linguistic symbols are not understood’ (Ross & Deverell, 2004, p. 27). As a result, interpreters are needed to facilitate communication between English-speaking staff and Arabic patients. Additionally, selecting an interpreter of the patient’s gender is likely to result in a more comfortable and efficient interpretation process with a consideration of religion and culture.
In the current study, focus group members affirmed frequently the benefits of translators services. Similarly, in the Middle East, a study conducted at King Khalid University Hospital (KKUH) in Riyadh, Saudi Arabia, focused on various aspects of services rendered to inpatients (Al-Doghaither, 2000). The study’s overall mean satisfaction percentage was lowest in nurses’ attention to listening to and conversing with patients. Indeed, this variety between high satisfaction in term of skilfulness and low satisfaction in terms of communication leads to an essential question: how can the nurse apply a procedure on such a patient without communicating effectively or collect sample data if there is a lack of language ability (Ross & Deverell, 2004)? Further, longer interaction with patients in a two-way communication is required for these skills to be manifest. This is difficult for nurses in KKUH for whom language is a barrier. The vehicle for the implementation and success of technical care is nurse-patient communication (Al-Doghaither, 2000). Communication breakdown will severely decline nurse-patient relationships and deteriorate the patient satisfaction.

The current study’s nurses also reported difficulties faced from language barriers and being unable to meet the language demands of Saudi Arabia. In the UK, a study testified that international nurses had difficulties with patients’ accents, often contributing to negative attitudes from their patients (Aiken, Buchan, Sochalski, Nichols & Powell, 2004). For some nurses, it was difficult to understand and interpret English as they were not well-versed in the language. Nurses faced complications in conversation with the patients and felt a level of anxiety, sometimes resulting in avoidance by the patients. These strains prevented the building of relationships with their peers and others health providers that nurses worked with and added to the deteriorating image of these nurses.
The next section will provide a comprehensive critique of the SCT and its application to the findings and discussion on nurses’ communication with patients in a Saudi Arabian context.

6.8 Critique of Application of sociocultural theory

This section explains the utilisation of SCT as a theoretical framework for the current study. In addition, this section reveals the current study findings of the SCT framework proposed by Vygotsky (Lantolf, 2000). SCT seeks to explain individual knowledge, development and competencies in terms of the guidance, support and structure provided by the broader cultural context. Rather than considering the individual in isolation, sociocultural theorists focus on the dynamic interaction between developing persons and the surrounding social and cultural forces.

Sociocultural theory (SCT) provided an exploratory framework that enabled an understanding of the nurses communication patterns, barriers and facilitators and the associated meaning of these clinical interactions. In Middle East, these were deeply imbedded in historical, social, religion and cultural backgrounds of patients and their families as well as the context in which that registered nurses is practicing. As a result, the applications of SCT as a framework for the thesis enabled an understanding of the Arabic cultural concepts and belief systems embedded within the language and communicated through speech. In the current study, STC application of the focus group data supported the utilisation of education in language and cultural promoting abilities to assist nurses to effectively communicate with patients. Nurses should use concrete messages because they do not require interpretation compared to abstract messages (Videbeck, 2011). Creating a shared social reality becomes problematic when shared sociocultural comprehensions are not evident.
The use of language and cultural tools as central SCT mechanisms for learning are important factors nurses must consider when communicating with patients in health settings. In the current study, SCT provided a framework for a constructive, self-regulated and goal-oriented environment with nursing at hospitals in Saudi Arabian health settings. All Arabic nurses in the current study identified that their families were an important element of their societies. Focus group members observed that most patients had an extended network that encompassed cousins, uncles, aunts, siblings, grandparents and parents. In respect to culture, Islam encourages adherents to show compassion, respect, support and care to their family members.

There are limitations in applying Vygotsky’s SCT theory to this thesis as it does not account for a time based approach neither for the ability of international nurses to integrate and assimilate with Saudi Arabian patients and surrounding cultural context was not studied. Nevertheless, Vygotsky described the boundaries between the self and society as part of the comprehensive relationship between cognitive development and learning (Spouse, 2001). SCT as used in this study inform patterns of communicating with most of the nurses interviewed feeling that they reasonably communicated effectively with local patients and often attended the limited language and cultural courses provided by education centres in Saudi hospitals.

Theses linguistic adaptations have applications in the new host culture. This is based on the literature review of communication modes and patterns of nurse communication across cultures and the results of the current research findings, a modified SCT model can be used for the implementation of a nurses’ effective communication program and the identification of suitable communication styles.
within Arabic context. The critique of the results from both the questionnaire and the ensuing discussions in the focus groups acted as the basis for Figure 6.1.

**Figure 6.1** Modified SCT communication model for health sectors in Saudi Arabia. Adapted from “Nurses’ perceptions of the barriers in effective communication with inpatient cancer adults in Singapore,” by Li Hui Tay, Emily Ang, Desley Hegney, 2012, Journal of Clinical Nursing, 21, p. 2651.

Figure 6.1 will be elaborated on in the following critique. Constructs such as ethnicity, religion, age and gender, interacting in further cultural contexts and professional and organisational communication factors were evident in the focus group data. Recent evidence suggests that nurse-patient congruence on their
preferences for patient involvement in care is more important than congruence on demographic variables such as ethnicity, age or gender (Tucker et al., 2003). The current study illustrates the importance of centralising the nurse and Saudi patient partnership and together negotiating the patient’s role, through communication (both verbal and non-verbal), partnerships, participation and cultural strategies. Adherence should be developed uniquely for each individual patient. Accordingly, SCT forces emphasised such demographic factors that enhance nurses’ communication towards patients in newly Arabic culture.

A sociocultural view occurs as a process of interaction between nurses and the health care organisation specifically the patient. The SCT is based on the assumption that the needs of all groups within a society are the same. This overlooks the existence of real differences and conflicts of interest as in the current study when international nurses communicate with non-Arabic patients more than Arabic patients (see Figure 6.1). This limits our understanding of difference, conflict and the dynamics of change in societies. The current study’s international participants reported facing communication barriers when providing nursing care to children and elderly patients. Further, in the UK, Allan, Larsen, Bryan and Smith (2003) conducted focus group interviews with 67 nurses from 18 countries and five continents (83% from developing countries, 78% non-whites) working in England. Main findings revealed a perceived discrimination, exploitation, professional exclusion by colleagues (all ethnic groups), conflicts with local practices in nursing and language problems.

In Saudi Arabia, cultural and language diversity exists and the majority of nurses do not have enough education or training relating to communication with cultural diverse patients in order to offer appropriate intervention. Application of a
modified SCT model in Saudi Arabia health setting will underpin communication initiatives in government or private hospitals and enable nurses to more effectively communicate cross culturally with their patients and improve health outcomes problems as it takes into considerations these factors.

The international nurses who participated in the study noted the different accents and dialects within the Saudi Arabian patients. Hence, according to SCT, competent nurse need to have enough communication proficiencies articulated with healthcare skills with the healthcare perceptions of the patients of different nationalities, cultures and languages. However, in the current study, the majority of participants lacked SCT application between nurses and patients, causing several communication barriers in Saudi hospitals. Competent communication skills and SCT needs to be embedded in undergraduate nursing studies and education.

Accordingly, the situation in Saudi Arabia’s clinical settings is very different from those in Western societies. There is considerable cultural diversity in Saudi Arabia’s healthcare setting and an imperative for expatriates nurses to communicate with the patients coming from different cultures, nationalities and languages. The SCT model postulates that nurses should not pre-empt what the patient wants to communicate, instead should let them communicate freely.

Nurses in the current study faced very challenging situations while communicating with local patients due to lack of knowledge of SCT experience in Arabic culture and the absence of support from Saudi Arabian health organisations. Further, a study in the US by DiCicco-Bloom (2004) found that for Indian born and educated nurses working in the US, racism and marginalisation were highlighted. Moreover, in Australia, Omeri and Atkins (2002) conducted a phenomenological study with five multinational nurses in which experiences were described as ‘mostly
unhappy’, where the main findings were professional negation, experienced in lack of support, otherness, experienced in cultural separateness and silencing, experienced in language and communication difficulties. As a result, utilisation of a modified SCT model for nurses working in Arabic cultures will minimise communication difficulties with local patients as it encourages these nurses to adjust interaction professionally with host cultures and self-learning styles.

The key finding of the current study was that healthcare professionals often faced a significant challenge when patients do not speak the same language. According to SCT, language provides objectivity and conceptualisations gives names to experiences and makes sense of the environment, objects, events and interactions. Communication across cultural groupings can produce problems when communicating. Hence, utilisation of SCT cover theses gaps such as adoption to hosted cultures and learning indigenous languages. This makes it easier for both local and international nurses to reduce language barriers. Nurses’ application of SCT and learning over time will allow nurses to relate past information to the development and integrate new ideas that can be applied for a lifetime.

6.9 Limitations of the Current Study

The NSACS used in the current study failed to capture a comprehensive picture of religious and cultural factors faced regularly by nurses when communicating with Arabic patients within KSA over time. This may be because the survey was developed from a Western base and as a result failed to adapt subscale of the highly salient religious and cultural influences in Middle Eastern healthcare settings. The researcher added and adjusted a small percentage of culturally determined questions to each questionnaire items based on the literature, which may have reduced previously established validity and reliability of the original
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questionnaire. Appropriate tools and scales designed and validated for specific cultural backgrounds to measure constructs related to nurse communication towards patients in the Middle Eastern countries have yet to be developed and validated. However, the researcher utilised focus group sessions through mixed-methods, in order to capture the contextual integration of religion and culture in the current study.

Other limitation of current study was focus on nurses perspectives only: as it did not involve patients acknowledgements of effective communication. As this study was focused on nurse-centred health outcomes, the current study did not included patients perspectives of effective communication. In excluding such patients outcomes, the current study could have missed comprehensive evidence of patients on successful communication from their side. Moreover, this study lacked comprehensive data from another health disciplines such as: physicians, pharmacists and health technicians in order to overcome communication barriers from their perspectives.

Another main limitation of this study was that no attempt was made to control acquiescent response bias, which is the tendency of many respondents to agree or strongly agree to most questionnaire items, irrespective of whether or not they actually do agree to them in reality. Although there was a high level of agreement with many of the items in this study, it is not known whether this was due to biased responses. An unknown proportion of the participants’ responses may have reflected the cultural communication style of some respondents to consistently provide biased responses to questionnaire items irrespective of what they really believe to be the ‘true’ answer (Fink, 2009). The nurses could potentially have provided biased answers for many reasons, including the fact that they are naturally
very polite and respectful people. It is not known whether any of the results of this study were influenced by acquiescent response bias, but it is possible that a few answers may have been misleading, thereby limiting the validity and reliability of the conclusions.

These data elected from the four focus groups provided highly salient contextual data on the other barriers and facilitators of nursing communication towards patients in the Hail region of Saudi Arabia. However, the employment of mixed-methodology had certain limitations. Due to the nature of such a design paradigm research, the second phase (qualitative phase) sample size was small and limited solely to convenience sampling of social and professional networks of nurses from the Health Ministry hospitals in Hail region. Although the sample size was appropriate for focus group techniques (Morse, 2003), a larger more purposive sample may be needed for future research.

An additional current study limitation in phase two was that homogeneous sampling was not chosen (Morse, 2008). This sampling can be of particular use for conducting focus groups because individuals are generally more comfortable sharing their thoughts and ideas with other individuals who they perceive to be similar to them. However, the researcher contends that the use of focus group in this second phase of the mixed-method study provided valuable information related to nurses’ communication towards patients, but the technique had certain limitations. First, that some participants may have been uncomfortable sharing their thoughts in front of a group, and group discussions may limit individual comments depending on the dynamics of the group and the topic of discussion. In addition, the themes analyses were limited by the extent to which individuals disclosed the issues that were relevant and important to them (Stewart, Shamdasani & Rook, 2007).
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Another limitation of the study was the time provided for the focus group. Participants were initially told that the focus group would not exceed 60 minutes and while groups did exceed this time, the time limited probing for additional information and may have resulted in participants not providing as many details to illustrate the meaning (Stewart, Shamdasani & Rook, 2007).

6.10 Summary

The first section of this chapter identified the surveyed nurses’ communication patterns towards patients, in an attempt to address the research question, which was then triangulated with focus group data. A triangulated comparison was made between the results from the surveyed nurses who answered the NSACS and those who attended the focus group interviews in order to provide methodological rigor. The second section of this chapter appraised the application of the SCT theory in light of the findings of the study. Strengths and weakness of the SCT contextual model of communication were discussed and an adaptation of the model was proposed. The remaining sections outlined the limitations of the study and conclusions.

Achieving effective communication between nurses and their patients in the Saudi Arabian context requires a complex understanding of the Middle Eastern and Saudi Arabian social and cultural environment as well as individual nurses’ self-awareness of personal, cultural and organisational constraints in order to achieve effective and competent communication. Application of this SCT model for the Saudi Arabian health sector contributes to high patient outcomes within Arabic cultural and religious content in additional to providing effective information about the patients’ progress and wellbeing in the clinical environment.
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The next chapter will outline the recommendations and implications for future studies as well as draw conclusions on the work.
Chapter 7: Conclusion

7.1 Introduction

Effective communication between nurses towards patients is an important feature for patient satisfaction, treatment outcomes and patient compliance. Nurses cannot perform their clinical roles such as delivering physical care, emotional support and exchanging information with patients without effective communication. Effective communication is of crucial importance in Saudi Arabian hospitals due to the diverse cultural issues the region faces. This is particularly highlighted in regard to engendered, linguistic, religious, social, professional and organisational structural agents that pose barriers. Moreover, nurse managers and policy makers in Saudi Arabian hospitals need an in depth understanding of the complexity of cultural values and beliefs and how these interface with the process of communicating in the delivery of healthcare.

The current study examined barriers and facilitators of nursing communication towards patients that local Saudi nurses as well as international nurses currently face within a Saudi Arabian cultural context. An explorative descriptive approach was used to develop first-time baseline data from which to recommend standardised nurse communication guidelines in order to improve current communication and patient safety in Saudi hospitals. The present study findings highlight that effective communication was not being achieved due to a number of complex and overlapping personal, professional and organisational factors.

This chapter outlines the major conclusions and recommendations derived from the findings of this study, and critiques the addressing of the research questions. Recommendations for clinical services, practices of policymaking,
nursing education and future research based on the current study findings are also provided in the following sections.

7.2 Overview of the Study

The current study findings are well supported by the literature in that effective communication is central to the delivery of effective nursing care. The current mixed-methods study adds to an existing body of international literature, yet presents a uniquely Middle Eastern context surrounding the culture-based barriers and facilitators of nurses’ communication towards patients in Saudi Arabian health settings. This study is the first of its kind carried out in a Saudi Arabian cultural context that investigated international and local nurses’ communication with patients.

Given the centrality of social, cultural, ethical, economical, legal and technological aspects of nurse-patient communication, the context in which care was provided was fundamental to the approach. Historically, research on communication has focused on interactions between patients and nurses without taking into account the sociocultural context. Nurses from different cultural and linguistic backgrounds more and more commonly work in an environment where the patients and other healthcare providers are of diverse cultural backgrounds different from their own values, beliefs, religion, traditions and behaviours. The nurses surveyed in the current thesis encountered many communication challenges in their work environment, in particular those that arose from cultural and linguistic diversity. As a result, the healthcare outcomes could be argued to be less than optimal.

The conceptual framework of sociocultural paradigms was utilised and then critiqued in terms of its application to the findings from the current study. According to the SCT, understanding cultural sensitivity enables optimal nursing care for
culturally specific groups across a spectrum of gender, age, culture, nationality, background and other factors. The findings of this study have been adapted to inform a modified conceptual framework that underpins the current study. The modified SCT added an element of where did cognition come from international and local nurses to effectively communicate with patients in KSA health organisations.

**7.3 Summary of the Findings**

The study consisted of two phases that addressed key research questions related to barriers and facilitators of nurse-patient communication in a Saudi Arabian context. The invited hospitals represented different affiliations and were in general representative of those in Saudi Arabia and both men and women in regards to their experience with communication with Arabic patients in KSA hospitals.

**7.7.1 Phase 1**

The target population for this study was full-time registered nurses assigned to adult medical and surgical departments including both local nurses and international nurses working at Hail public hospitals in Saudi Arabia. A simple random sampling was utilised in phase 1. In the first instance, the quantitative data indicated that the effect of nurses’ nationality was found to be statistically significant according to the NSACS subscale. The Filipino nurses scored higher than nurses of other nationalities on the personal/social NSACS Scale. The implications were that international non-Filipino nurses perceived greater barriers to communication with respect to their personal/social characteristics than the nurses of other nationalities. The reasons behind that, as critiqued in Chapter 6, could be informed by cultural differences and similarities between the nurses and their patients in health settings. Another important finding was the significant difference between the participants’ years of experience and their communication skills towards patients in a Saudi
Arabian context. The implications were that nurses with shorter experience perceived greater barriers to communication with respect to the clinical situation of patients and the environmental NSACS subscales than did the nurses with longer clinical experience. Additional empirical findings in the current study included the effect of nurses attending specialist communication courses, the implications being that nurses who had not attended specialist courses perceived greater barriers to communication with respect to personal characteristics and job specifications NSACS subscales than the nurses who had attended courses.

7.7.2 Phase 2

For phase 2, a total of 34 consenting participants were invited from phase 1 who were from either Saudi Arabia, the Philippines, India or Indonesia. Upon completion of the focus group, 23 participants engaged in four independent focus group sessions. The findings showed that there were individual nuances, which included language barriers, cultural barriers and gender barriers, that hindered effective nursing communication. According to the nurse participants, Arabic was a difficult language and they had to contend with different dialects. The differing cultural backgrounds between the international nurses and Saudi patients posed a difficulty that nurses had to overcome. The nurses also had to deal with cultural complexities such as the practice of Ramadan and fasting, the issue of traditional Arabic medicine, age and illness of the patients affecting their way of communicating, as well as the effects of pain. Also of considerable concern were the gender barriers nurses had within the cultural context, as seen in that male patients in Saudi Arabia refusing to be cared for by male nurses. Conversely, the female nurses preferred or were culturally restricted not to care for male patients.
The application and use of professional nursing standards facilitated effective communication as seen in more awareness of acceptance and trust between the patients and the nurses. According to the nurses, their salary may or may not affect their communication style and the effectiveness of the style they have. However, professional assistance from senior colleagues was important for effective communication. Unique to KSA, the senior colleagues were seen to serve as role models due to their previous experience with the language and culture. The extent of the nursing workload was also seen to affect the effectiveness of nursing communication. The higher the workload of the nurses, the less time they would have to communicate with patients and the less time they would have for other responsibilities. In the Middle East, the timing and duration of shift work also affected the nature of communication interaction with patients. The heavier the workload, the nurses had less perceived effectiveness their communication. The complex and cumbersome KSA workload organisation systems contributed to these problems, made worse when personal issues, tiredness and poor mood were also factored in.

The KSA nurse participants recommended specific communication approaches and policies that would shape their communication levels effectively. The finding of insufficient knowledge of Saudi Arabia society and the associated cultural context needs to be addressed through targeted education. The current study findings recommend that KSA hospitals develop guidelines such as cultural and contextual courses as well as patient-centred nursing care delivery approaches to facilitate effective communication. The use of documentation between nursing shifts and iPhone apps can also help in making communication effective and culturally competent. The participants also claimed that there should be educational offerings
and orientation programs in both basic and in-service nursing education. In particular, for newly recruited international nurses, education programs should be developed supported by guidebooks about Islamic religion and how to be accepting of others. The nurse participants also claimed that the hospital should provide professionally educated bilingual translators on each shift on call as well as several multilingual signs and directional markers.

The next section identifies the how the current study met the research objectives and research questions.

7.4 Strength of the Study

The present study is unique in its examination of barriers and facilitators of nurse-patient communication within a culturally unique, complex Arabic context. The empirical findings in the current study offer a comprehensive understanding of the cultural values, work experience and benefits of professional education in communication for both Saudi and international nurses employed in Saudi Arabian hospitals. Despite the limitations as stated in Chapter 6, the current study has attended to a gap in the literature by examining the barriers and facilitators of nurse-patient communication in Saudi Arabia. Recommended is the process of establishing an educational program delivered online and through iPhone apps in order to enhance communication skills for both local and international nurses. The study provides a critical discussion on the cultural influences on Arabic patients’ health status. It points to the need for changes in the current communication style and contends the importance of policy makers implementing new protocols to enhance communication and patient safety in Saudi Arabia.
7.5 Implications for Clinical Practice

This study informs the future development of systemic guidelines and protocols for international and local nurses to develop and sustain effective communication with Arabic patients in KSA hospitals. Appropriate application of these protocols would facilitate nurses’ communication towards Arabic patients, thereby maximising the effectiveness of nursing interventions.

Collaborative efforts across the boundaries of healthcare, between all policy makers, patients, nurses, doctors and hospital stakeholders are needed for the development of effective nurse-patients communication protocols within a Middle Eastern context. For instance, creating teams with mixed gender, cultural backgrounds length of work experience, with international and local nurses working together on the same shift to provide optimal nursing care for Arabic patients in KSA hospitals. Effective communication and cultural competency are increasingly essential in providing healthcare today. It is strongly recommend that nurses improve their understanding of the Arabic culture by way of a six week tailored program on cross-cultures and common Arabic words to improve international understanding of the Arabic culture and local patients’ dialects. These can take the form of both online and face-to-face modules. Furthermore, including the language of some healthcare issues such as communicating pain would need to be accommodated in the form of pain workshops plus online sessions of common Arabic expressions of pain.

The findings call for the nursing profession to recognise that there exists subcultures, ethnic groups or ethnocultural populations—groups who have experiences different from those of the dominant culture with which they identify. This may be by nationality, language, socioeconomic status, education, sexual orientation or other factors that functionally unify the group and act collectively on
each member with a conscious awareness of these differences. In KSA hospitals, the
presences of professional translators with a deep knowledge of ethics were essential
to secure patient safety and provide effective communication. Therefore, the current
study recommended the utilisation of well-trained translators who are able to use
their skill in Arabic and a foreign language such as English to provide professional
services to patients and doctors alike. The person who is acting as a translator should
be highly skilled in the medical terminology, with an ability to adapt to different
dialects in Saudi culture and have a professional attitude in order to provide
competent communication and ensure high-quality healthcare. Hospitals translators
should also have in-depth knowledge of the Middle Eastern culture of their patients.
Translators should rely on strong and unbiased interpersonal skills with patients
families in order to facilitate communication and provide optimal care. Moreover,
hospital translators must demonstrate strong commitment to professionalism and
code of ethics, especially in the area of patient confidentiality. Failure to use a
qualified professional translator in medical settings can lead to breaches in patient
confidentiality and can compromise quality patient care.

Furthermore, in Saudi Arabia, nurses need additional attention drawn to
patients’ disease trajectory and their readiness to communicate in light of cultural
backgrounds. Linguistically appropriate nursing care must be expanded to use
language, examples and descriptions that all healthcare nurses can understand. An
important component would be that of evaluation by actively seeking feedback for
assessing current levels of shared understanding in order to direct future
communications.
The next section outlines essential nursing communication recommendations in relation to the hospital workforce, organisational strategies and continuing professional education development.

### 7.6 Recommendations

#### 7.7.1 Nursing education and continuing professional development

The onus is on the healthcare organisations of the Middle East to provide relevant, accessible educational packages, both orientations as well as ongoing refresher courses, to improve their health workforce and in particular nursing understanding of communication processes. The current study identified specific continuing of nurse education in order to increase the quality of care and maintain patient safety in a multicultural environment. Recommend is a well-structured continuing education packages for graduate nurses when they commence employment that aims to increase their communication skills, to enable them to provide high quality care and practice high levels of patient safety, including emotional, psychological, spiritual, cultural, professional and physical safety. In addition, these educational packages should utilise and employ the optimal learning approaches to ensure participation, comprehension and understanding.

In relation to educational programs and workshops in a multicultural environment, the study findings recommend the need for an ongoing evaluation process of the nurses’ understanding of the courses’ content, which evaluates the effectiveness of cross-cultural communication. Such evaluation is important in a multicultural environment, because English is not the first language for most of the nurses hired from Asian and Arabic countries and they therefore have varying levels of proficiency in the language. Additional recommendation in terms of training courses is to offer them to all staff and employees such as doctors, social workers,
nurses, nursing students and other staff who have patient contact or play a role in the delivery of patient care. Also, improving cultural education programs for health staff working with Arabic patients should involve building a comprehensive database of the cultural education programs and materials available to service providers, who are often unaware of such resources (expanding on existing publications such as the Cross-Cultural Communication Guide used in Hail, KSA). Moreover, it is recommended to develop resources to support self-directed learning that can be easily accessed by staff to meet their changing needs and are regionally specific in order to address specific workplace needs.

7.7.2 Health service delivery care and hospital policy

A key finding from the data and subsequent recommendations was that teamwork was needed to improve communication. Indeed, developing and implementing a standard set of behaviour policies and procedures is vital. It is recommended that hospitals initiate a process to educate and train current international and local nurses in the utilisation of team-based, patient-centred practice. This can include repeated monthly lessons in team training and simulations focusing on inter-professional communication, allowing opportunities for nurses, doctors and social workers to work together to provide optimal care for Arabic patients. In the qualitative data, the overall collaboration among the entire unit staff was seen to be important for nursing team members to communicate effectively with their patients.

In KSA, it is of paramount importance that chief nurse directors, chief medical managers and hospital administrations cooperate on a team based cultural and linguistically centred framework to work towards improving relationships between patients and health providers. Prior to implementation, hospital
administrations must make sure all employees are familiar with the existence, purpose and intent of the policies and procedures. Moreover, policies and procedures training should be implemented every four months for all hospital staff. Policies should focus on building team collaboration as well as accentuate the importance of trust and respect as core cultural competent of the Saudi Arabian health service delivery. Central to these teams should be the embedding of the findings on open communication, shared decision-making and feedback.

Interactive multimedia training materials are a currently under-utilised option that could be accessed on CD/DVDs, smartphones and/or the internet, as well as through the Ministry of Health in Saudi Arabia intranet, therefore, accessible to all public service staff at any time, at no cost. Moreover, an evaluation of current cultural education practices across a range of health services could be productive given the concerns of both users and providers about current inadequacies in cultural education services. Further documentation and research of good practice in cultural education and its consequences could inform future developments in this area.

7.7.3 Future research

The quantitative and qualitative components in this study investigated the influence of communication barriers and facilitators towards patients in a Arabic context from the perspective of international and local nurses. A limitation was that only the nurses were interviewed; for this reason, future research is recommended to explore qualitatively patients’ perspectives on the barriers and facilitators of communication in this multicultural environment where they are being treated by nurses from different cultural and linguistic backgrounds. The patient’s voice is central because patients are care recipients and are in a position to judge the quality of care and express their feelings about effective communication.
Future research is recommended to investigate independent nurses groups according to their experience and religion and cultural competency in multiple health settings, such as registered nurses and nurse educators. The inclusion of the nurse educators is important, because educators are dealing with nurses from different cultural and linguistic backgrounds; their cultural competence is important to ensure effective communication skills education.

Some participants may be uncomfortable sharing their thoughts in front of a group or group discussions may limit individual comments depending on the dynamics of the group and the topic of discussion. Therefore, further research instruments should be established with subscale designed accommodate religion, culture and families practices. In addition, these new inventions should measure and eliminate acquiescent response bias. It is recommended also, to develop new self-administered communication surveys in Arabic with key subscales of gender, religion, culture and language to capture Arabic patients’ perspectives in order to measure nurse-patient communication and explore current communication inefficacy in KSA hospitals.

7.7 **Conclusion**

Communication is essential in order to provide high quality healthcare, promote patient satisfaction and patient adherence with treatment. Nurses should therefore understand perception differences between patients and nurses and practice strategies to reduce the associated communication barriers. This study contributes to promoting awareness and the importance of recognising the barriers and facilitators of nurse-patient communication in multicultural diversity in order to provide improved healthcare outcomes for patients in the Hail region of Saudi Arabia. Also, this project indicated the need for effective orientation and ongoing educational
packages on communication skills for newly employed Saudi and expatriate nurses.

This research has provided significant and new knowledge in the area of effective communication skills in Middle Eastern healthcare settings, and can be used to facilitate communication and improve patient care outcomes in multicultural contexts.
References


REFERENCES


REFERENCES


REFERENCES


Health in South Western Sydney. (2000). *Epidemiological profile*. Epidemiology Unit, South Western Sydney Area Health Service.


REFERENCES


Kitzinger, J. (1994). The methodology of focus groups: The importance of interaction between research participants. *Sociology of Health & Illness, 16*(1), 103–121.

REFERENCES


REFERENCES


Appendix A: Research Approval from CHEAN

25th May 2011

Bander Albagawi
44/14 Bell Street
Coburg VIC 3058

Dear Bander

BSEHAPP 07 – 11 ALBAGAWI Examining Barriers and Facilitators to Effective and Safe Nursing Communication within a Saudi Arabic Cultural Context

Thank you for submitting your amended application for review.

I am pleased to inform you that the CHEAN has approved your application for a period of 7 Months to December 2011 and your research may now proceed.

The CHEAN would like to remind you that:

All data should be stored on University Network systems. These systems provide high levels of manageable security and data integrity, can provide secure remote access, are backed up on a regular basis and can provide Disaster Recover processes should a large scale incident occur. The use of portable devices such as CDs and memory sticks is valid for archiving; data transport where necessary and for some works in progress.

The authoritative copy of all current data should reside on appropriate network systems; and the Principal Investigator is responsible for the retention and storage of the original data pertaining to the project for a minimum period of five years.

Annual reports are due during December for all research projects that have been approved by the College Human Ethics Advisory Network (CHEAN).

The necessary form can be found at: [http://www.rmit.edu.au/governance/committee/hrec](http://www.rmit.edu.au/governance/committee/hrec)

Yours faithfully,

Linda Jones
Acting Chair, Science Engineering & Health
College Human Ethics Advisory Network

Cc CHEAN Member: Amanda Kimpton School of Health Sciences
Supervisor: Eleanor Hulroyd School of Health Sciences
Appendix B: Permission from the Hail Region Health Affairs Directorate, Saudi Arabia

Dear Mr. Bander Saud Al-Bagawi

15 December 2010

It is my pleasure to inform you that we approved your study titled: Examining the Barriers and Facilitators of Effective Nurse’s Communication in Related to Patient Safety within a Saudi Arabic Cultural Context.

Please be informed that in conducting this study, you as Principle Investigator is required to abide by the rules and regulations of the Government of Saudi Arabia and Ministry of Health. The approval of this proposal will automatically be suspended 2 March 2012 pending the replication to renew the approval.

Please observe the following:

1. Personal identifying data should only be collected when necessary for research;
2. The data collected should only be used for this proposal;
3. Data should be stored securely so that only a few authorised users are permitted access to the database;
4. Secondary disclosure of personal unidentified data is not allowed.

An ethical approval from human ethics committee in RMIT Australia is required to begin collecting your data at Hail region hospitals. General Director of Health Affairs in Hail Region support this research project and look forward to receiving a copy of the final result and dissertation.

Should you have any inquiries or concerns in relation to this approval do not hesitate to contact Mr. Talal Majed on +96665381077, or by email at talal7990@hotmail.com.

We wish you every success in your research endeavor.

Sincerely,

Dr. Nawaf Al Hamby
General Director of Health Affairs
Hail, KSA
Appendix C: Project Information Statement

Nurses’ Survey

Invitation to participate in a research project

Project Information Statement Nurses Survey

Project Title:

- Examining Barriers and Facilitators to Effective and Safe Nursing Communication within A Saudi Arabian Cultural Context.

Investigators:

<table>
<thead>
<tr>
<th>Mr Bander Albagawi</th>
<th>Professor Eleanor Holroyd</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Nursing PhD Candidate)</td>
<td>(Project Supervisor: School of Health Sciences, RMIT University,</td>
</tr>
</tbody>
</table>

Dear Participant,

You are invited to participate in a research project being conducted by RMIT University, Melbourne Australia. This information sheet describes the project in straightforward language, or ‘plain English’. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?

You are invited to participate in the above research project, which is being conducted by Mr Bander Albagawi (PhD Candidate) of the Discipline of Nursing at RMIT University. Your contact details were obtained from the hospital’s nursing office. A special permission was obtained from Hail Region Health Affairs Directorate prior of collecting your information. This project will form part of Mr Bander Albagawi PhD thesis, and is being conducted under the supervision of Professor Eleanor Holroyd, and has been approved by the RMIT Human Research Ethics Committee.

Why have you been approached?

As a professional nurse, you are invited to take part in a research study on Examining Barriers and Facilitators to Effective and Safe Nursing Communication within a Saudi Arabian Cultural Context.

What is the project about? What are the questions being addressed?

This project aims to provide an evidence base from which to develop standardised nurse communication guidelines in order to prevent current communication barriers in Saudi Arabia hospitals. It will contribute to promoting awareness of the importance of an understanding of multicultural diversity among nursing staff in order to provide more effective communication and improved healthcare outcomes for patients in the Hail region of SA, which could in turn be generalised in the form of communication and safe practice protocols for all Arabian general hospitals. Also, this project will help to build effective orientation and ongoing educational packages for newly employed Saudi and expatriates nurses.
If I agree to participate, what will I be required to do?

Should you agree to participate, you would be asked to complete 15–20 minutes questionnaire. Once completed kindly use the prepaid envelope provided with the letter and drop it in the return box located at nursing office. If you are currently on leave and received this letter by mail, kindly use the prepaid attached envelope and drop it to your nearest mailbox/office. Informed consent is implied by submission of the survey. You are encouraged to examine or browse through the questionnaire as it may aide in your decision to participate in the study.

What are the risks or disadvantages associated with participation?

While there are no direct risks or disadvantages involved in your participation in the present study, if you feel concerned about your responses to any of the questionnaire items or if you find participating in the project distressing in any way, you should contact Bander Albagawi as soon as convenient. Bander Albagawi will discuss your concerns with you confidentially and suggest appropriate follow-up if necessary.

What are the benefits associated with participation?

While there are no direct benefits for participating in this study, your participation will assist improved health outcomes by maximising communication and hence ensuring both patient safety and optimal practices are adhered too, thereby improving the health of KSA.

What will happen to the information I provide?

The only individuals with access to the information you provide are the primary investigator and the project supervisor. The findings from this study may be presented at conferences or published in scientific journals. If this does occur, only group data will be presented and under no circumstances will individual scores be reported.

What are my rights as a participant?

As a participant, you have the right to have any questions answered at any time. You also have the right to withdraw from the study prior to completion of the questionnaire, without prejudice. You are welcome to read this information sheet and browse through the questionnaire prior to deciding whether you would like to participate. Since the research is completely anonymous, there will not be any identifying information located on your submitted questionnaire. As such, it will not be possible to withdraw your data from the study once your questionnaire has been submitted.

Whom should I contact if I have any questions?

If you have any questions, you should contact Bander Albagawi via email at.

Alternatively contact the primary supervisor Eleanor Holroyd on, or by email at.

Bander Albagawi Eleanor Holroyd

PhD Candidate Project Supervisor

This information sheet is yours to keep.
Appendix D: Demographic form

DEMOGRAPHIC FORM
Please answer the following questions. Complete the blanks or check the boxes next to the category that best describes your situation.

1. What is your date of birth? __ / __ / __ __ __
   dd mm yyyy

2. What is your gender? □ 1 Male □ 2 Female

3. What is your religion? □ 1 Islam □ 2 Buddhist □ 3 Hindu
   □ 4 Christian □ 5 others (specify) ________

4. Where are you from? □ 1 Saudi Arabia □ 2 Philippines □ 3 India
   □ 4 South Africa □ 5 others (specify) ________

5. What is your racial or ethnic background? *(Please check all that apply)*
   □ 1 Caucasian
   □ 2 Arabic
   □ 3 American-Indian/Alaska Native
   □ 4 Asian
   □ 5 African

6. What is your current relationship status?
   □ 1 Never married
   □ 2 Married
   □ 3 Living with partner in committed relationship
   □ 4 Separated
   □ 5 Divorced
   □ 6 Widowed

7. What is the highest grade in school that you completed?
   □ 1 Elementary/primary school
   □ 2 Secondary/high school
   □ 3 Some college
   □ 4 Undergraduate degree
   □ 5 Postgraduate degree

8. What is your current occupational status?
   □ 1 Full-time employed
   □ 2 Part-time employed
   □ 3 others

9. Have you worked in the Saudi Arabia before? *(please √ one)* □ 1 Yes □ 2 No

10. How long have you worked in this hospital?
    □ 1 (1–4 month) □ 2 (4–8 month) □ 3 (8–12 month)
    □ 4 (12–24 month) □ 5 > 24 month. Please specify the number of month ________
11. What are specialist courses that you have undertaken in post grad? *(Please check all that apply)*

☐ 1 Communication skills  ☐ 2 Patient safety policies  ☐ 3 Saudi Arabia culture program
☐ 4 Arabic language vocabulary  ☐ 5 Others (specify) _______________________

Please feel free to add any additional comments:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Return to (name) ____________________________ by (date/time) _____________
at (place) ________________________

Thank you for your participation in this research project.
### Appendix E: NSACS

Please select one response in respect to communication indicates the extent you agree with the following statements:

<table>
<thead>
<tr>
<th>No.</th>
<th>Nurses self-administered communication</th>
<th>Completely agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Completely disagree</th>
</tr>
</thead>
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<tr>
<td></td>
<td><strong>Section 1: Personal &amp; Social Characteristics (10 items)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1</td>
<td>Age difference</td>
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<tr>
<td>2</td>
<td>Sex difference</td>
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<tr>
<td>3</td>
<td>Nurses religion</td>
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<tr>
<td>4</td>
<td>Nurses nationality</td>
<td></td>
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<tr>
<td>5</td>
<td>Unfamiliarity with dialect</td>
<td></td>
<td></td>
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<td>6</td>
<td>Social class difference</td>
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<td>7</td>
<td>Problems outside work environment</td>
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<tr>
<td>8</td>
<td>Unfamiliarity with nursing job description</td>
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<tr>
<td>9</td>
<td>Aggressiveness of nurses</td>
<td></td>
<td></td>
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<tr>
<td>10</td>
<td>Too much expectation of patients</td>
<td></td>
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<td></td>
<td><strong>Section 2: Job Specifications (9 items)</strong></td>
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<tr>
<td>11</td>
<td>Lack of welfare facilities for nurses</td>
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<tr>
<td>12</td>
<td>Low salary</td>
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<td>13</td>
<td>Hard nursing tasks</td>
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<tr>
<td>14</td>
<td>Heavy nursing workload</td>
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<tr>
<td>15</td>
<td>Nursing shift work</td>
<td></td>
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<td>16</td>
<td>Lack of interest to work</td>
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<tr>
<td>17</td>
<td>Nurses’ burn-out (physical and mental tiredness)</td>
<td></td>
<td></td>
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<tr>
<td>18</td>
<td>Patient contact with different nurses</td>
<td></td>
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<tr>
<td>19</td>
<td>Lack of information &amp; skills in communication</td>
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<tr>
<td></td>
<td><strong>Section 3: Clinical Situation of Patients (4 items)</strong></td>
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<tr>
<td>20</td>
<td>History of hospitalisation</td>
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<tr>
<td>21</td>
<td>Presence of a helper for providing care</td>
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<tr>
<td>22</td>
<td>Disease severity</td>
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<td>23</td>
<td>Having a contagious disease</td>
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<td></td>
<td><strong>Section 4: Environmental</strong></td>
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</table>
## Factors (7 items)

<table>
<thead>
<tr>
<th></th>
<th>Factors</th>
<th>agree</th>
<th>disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Lack of educational background in communication skills</td>
<td></td>
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<tr>
<td>25</td>
<td>Lack of continuing education in communication skills</td>
<td></td>
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<tr>
<td>26</td>
<td>Lack of welfare and medical facilities for patients</td>
<td></td>
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<tr>
<td>27</td>
<td>Poor sanitation in patients’ rooms</td>
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<tr>
<td>28</td>
<td>Feeling of injustice at workplace</td>
<td></td>
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<tr>
<td>29</td>
<td>Lack of managerial appreciation from nurses</td>
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<tr>
<td>30</td>
<td>Lack of nurses’ participation in decision-making</td>
<td></td>
<td></td>
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</tbody>
</table>

Would you like to participate in the focus group session*: □ Yes □ No

*Note: If you wish to participate in the focus group sessions, you should contact Bander Albagawi via email with your name and contact details.
Appendix F: Permission to Use the NSACS

Permission Request

Permission Requests - UK permissionsuk@wiley.com

Dear Bander Albagawi,

Thank you for your email request.

Permission is granted for you to use the material requested for your thesis/dissertation subject to the usual acknowledgements and on the understanding that you will reapply for permission if you wish to distribute or publish your thesis/dissertation commercially.

Permission is granted solely for use in conjunction with the thesis, and the article may not be posted online separately.

Any third party material is expressly excluded from this permission. If any material appears within the article with credit to another source, authorisation from that source must be obtained.

Kind Regards

Emma Wilcox
Permissions Assistant
John Wiley & Sons Ltd.
Appendix G: Project Information Statement—Nurses

Focus Group

Invitation to participate in a research project

Project Information Statement Nurses Focus Group

Project Title:

- Examining Barriers and Facilitators to Effective and Safe Nursing Communication within A Saudi Arabian Cultural Context.

Investigators:

<table>
<thead>
<tr>
<th>Mr Bander Albagawi</th>
<th>Professor Eleanor Holroyd</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Nursing PhD Candidate)</td>
<td>(Project Supervisor: School of Health Sciences, RMIT University,</td>
</tr>
</tbody>
</table>

Dear Participant,

You are invited to participate in a research project being conducted by Discipline of Nursing and Medical RMIT University, Melbourne Australia. This information sheet describes the project in straightforward language, or ‘plain English’. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project? Why is it being conducted?

You are invited to participate in the above research project, which is being conducted by Mr Bander Albagawi (PhD Candidate) of the Discipline of Nursing at RMIT University. Your contact details were obtained from the hospital’s nursing office. A special permission was obtained from Hail Region Health Affairs Directorate prior of collecting your information. This project will form part of Mr Bander Albagawi PhD thesis, and is being conducted under the supervision of Professor Eleanor Holroyd, and has been approved by the RMIT Human Research Ethics Committee.

Why have you been approached?

As a professional nurse, you are invited to take part in a research study on Examining Barriers and Facilitators to Effective and Safe Nursing Communication within a Saudi Arabian Cultural Context.

What is the project about? What are the questions being addressed?

This project aims to provide an evidence base from which to develop standardised nurse communication guidelines in order to prevent current communication barriers in Saudi Arabia hospitals. It will contribute to promoting awareness of the importance of an understanding of multicultural diversity among nursing staff in order to provide more effective communication and improved healthcare outcomes for patients in the Hail region of SA. Also, this project will help to build effective orientation and ongoing educational packages for newly employed Saudi and expatriate nurses.
If I agree to participate, what will I be required to do?

Should you agree to participate, we would ask you to participate in a focus group sessions of about 50 minutes, so that we can get a more detailed picture of current situation and what improvements could be made. With your permission, the focus group sessions would be tape-recorded so that we can ensure that we make an accurate record of what you say.

What are the risks or disadvantages associated with participation?

While there are no direct risks or disadvantages involved in your participation in the present study, if you feel concerned about your responses to any of the focus group questions or if you find participating in the project distressing in any way, you should contact Bander Albagawi as soon as convenient. Please note that loss of anonymity will occur for focus group participants and all participants are asked to keep names of participants and their contributions confidential. Bander Albagawi will discuss your concerns with you confidentially and suggest appropriate follow-up if necessary.

What are the benefits associated with participation?

While there are no direct benefits for participating in this study, your participation will assist improved health outcomes by maximising communication and hence ensuring both patient safety and optimal practices are adhered too, thereby improving the health of KSA.

What will happen to the information I provide?

I will protect your anonymity and confidentiality as participants and your contributions by: identifying individuals by numeric code rather than name, ensuring that participant names do not appear on any documentation; restricting access to collected data by the researcher only (only the recorder and facilitator will have access to the raw data); ensuring that transcribed data is checked for accuracy and validated by the participant and de-identified for anonymity prior to sharing results with others. Collected data will remain securely locked until it is manually destroyed following release of final thesis. The findings from this study may be presented at conferences or published in scientific journals. If this does occur, only group data will be presented and under no circumstances will individual scores be reported.

What are my rights as a participant?

Your decision whether or not to participate in this project will not prejudice any future relations your hospital. If you agree to participate in the focus group, please read the attached Focus Group and Consent Form and sign where indicated. Kindly bring the signed consent form with you to the focus group session. If you do not wish to participate in this research study, kindly leave a voice message as soon as possible and your name will be removed from the follow-up list. You will not be contacted again regarding the focus group. If you withdraw from the study midstream, the data you have provided will be included unless you request it be removed.

Whom should I contact if I have any questions?

If you have any questions, you should contact Bander Albagawi via email.

Alternatively contact the primary supervisor Eleanor Holroyd, or by email.

Bander Albagawi
Eleanor Holroyd
PhD Candidate Project Supervisor

This information sheet is yours to keep.

Any complaints about your participation in this project may be directed to the Executive Officer, RMIT Human Research Ethics Committee, Research & Innovation, RMIT, GPO Box 2476V, Melbourne, 3001.
Details of the complaints procedure are available on the ‘Complaints with respect to participation in research at RMIT’ page
Appendix H: Nurses’ FG Consent Form

NURSES’ FOCUS GROUP CONSENT FORM

Portfolio
School of
Name of participant:
Project Title:

Science, Engineering and Health
Health science
Examing Barriers and Facilitators to
Effective and Safe Nursing
Communication within a Saudi
Arabian Cultural Context

Name(s) of investigators: Bander Albagawi
(1)
Eleanor Holroyd
(2) Phone:

1. I have received a statement explaining the interview/questionnaire involved in this project.
2. I consent to participate in the above project, the particulars of which - including details of the interviews or questionnaires - have been explained to me.
3. I authorise the investigator or his or her assistant to interview me or administer a questionnaire.
4. I acknowledge that:
   a. Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
   b. I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
   c. The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
   d. The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
   e. The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to RMIT Library. Any information which will identify me will not be used.

Participant’s Consent

<table>
<thead>
<tr>
<th>Participant:</th>
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Participants should be given a photocopy of this consent form after it has been signed.

Any complaints about your participation in this project may be directed to the Executive Officer, RMIT Human Research Ethics Committee, Research & Innovation, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 2251.
Details of the complaints procedure are available from the above address.
Appendix I: Nurses Focus Group Questions (Semi-Structured)

Nurses Focus Group Questions (Semi-Structured)

1. In your point of view, what are the barriers effective nurse communications in term of nurse-patient relationships in your hospital?
2. What are the facilitators to effective nurse communication in term of nurse-patient relationships in your hospital?
3. Do the current guidelines or approach in your hospital ‘if any’ mean that you can ensure effective and safe nursing communication in your hospital? If so how and if not why not?
4. In what ways do you think that nursing heavy workload will affect nurse communication towards patients?
5. How do you think the beliefs of your home country about shift work, may influence nurse communication towards your patients?
6. How might or might not the presence of a bilingual helper for providing care will facilitate communication between nurse and patients as non-Muslim nurse?
7. As experienced nurse, what are the ways in which you consider a patient disease severity may interfere with communication with patients?
8. For those local nurses; do you believe that lack of good organisational conditions and support services for nurses impacts on the quality of nurse communication?
9. How would you prefer to learn about effective and safe nursing communication in your hospital? For example, some people prefer to learn individually or as part of a team. What’s important to you, and what helps you, to learn about effective and safe nursing communication in your area of work?
10. In your experience as foreign nurses in KSA nurse, would you find it helpful to refer to a small booklet or DVD, IPhone program, containing simple Arabic phrases? Please state why?
11. Closing question: Do you have any other comments or remarks about the focus group questions?