

Nurse-Parent Communication in Pediatric Units of B. P Koirala Institute of Health Sciences, Dharan, Nepal: A Parent's Perspective Study

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Abstract: *Background & Objective:* Communication is challenging in pediatric setting. Parent's need for communication may not always be met by the nursing staff. So, this study aimed to describe the influencing factors, strength and weakness of nurse-parent communication. *Materials & Methods:* A descriptive cross-sectional study with 150 parents of hospitalized children was carried out at Pediatric Unit I & II of BPKIHS, Dharan. Consecutive sampling technique using pre-tested self-prepared semi structured interview questionnaire was used for the data collection. Parents' perspective about their communication with the nurses was interviewed. Collected data were analyzed using descriptive and inferential statistics. *Results:* The mean age of the parents was 30 years. Parents rated communication with the nursing staff positively and about 68% of the parents felt that it was easy to communicate with the nurses. About 61% described strength and about 39% described weakness of nurse-parent communication. More than half (52%) of the parents were completely satisfied with the communicating nurses. Mother tongue, ethnicity, ability to understand Nepali language by parents, length of hospital stay and discharge of the child are statistically significant with nurse-parent communication (0.010, 0.004, 0.005, 0.045 & 0.030 respectively). *Conclusion:* The findings concluded that majority of the parents had received emotional support and regular information from the nurses and mother tongue, ethnicity, ability to understand Nepali language by the parents, the length of hospital stay and discharge of the children were associated with nurse-parent communication and were the factors influencing the nurse-parent communication in the study. Thus, these factors should be considered for effective communication in pediatric settings.

Keywords: Nurse, Parent, Communication, Pediatric Units

1. Introduction

Communication is at the heart of which, we are as human beings[1]. Communication skills have long been recognized as an important element of nursing, and nursing training, with many arguing that effective communication is fundamental to quality nursing practice. Research suggests that nurses lack necessary communication skills due to inadequate training, and at times, an under appreciation of the importance to patient-centered communication [2].

According to child life specialists play and developmentally appropriate communication are used to: promote optimal development; educate children and families about health conditions; prepare children and families for medical events or procedures; plan and rehearse useful coping and pain management strategies; help children work through feelings about past or impending experiences; and establish therapeutic relationships with patients, siblings, and parents to support family involvement in each child's care [3].

Participants in communication reciprocally influence each other through both verbal and nonverbal behaviors. Medical jargon, which can be meaningless to laypersons, can create fear, irritation, intimidation, and confusion for children and their families and thereby create communication failures [4].

The ability to interact positively with patients and their

families who are facing crisis during illness and hospitalization is essential for professional nursing care. Communication with child patients and their parents can be one of the most challenging tasks for pediatric nurses. Often, nurses tend to interact with caregivers (usually mothers) rather than with their young patients [5].

Objectives

- To assess the factors influencing nurse-parent communication in pediatric wards.
- To describe the strength and weakness of nurse-parent communication in pediatric wards.
- To find out the association between selected variables and nurse-parent communication.

2. Materials and Methods

Design: A cross-sectional descriptive study design. **Setting:** Pediatric Units I & II of BPKIHS, Dharan. **Sample Size:** The total cases of hospital stay of 3 days or more in the month of April 2014 Pediatric Ward-I was 66 and for Pediatric ward-II was 69 ie 135. As per Medical Record section data of 2013/014 B.S, the total patient admitted in Pediatric unit I and Pediatric Unit II was 1495. So, taking 10% of 1495, the sample size calculated was 149.5 \cong 150. Thus, the calculated sample size was 150. **Sampling Technique:** Consecutive Sampling Technique. **Research Instrument:** A self-prepared, pretested semi-structured

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interview questionnaire was used. Data Collection Procedure: Data was collection after obtaining permission from the Institutional Review Committee and all the concerned authority of BPKIHS. Pretesting and was done and necessary modifications was done in the tool before starting data collection procedure. Informed written consent was obtained from each respondent. Data collection period was of 4 weeks from 21st December 2014 to 17th January 2015. **Data Analysis Procedure:** Collected data were analyzed using descriptive statistics (Mean, Median, Mode, Standard Deviation, Inter Quartile Range, Percentage and Frequency) and inferential statistics (z test and One Way ANOVA) using SPSS version 16. The p-value was calculated at 95% Confidence Interval and 5% permissible error. Applying tests of normality, the distribution of the data was checked and so Parametric tests were used.

3. Results & Findings

The findings of the study showed that about 69% of the parents were mother of the index child. More than half (58.7%) of the parents spoke Nepali language followed by Maithili (26%) as their mother tongue.

Nearly 67% of the parents were from ecological zone, Terai and only 29% were from Mountain zone. Nearly half (48.7%) of the parents belonged to Disadvantaged Janajatis (Rai, Limbu, Magar, Tamang, Sherpa, Tharu, Rajbanshi, Meche, Satar and Koche) followed by Disadvantaged Non-Dalit Terai Caste Groups (Yadav, Teli, Kalwar, Koiri, Sudhi, Kurmi, Haluwai, Hajam and Mallah).

More than half (53.3%) of the parents were living in joint family. Either father or mother of the child was only included in the study. In case of presence of the both parents, only father was included in the study. The mean age \pm S.D of the parents was 30.1 ± 8.3 years. Majority (84%) of the parents were literate.

Regarding socio-demographic characteristics of the child, the median age of the index child was 24 months. More than half (58%) were male child. About 62% of the child belonged to non-school going age group. Among 67 children, 55 children were able to understand Nepali language. The median length of the hospital stay in the pediatric ward was 4 days. The median duration of present illness was 7 days.

Regarding the nurse-parent communication majority of the parents had received orientation at the time of admission about store room (96.7%), visiting time/ hours (80.0%), waste management services (76.7%), bathroom & toilet facilities (66.0%) and drinking water-hot & cold supply (63.3%). Parents were also oriented about laboratory services (39.3%), admission procedure and rules and regulations of pediatric ward (38.0%), pharmacy services inside (22.7%) bed charges (14.7%), recreation facilities/ Play room for children (14.0%) and doctor and nurses round (14.0%). Parents received information and explanation about complications of disease (29.0%), drugs response (25.8%), prognosis of the disease (20.9%) treatment response (16.1%)

and investigation report (8.1%) as well.

The study consists of descriptive analysis of strength and weakness perceived by parents in their communication with the nurses in the pediatric units. Elements in the participants' descriptions of strength and weakness in nurse-parent communication were sorted into domains and categories. Each parent was asked about either strength or weakness. Multiple responses in case of domain but not in category were present. The five most common categories were reported. The parents' freely worded comments gave important information about the reasons for the satisfaction and dissatisfaction expressed as strength and weakness in the study.

Sixty-one percent of the parents described strengths and about 39% described weakness of nurse-parent communication. Among them, majority of the parents described emotional support (89.1%), good information giving (100.0%), professionalism of nurse (75.8%), and organizational strength (61.5%) in case of strength of nurse-parent communication. Regarding weakness of nurse-parent communication, almost all (100%) perceived lack of emotional support, about 78% perceived poor information giving, about 86% perceived lack of professionalism and about 59% perceived organizational problems.

Table 1: Parental Perception regarding Domains of Nurse-parent Communication (n=150)

Domains of Nurse-Parent Communication	No. of items	Obtainable value	Minimum & Maximum Score	Mean \pm S.D	Mean Percentage Score \pm S.D
Information Giving and Supportive Communication	11	11-55	17-39	35.02 \pm 3.73	63.67 \pm 6.79
Communication related to respecting, enhancing and supporting parental role in care decisions	5	4-25	9-22	18.48 \pm 2.38	73.92 \pm 9.55
Communication related to emotional support	7	8-35	7-25	19.36 \pm 2.43	55.33 \pm 6.95
Total Score:	23	23-115	33-86	72.86 \pm 5.41	63.36 \pm 4.70

Table 1 depicted that the parents score for domains of nurse-parent communication. Out of total obtainable value 55 score, the domain information giving and supportive communication had mean score 23.05 ± 3.65 . Similarly, in domain communication related to respecting, enhancing and supporting parental role in care decisions, out of 25 obtainable score, the mean score was 15.67 ± 2.33 . In domain communication related to emotional support, out of 35 obtainable score the mean score was 13.67 ± 2.84 .

Regarding association with three subscales of nurse-parent communication, mother tongue, ability to understand Nepali language, ethnicity, type of family, age of parents,

educational status of parent, age of the children, sex of the children and ability to understand Nepali language by the children were not statistically significant with information giving and supportive communication whereas length of hospital stay and discharge of the children were statistically significant with information giving and supportive communication (p-value 0.002 and 0.002 respectively). This illustrates that the parents and children staying for more than 15 days in the ward were provided more information and supportive communication by the nurses as shown by mean \pm SD (68.14 \pm 5.36) than staying for less than 7 days (62.84 \pm 6.89). Similarly, during the discharge of the children nurses provided more information or discharge teaching than those who were not discharged (mean \pm SD: 64.35 \pm 8.31).

Mother tongue, ability to understand Nepali language, ethnicity, and length of the hospital stay and discharge of the children were statistically significant with parental role (p-value 0.010, 0.000, 0.004, 0.001 and 0.030 respectively). This depicts that those parents who had mother tongue Nepali were more communicated about parental role in care as that was easy to understand and explain by the parents and nurses (mean \pm SD: 76.09 \pm 8.89). Those parents staying for 3-7 days (75.83 \pm 9.09) and not discharged from the ward (74.99 \pm 9.56) were communicated more about parental role by the nurses. Mother tongue, ability to understand Nepali language by parents and children, ethnicity, type of family, age of parents and children, sex of children, educational status of parents, length of hospital stay and discharge of children were not statistically significant with communication related to emotional support.

Table 2: Association between Selected Socio-Demographic Variables of Parents and Nurse-Parent Communication (n=150)

Variables	Category	Frequency	Nurse-Parent Communication Mean Percentage Score	p-value
			Mean \pm S.D	
Mother Tongue*	Nepali	88	64.14 \pm 4.74	0.056
	Maithili	39	62.43 \pm 4.92	
	Kirant	16	62.77 \pm 3.60	
	Others	7	60.12 \pm 3.07	
Ability to understand Nepali language**	Yes	115	63.86 \pm 4.15	0.005
	No	35	61.71 \pm 5.97	
Ethnicity*	Disadvantaged Janajatis	73	64.08 \pm 4.40	0.120
	Disadvantaged Non-Dalit Terai Caste Groups	30	61.62 \pm 5.05	
	Upper Caste Groups	30	63.36 \pm 3.93	
	Others	17	63.32 \pm 6.05	
Type of Family**	Nuclear	70	63.50 \pm 4.39	0.733
	Joint	80	63.23 \pm 4.98	
Age of the parents (in years)*	< 20	4	59.34 \pm 6.86	0.348
	20-30	74	63.67 \pm 4.64	
	30-40	52	63.19 \pm 4.82	
	40-50	20	63.43 \pm 4.13	

Educational status of the parents**	Illiterate	24	61.99 \pm 4.57	0.120
	Literate	126	63.62 \pm 4.70	

Key:

* **One Way ANOVA test**

****Z test**

Table 2 showed that mother tongue, ethnicity, type of the family, age and educational status of parents are not statistically significant with the nurse-parent communication (p-value 0.056, 0.120, 0.733, 0.348 and 0.120 respectively) whereas ability to understand Nepali language by the parent is statistically significant with nurse-parent communication (p-value 0.005).

Table 3: Association between Selected Socio-Demographic Variables of Children and Nurse-Parent Communication (n=150)

Variables	Category	Frequency	Nurse-Parent Communication Mean Percentage Score	p-value
			Mean \pm S.D	
Age of the child (in months)*	Neonates	26	61.50 \pm 4.50	0.364
	Infants	32	63.83 \pm 5.97	
	Toddler	29	64.04 \pm 4.17	
	Preschooler	18	63.04 \pm 4.27	
	School aged child	30	63.88 \pm 4.64	
	Adolescence	15	63.59 \pm 3.18	
Sex of the child**	Male	87	63.87 \pm 5.36	0.115
	Female	63	62.65 \pm 3.51	
Ability to understand Nepali language**	Yes	55	63.50 \pm 4.02	0.637
	No	12	64.13 \pm 4.48	
Length of the hospital stay*	3-7 days	97	63.25 \pm 4.77	0.045
	7-15 days	30	62.17 \pm 5.09	
	\geq 15 days	23	65.36 \pm 3.15	
Discharge of the children**	Yes	43	63.01 \pm 5.95	0.566
	No	107	63.50 \pm 4.12	

Key: *One Way ANOVA test

****Z test**

Table 3 concludes that age, sex, ability to understand Nepali language by the children and discharge of the children are not statistically significant with the nurse-parent communication (p-value 0.364, 0.115, 0.637 and 0.566 respectively). But length of hospital stay is statistically significant with nurse parent communication (p-value 0.045).

Above all of the findings conclude that although more than half (52%) of the parents were completely satisfied with the conversation they had with the nurses but still they realized that there was something missing in the communication. Mother tongue, Ability to understand Nepali language by the parents, ethnicity, length of hospital stay and discharge of the children were the factors influencing nurse-parent communication in the pediatric units.

4. Discussion

This is a descriptive study, which was intended to assess the nurse-parent communication in Pediatric Units of BPKIHS.

A total of 150 parents, either father or mother of the index child were included in the study.

Nepal hosts 125 ethnic and caste and 123 linguistic groups where Nepali serves as a lingua franca [6]. Nurses, who work with patients from increasingly diverse cultural groups, experience daily how these three threats offer a challenge to the effective provision of care at the system, provider, and patient levels [7]. More than half (58.7%) of the parents spoke Nepali language followed by Maithili (26%) as their mother tongue and only 4% of the parents spoke other languages as mother tongue i.e, Urdu, Tharu, Satar, Sherpa and Tamang. About 77% of the parents were able to understand Nepali language.

More than half (68%) of the parents felt that it had been somewhat easy to communicate with nurses in the pediatric ward and about 71% felt that the nurses with whom they talked to in the pediatric ward somewhat understood their emotional situation. But the findings of study done by Wigert et. al [8] in Sweden depicted that about 68% of the parents felt very easy to communicate with the nurses in the NICU and more than half (57%) felt that the nurses understood their emotional situation.

The descriptive analysis revealed that parents were overall very satisfied (52%) and very dissatisfied (1.3%). Wigert et al. [8] in her study concluded that the parents were very satisfied (70.4%) and very dissatisfied (0.4%), which is contradictory to the findings of the present study.

Regarding the findings of strength and weakness of nurse-parent communication, question was asked to every parent either father or mother of the child. Majority of the parents described emotional support (89.1%), good information giving (100.0%), professionalism of nurse (75.8%), and organizational strength (61.5%) in case of strength of nurse-parent communication. Good information giving is supported by the findings of the study done by Panickera [9].

Weiss et al. in his study have shown that availability of staff for conversations has a significant impact on parent's perception of staff as empathetic and understanding. The physical accessibility of nurses and the practical caregiving involved in their work may also explain why they were experienced as encouraging parents to be involved in caring for their child [10].

Parents described organizational strength in terms of team spirit (32.1%), good sanitation of ward (46.4%) and adequate support from other ward/ department (16.1%). Hupcey emphasized that teamwork and cooperation between nurses and family members benefitted the patient which is accordance to this finding of the present study [11].

Similarly, humour in the nurse-patient relationship helps to establish rapport and trust, relieves anxiety and tension and conveys unspoken emotional messages. This is evident from the findings of this study [12]. Nurses need to be aware of the impact their communication has on parents and help them to clarify their role as parents in hospital [13].

Some of the patients consider disease as divine try and they believe that if they are religious, they will be saved. Other people think that they are punished due to their immoral behaviors. They believe that prayer, repentance increase the toleration of people against the disease and problems [14]. According to Redfern and Norman, when human being is at loss, he asks for God help and returns to him. Religious act as saying prayer, praying are common mechanisms increasing the hope and qualification feeling [15].

A task-orientation toward providing nursing care made it difficult for nurses to give quality care to patients in this study. The nurses were always busy and unable to effectively communicate with their patients' family. The majority of nurse-patients' family interactions were related to tasks and routines [16]. The findings of study by Oflaz and Vural is contradictory to the present study findings that most of the patients were satisfied with the nursing care despite the task-oriented environment [17]. These findings correlate with the findings of this present study.

Parents described organizational problems as different attitudes of different nurses (25.7%) and no nurse especially responsible for the patient (45.7%). The number of nurses and shift changes can lead to problems in continuity. Other studies have shown it to contribute to a sense of insecurity on the part of patient's families [18, 19].

Those parents staying for 3-7 days (75.83 ± 9.09) and not discharged from the ward (74.99 ± 9.56) were communicated more about parental role by the nurses. This finding is supported by the findings of Pinelli et al. in his study but information at the time of discharge is provided by the doctor unlike nurses in the present study [20].

This concludes that ability to understand Nepali language by the parents (63.86 ± 4.15) and length of hospital stay for more than 15 days (65.36 ± 3.15) helps in more supportive nurse-parent communication. Those parents were more communicative. The association with ability to understand Nepali language and nurse-parent communication is supported by findings of study done by Kourkouta et al. [21] This illustrates that more time is required for the nurses and parent for rapport building, exchange of ideas and information for effective communication.

Parents whose infants have most medical issues and a long length of stay also receive more attention and have more opportunities of communicating with the medical providers than parents' of infants with minor illness [22]. This is in accordance to the findings of the present study.

5. Conclusion

The study concluded that majority of the parents had received emotional support and regular information from the nurses and mother tongue, ethnicity, ability to understand Nepali language by the parents, the length of hospital stay and discharge of the children were associated with nurse-parent communication and were the factors influencing the nurse-parent communication in the study. Thus, these factors

should be considered for effective communication in pediatric settings.

6. Limitations of the Study

This study is limited to perception of parents regarding nurse-parent communication. It is one sided approach and subjective responses given by either father or mother regarding conversations they had with the nurses working in pediatric wards only and the study cannot be generalized for the entire hospitals of Nepal.

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