Nurses' experiences on the use of Afrikaans for nursing documentation and handovers at a central hospital in the Western Cape

Mangoyi Mgoqi

Thesis presented in partial fulfilment of the requirements

for the degree of Master of Nursing Science

in the Faculty of Medicine and Health Sciences

Stellenbosch University

Supervisor: Mrs T. Crowley

Co-supervisor: Mrs M. Van der Heever

March 2017

DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the sole author thereof (save to the extent explicitly otherwise stated), that reproduction and publication thereof by Stellenbosch University will not infringe any third party rights and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Signature: ……

Date: March 2017

ABSTRACT

Background: A traditionally Afrikaans central hospital in the Western Cape continues to use mostly Afrikaans for handovers and documentation despite an increase in the presence of isiXhosa speaking nurses. As not all isiXhosa speaking nurses are Afrikaans competent, it was necessary to explore the experiences of nurses regarding the use of Afrikaans for documentation and handovers, and how it may influence team cohesion and the quality of patient care rendered.

Methods: A qualitative approach with a descriptive phenomenological design was used to explore nurses' experiences on the use of Afrikaans for nursing documentation and handovers at a central hospital in the Western Cape. Purposive sampling was applied to select 12 participants of different language backgrounds and nursing categories. Permission to conduct the study was granted by the Health Research Ethics Committee of Stellenbosch University, the central hospital where the study took place and the individual participants. Data collection occurred with the use of semi-structured interviews which were transcribed verbatim and analysed using Colaizzi's seven-step phenomenological method.

Results: The four themes that formed the essential structure of the phenomenon were: differences which disunite, reverberations, historical influences and language discourses. Participants from different racial and language groups had varying experiences of the use of Afrikaans in the workplace. Language incompatibilities and the hegemonic role of Afrikaans in certain wards caused feelings of being 'othered', isolation and team divisions. Non-Afrikaans speaking participants felt that the use of Afrikaans for handovers and documentation impeded their ability to perform certain nursing duties and contributed to instances of omitted nursing care which may affect the quality of care rendered. Participants cited historical occurrences such as Apartheid as contributing to the use of Afrikaans at the institution and implicated those in higher positions for perpetuating the disregard for non-Afrikaans speakers. Certain Afrikaans speakers were adamant about holding on to their language lest it go into extinction. Some participants from both language groups felt that a common language, preferably English, would benefit all nurses involved in patient care.

Conclusion: The findings of this study demonstrated that the use of Afrikaans for documentation and handovers does not contribute to team cohesion and the rendering of quality patient care. This could be attributed to the perceived lack of managers to enhance the implementation of language practices that accommodates non-Afrikaans speaking staff.

It is recommended that institutions should implement language policies relevant to their nursing population demographics in order to improve quality of patient care delivered and increase cohesion of multi-cultural teams

Key words: Afrikaans, language barriers, nursing documentation, end-of-shift handovers, multicultural nursing environmnent, lingua franca, communication in health.

OPSOMMING

Agtergrond: `n Tradisioneel Afrikaanse sentrale hospitaal in die Wes-Kaap gaan voort om meestal Afrikaans vir verslaggewing en dokumentasie te gebruik, ten spyte van `n toename in die teenwoordigheid van isiXhosa-sprekende verpleegsters. Siende nie alle isiXhosa-sprekende verpleegsters ook Afrikaans magtig is nie, was dit nodig om verpleegsters se ervarings te ondersoek oor die gebruik van Afrikaans vir dokumentasie en verslaggewing, en hoe dit spaneenheid en die gehalte van die gelewerde pasiëntsorg beïnvloed.

Metodes: `n Kwalitatiewe benadering met `n beskrywende fenomenologiese ontwerp was gebruik om verpleegsters se ervarings rakende die gebruik van Afrikaans vir verplegingsdokumentasie en verslaggewing by `n sentrale hospitaal in die Wes-Kaap te ondersoek. Doelgerigte steekproefneming is aangewend om 12 deelnemers van verskillende taal agtergronde en verpleegkategorieë te kies. Toestemming om die studie te loods is van die Gesondheidsnavorsing- en Etiekkommittee te Universiteit Stellenbosch, die sentrale hospitaal waar die studie plaasgevind het en die individuele deelnemers verkry. Dataversameling is deur middel van semi-gestruktureerde onderhoude wat *verbatim* getranskribeer is, gedoen en volgens Colaizzi se sewe-stap fenomenologies metode geanaliseer.

Resultate: Die vier temas wat die essensiële struktuur van die fenomeen geskep het was: verskille wat verdeel, nagevolge, historiese invloede en taalgesprekke. Deelnemers van verskillende ras- en taalgroepe het verskillende ervarings oor die gebruik van Afrikaans in die werksplek gehad. Die onverenigbaarheid van taal en die oorheersende rol van Afrikaans in sekere sale het die gevoel van "anderswees", isolasie en verdeeldheid in die span geskep. Nie-Afrikaanssprekende deelnemers het gevoel dat die gebruik van Afrikaans vir verslaggewing en dokumentasie hulle vermoëns beperk het om sekere verplegingstake te voltooi, en dat dit bygedra het tot gevalle van die gebrek aan verpleegsorg wat die gehalte van pasiëntsorg mag beïnvloed. Deelnemers het historiese gebeurtenisse soos Apartheid genoem as een van die bydraende faktore tot die gebruik van Afrikaans by die onderneming en het diegene in hoër posisies geïmpliseer vir die voordurende minagting van nie-Afrikaans sprekendes. Sekere Afrikaanssprekendes was vasbeslote om vas te hou aan hulle taal uit vrees dat dit tot uitsterwing gedoem sal wees. Sommige deelnemers van altwee taalgroepe het gevoel dat `n gemeenskaplike taal, verkieslik Engels, alle verpleegsters betrokke in pasiëntesorg sal bevoordeel.

Gevolgtrekking: Die bevindinge van die studie het gedemonstreer dat die gebruik van Afrikaans vir dokumentasie en verslaggewing nie tot hegtigheid van die span en die lewering van gehalte verpleegsorg bydra nie. Dit kan toegeskryf word aan die waargeneemde trae bydraes van bestuurders om die implementering van taalpraktyke wat nie-Afrikaanssprekende personeel akkommodeer, te verhoog.

Daar word aanbeveel dat ondernemings taalbeleide wat relevant is tot hulle verpleegsters se populasie demografie implementeer, ten einde die kwaliteit van pasiëntesorg en begrip tussen multi-kulturele spanne te bevorder.

Sleutelwoorde: Afrikaans, taalverskille, verplegingsdokumentasie, einde van skof, verslaggewing, multikulturele verplegingsomgewing, lingua franca, kommunikasie in gesondheidsorg

ACKNOWLEDGEMENTS

First and foremost, I'd like to give thanks to He who gives life and strength, God. Without His favour and anointing I would not have made it!

To my parents: Thank you for your unwavering support in all my endeavours. I would thank you from the bottom of my heart, but for you my heart has no bottom

To my supervisor, Mrs Talitha Crowley, 'amazing' does not even begin to describe you. Thank you.

To my co-supervisor Mrs Mariana van der Heever, thank you for your insight and constant assistance from the very start.

A heartfelt 'thank you' to all the participants who took part in the study and shared their experiences and the hospital for granting me permission.

Thank you to Mr David Kwao-Sarbah and Miss Lize Vorster for their assistance with language editing and technical formatting respectively, and Mr Alex Coyne for translations.

To my friends and family for all your understanding and support. I thank you.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

ABBREVIATIONS

ENA	Enrolled nurse auxiliary
EN	Enrolled nurse
PN	Professional nurse
NLPF	National Language Policy Framework

CHAPTER 1:
FOUNDATION OF THE STUDY

1.1 INTRODUCTION

South Africa remains one of the world's most culturally and linguistically diverse nations; with eleven official languages and other dialects (Plüddemann, Braam, Broeder, Extra & October, 2004:13). The diversity of this nation is evident in the health care workforce, with possibly every race and ethnicity represented, more so with the increase of internal migration amongst the provinces (Deumert, 2010:53).

This economically driven internal migration is evident in the Western Cape's inhabitants due to an influx of Black isiXhosa speaking people from the Eastern Cape to the Western Cape which was predominantly Coloured and White pre-1994 (Plüddeman *et al.*, 2004:19). Consequently, the three most spoken and official languages in the Western Cape are Afrikaans, isiXhosa and English, with isiXhosa now replacing English as the second most spoken language in the Western Cape (Plüddeman *et al.*, 2004:19).

The early development of Afrikaans took place in and around Cape Town during interactions between the Dutch settlers and the indigenous people in the southern tip of South Africa (Deumert, 2002:302). By 1909, an institution was set in place to start with the standardisation process of the Afrikaans language throughout the country. Over the next 80 years, concerted efforts were made to enforce dominance of Afrikaans. By 1914, Afrikaans was acknowledged as a medium of instruction in most state schools (McCormick, 2006: 92). Afrikaans, alongside English, was declared an official language in 1925 and was promoted in political and cultural institutions across all sectors in South Africa (McCormick, 2006:99). In 1948 the National Party (Afrikaner rule) came into power and took over from the Union Party (British and South African rule) as supported by Waddy (2010:78). The National party government introduced the Bantu Education Act of 1953. This Act stated that as of 1955, the language medium of instruction in the then Bantu education schools would be Afrikaans. Post 1948, for many Black South Africans, Afrikaans was considered a language of oppression and control as it was reinforced by the institution of the Bantu Education Act of 1953. In the 1980's, the dominance of Afrikaans was greatly opposed by those who spoke other dialects and throughout the standardisation process of Afrikaans, the influence of political efforts was evident. The role and place of Afrikaans was affected by the change of political power in the new democratic era (post-apartheid, that is 1994) as there were now 11

official languages (instead of just two, with Afrikaans at the helm) and many other non-official languages (McCormick, 2006:100).

In South Africa's multilingual society, it is inevitable that there will be encounters between people who speak different languages. A lingua franca then becomes necessary to enable communication between those of different language groups. In South Africa, English fulfils this role (Minow, 2009:41) and has global status, which allows broad interaction with many countries (McCormick, 2006:106). Nurses worldwide represent the largest group involved in delivery of healthcare services but in South Africa, very few studies of nursing interaction have been conducted especially in the area of linguistic discourse (Candlin & Candlin, 2003: 144).

Communication is the exchange of information between individuals, groups or larger entities. Communication can be more than just what a person says but includes written communication, body language, tone and attitude (Nadzam, 2009:184). Communication is also the transmission of a message from a sender to a receiver. It is a process of sending messages, emotions and ideas. For communication to be effective, a common understanding should be established, for example, the people communicating must share an understanding of the message constructed (Shannon and Weaver Model of Communication, 2010). Suppose in the clinical setting a professional nurse utters these words to another professional nurse of a different language group: "Die pasiënt kry 'n hartstilstand. Maak gou en bring die noodtrollie" ("*The patient is going into cardiac arrest. Hurry up and bring the emergency trolley"*) and although the professional nurse hears these words, he or she may not understand what the other professional nurse is requesting. When language is used, the meaning of what is being said facilitates an appropriate response that indicates that the message is understood (Nadzam, 2009:184).

"Effective communication occurs only if the receiver understands the exact information or idea that the sender intends to transmit. Many of the problems that occur in an organization are either the direct result of people failing to communicate and/or process the information, which leads to confusion and can cause good plans to fail – Pranav Mistry" (Maforo, 2015: 4).

Proper communication in healthcare is vital. Language barriers impede the delivery of safe and quality care (Bernard, Whitaker, Ray, Rockich, Baton-Baxter *et al*., 2006:356). Communication is also the focal point of nursing (Clayton, Isaacs & Ellender, 2016:7; Candlin & Candlin, 2003:146) and proper communication becomes even more important when working in a multicultural milieu.

1.2 RATIONALE

In nursing, the role of communication infiltrates all aspects of health care delivery, from the handover at the end of every shift, implementation of nursing care and the quality thereof, nursing documentation to the atmosphere in the ward. Quite a few international studies have addressed the issue of communication complexities in contexts of linguistic and cultural diversity which has become a prevalent occurrence due to increasing rates of immigration (Candlin & Candlin, 2003:144; O'Neill, 2011:1121; Almutairi *et al*., 2015:16; Hearnden, 2008:51; Allan, Cowie & Smith, 2009:903).

The effect of globalization and internal migration have increased the likelihood that nurses will find themselves working in a team with those who do not share a common mother tongue (Hull, 2015:3). Hull (2015:5) further points out that when there is a mixture of languages or there are varying levels of proficiency in the language being spoken in a health care setting, the possibility of misunderstandings and the occurrence of errors are likely.

Extensive research has been done on language barriers between health care workers and patients and the implications on patient care (Deumert, 2010:55; Antia & Berlin, 2004:107; Bischoff, Bovier, Isah, Francoise, Ariel & Louis, 2003:75; Coovadia, Jewkes, Barron & McIntyre, 2009:818; Elderkin-Thompson, Silver & Waitzkin, 2001:1346; Grant, 2006:55; Levin, 2006a:1077; Levin, 2006b:1081). Hull (2015:2) concurs that while risks have been identified when there is language discordance between health care provider and patient, very little is known about the discordance when occurring within health care teams themselves.

With language being one of the drivers of communication, a break-down in language comprehension amongst nurses could have an effect on the functioning capabilities of nurses. While the post-apartheid constitution has aimed for a pluralistic approach to the face of health care, language has become a moot point in many institutions (Song, 2007:5.) Moreover, the language of the "elite" is being imposed as the norm and also functions as a gate-keeper (Parmegiani, 2008:107). This especially has an effect on the cohesion of a linguistically diverse nursing team. People will likely polarise towards their own language group at the expense and exclusion of another. Cultural diversity and multicultural communication of health care staff are said to be possible risks to patient safety and continuity of care (Almutairi *et al*., 2015:17). Clayton *et al*. (2016:10) concurs that multiculturalism affects patient care and is therefore an element that needs attention for the improvement of patient care and patient safety. The differences in language could also lead to cultural segregation within the workplace as those who do not understand the vehicular

language of an institution may feel unaccepted and not part of the team (O'Neill, 2011: 1122).

The central hospital where the study was undertaken is situated on the Cape Flats, an area that has predominantly Afrikaans speaking residents. The central hospital was designed and built 60 years ago as a tertiary hospital. The hospital itself was initially racially divided, with each wing (East and West) catering for non-whites and whites respectively (Brink & Dreyer, 2006:179). During her undergraduate years, the researcher was placed in various clinical settings at the central hospital for experiential learning and it was during these years that she witnessed the disregard of non-Afrikaans speakers at the central hospital. In many of the wards, communication occurred mainly in Afrikaans which meant exclusion of those who did not understand Afrikaans. Communication in Afrikaans was particularly problematic during handovers and documenting nursing care in patient folders.

The researcher has since then completed her undergraduate studies and had, for a short while, continued working at the central hospital in various wards via a nursing agency and had noticed that the practice of communicating in Afrikaans in the presence of non-Afrikaans speakers still continued.

Therefore, for the context of this study, the focus will be on the use of Afrikaans during handovers and nursing documentation in a context where not all nursing staff may understand the language. A South African Nursing Council (SANC) professional advisor has stated that the Council itself does not have a policy which governs nursing language interactions, but rather each institution is responsible for implanting language policies according to the nursing demographics (Sumbane, 2015). The hospital under study functions within the parameters of the Western Cape government language policy which promotes equity of the three official languages of the Western Cape, but dominance of the Afrikaans language continues and therefore perpetuates the institutional culture norm that has upheld Afrikaans to the exclusion of other languages.

With the institution of the Western Cape language policy, the aims are to promote the use of the three official languages, namely, Afrikaans, isiXhosa and English, within its provincial and local governments (Western Cape Language Policy, 2004:1). The language policy states that a consensus needs to be reached as to which language should be used for internal communication between employees and various departments within the institution. In 2003, the Cabinet developed and approved the National Language Policy Framework (NLPF). The purpose of the NLPF was to guide all government departments and other state institutions to translate the linguistic constitutional provisions into positive measures that

address linguistic imbalances (National Language Policy Framework, 2003:5). It is therefore imperative to scientifically investigate whether linguistic imbalances exist in institutions in order to develop and implement strategies to ensure effective communication.

1.3 RESEARCH PROBLEM

Over the last 21 years, since the dawn of the democratic era, the nursing staff and patient population at the central hospital under study have become more diverse. Due to the historical background of the area and the hospital itself, there may be a tendency to continue using Afrikaans for nursing documentation and handovers, as the surrounding neighbourhoods are predominantly Afrikaans and throughout the years the nursing staff at the hospital has mainly been Afrikaans speaking. The researcher is a professional nurse who has observed in her own practice that nurses often do not use a language-medium suitable and applicable to the general nursing personnel of the ward which could lead to misinterpretation of the information conveyed. This could have harmful effects on patient interventions and patient care. It would therefore seem that there is a gap in knowledge of how language barriers or not using a lingua franca between professionals in the clinical setting may affect the implementation of patient care.

The literature has illustrated and emphasized the importance of communication between health care staff in ensuring team cohesion, quality patient care and patient safety. The views of the nurses concerning language practices, particularly the use of Afrikaans at this central hospital have not yet been explored. It is against this background that the study was undertaken.

1.4 RESEARCH QUESTION

What are the nurses' experiences regarding the use of Afrikaans for documentation and patient handovers at a central hospital in the Western Cape?

1.5 RESEARCH AIM

The aim of the study was to explore nurses' experiences regarding the use of Afrikaans for documentation and patient handovers at a central hospital in the Western Cape.

1.6 RESEARCH OBJECTIVES

The objectives of the study were to:

- Explore how nurses experience the use of Afrikaans as it relates to documentation and patient handovers in a central hospital.

- Understand how the use of Afrikaans for communication influences team cohesion at the central hospital.
- To ascertain whether the current language practices at the hospital influence the quality of patient care rendered.

1.7 RESEARCH METHODOLOGY

Figure 1.1 provides an overview of the research methodology. The research methods used are briefly described in the current chapter. Chapter three contains a detailed description of the methodology that was applied in the study.

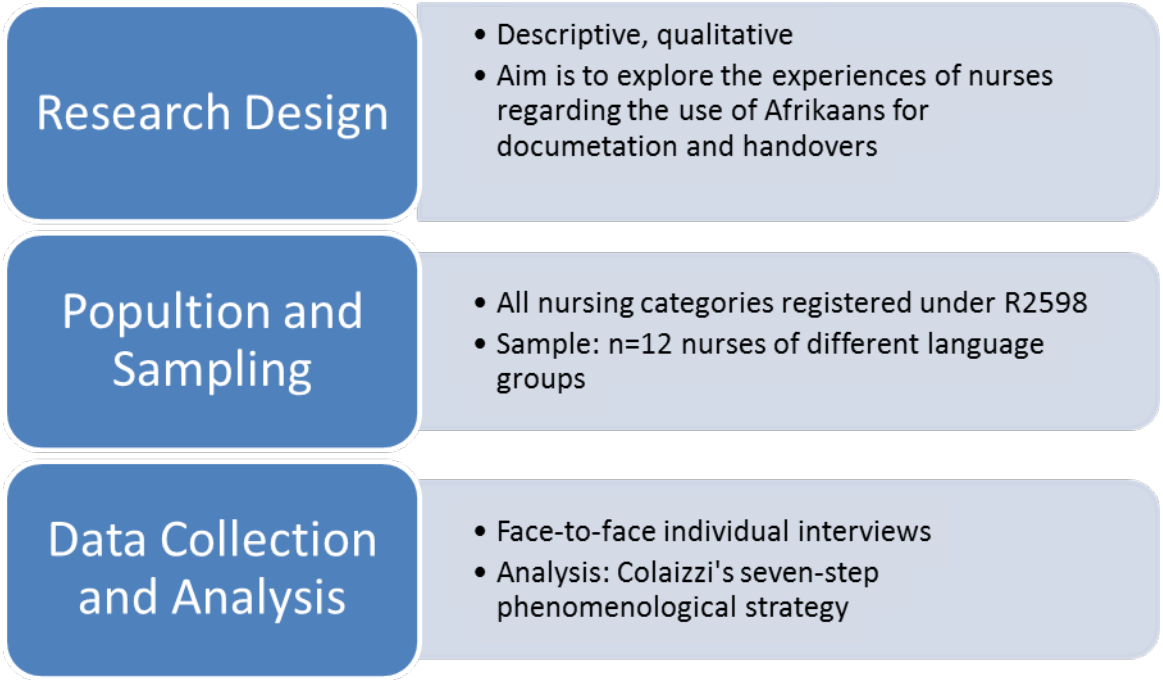


Figure 1.1: Research methodology for this study

1.7.1 Research design

The researcher followed a qualitative research approach with a descriptive phenomenological design to guide the study.

1.7.2 Study setting

This research focused on language practices at a central hospital in the Cape Metropole in the Western Cape. A central hospital is a hospital which renders specialized care and the receiving hospital for primary health care centres, district and regional hospitals (Republic of South Africa, 2012:36). There are three central hospitals in the Cape Metropole which provide tertiary care services.

1.7.3 Population and sampling

The focus of the proposed study was nurses of all categories registered and enrolled under the Nursing Act, 1978 (Republic of South Africa, 2005) working in the different divisions of the hospital.

The population for this study consisted of all nursing categories either working permanently or via an agency at the central hospital in the Western Cape. The researcher used purposive sampling whereby the researcher applied her judgement regarding the selection of participants who were knowledgeable about the research question (Brink, van der Walt & van Rensburg, 2012:141). The researcher purposively chose the participants according to the first language and nursing category whilst the wards where the participants were chosen, were randomly selected.

A total of 12 nurses working at the central hospital participated in the study.

1.7.3.1 Inclusion criteria

- All nurses who are first language speakers of any of the 11 official languages in South Africa.
- Nurses of all categories, including agency nurses and contractual nursing staff.

1.7.4 Data collection tool: Interview guide

A semi-structured interview guide with open-ended questions and probes was used to conduct all interviews (see Appendix 4). The interview guide questions were based on the objectives of the study.

1.7.5 Pilot interview

The researcher conducted one interview with a nurse who met the inclusion criteria. The pilot interview was done to ascertain the efficiency of the interview guide; whether it elicited answers that relate to the research question, and interview skills of the researcher. The data generated from this interview was included in the study as the interview guide remained mostly unchanged.

1.7.6 Trustworthiness

Trustworthiness is about accurately reflecting the data as experienced by participants and the accurate reflection of data processes (Edmen & Sandelowski, 1999:6). Trustworthiness was ensured by using the four principles proposed by Lincoln and Guba (1985:290) namely; credibility, transferability, dependability and confirmability.

1.7.7 Data collection

Due the exploratory nature of the study, data was collected by the researcher via face-to-face individual interviews whilst making use of a semi-structured interview guide.

The researcher made use of a voice recorder to collect the data. The data collected was clearly marked and dated. The interviews took place in the participants' respective wards while one interview, that of the agency nurse, was conducted at her home. The duration of the interviews was approximately 30 to 45 minutes.

1.7.8 Data analysis

Analyses of data occurred with the use of Colaizzi's seven-step phenomenological strategy (Shosha, 2012:33).

1.8 ETHICAL CONSIDERATIONS

Researchers have a duty and a responsibility to uphold and protect the human rights of their participants (Burns & Grove, 2011:104). Ethical approval to conduct the study was obtained from the Health Research Ethics Committee at Stellenbosch University (Reference: S16/03/042 – see Appendix 1), including the institution under study (see Appendix 2). The name of the institution was not mentioned anywhere in this text, including referencing and appendices, to uphold confidentiality. Full description of the study was provided to potential participants during the information sessions. Interested participants were given participant information leaflets for further reading. Written informed consent was obtained from the participants prior to each interview and participants were informed that interviews would be recorded for transcription purposes. The ethical principles of right to self-determination, right to confidentiality and anonymity, right to protection from discomfort and harm were upheld for both participants and the hospital involved.

1.8.1 Autonomy

The principle of autonomy refers to respect for persons and the right of participants to make their own decisions regarding their destiny (Burns & Grove, 2011:110). This principle was adhered to in this study as participants were well informed about the purpose of the study and were not forced to participate. Participants were also informed that they may leave the study at any point (the right to withdraw) and it would not be held against them. Signed informed consent, which was available in Afrikaans, English and isiXhosa, was obtained from the participants prior to commencement of the study and it was required that the participants have an understanding of the study and their role. Participants were also informed that participation in the study was voluntary (see Appendix 3).

1.8.2 Right to confidentiality and anonymity

The usage of numbers was employed during transcriptions and findings to protect the identity of the participants to ensure privacy of the participant and also protect the participant once findings are released. The hospital where the research was undertaken was not named to protect the reputation and staff of the hospital.

1.8.3 Right to protection from discomfort and harm

The researcher acknowledges the research topic to be a sensitive one and the possibility existed that some participants might become emotional or experience discomfort during the interviews. As phenomenology assists with reflection and understanding experiences through showing empathy and sympathy (Van Manen, 2007:20-24), had any of the participants experienced discomfort during an interview, the researcher would have allowed the participants to unpack these emotions as advised by Van Manen (2007:20-24). Participants who remained emotionally distressed would then be referred for therapeutic counselling with ICAS (Independent Counselling and Advisory Services).

1.9 SIGNIFICANCE OF THE STUDY

This study on the experiences of nurses with regard to Afrikaans being used for handovers and documentation provides information and insight into how language influences clinical practice as well as how to improve communication amongst nurses. From the study findings, recommendations will be made to the institution that could lead to interventions for creating an environment of cultural awareness and diversity. It furthermore allowed the researcher to make recommendations to improve communication between nurses and positively affect patient care. Language as a medium of communication and how it influences nursing care and patient safety and team cohesion, had not yet been explored prior to this study at the central hospital. No similar studies within the South African context were discovered by the researcher, which further necessitated a study of this kind. The study findings also have the potential of influencing nursing education and training with the possibility of including multicultural awareness and training on effective communication within multilingual nursing teams, in the curriculum.

1.10 DEFINITIONS

Communication: The exchange and flow of written and verbal information or knowledge from one person to another (Siemsen, Madsen, Pedersen, Michaelsen & Pedersen *et al*., 2012:441).

Ethnicity: A shared heritage defined by common characteristics such as language, cultural practices, religion and nationality that differentiate it from other groups (Romero, 2014:262).

First language: A language acquired chronologically first as a child (Slavkov, 2015:2).

Handover: The verbal transfer of information, professional responsibility and accountability among healthcare providers (Ganz, Endacott, Chaboyer, Benbinishty & Nun *et al*., 2015:50).

Lingua franca: The common language of choice, among speakers who come from different linguacultural backgrounds. In most cases it means English being used amongst non-native English speakers (Jenkins, 2009:200).

Multilingualism: The ability for one to communicate in more than one language, be it through active (speaking or writing) or passive (listening and reading) (Cenoz, 2013:5).

Nursing documentation: Written records of patient's condition and outcomes of care to ensure patient safety (Jefferies, Johnson, & Nicholls, 2011:7).

Race: Race is a socially constructed concept based on phenotypic characteristics such as skin colour (Santos, Palomares, Normando & Quintão, 2010:123).

1.11 DURATION OF THE STUDY

Ethical approval from the Health Research Ethics Committee was obtained 06 June 2016. Permission from the central hospital to conduct the study was obtained on 14 July 2016. Data collection commenced on 19 July 2016 and was finalised 14 November 2016 when data saturation occurred. The data analysis process occurred simultaneously to data collection.

1.12 CHAPTER OUTLINE

Chapter 1: Foundation of the study

This chapter portrays the background and motivation for the study. It also provides the significance of the study, the research problem, the research question, the objectives, the research design, the methodology and the ethical considerations.

Chapter 2: Literature review

This chapter is a presentation of the literature reviewed in relation to the research topic.

Chapter 3: Research methodology

In this chapter, the research design and methodology that was applied to the study are discussed in detail.

Chapter 4: Data Analysis

The data analysis and interpretation of the participant's experiences are described in this chapter.

Chapter 5: Discussion, conclusions and recommendations

This chapter provides a discussion, conclusions and recommendations derived from the study.

1.13 SUMMARY

In this chapter, the background and the rationale for the study are provided. The language inequities that now exist in many public sectors are embossed in the nation's history of segregation.

Language is used as a means of communication, however if the language used is not understood, effective communication cannot be achieved. This may in turn affect patient care and the milieu in a ward comprising of multilingual and multicultural nurses.

The study employed descriptive phenomenology to explore the experiences of nurses through 12 face-to-face individual interviews. Data was analyzed using Colaizzi's seven-step phenomenological strategy.

The ethical principles of right to self-determination, right to confidentiality and anonymity, right to protection from discomfort and harm that were adhered to in the study were described in this chapter.

Chapter two will present the literature review providing an in depth understanding of the importance and role of language in healthcare.

1.14 CONCLUSION

With a nation so diverse, even termed the "rainbow nation", constant intentional effort is needed to maintain world-class healthcare standards that there may not be regression to a state where there is isolation of a group of people. Extensive research has been done internationally regarding the issue of language problems in health care; however the same cannot be said for South Africa. In this study, the researcher used descriptive phenomenology to explore the experiences of nurses about the use of language in a South-African context.

Recommendations from this study will hopefully increase the effect of positive language practices in healthcare and develop nurses' cultural competence within the workplace for improvement of patient care and enhancement of work environments.

CHAPTER 2:
LITERATURE REVIEW

2.1 INTRODUCTION

This chapter focuses on the review of literature that is relevant to the study. A literature review allows the researcher to be aware of what information is known or not known about the research problem (Brink *et al*., 2012:54) and identifies gaps in the knowledge base (Burns & Grove, 2011:189). The researcher identified paucity in literature about the experiences of nurses with regard to the use of South African languages in the clinical setting during handovers and for documentation. This chapter therefore contains a review of literature pertaining to language discourse in healthcare.

2.2 SELECTING AND REVIEWING THE LITERATURE

A literature review provides a theoretical base for the study and enables the researcher to gain knowledge which may be used to guide the study and ultimately affect a change in nursing practice (Burns & Grove, 2011:189). A preliminary literature review, which commenced prior to the completion of the research proposal was conducted by the researcher to ascertain the existence of similar studies within the South African context. The preliminary literature review was extended after the completion of data analysis and presentation of the findings, therefore both the preliminary and extension of the literature are presented in this chapter. The extension of the literature review beyond data analysis and findings allows the researcher to enrich the context of the study and review issues that were not attended to in the preliminary review (Terre Blanche, Durrheim & Painter, 2006:19). A literature review is aimed at obtaining an understanding of the nature and context of the research studies that were identified (De Vos, Strydom, Fouche & Delport, 2004:128).

Various search engines such as SUNSearch (Stellenbosch University Library and Information Service) and EBSCOhost (Elton B Stephens Company research database), PubMed, CINAHL, Science Direct and MEDLINE were used in addition to the on-going support and assistance of the supervisor and co-supervisor. Key words included: language barriers, nursing documentation, end-of-shift handovers, multicultural nursing environment, lingua franca, and communication in health. The majority of the publications accessed and material used were published within the past ten years. A few seminal references were used. The literature review was completed over a period of 18 months.

The literature review is presented under the following headings:

- Language as a medium of communication

    - Berlo's model of communication
- Language in the health care context
    - Nursing handover
    - Documentation
- The influence of language on health care
    - Patient care
    - Team cohesion
- Factors influencing use of language in health care
    - Geographical location
    - Culture, ethnicity and race
    - Cultural awareness and competence
    - Institutional culture
    - Legislation
- Language as a vehicle of justice: social and distributive

2.3 LANGUAGE AS A MEDIUM OF COMMUNICATION

Communication, by definition, is an act that affects the behaviour of others by transmitting information (Rowe & Levine, 2015:2). As a result, communication produces change. Language, unlike communication, is a narrower concept which is uniquely human and used to produce and understand distinct words (Rowe & Levine, 2015:2). Language, with its expressive power, provides the most vital source for accounts. As a vehicle of communication, language carries the capacity to convey explanations and descriptions about many aspects of the world (Hammersley & Atkinson in Ritchie & Lewis, 2003:13). Language is a pivotal factor that enables individuals to become fully functioning members within the group into which they are assimilated or born into. Language also provides an important link of interaction between an individual and the environment (Mutasa, 2012:218), which in the context of nursing, describes the nurse's ability to interact within the nursing team.

All communication, including verbal communication with the use of words (language), affects the existing relationship between the sender and the receiver. It may either move the relationship forward or backward (Johnson, 1997:121; Rowe & Levine, 2015:5).

2.3.1 Berlo's Model of Communication

Berlo's Model of Communication is a linear model of communication which focuses on four elements namely the Source-Message-Channel-Receiver. A linear model of communication is essentially two linear models of communication one after the other in which the sender

sends a message to the receiver, who then becomes the sender and in turn sends a message to the original sender. This implies that communication is a two-way process (Rowe & Levine, 2015:2). According to Berlo's Model of Communication (2008:1), the effectiveness of communication relies upon the ability of the sender to encode the message in a way in which the receiver will be able to decode the message. Within each of the elements of the model, there are various factors which influence the communication process. The factors influencing the source and the receiver are communication skills, attitudes, knowledge, social system and culture (Berlo, 2008:3). Figure 2.1 is a depiction of the communication process and the factors influencing its flow.

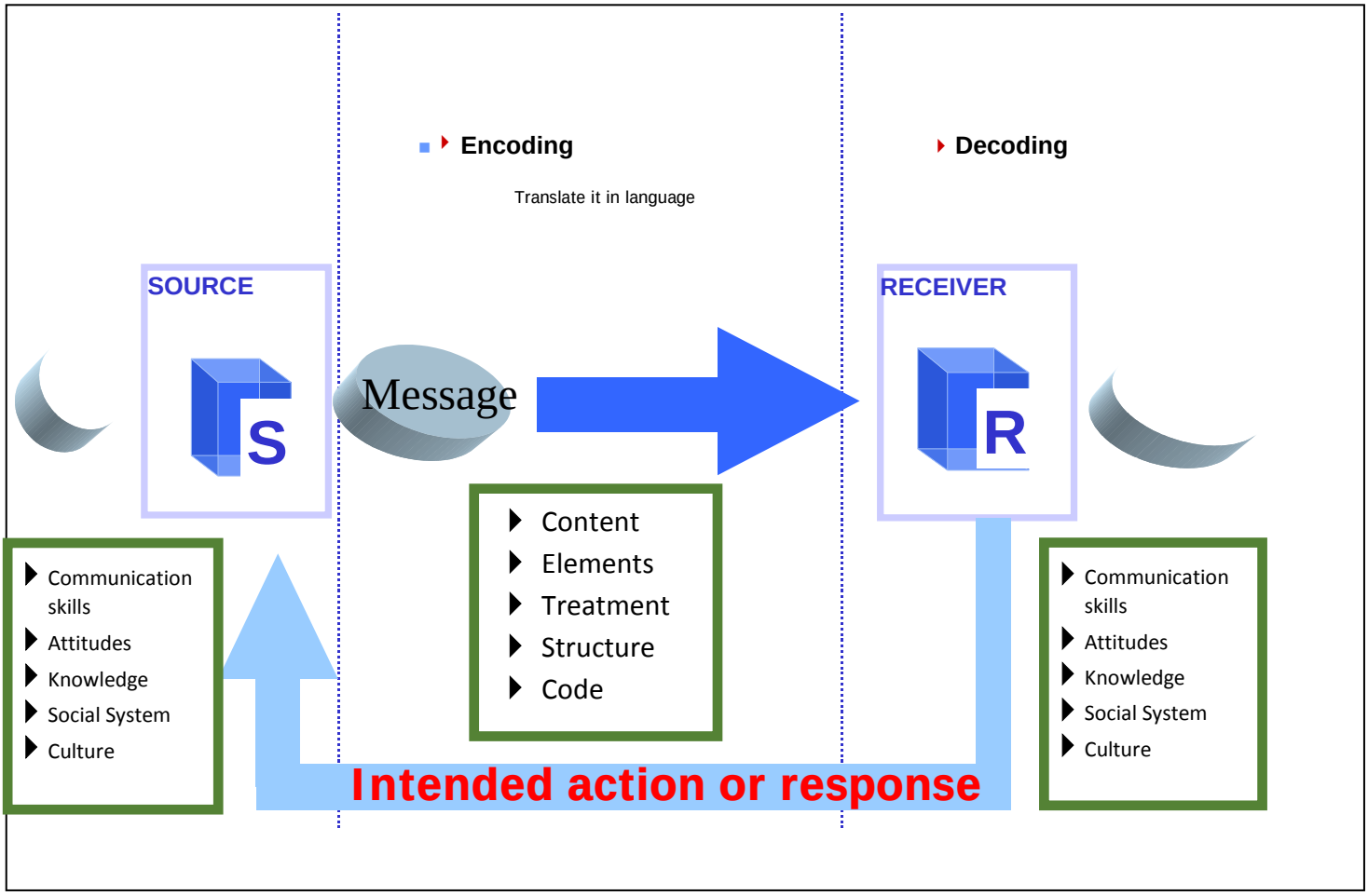


Figure 2.1: An illustration of a basic model of communication adapted from Berlo's Model of Communication (2008:1)

The message originates from the source/sender who sends an encoded message to the receiver to incite the required and appropriate reaction towards the message. The attitudes of the sender towards the receiver(s), towards their own personal self and towards the subject have an influence on how the message is received, perceived and decoded (Rowe & Levine, 2015:3). The knowledge level of the sender towards his/her attitudes regarding a

situation and knowledge of the appropriate language to be used are important factors to be mindful of in producing effective communication (Rowe & Levine, 2015:5). The message is usually distorted when it comes to encoding (by sender) or at decoding (by receiver) when one or both of the communicators lack skills to translate the message due to culture, language or attitudes (Berlo's Model of Communication, 2008:3). The message, which is the information or idea that the sender wishes to convey, may be affected by factors such as content, elements, treatment, structure and code (see Figure 2.1). The content is what is contained within the message, while elements refers to non-verbal cues like facial expressions and gestures. The way in which the message is delivered to the receiver(s) also has an influence in whether the message is received. How the message is arranged, meaning in a way in which distortion and miscommunication is avoided is important. Lastly, the code includes the language used, gestures and movements used by the sender to convey the message (Rowe & Levine, 2015:6). In this study the focus was on both verbal (during handovers) and written (within documentation) communication as encoded in language.

In a clinical setting, during an end-of-shift handover, the sender of the message relaying patient progress, nursing care and other interventions that had occurred, must do so in a way that will be appropriate for the receiver to assimilate the information and ensure continuity of care. In the event that the message is encoded in a language that the receiver will not be able to decode, the linear progression of communication is not completed. Likewise, receivers should possess communication skills that will enable them to decode the incoming message. The sender and the receiver should be at the same communication level in order for communication to be effective, which means that the receiver should have the ability to decode the message received (Rowe & Levine, 2015:5). Allan and Westwood (2016:1) mention that an incompatibility of the sender and receiver in communication or language skills can be a cause of social misunderstandings and a source of miscommunication leading to potential risks to the patient. Hearnden (2008:52) points out that in order for communication to be effective, one of the indicators is that the language used should be appropriate to the listener.

2.4 LANGUAGE IN THE HEALTH CARE CONTEXT

Various studies have been conducted in countries such as Australia, Canada, the United States and the United Kingdom where due to staff shortages, nurses from abroad have had to be recruited (Hearnden, 2008:49; Probst & Imhof, 2015:1; Allan *et al*.,2009:899; Almutairi *et al*., 2015:16). On commencement with employment, these internationally recruited nurses experienced language difficulties as a result of differences in the spoken languages of the

nurses (Hearnden, 2008:51). The researcher could liken this situation to that of the South African context, as in the Western Cape healthcare setting alone there are vast nationalities, races and ethnicities each with different languages, cultural beliefs and values (Kahn, 2014:1).

Many Black isiXhosa speaking individuals come from a background that is largely unilingual (Plüddeman *et al.*, 2004:28) with few proficient even in English and much less Afrikaans (Plüddeman *et al.*, 2004:29). Furthermore, 1,5% of the health care workers in South Africa's public sector are foreign nationals (Kahn, 2014:1) who may not be familiar with South Africa's official languages. First language acquisition occurs in the early chilhood years and is largely influenced by socialisation. Kamwangamalu (2003:226), however, notes the language shift among the younger generations from unilingualism to multilingualism particularly among speakers of African lanugages. Multilingualism occurs as a result of social contact with another, usually economically and socially dominant, group (Kamwangamalu, 2003:226). In the clinical setting, especially for handovers involving different races and cultures, it would be more ideal for a lingua franca to be used and the consensus is that this language is English (Plüddeman *et al.*, 2004:13; Deumert, 2010:57). Although English is also not necessarily everyone's first language, it is however a useful lingua franca for all South Africans and visitors to the country. With nursing being a 24 hour service, the exchange of verbal (handovers) and written (nursing documentation) information is regarded as a vital part of nursing communication for the transfer of relevant information between shifts (Meißner, Hasselhorn, Estryn-Behar, Nézet, Pokorski & Gould, 2007:536). These two primary ways in which nurses communicate are further described below.

2.4.1 Handovers

A handover can be described as the passing of information, duties and responsibilities among healthcare workers (Ganz *et al*., 2015:50; McKenna, 1997:637). One of the main purposes of a handover is to provide information that is accurate, relating to current patient issues, treatment and any anticipated changes to a patient's condition (Street, Eustace, Livingtson, Craike, Kent & Patterson, 2011:134). Street *et al.* (2011:139) state that a handover is a two-way process occuring between the sender and the reciever of the handover information. Another function of handovers, besides the transfer of information, is socialization, learning and education, group cohesiveness and emotional support (Gage, 2013:43; O'Connell, Macdonald & Kelly, 2008:3; Scovell, 2010:35; Meißner, Hasselhorn, Estryn-Behar, Nézet & Pokorski *et al*., 2007:536). Handovers form the basis for continuity of care and for formation and implementation of a nursing care plan which then aids in decreasing errors and omissions that affect quality and safe nursing care (Ganz *et al*., 2015:

50). The World Health Organization (WHO) identified that 'twice as many adverse incidents resulting in harm to patients arise from poor communication rather than inadequate skills of the practitioner'(World Health Organization, 2007:2). Nursing handovers that are misinterpreted, inaccurate, biased or incomplete may lead to some delayed or failed recognition of serious patient problems and an inability to prevent serious patient harm from ensuing (Holly & Poletrick, 2013:2388).

Working in a culturally and linguistically diverse setting necessitates the use of effective communication within the team for the ultimate benefit of the patient (Clayton *et al.,* 2016:7). As the exchange of information about a patient at the end of a twelve hour shift is critical because it forms the basis for continuing safe and effective nursing care (Johnson, Arora, Bacha & Barach, 2011:136), one could infer that effective end-of-shift handovers may enhance safety of care rendered (Johnson *et al.*, 2011:136). Ineffective handovers, such as when there is a discordance of sorts, may be a hazard to both patients and staff alike (Street *et al*., 2011:134). Additionally, an appropriate language used as a means of communication aids in conveying information from the sender to the receiver of the message (Allan & Westwood, 2016:1). However, when there are factors that prevent the message from being conveyed properly, it can lead to stress, low job satisfaction and lack of team cohesion (Madera, Dawson & Neal, 2014:119).

2.4.2 Nursing documentation

Patients' records in the form of nursing documention, are an important and essential communication tool between nurses (Meyer, Naudé, Shangase & van Niekerk, 2011:331). Documentation in nursing is used as a means of communication to inform health care workers of the patient's condition, what has been done to the patient (nursing care rendered) and the outcomes of the nursing care rendered (Teytelman, 2002:122). As nurses form part of the medical multidisciplinary team, there is constant exchange of information among these disciplines. Apart from conveying information about the patient's condition, there is usually a directive from a member of the team which is to be implemented. In the instance that this directive is written in a language that one does not understand, the directive may be omitted or not rendered according to instruction. Consequently a non-standardised means of communication could inadvertently lead to actions or omissions that could harm the patient (Teytelman, 2002:122).

Documentation assumes a vital role in patient safety if the information is relayed in a clear, appropriate and accurate way. The written information should be meaningful to the recipient or reader (Jefferies, Johnson & Nicholls, 2011:7). Language barriers whether written or

spoken should be prevented as they remove from the staff their ability to perform even basic tasks which form part of their duties (Bernard *et al.*, 2006:356).

2.5 THE INFLUENCE OF LANGUAGE ON HEALTH CARE

The type of care delivered to patients should be conducive to their health and recovery. That is why safe and quality care should be delivered in an environment that promotes healing and one that inculculates the spirt of cohesion amongst the nurses who provide the care (Searle, 2007:201).

2.5.1 Quality of patient care and patient safety

The core principle in nursing practice is care (Searle, 2007:92); caring for the patient in a safe and holistic manner. Booyens (2004:304) mentions that there are six elements used to describe quality health care provision: the care provided should be *acceptable* meaning the patient should be supplied with sufficient information to equip them with decision-making abilities pertaining to their own care. Secondly the care delivered should be *accessible* to all despite geographical disposition as in the case of rural inhabitants. Accessibility, however, does not only refer to convenience in terms of transport, but refers to the provision of appropriate knowledge and skills-set according to patient acuity. The third element used to describe quality health care provided is *appropriateness* of care which focuses on the "patient centeredness" of the care provided according to the patient's holistic needs. The care should be *effective* which is achieved by measuring the outcomes of care provided and by constantly engaging in research. The correct use of time in order to see to the array of patient needs, with the skilled use of available resources amount to *efficiency* in the care provided. Lastly, the care must be *equitable* meaning that there should be no discrimination of any kind when providing care. The role of linguistic discourse and cultural diversity should not be overlooked when attempting to attain quality of care provided and the role of leadership is vital in achieving these (Jooste, 2009:156).

Manser and Foster (2011:182) point out that the communication process is especially vulnerable at end-of-shift handovers or times of transition of care. An important aspect of quality care is patient safety (Liaw, Zhou, Lau, Siau & Chan, 2014:259). Proper communication, which includes the use of a language that is understood by all nurses, enhances patient safety (Edwards & Siassakos, 2012:13; Wagner, Brush, Castle, Eaton & Capezuti, 2015:47). The Australian Commission on Safety and Quality in Healthcare reported that problems in communication contributed to 11% of the adverse outcomes during hospital stay (Jefferies, Johnson, Nicholls & Lad, 2012:647). When there are communication difficulties, especially in high pressure clinical environments, there is a greater potential for

adverse outcomes for patients such as unnecessary pain inflicted, emotional and psychological trauma (Braaf, Manias & Riley, 2011:1025; Hewett, Watson, Gallois, Ward & Leggett, 2009:1732; Liaw, Zhou, Lau, Siau & Chan, 2014:259). Candlin and Candlin (2003:142) point out that there is a direct link between the quality of care provided and the quality of communication between those involved in rendering the care. It is evident therefore that communication methods, which include the language used, either written or spoken, play a vital role in rendering quality care to patients.

2.5.2 Team cohesion

Places of employment are areas where people from different backgrounds, cultures, races, ethnicities, social and financial standing convene. Relationships of those working within a team structure are built on interdependence. Interdependence refers to those within a team, sharing mutual goals with each other and needing the coordination of one another within the team to complete an action or task required (Johnson, 1997:3). Team cohesion refers to the strength of the group in terms of the bond that the team members share with one another (Booyens, 2004:241). Booyens (2004:241) is also of the belief that team cohesion begins with internal processes that are operating at an individual level. At the individual level, cohesiveness to the group begins with attraction which each team member has for other members. At the second level, cohesiveness is about the common identity welding the team together (Booyens, 2004:242). With increased team cohesion, individual enjoyment and satisfaction also increases. Team cohesion imbues and facilitates activities to be continuous and coordinated to the benefit of the patient (Jooste, 2009:161).

Socio-cultural dynamics involved in the congregation of different people are not easy. The absence of congruence in language between nurses in a team interferes with initiating relationships (Jooste, 2009:211). Team conflict can arise from socio-cultural factors which are attributed to non-converging views such as the language used (Hewett *et al*., 2009:1732). Consequently, ineffective teamwork has been identified as an underlying cause of many adverse events (Hindle, Braithwaite, Travaglia & Iedema, 2006:32). Furthermore, research shows that collaboration between members of a team is an important factor contributing to positive health outcomes through use of a lingua franca that influences effective communication (McNair, Stone, Sims & Curtis 2005:579). Not only does poor communication affect the quality of health care rendered to a patient, but it also creates frustration and team segregation (Clayton *et al*., 2016:11). Studies have shown that the language used and a sense of understanding among cultures heightens the efficiency of inter-professional communication (O'Neil, 2011:1121; Lockwood, 2015:131; Buengeler &

Den Hartog, 2015:831). Therefore, institutions should promote multiculturalism and equality of all cultures and ethnicities represented (Clayton *et al*., 2016:13).

2.6 FACTORS INFLUENCING THE USE OF LANGUAGE IN HEALTH CARE

Multicultural nursing teams have both strengths and weaknesses stemming from the diversity in language, culture, background and socialisation. García and Cañado (2009:88) assert that language plays a strategic role in multicultural teams as those who possess or adopt the vehicular language of an institution are in an advantageous position because of access to information. Knowledge of the vehicular language translates as power, which asserts an institutional culture.

2.6.1 Geographical location

The ethnic composition of Cape Town's population is quite unique compared to other provinces in South Africa. This uniqueness arises from the large Coloured population, making up almost half of the Western Cape's population, followed by the Black and lastly White and Indian populations. The uniqueness of the Cape population is in stark contrast to other provinces where the Black population are the majority (Statistics South Africa,2011:1).

The historical development of the areas known as the Cape Flats dates back to 1948 with the inception of the Group Areas Act in 1950 instated by the National Party which enforced the principle of residential segregation according to racial profiles (Wilkinson, 2000:197). The implementation of the Group Areas Act had a disastrous effect that led to the dismantling of defined communities by forced removal of approximately 150 000 people by the end of the 1960s to the sandy expanses known as the Cape Flats. The Cape Flats became acknowledged as the "apartheid dumping ground" for non-Whites away from the more central urban areas reserved for Whites (Wilkinson, 2000:200).

The Cape Flats comprises different areas of which four (Langa, Nyanga, Gugulethu and Khayelitsha) consist of predominantly isiXhosa speaking inhabitants while the rest (Mitchell's Plain, Bishop Lavis, Hanover Park, Bonteheuwel, Manenberg, Elsies River, Athlone, Grassy Park, Macassar and more) consist of Coloureds who speak Afrikaans or in some areas a variation of Afrikaans coined "kombuis Afrikaans" (Western, 2002:712).

The colossal central hospital arose on the Cape Flats as a result of a growing need from the community, students from the adjoining university, other health care workers and the hospital which has since been a major partner to the central hospital (Brink & Dreyer, 2006:174). The central hospital is situated in the Cape Metro in the Western Cape, surrounded by predominately Afrikaans-speaking Coloured neighbourhoods. Under the

possible influence of both the geographical location of the hospital (i.e. Afrikaans speaking community in the Cape Flats) and the historical roots and accepted traditions of hospital, the chosen vehicular language has been Afrikaans.

2.6.2 Culture, ethnicity and race

Culture, ethnicity and race are largely intertwined and constitute a major role in socialization within a group of people. The history of race and racial classifications is deeply-rooted in prejudices, with the mentality of segregation predating race which is why race exists mostly as a socially constructed norm that has little to do with genetics (Santos *et al.*, 2010:121). Most modern-day geneticists are becoming increasingly convinced that race is more a social construct than it is scientific merely because on a "skin-deep" level, human genomes have little variance (Santos *et al*., 2010:122). This knowledge does not automatically cancel the dichotomy of race, as the concept of race (biological distinctions such as skin colour) and racial classification has been useful in health research. The central hospital in which the study was conducted is composed of predominantly Coloured, Afrikaans speaking nurses and a Black minority of nurses. This majority-minority dynamic may be causing a hieracharal structure that places Coloured nurses at the top creating a perception of superiority. In South Africa currently, the racial classification system is used to mainly redress injustices of the past by affording those from previously oppressed groups equal opportunities (James, 2012:32).

Ethnicity, as previously defined, relates to cultural factors which include language, affiliations to a particular group and traditions (Romero, 2014:240). Within a particular race, there may be different ethnicities, each with their own language and traditions as seen in South Africa.

Culture pertains to the belief systems, customs and socialization among a group of people. Like ethnicity, culture is learned and largely connected to language (Hearnden, 2008:50).

Diversity in the form of race, ethnicity and culture may have both positive and negative influences in health care in that socialization among different racial, ethnic and cultural groups differs and therefore bring about perceptions about the way in which people should relate to each other (Hearnden, 2008:51). In most African contexts, for example, it is a sign of disrespect to look an elder in the eye when addressing him/her, however in Western society, a lack of eye contact is a sign of dishonesty (Zhi-peng, 2014:1031). Interactions in the health care setting may be problematic as relations become strained by differing perceptions.

2.6.3 Cultural awareness and competence

Language cannot be separated from culture and cultural systems (Hearnden, 2008:51). It is the defining and central point of the cultural systems of all societies (Madonsela, 2012:91). Language is a prerequisite for social interaction and acceptance (Herbert, 1992:1), and therefore when a person is unable to linguistically interact within a culture, it could have a negative bearing on that particular person's status within the culture. Any language is said to have a dual function: it is a means of communication and a carrier of culture (Wa Thiong'o, 1981:24). The spoken languages of individuals convening in the workplace are highly influenced by their respective cultural backgrounds as language and culture are intimately connected (Hearnden, 2008:49). In a multicultural nursing environment, an understanding of how cultural and social factors are interconnected with language is vital to advance effective communication (Hearnden, 2008:51). Candlin and Candlin (2003:145) emphasize that unless there are educational courses on cultural and linguistic differences after qualification, it is almost inevitable that nurses will not be able to deliver and patients will not receive safe and holistic care. The idea of cultural competence and awareness in a multicultural nursing team has not been extensively explored worldwide and in South Africa (Almutairi *et a*l., 2015:17).

Cultural competence strives to improve the quality of health care provided by reducing the culturally-based issues that arise when there are different cultures present in a health care context (Almutairi *et al*., 2015:17). A lack of cultural competence in nursing practice may affect the adaptation and integration of new nurses into the ward, which then affects patient care delivered.

Within culturally diverse teams, as those found at the central hospital, it is postulated that there will be greater affinity of individuals with similar characteristics (racial, linguistic, educational level and age) and they will experience greater sense of cohesion and social integration than those in dissimilar groups (Mannix & Neale, 2005:32). The nature of South African social interaction in the workplace is mostly between dissimilar groups, be it racial or linguistic differences. Staff members with these social differences tend to be affected more negatively as it affects the groups' ability of functioning effectively (Mannix & Neale, 2005:33). Issues of diversity in teams are difficult for cultural incompetent team members and it becomes an equally murky state to manage as it forces focus on issues of exclusion and discrimination (Mannix & Neale, 2005:33). It is argued that team members who are linguistically divergent are less likely to initiate communication with each other, which may lead to lower levels of cohesion and greater levels of conflict. What then are the kinds of relationships forged among nursing team members if Mannix and Neale (2005:39) have

discovered that people will avoid communicating with those with whom they hold different views and opinions or whom they dislike? García and Cañado (2009:88) state that the individual who does not speak the vehicular language is forced to develop 'dependence relationships' with the staff members who possess the ability to speak this language, while Parmegiani (2008:107) asserts that this places those with the knowledge of the vehicular language at a position of power. Ultimately the operational manager of the team holds a critical position in bringing issues of cultural competence, which affects the minority, to the fore to be heard. The operational manager is the impetus behind channelling respect for the minority in the midst of all the differences that the team encounters (Muller, 2011:104).

2.6.4 Institutional culture

Institutional culture differs from ethnic or national culture in that its only focus point is on institutional life (Booyens, 2004:195). Institutional culture reflects the personality of the institution. It comprises of its values, norms and certain artefacts, which may be directed or supported by management (Coustasse, Main, Lykens, Lurie & Trevino, 2008:41). Institutional culture refers to how an institution functions or "*the way we do things around here*". These values, shared by a group of people, tend to shape behaviours and are perpetuated over time even when membership changes (Coustasse *et a*l., 2008:41). Because institutional culture has a profound influence on human behaviour, it can be difficult to change, as it is an insidious force, making it hard to address it directly. Institutional policies, social behaviour, communication, rituals and rules all reflect the cultural norms and values of an institution (Booyens, 2004:195).

Thackwell (2014:65) states that if the institutional culture of a hospital has been historically established in accordance with certain ideologies that favour a certain group of people, that group of people will feel superior to groups that are not favoured.

At this juncture it would be beneficial to delve into the dynamics of racial groups within the Western Cape and how these dynamics may feature within the institutional social interaction structure. South Africa, to this day, uses four racial classifications which were established by the apartheid regime under the Population Registration Act also referred to as the Race Classification Act to enforce the agenda of segregation amongst these groups. These four racial classifications are White, Coloured, Indian and Black, with the White minority at the top of the hierarchy and Black majority at the bottom (Brown, 2000:198). The laws were promulgated firstly to ensure purity of the White race, and secondly, to solidify the boundaries and division between Blacks and Coloureds. Coloureds, for the most part, have always numerically dominated the Southernmost tip of Africa that by 1980 there was a documented 87% of Coloured people residing in the Western Cape (Brown, 2000:199).

Fast-forward to 2016, Blacks and Coloureds are still grappling with the legacy of apartheid which has segregated them in the Western Cape. The relations between Black and Coloured have always been marred by a perceived lack of similarity and an awareness of differences brought about by the segregation commenced during the apartheid years (Brown, 2000:201). Furthermore, Brown (2000:204) notes that Black people have expressed a more positive attitude regarding the changes that have occurred in the country since the dawn of democracy, while the Coloured population have maintained a more neutral stance due to uncertainty of their security within the new political order. The belief resides within the Coloured population that they are not afforded equal opportunities such as employment preference, housing and education which has led to some Coloureds resisting any proposals and policies which could lead to weakening their connection and influence in the region of the Western Cape. The perceptions of threat to the Coloured-dominated stronghold have led to a heightened sense of vigilance against those not of the Coloured community, in particular Blacks (Brown, 2000:204). As a result, Afrikaans has been firmly held on to, fuelled by fears of usurpation by Black languages (Brown, 2000:205).

Without a common business language, the transformation of institutional culture and therefore improvements in organisational culture, become restricted in the basic conditions for free communication. With these restrictions the individuals who strive to function within the nursing team are unable to perform their duties. The process of communication as described in 2.3.1 is not actualised because of the organisational culture that perpetuates communication practices that exclude some members of the nursing team.

Those in leadership positions are the drivers of institutional culture and they are therefore required to acquire knowledge pertaining to their own cultural patterns and norms and also of those of other cultures as a tool towards the development of culture-sensitive skills (Jooste, 2009:185). Leaders within the confines of nursing have an enormous responsibility to cultivate multi-cultural environments that welcome cultural (thereby linguistic) diversity in the workplace (Jooste, 2009:185). Leaders that are themselves culturally sensitive, need to build a multi-culturally sensitive institutional culture that welcomes and accommodates those of different cultural backgrounds (Jooste, 2009:186).

According to Medina (2012:3), institutional culture has a bearing on job satisfaction and staff turnover. Job satisfaction is the employee's reflection of their work expectations versus the reality of the work (Lund, 2003:223) and may be based on intrinsic elements such as feelings about the work environment or it may be extrinsic elements such as the salary one receives (Medina, 2012:3). When employees perceive the institutional culture as supportive and harmonious, they are more likely to experience job satisfaction and lower intent to leave

(Medina, 2012:8). Institutional culture is an all pervading non-tangible construct that has positive ramifications for some, and negative for others in the hospital context.

2.6.5 Legislation

Chapter one, section six of the Constitution (Republic of South Africa, 1996:4) recognises the pluralistic and multilingual nature of our society by granting official status to 11 languages.

Language categories as stipulated in section 6(1) are:

- Sotho group: Sepedi, Setswana and Sesotho;
- Nguni group: isiXhosa, isiZulu, isiNdebele and siSwati;
- Tshivenda and Xitsonga; and
- English and Afrikaans.

The Constitution of South Africa of 1996 was promulgated with the intention that all the above mentioned languages enjoy “parity of esteem” and be treated equitably in all South African institutions. Mutasa (2012:223) sees ‘language equity’ as merely an idea rather than a visible reality which has taken shape in our society because of the wider usage of English and Afrikaans and their dominance in political, administrative and business spheres. The Constitution obliges that provincial governments regulate their use of the official languages to ensure fair usage. However, government departments are given the choice of freewill to formulate their own language policies which then creates a major loophole which means the implementation of Section 6 of the Constitution can be waived (Madonsela, 2012:92). One of the guiding principles of the Constitution (1996) is to uplift and promote previously marginalised languages in the pursuit of linguistic diversity in institutions. Institutions are to review their language policies in accordance with the nature and aim of their service, aligning with the needs and rights of those employed.

The South African Nursing Council (SANC) is the regulatory body that puts in place standards of nursing education and practice in South Africa (Muller, 2011:4). SANC operates under the Nursing Act (No. 33 of 2005). Despite its regulatory status, SANC does not have a language policy designed to regulate the usage of languages within the health care status but transfers this regulatory authority to each institution in which nurses are employed (Personal communication, 2016).

Provincial and local governments in the Western Cape region, have instituted the Western Cape Language policy recognising isiXhosa, English and Afrikaans as the official languages of the province (Republic of South Africa, 2004:1). The language policy states that a

consensus needs to be reached as to which language should be used for internal communication between employees and various departments within the institution. In 2003, the Cabinet developed and approved the National Language Policy Framework (NLPF). The purpose of the NLPF was to guide all government departments, government-funded institutions and other state structures to translate the linguistic constitutional provisions into positive measures that address linguistic imbalances (National Language Policy Framework, 2003:5). The NLPF takes into consideration regional circumstances and preferences of the locals of each province. Provincial governments have therefore been required to model their policies in accordance with the demographic characteristics of their population and are required to have at least three of the 11 official languages as provincial official languages.

According to the NLPF and Western Cape Language policy, within government structures, such as hospitals, a consensus should be reached on a working language(s) for all communication within a department and externally. The hospital under study functions within the parameters of the Western Cape government language policy which aims to promote all three Western Cape official languages and also to do away with the serious marginalisation of isiXhosa (Western Cape Language Policy, 2004:1). Mutasa (2012:222), in his findings states that if one language is held at higher esteem to others of equal official status, then the language policies have not fulfilled their intended practical purpose and are only good on paper. It is different for the public however, as it is enshrined within the Patient Rights Charter (Department of Health, 2008:1) and the Western Cape language policy that official correspondence shall be in the patient's language.

2.7 LANGUAGE AS A VEHICLE OF JUSTICE: SOCIAL AND DISTRIBUTIVE

The principle of justice has to do with the fair allocation of resources, which may be tangible in the form of remuneration or intangible in the form of, for example praise from the operational manager (Jooste, 2009:272). Distributive justice refers to the principles by which goods are fairly distributed within a society. Distributive justice has, but not exclusively, been used almost interchangeably with social justice (Mwaniki, 2011:216; Young, 1990:16). However, social justice extends further by referring to the nature of relationships, which is a structure of society, to issues about power and how people interact and treat each other (Mwaniki, 2011:216). Social justice is largely concerned with the nature of interactions between individuals and not so much how much each individual gets (Mwaniki, 2011:217). Young (1990:32) proposes that justice in the work place should not only refer to distributive justice, but it should also deal with institutional (social) conditions that are necessary for the development of individual capacities and collective communication. According to Young (1990:16), the starting point for a conception of social justice, should be the concepts of

oppression and domination. Given South Africa's history of apartheid (system of racial segregation), issues of social justice are more pronounced and how language is used in institutions perpetuates a system of social injustice (Mwaniki, 2011:214). Young (1990:22) concurs with Mwaniki in that social injustices in an institutional context are further seen in structures, rules and practices which include language and symbols that mediate social interaction within the institution. These conditions and structures as they exist in institutions condition the group members' ability to carry out actions. Language has been, and continues to be a topical subject in South Africa and this is coupled by the fact that language has been used to serve the ends of social exclusion for some and inclusion for others (Mwaniki, 2011:214).

Young (1990:3) argues that when differences exist within a group, where some are favoured and others oppressed, the first step in remedying the group towards social justice is acknowledging and addressing that differences exist in order to undermine the oppression. The question of social justice in language cannot be excluded because as discussed, language is a carrier of culture, and the marginalisation of one language to the advantage of another perpetuates cultural domination. In the Western Cape, there is a perceived discrimination against those who are not fluent in either of the dominant languages – English and/or Afrikaans as these two languages were and are still being used as markers of identity and "eliteness" (Parmegiani, 2008:120). For many Black people in South Africa, Afrikaans carries connotations rooted within a historical context of oppression (Snail, 2011:66) and the attitudes of linguistic exclusion exist at the central hospital where certain departments insist on conducting their communication in Afrikaans as a matter of tradition (Thackwell, 2014:69). This institution (central hospital) was deemed the loci of White power and promoted the use of Afrikaans within these realms for the purpose of exclusion (Thackwell, 2014:59).

2.8 CONCLUSION

Language provides an important link between the individual and his/her social environment. Multicultural nursing teams are said to be more encumbered by issues of language discourse; creating rifts between cultures and those of different language groups, isolation and low job satisfaction. Cultural awareness therefore becomes a major prerequisite for those working or entering a multicultural hospital setting. The concept of social justice also becomes a priority to be explored when language, especially in the South African context, is concerned as it was previously a method of social exclusion and domination. To ensure that institutions are not perpetuating this form of injustice in health care settings, institutions must engage in positive language discourse discussions.

In chapter 3, the methodology that was used to explore the experiences of nurses with regard to the use of Afrikaans for nursing documentation and handovers are covered.

CHAPTER 3:
RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter contains the research methodology, which is inclusive of the research design, population and sampling, data collection and data analysis. These are described in greater detail here than the overview given in chapter 1. The two previous chapters described the background to the study and the existing global knowledge pertaining to language discourse in the health care setting. This chapter aims to describe the methodology used to explore the experiences of nurses regarding the use of Afrikaans for documentation and handovers at a central hospital in the Western Cape.

3.2 AIM

The aim of the study was to explore nurses' experiences regarding the use of Afrikaans for documentation and patient handovers at a central hospital in the Western Cape.

3.3 OBJECTIVES

The objectives of the study were to:

- Explore how nurses experience the use of Afrikaans as it relates to documentation and patient handovers in a central hospital.
- Understand how the use of Afrikaans for communication influences team cohesion at the central hospital.
- To ascertain whether the current language practices at the hospital influence the quality of patient care rendered.

3.4 STUDY SETTING

The study setting refers to the location where the study is conducted (Burns & Grove ,2011:40). In this study data were collected at the second largest hospital in South Africa, a central hospital in the Northern Suburbs on the Cape Flats in Cape Town. This central hospital is one of three central hospitals in the Western Cape. A central hospital is a highly specialized hospital that renders tertiary level services and provides a platform for the conduction of research and is ground for training health care workers. These hospitals also provide central referral services and may provide national referring services. It receives patients referred from more than one province (Republic of South Africa, 2012:36). Central hospitals must also be attached to a medical training school as the main teaching platform

for its students. The bed capacity at the central hospital under study is 1 899, which meets the central hospital minimum required bed capacity of 1 200 and has over 70 in-patient wards (Western Cape Government Health, 2013:322). A large portion of the care provided at central hospitals requires expertise of teams led by a specialist. These areas of speciality include but are not limited to paediatrics, obstetrics and gynaecology, cardio-thoracic surgery, cardiology, infectious diseases, and human genetics.

The data collected from the participants were recollections of accounts which occurred in a natural study setting where no manipulation of the environment occurred. The wards where the research was undertaken had been randomly selected by obtaining a list with all the wards and randomly selecting three wards by using the fishbowl technique. This was done to reduce researcher bias regarding ward selection. The researcher is a professional nurse who, during her undergraduate student years, was placed at the central hospital for practical exposure and completed her community service at the hospital. At the time of the study, the researcher was not permanently affiliated to the hospital but rendered services via an agency.

3.5 RESEARCH DESIGN

Burns and Grove (2011:49) refer to the research design as the blueprint of the study which stipulates how the study should be conducted. The chosen design informs the selection of a population group, the sampling sequence, and plans of data collection and analysis (Burns & Grove, 2011:49).

This research study followed a qualitative research design, with a descriptive phenomenological approach. Qualitative research designs allow the researcher to dig deep and provide an in-depth meaning of human experiences (Brink *et al*., 2012:120). Furthermore, it allows meaning to be attached to these human experiences.

Phenomenology, derived from the Greek word "*phainomenon"* meaning to bring into light (Pringle, Hendry & McLafferty, 2011:8), is a broad discipline that explores people's experiences to uncover what lies "hidden" in them (Matua & Van Der Wal, 2015:22). The phenomenological method allowed the researcher to critically delve into the experiences of nurses regarding the use of Afrikaans in the workplace, thereby revealing "hidden" meanings of these experiences which may be used in the area of language discourse.

Edmund Husserl is said to be the father of phenomenology. He believed that the individuals' experience was core to the generation of meaning and knowledge (Watson, McKenna, Cowman & Keady, 2008:233). Husserl developed a method of inquiry that is focused on

describing a phenomenon as experienced by an individual. This method of inquiry is called descriptive phenomenology. Descriptive phenomenology allows the researcher to explore the lived experiences of participants, analyse them and describe the experience while still maintaining depth and richness (Matua & Van Der Wal, 2015:23). Lived experiences reveal the meaning of an event or phenomena before reflection has occurred. These lived experiences form the basis of future recollection as to how one lived through the experience (Kleiman, 2004:10). This requires that the researcher seek and obtain the thought content in a "pure form", devoid of any researcher preconceived ideas by engaging in 'phenomenological ephoché' or bracketing (Matua & Van Der Wal, 2015: 23). The essence of phenomenological ephoché or bracketing lies in seeing things 'directly as they are', which is paramount to understanding an experience and enabling the researcher to go beyond their own preconceptions and delve into the essence of the participant's experience. To ensure that the researcher did not 'contaminate' the study findings by her own preconceptions, the researcher kept a reflective journal in which she jotted down her thoughts relating to the study topic. The researcher also wrote down her preconceived ideas prior to and after data collection to 'off-load' thoughts that may have tainted study findings.

3.6 POPULATION AND SAMPLING

According to Brink *et al.* (2012:131), a population refers to a large group of persons that the researcher has an interest in and is the focus of the study. A population is known to have similar characteristics or a common factor. The focus of the proposed study was nurses of all categories registered and enrolled under the Nursing Act 33, 2005 (Republic of South Africa, 2005) working in the different divisions of the hospital. According to the October 2015 statistics of the particular central hospital, there were 1995 filled nursing positions. The majority of the nurse population are Afrikaans first language speakers (50%), followed by Xhosa (23%), English (21%), Zulu (2.5%) and other languages (2.3%) (Hospital Administrator, 2015).

A sample is a group of people selected for the study from the population (Burns & Grove, 2011:548). Sampling is a process of selecting people from the population, with which to conduct the study (Burns & Grove, 2011:40). Because verbal communication and written communique is an integral part of nursing culture, every single nurse is affected and therefore eligibility to the study was broad. However, the researcher used non-probability purposive sampling whereby the researcher applied her judgement regarding the selection of participants who were knowledgeable about the research question (Brink *et al*., 2012: 141). Eligibility refers to the reason that participants are chosen for inclusion as part of the sample in the study (Polit & Beck, 2004:290).

3.7 SELECTION OF WARDS

The wards from which participants were purposively sampled were randomly chosen using the fishbowl technique. The following steps were adhered to: a) A list of all hospital wards were obtained from the administration department and b) placed in a bowl after which c) the researcher randomly chose a slip with the ward and jotted the ward on a separate sheet and then replaced the slip with the ward back into the bowl. The researcher then selected a second and a third ward and each time replaced the slip back into the bowl. This is known as random sampling with replacement, which ensures each ward has an equal and independent chance of being chosen each time (Brink *et al*., 2012:135). This technique of ward selection also decreased researcher bias. Wards where the researcher worked as a professional nurse during her community service year and via the agency were excluded prior to fishbowl selection. This exclusion was done as to ensure that familiar researcher presence does not influence the study findings.

3.8 SELECTION OF PARTICIPANTS

The participants were purposively chosen according to first language spoken and nursing category: four Professional Nurses (PNs), three Enrolled Nurses (ENs) and five Enrolled Nurse Auxiliaries (ENAs) were included in the study. Each nursing category occupies a different role within the nursing team; the professional nurse holds a more superior role of supervision, team leader and is responsible for the cohesion and well-functioning of the team and they also conduct end-of-shift handovers. The ENs and ENAs are more involved with direct care and patient interaction. The views from different categories would therefore provide different perspectives of the use of Afrikaans and how it affects them. Purposive sample units have specific characteristics or traits in which the researcher is interested and wishes to further study (Ritchie, Lewis, McNaughton Nicholls & Ormston, 2013:113). Heterogeneous sampling, a purposive sampling technique, is used to capture varying perceptions relating to the phenomena under study (Ritchie *et al*., 2013:114). The principle behind heterogeneous sampling is to obtain deeper insight into a phenomenon.

The researcher wished to have a multi perspective approach and therefore included the three main languages spoken in the Western Cape (Statistics South Africa,2011:1) and other dialects such as Tshivenda and Shona. This was to ensure that various views were captured. Six of the participants were first language isiXhosa speakers, four were Afrikaans first language speakers and two were Tshivenda first language speakers.

An operational manager was included to provide a perspective of how management functions to promote and maintain team relationships, group cohesiveness, and daily ward

functioning. There were 65 operational managers who were Afrikaans first language speakers, 26 who are English first language speakers and two Xhosa first language speakers. The inclusion of an operational manager is important in this study as their authoritative role is pertinent to the ward milieu. The operational manager was purposively chosen to participate in the study from one of the randomly chosen wards based on her first language and experience in nursing. She was an Afrikaans first language speaker who was also proficient in English.

The researcher initially approached the three selected wards with an approximate total of 60 potential participants. In one of the wards approached, no participants were recruited in both shifts as all the staff cited: '*We are ok here, we don't have problems with Afrikaans, we only have one Xhosa nurse on this shift*'. The researcher however explained that the aim of the study was not to identify problems with Afrikaans and that useful information could also be elicited from a ward that has 'no language discordance issues'. Another ward was chosen randomly to replace the ward that yielded no participants. The researcher aimed to do 12 to 15 in-depth interviews, however the final sample size was determined by reaching data saturation which occurred before the anticipated number was reached. Data saturation occurs when there is no new data being generated during the data collection process (Brink *et a*l., 2012: 141). Data saturation was reached at participant 11, while participant 12 was an operational manager who offered similar information from a different perspective. The final sample comprised of 12 nurses, 11 of whom were permanently employed at the hospital and one agency nurse.

3.8.1 Inclusion criteria

Nurses of all categories, including agency and contractual nurses as they too are exposed to the hospital's language practices and also all nurses who are first language speakers of any of the 11 official languages in South Africa.

For rich data extraction from the participants, a minimum of four months was required at the institution for in-depth experience on the phenomenon.

No participants, for any reason, were excluded from participating in the study.

3.9 INTERVIEW GUIDE

The researcher made use a semi-structured interview guide for the collection of data. The data collection tool attached as Appendix 4 consists of two subsections namely; section A and section B. Section A was for the extraction of relevant demographical information of the participant like race, ethnicity, first language and age which were self-indicated by the

participants and not assumed by the researcher. Section B consists of five pre-determined open-ended questions to acquire a deeper understanding into the participants' thoughts pertaining to the subject matter. Open-ended questions allow the participant to speak their mind without the restriction of the dichotomous yes/no answers (Polit & Beck, 2004:139). The questions were deliberately formulated based on the study objectives. Probing and closed-ended questions were used as per the researchers' discretion. Probes allow the researcher to fully probe the underpinning factors of the participants' answers (Ritchie & Lewis, 2003:141). The questions were categorised under: general languages practices (for an overview of what happens daily at the hospital in terms of language), patient care, and institutional culture.

3.10 PILOT INTERVIEW

A pilot study is a small-scale version of the actual study, usually done to refine the methodology (Brink *et al*., 2012:56; Burns & Grove, 2011:49). A pilot interview is done to refine the interview guide by identifying flaws and irrelevant questions (Brink *et al*., 2012:57).

The researcher conducted one interview with a nurse who was permanently employed at the hospital who met the study inclusion criteria. This was done to ascertain the efficiency of the interview guide (whether it elicited answers that relate to the research question) and interview skills of the researcher. The researcher underwent interview training over a period of a week during a workshop offered at Stellenbosch University. An important aspect covered in the training was that of reflexivity to ensure that researchers are aware of themselves and the part they play during data collection. The interview skills of the researcher were assessed by the study supervisor during the pilot interview, and the researcher was consequently found to be competent in the conduction of interviews. The pilot interview took place in one of the randomly chosen wards, in an office near the rear of the ward where noise was reduced. The data generated from this interview was included in the study as the interview guide remained mostly unchanged and it also yielded valuable information imperative to the study.

3.11 TRUSTWORTHINESS

Trustworthiness is about accurately reflecting the data as experienced by participants and the accurate reflection of data processes (Edmen & Sandelowski, 1999:6; Brink *et al.*, 2012:172). To ensure trustworthiness, Lincoln and Guba (1985:290) propose that the following four principles be considered, namely; credibility, transferability, dependability and confirmability.

3.11.1 Credibility

Credibility refers to the accurate identification and description of the data collected, in other words, the truthfulness of the data (Brink *et al.*, 2012:172). The researcher applied several techniques to enhance credibility.

3.11.1.1 Bracketing

In qualitative research, the researcher is a vital tool for data collection and analysis because of the interaction with participants. It is with this interaction that the researcher may project their assumptions and preconceptions onto the participant and by so doing influence data collection and analysis (Tufford & Newman, 2010:81). The credibility of the study was enhanced by the researcher bracketing out her own pre-conceived notions and applying what is known as phenomenological epoché. Bracketing employed by the researcher allows the data to speak for itself without being tainted by the researcher's own preconceived ideas about the phenomenon under study and allows the researcher to engage in deeper reflection through all the phases of the research (Tufford & Newman, 2010:81). Bracketing was done throughout the research process; from conceptualisation through receiving input from other academics during the Master's tutorial and with various discussions with the study supervisors.

Bracketing was employed by the researcher during interviews because of the possibility of the interview provoking emotions related to the topic. Bracketing during interviews allows researchers to be able to manage possible intense emotions and also allows researchers to be cognizant of their own body language which may elicit a certain response from the participant and moreover allows the researchers to be aware of the participants' body language which may be a sign of discomfort (Tufford & Newman, 2010:90). Bracketing during interviews, allows each participant to be given an equal voice even if the participant does not echo the same sentiments as other participants. Bracketing was achieved by the researcher keeping a reflective journal which she began keeping prior commencement of data collection for the purpose of identifying preconceptions that may influence the research. Included in the journal were the researcher's own experiences and how she felt regarding these experiences at the time as a Black, isiXhosa-speaking professional nurse in an environment where her colleagues would continue a handover in Afrikaans failing to accommodate others that may not understand. The researcher had questions on race and language in the city in terms of the inclusion of Black persons in the Western Cape society; socioeconomic disparities and her dwindling feelings on the appreciation of the Afrikaans language in the way it is used at the institution. The researcher had to bring these to the fore during the process of reflective journaling to ensure the data itself was not tainted by her

presence. Bracketing was employed doing the write up to ensure that the voice of each participant was audible.

3.11.1.2 Prolonged engagement

The researcher engaged in at least three preliminary visits prior to the actual data collection dialogue. These visits allowed the researcher and the participant to become acquainted and develop a relationship of trust. During one of these visits, one participant was elated that the researcher understood and spoke Afrikaans, which developed a heightened sense of trust and comfort for the participant.

3.11.1.3 Peer debriefing

The researcher incorporated the experienced ear and eye of the supervisor and co-supervisor in reviewing of the interviews, known as peer debriefing (Shenton, 2004:67). Regular communication via electronic email and face-to-face meetings with supervisor where she engaged with researcher on the research processes was also a form peer-debriefing which enhances credibility of the study.

3.11.1.4 Member checking

The researcher made use of reflecting and summarising during the interviews which involved participants verifying what the researcher had summarised as accurate and congruent to what they had meant. During data analysis, the emergent themes were also verified by the study supervisor, which is another element of member checking. The final study framework was then taken back to participants for verification of the accuracy of the information and whether what was captured was a true intent of meaning. The researcher was able to conduct member checking with eight participants while the rest of the participants cited various reasons for not being able to meet such as being on leave, work pressures and personal reasons. The four above-mentioned strategies, namely; bracketing, prolonged engagement, peer-debriefing and member checking are strategies employed to increase the credibility of the study (Shenton, 2004:69).

3.11.2 Transferability

Transferability refers to how the findings of the data collected can be applied or generalised in other research studies (De Vos, Strydom, Fouche & Delport, 2011:420). The researcher enhanced transferability by providing a detailed description of the research process e.g. selection and recruitment, how data was collected and the process of data analysis. The researcher richly described the study setting and the context of the study relating to the use of a language not generally understood, in the clinical setting as means of communication.

The detailed description of the processes and context was done to enable an interested party in making a conclusion as to whether a transfer can be made to other contexts.

3.11.3 Dependability

Dependability refers to the stability of the research study over time, that if the study were to be repeated in a similar context, it would yield the same or similar findings (Brink *et al*., 2012:172). Shenton (2004:71) however argues that due to the changing nature of phenomena and how people experience it, the study may not yield similar results. Polit and Beck (2012:492) state that credibility of a study cannot be achieved without dependability. Dependability was ensured by explicitly recording all the steps undertaken during the research process, making sure that it follows the process as stipulated in the proposal. Such in-depth description allows the reader to follow the processes and assess whether proper channels have been adhered to throughout the study. Dependability in a study requires an audit and an internal auditor in the form of the study supervisor reviewed the interview skills of the researcher, listened and validated the audio-recordings against the transcripts, and supervised the data analysis process. An audit trail in the form of electronic mail between supervisor and researcher was kept. Reflective notes made by the researcher before, during and after the data collection process were kept. Reflective notes were also kept for contact meetings between researcher and the supervisors.

3.11.4 Confirmability

Confirmability is established when the data collected by the researcher can be linked to their respective sources or participants and resonates with them and that no bias is involved on the part of the researcher. To reduce researcher bias and thereby increasing confirmability of the study, the researcher kept a detailed description of methodological processes, which will allow the reader to trace the course of the research study step-by-step, this is known as an audit trail. The audit trail can be used to demonstrate the consistency of the study when sharing the data (Macnee & McCabe, 2008:171).

3.12 DATA COLLECTION

Data collection is the precise, orderly and systematic gathering of information that is relevant to the purpose, objectives and questions of the study (Burns & Grove, 2011:52). Permission from the central hospital to pursue the study was obtained on the 14th of July 2016 (see Appendix 2). A detailed discussion of the ethical principles applied is provided in chapter 1.

Phenomenological research not only aims to explore the lived experiences of the participants but it further aims to examine the way the participant perceived a situation, meaning that phenomenology regards one's reality as subjective (Burn & Grove, 2011:76).

Participants were recruited by holding information sessions in each of the randomly chosen wards during the handover meeting at the beginning of the shift. The researcher conducted the information sessions on both shifts. After each information session, the researcher collected the names and exchanged numbers with those interested and also left a poster with her contact details and research information for those who had not decided at the time of the session. For wards that do not routinely hold handover meetings, one was requested by the researcher from the operational manager.

Due to the exploratory nature of the study, data was collected via face-to-face individual interviews whilst making use of a semi-structured interview guide. The role of the researcher in phenomenological interviewing is important as the researcher is an instrument by which data is collected. Therefore, to improve researcher interviewing skills and consequently richer data collection, the researcher underwent training in qualitative interviewing. The researcher employed mainly the use of open-ended questions, probing questions, and the occasional use of closed-ended questions for clarification of a point. The purpose of probing questions is to obtain clarity to elicit further explanation and detail from the participant and relate directly to the preceding response (Ritchie & Lewis, 2003:141). The researcher's goal was to seek answers relating to the research question and objectives. Demographic data were also obtained from the participants which included their age, race and first language.

Written informed consent was obtained from participants prior to commencement of interviews and participants were informed that participation is voluntary and they may withdraw at any point in time. All the participants chose to be interviewed on the hospital premises but to reduce ward routine disruptions, interviews were held on the participants' own time i.e. lunch hour and after a pm shift, at a pre-approved location in each of the wards. In two of the wards, the office of the operational manager was utilised for the interviews and in the third ward a vacant room at the rear of the ward was used. A "do not disturb" poster was placed on the door in all three wards to ensure that interviews proceeded undisturbed. One agency nurse was interviewed at her home in Site B, Khayelitsha. There were no disturbances as she lives alone.

The researcher is proficient in English and fluent in Afrikaans and isiXhosa. Proficiency in a language refers to the person being able to think in the language, voice opinions and ideas, comprehension of humour and no hesitation in communication. It also refers to being able to read, write, speak and listen in the language (Hull, 2015:4). Fluency however, refers to the ability to orally communicate in the language with slight hesitation and being less able to engage in complex conversation as a result of limited vocabulary. The person may face

challenges with listening, reading and/or writing in the language (Hull, 2015:4). All interviews were conducted in English as all the participants felt comfortable with English. An Afrikaans and isiXhosa interviewer was however available had any of the participants wished to be interviewed in either of the languages.

A quiet, undisturbed room in each of the wards was utilised to conduct the interviews. The researcher created an environment conducive to conversation by arranging the chairs in a way that they were facing each other with no furniture obstructing between the two individuals. Water in a jug was available for the participants. The researcher, as an instrument pivotal in data collection developed her skills in phenomenological interviewing which would enable her to obtain the essence of the participants' lived experiences without herself contaminating the data. Prior to each interview, the researcher and participant engaged in casual conversation to allow the participant to feel comfortable and build a rapport between the researcher and participant. The interview commenced with a general question to provide the researcher with reference points and to allow the participant to ease into answering questions without feeling apprehensive. The general guiding question in phenomenological interviewing is "what is the essence of the phenomenon as it is experienced by the participants?"

The researcher made use of a voice recorder to collect the data. The data collected was clearly marked and dated and saved on the researcher's personal computer under password security. Numbers were used during the transcription of interviews and findings to protect the identity of the participants involved in the study. The duration of the interviews was approximately 30 to 45 minutes. None of the participants interviewed became emotionally distressed during data collection.

Data collection commenced in August 2016 to November 2016.

3.13 DATA ANALYSIS

In qualitative research, the analysis of data involves the examination of non-numerical data usually in the form of audiotapes and written information (Brink *et al*., 2012:193). Data analysis involves breaking up the data into more manageable themes (Mouton, 2014:108).

Data collection and data analysis occurred as a simultaneous process, meaning the process of data analysis started after each individual interview. Transcripts were compared with the audiotaped interviews from which they were prepared to obtain accuracy of the data. All transcripts and audiotaped interviews were stored on the researcher's password-protected personal computer and on an external hard drive that was kept in a safe. Analyses of data

occurred with the use of Colaizzi's seven-step phenomenological strategy (Shosha, 2012:33):

- Each participant's transcript was read and re-read by the researcher to obtain an overview and understanding of the text to make sense of it. At this stage the researcher bracketed her own experiences relating to the languages issues she may have encountered. This allowed the researcher to explore the participants' experiences fully.
- Significant statements directly related to phenomenon being researched were extracted from each transcript.
- The researcher attached meanings to these extracted statements.
- The meanings attached to the statements were categorised into clusters of themes.
- Results obtained thus far were integrated into an exhaustive description of the phenomenon under study.
- The essential structure of the description of phenomenon was identified.
- Finally, validation of findings was sought from the participants for comparison between researchers' findings and their (participants) experiences.

Each of these steps will are discussed in more detail.

3.13.1 Transcription of all interviews then reading and re-reading (immersion into data) of transcriptions

Transcription of interviews refers to the copying by writing down or typing of audio-recorded interviews word for word (Burns & Grove, 2011:93). The researcher undertook to do her own transcribing of the audiotaped interviews soon after each interview was conducted which further allowed her to become familiar with the data. Interviews were transcribed verbatim. Once transcribed, the researcher immersed herself in the data by reading and re-reading the transcripts to obtain a sense of the participants' experiences. Burns and Grove (2011:94) state that initially the aim of immersion is to ask oneself the question: *"What is going on?"* to initiate the cognitive process of analysis. The supervisor and co-supervisor also read and checked the transcripts. Management of data involved typing all handwritten notes and saving the data on the researcher's password-protected personal computer and external hard drive which was kept in a safe at the researcher's home.

3.13.2 Extraction of significant statements

At this stage of data analysis, significant phrases and statements pertaining to the use of Afrikaans during handovers and in documentation and the effects of these (on patient care, team cohesion) were extracted. The researcher then, on separate sheets of paper, wrote

and coded these statements according to their transcript and page numbers. Four hundred and twelve significant statements were extracted from 11 transcripts.

3.13.3 Meanings attached to significant statements

Meanings were then formulated from the extracted significant statements. The meanings were formulated through an iterative process of oscillating between the extracted statements and the individual participants' transcripts to ensure that the essence and meaning were accurately captured. A total of one-hundred and eighty-six meanings were formulated.

3.13.4 Statements categorised into clusters of themes

The one-hundred and eighty-six meanings were colour-coded by the researcher according to similarities and then grouped together to form clusters according to colours showing similarities. Eleven sub-themes were then grouped into four emergent themes. This process was reviewed by the supervisor – which increases rigour of the study. Care was taken to ensure that themes and sub-themes accurately captured the essence of the phenomenon that emerged from the participants' accounts.

3.13.5 Exhaustive description

At this stage of analysis, the researcher organised and gathered all the emergent themes into an exhaustive description. The phenomenon was described using the participants' verbatim quotations to further substantiate the themes and sub-themes. The exhaustive description was portrayed in such a way as to resonate with the reader by providing a thick description and context. The description was then reviewed by the study supervisor for validation of an exhaustive description that captures all the elements of the phenomenon as related by the participants.

3.13.6 Essential structure of phenomenon identified

In this step the exhaustive description is deduced to an essential structure by removing unused redundant descriptions and reveals the key findings of the fundamental structure. Clear relationships between the clusters of themes and emergent themes and sub-themes were generated, eliminating ambiguities that could possibly weaken the description.

3.13.7 Validation of findings

To validate the study findings, the descriptions of the phenomenon were taken back to the participants and discussed with them. The participants' views on the findings were sought from them. Validation was obtained via face-to-face contact. Eight of the participants were available for validation while the others cited personal reasons for being unable to meet with the researcher. The validation of findings with participants was previously mentioned in

section 3.11.1.4 but repeated at this juncture as it also relates to the steps of the data analysis approach that was applied. The participants were satisfied with the description of themes and sub-themes that emerged and had no additional comments. The participants had no further suggestions and stated that all the information they wanted to convey was present. The participants approved the findings and stated that it reflected their experiences, thoughts and feelings.

3.14 SUMMARY

This chapter contained a detailed description of the research process involving the aim, objectives, the research design which corresponds to descriptive phenomenology to explore experiences, population and sampling, data analysis of which Colaizzi's seven-step phenomenological method was applied. The criteria of Lincoln and Guba (1985:290) was used to ensure trustworthiness.

The next chapter contains an in-depth presentation of data analysis and findings.

CHAPTER 4:
FINDINGS

4.1 INTRODUCTION

Presented and discussed within this chapter are the findings of the study that were yielded. The interviews were captured by using an electronic audio recorder and all interviews were transcribed verbatim by the researcher using MS Word. The interviews were then analysed using Colaizzi's method of data analysis to describe the experiences of nurses regarding the use of Afrikaans at the central hospital for handovers and documentation.

The findings are described under two sections: Section A describes the demographical data and section B consists of the themes and subthemes that have emerged from the interviews.

4.2 SECTION A: DEMOGRAPHIC DATA

A total of twelve participants were interviewed by the researcher. Eleven of the participants were permanently employed at the central hospital, whilst one was working via a nursing agency. Two were on night duty at the time of the interviews and nine were on day duty. At the time, the agency employee had only worked on day shift at the central hospital under study.

Participants were asked to indicate their demographic details (age, first and second language, race and ethnicity) on a sheet. The study consisted of eight Black (of different ethnic groups) and four Coloured participants. The study contained no White participants as there were no White nurses in the randomly chosen wards at the time of the study. Two of the participants were Tshivenda first language speakers, four were Afrikaans first language speakers and six were Xhosa first language speakers. All the participants were female. None of the wards that were randomly chosen had male nurses. One of the participants, a professional nurse, stated that she was racially of mixed race as her biological father was Coloured and her biological mother was Black. She however identified with the Black, Xhosa side of her family and indicated that her first language was isiXhosa. Four Professional Nurses, three Enrolled Nurses and five Enrolled Nurse Auxiliaries were included in the study (see Table 4.1). The youngest participant was 25 and the oldest was 50 years old. The mean age was 34. The duration of employment at the hospital of the participants were between 4 months and 30 years. The wards from which the participants were chosen fell under Emergency, Medical and Surgery nursing modules.

Table 4.1: Participant demographical data

Participant number	Race	First language	Ethnicity	Nursing category	Age	Years of experience at institution
One	Black	Tshivenda	Venda	ENA	41	1.5 years
Two	Coloured	Afrikaans	Coloured	ENA	39	8 years
Three	Black	Tshivenda	Venda	ENA	34	4 months
Four	Coloured	Afrikaans	Coloured	ENA	44	3 years
Five	Coloured	Afrikaans	Coloured	EN	50	30 years
Six	Black	isiXhosa	Xhosa	EN	28	2.5 years
Seven	Black	isiXhosa	Xhosa	ENA	30	10 months
Eight	Mixed race	isiXhosa	Xhosa	PN	26	2 years
Nine	Black	isiXhosa	Xhosa	PN	25	11 months
Ten	Black	isiXhosa	Xhosa	ENA	35	AGENCY
Eleven	Black	isiXhosa	Xhosa	PN	30	1 year
Twelve	Coloured	Afrikaans	Coloured	PN(OPM)	50	4 months

4.3 SECTION B: ESSENTIAL STRUCTURE OF THE PHENOMENON

Four major themes were identified by the researcher from interaction with participants during the interviews that formed the essential structure of the phenomenon. The themes and sub-themes are depicted in Table 4.2.

Table 4.2: Themes and sub-themes

Themes	Sub-themes
Differences which disunite	Isolation Generational gap differences Segregated team Feeling disparate Afraid to speak up
Reverberations	Patient care Repetition: “I did it again” Desire to work decreased Conveying respect Begging to be heard
Historical influences	Power lies with those in higher positions Deeply-rooted: it came from the years of apartheid Higher learning: the nature of learning institutions
Language discourses	Need for English The state of Afrikaans The nature of being umXhosa: uBuntu

Table 4.3 Indicates the meanings formulated from the significant statements in the participants’ accounts, categorised according to the sub-theme.

Table 4.3: Sub-themes and meanings formulated

Sub-themes	Meanings formulated
Isolation	-experiences of isolation from team members -a divide between the two major language groups -self-exclusion -staffing allocations reflective of segregation -segregation as a solution and coping mechanism -racial cliques -feeling that language separates not unite -feeling unwelcome in the ward -sensing apartheid all over again
Generational gap differences	-generational clash -transition hard for older generation -new generation does not see colour
Segregated team	-non-existent relationship with team members -team work is beneficial to patient satisfaction
Feeling disparate	-feelings of incompetence -feeling stupid -feelings of hopelessness -feeling defeated -feeling discouraged
Afraid to speak up	-fear of losing job -fear to voice concerns -newcomers' fears
Patient care	-delay in delivery of nursing care -little knowledge of patient information by nurse -omitted nursing care -halted continuation of care -worst case scenario: the patient could die -unnecessary suffering of the patient
"I did it again"	-repetition of orders and notes -incorrect implementation of orders
Decreased desire to work	-no desire to go to work -intent to leave -agency staff cancel shifts -intentional late arrival
Begging to be heard	-constant reminding of others to speak English -asking for change that never came

Conveying respect	-lingua franca usage in a multicultural setting a sign of respect to colleagues -certain wards respect diversity -not wanting to interrupt seniors during handover because of respect (cultural) -writing in English to accommodate everyone
Power lies with those in higher positions: Doctors	-orders and ward rounds in Afrikaans -perceived low English proficiency of doctors
Managers	-operational managers perpetuate use of Afrikaans in wards -biasness of management -aggressive involvement of operational managers needed -no representation of Blacks in management -older generation hospital management using old methods - operational managers have power -management heading in right direction -management has failed
Professional Nurses	-Professional nurses conduct handovers in Afrikaans
Deeply rooted: it came from the years of apartheid	-nursing has changed for the worse -the hospital's foundation is Afrikaans -physical structure of building depicts intended segregation -racial issues at hospital blamed on country's history -long-standing language traditions have become norms -life was better under apartheid regime -politics play a role in enforcement of language -apartheid has ingrained a mentality of submission in Black people
Higher learning: nature of learning institutions	-health workers' training institutions have an influence on language practices -management were trained in Afrikaans
Need for English	-English is perceived as the ideal lingua franca for workplace -tri-lingual ability in Western Cape is advantageous -the world is evolving towards English -blaming low English proficiency levels for use of Afrikaans -hospital commended for language policy -implementation of language policy for international students
The state of Afrikaans	-more comfortable expressing oneself in Afrikaans -being in Cape Town you must speak Afrikaans -disregard of non-Afrikaans speakers -widespread use of Afrikaans at hospital -dwindling Afrikaans -the beauty of Afrikaans
The nature of umXhosa: Ubuntu	-Xhosa culture -barred from conversing

4.3.1 Theme one: Differences which disunite

All the participants expressed that there is a vast ocean of differences such as language, culture, background and socialization that exist amongst them as nurses and these have not united them, but instead have served as platforms for division among the team. The generational gaps (youngest participant was 25 and the oldest was 50 years old) between staff have also been identified as having an influence in how staff relate and how they use and approach language. Isolation occurs where certain members who do not speak and understand Afrikaans feel like outsiders within the team. Isolation, as verbalised by the non-Afrikaans speaking participants has caused divisions amongst nursing staff of different linguistic and racial backgrounds. Differences which disunite them is narrated under the sub-themes: Isolation, generational gap differences, segregated team, nation of diversity, feeling disparate and afraid to speak up.

4.3.1.1 Isolation

Non-Afrikaans speaking participants have expressed feeling isolated from the rest of the nursing team as a result of Afrikaans being spoken in their presence during handovers. Handovers are done with the purpose of informing the nursing team about everything pertaining to the patient. It is done to ensure continuity of care and improve patient outcomes. However, some participants expressed not being privy to receiving the information contained within handovers. This EN expressed her despair at being left out during handovers whilst still being expected to perform optimally as a nurse.

> *"Totally its bad. You're left out. They finish to handover with the patient and they expect you to do the procedure while they speak with Afrikaans."* (Participant 6 - EN).

This is a sentiment echoed by most of the non-Afrikaans speaking participants of feeling isolated. The following non-Afrikaans speaking professional nurse who has been working at the institution for one year relates the feeling she has when she does not understand a language spoken in her midst as a team member.

> *"When you don't understand the language that has been spoken, firstly, you don't know whether you have done something wrong when they're commenting or carrying on the conversation. Basically you do not know what to do. You feel disorientated. You feel lost. And you feel like you're not part of this team because the language alone has separated you from everyone. Isolating you in a way."* (Participant 11 - PN).

Non-Afrikaans speaking participants described that the staff allocations (duty roster and tea-times) were also indicative of the divisions that exist in the hospital wards. Below a non-Afrikaans speaking professional nurse shared how lunch time allocations are done in her ward and she relates that the allocations are done according to race, possibly because of different languages.

> *"Staffing, the allocation is different, like the Coloureds, the Blacks and the Whites – which are Boer – when you go to tea, you are separated. It's not the same. The Blacks go to the Blacks and the Coloured's with their own race and the Boere will mix with their own. I think it's because we don't speak the same language."* (Participant 8 – PN).

When asked if she as a professional nurse had ever done allocation duty, she responded:

> *"Allocations in my ward are done by the shift leader. And because I'm a junior sister, I have not been placed as shift leader yet. Sometimes my manager would also do the allocations and she would also divide the team according to Coloured people and Black people. I want to leave this place, it's toxic."* (Participant 8 - PN).

Tea/lunch breaks according to race or language preference do not seem to be the norm. Yet, isolation is experienced as some staff members tend to communicate in their native tongue during breaks; in this case Afrikaans. An isiXhosa speaking participant, an EN, from a different ward voiced that even though the nurses were mixed during tea-times, she felt left out. Partaking in the tea/lunch break conversations in English does not seem to help as the Afrikaans speaking staff would continue the conversation in Afrikaans.

> *"And even maybe on the tea-times, during the tea-times, I for me, I don't like to sit with them because they will be communicating with this Afrikaans. Even though you communicating with them with English they will change it to Afrikaans so I feel left out. It's like that. It's not nice at all."* (Participant 6 - EN).

Black, non-Afrikaans speaking participants expressed that they sensed territorialism as they were constantly being told they do not belong at the hospital or in the Western Cape by their colleagues.

> *"Ja mos, they demand this hospital was for them. So why now must it be changed?"* (Participant 6 - EN).

When probed as to who 'them' was, she replied:

> *"The Afrikaans people. We only came now and then we want to change things. That's what they are saying. So I don't want to fight with my colleagues so I just keep quiet and do what I can do, what I'm understanding and that's all."* (Participant 6 - EN).

The above EN relays what she had been told by her Afrikaans speaking colleagues. She would resort to keeping quiet to avoid any conflict between them. The participant would value working in an inclusive environment where she feels she belongs.

One isiXhosa speaking professional nurse participant mentioned that the coping mechanism that she and her fellow non-Afrikaans speaking colleagues have adopted, and her proposed solution to the language issue was for everyone to 'stick to their own kind'.

> *"Our coping mechanism is only stick with your own. That's our coping mechanism. So if they don't want to speak to you, they don't want to speak in any other language rather than Afrikaans…so you just don't speak to them. You just speak in your own language to your own people."* (Participant 8 - PN).

The professional nurse relates that at times her colleagues would address her in Afrikaans, refusing to address her in English. It is then that she would refrain from communicating with them and rather speak to other nurses who are Xhosa.

4.3.1.2 Generational gap differences

Both Coloured Afrikaans speaking participants and Black non-Afrikaans speaking participants have observed notable differences with nurses from different generations when it comes to adapting to a different language. They have divided the generations into the "older generation" which are nurses who have been at the hospital or have been in nursing for 20 or more years and the "younger generation" of nurses who are the recently qualified or those who do not have substantial experience in years.

> *"Some of the nursing staff I see they can't write in English, I've noticed that. But I see it also when I look at the person who did the entry, I see the person is maybe 20 years already here, 30 years already here, I can't change that person now."* (Participant 4 - ENA).

This Afrikaans speaking nurse noted that some of her Afrikaans speaking colleagues did not possess a strong command of the English language and it translated into the quality of record-keeping. She also noted that the colleagues who were unable to express themselves

in English on paper were nurses who were older and were used to writing in Afrikaans but were now trying to write in English.

An isiXhosa speaking professional nurse participant describes that the way of thinking of the older generation is somewhat stuck in a different era which may not be suitable with the current times:

> *"Its old people who have the mentality that's still stuck in the nineties or the eighties. But the same people who were in the positions are still the same generation. They're carrying on the generation…the old traditions. They bring them forth."* (Participant 11 -PN).

Conversely, an Afrikaans speaking nurse who had been a nurse at the hospital for thirty years mentioned that even though she had been used to doing things in Afrikaans over the years, she was open to change and accommodating her isiXhosa speaking colleagues.

> *"You see, when we started most of us were Afrikaans speaking here so I can say over the years, there was mos now, most of the time Xhosa coming with us so we had to change so we had to grow up, I mean, we had to try and accommodate them also because why we were almost, how can I say, there was like how many Xhosa people working here."* (Participant 2 - ENA).

The younger isiXhosa speaking professional nurse continued to mention how her generation views people in general.

> *"We grew up, my generation, believing there is some sort of cohesion: we are one. When I see a person I don't see colour, I see another human being. That human being deserves to be able to communicate with me."* (Participant 11 - PN).

This participant values cohesion that comes through understanding the language of your colleague and values humans regardless of their skin colour.

4.3.1.3 Segregated team

In most of the wards where the interviews were conducted, both the Coloured Afrikaans speaking participants and non-Afrikaans speaking participants professed to observing divisions among the team. Only one participant expressed that there was a sense of unity between those who speak Afrikaans and those who do not. This participant also spoke of embracing change. Both Afrikaans speaking and non-Afrikaans speaking participants admitted to having instances where they spoke their native languages (Afrikaans and isiXhosa); however, it was mainly in their private time (during tea-time and lunch-time). The

ward routines in the different wards differed, however team work was mentioned to be important. It was noted by the researcher that division occurred mainly when each group of nurses communicated in their native tongue, which other nurses may not have comprehended.

An Afrikaans speaking ENA working night shift with two isiXhosa speaking ENA's commented that whilst helping to turn a heavy patient, her colleagues spoke isiXhosa, which concerned her as she could see that they needed her assistance. She alluded that it helps when one communicates their needs (like wanting help from a colleague) in a language that is suitable for one's team as this translates to the patient receiving assistance timeously.

> *"We were uh, there was a heavy patient in the ward. we were working night and there was a heavy patient so three people had to help that patient. so I was like the only one that's Afrikaans speaking and then the two Xhosa speaking people. So they were talking Xhosa while I'm helping them but I can see that one is now telling in Xhosa the other one that she needs help that side, but then I said if we're working with the patient I told the nurse, that day, if we're working with the patient, then can you please speak English so that I can understand."* (Participant 2 - ENA).

The above Afrikaans speaking ENA indicated that speaking isiXhosa was not beneficial as she was not able to understand, hence requesting that English be spoken as it would enhance her understanding of what needed to be completed. This participant valued being able to understand the language of her team members even though she could ascertain from their body language what they were talking about.

Non-Afrikaans speaking participants, EN's and ENA's, of one ward confessed that handovers in the morning were done in Afrikaans and despite many attempts to address the issue, it was in vain. Consequently, this led to the participant and her non-Afrikaans speaking colleagues arriving late at work. To remedy the solution, her ward implemented two handovers, one for Afrikaans speakers and the second was conducted in English for the non-Afrikaans speakers.

> *"They don't use English as a medium language. I've tried many times since I came here when they do the handover they will just speak two lines and go back again in Afrikaans. And that resulting of us, many of us, coming later not to attend the handover at 06h45 because of we know they say they will be in a rush and they will speak Afrikaans so what the use of coming early at 06h45 not attending the*

> *handover because we know they're gonna do another second handover in English but even though they mix it with Afrikaans."* (Participant 6 - EN).

Some Afrikaans speaking participants (ENA's) expressed that even though the professional nurses would start a handover in either isiXhosa or in Afrikaans, they would stop them and request that they speak in English as there are different races and language groups listening to the handover and they would comply. The Afrikaans speaking ENA understands that processes such as handovers are for the patient's benefit and she is mindful of her non-Afrikaans speaking colleagues.

> *"Handovers we usually speak English. Maybe you have the sister will maybe change to Afrikaans, here is mos Afrikaans speaking people. So maybe she is speaking Afrikaans we will say 'Sister, here's English people here'…then they will go to English so uhm handover is fine we all speak in a language that we all understand because handover is for the patients; we want to know their diagnosis and stuff and what procedures they will go on. So it's really its English is fine for me….so for me it's not difficult to say listen here sister there is English people, consider other people also."* (Participant 2 - ENA).

Some non-Afrikaans speaking participants did not enjoy the ward environment as Afrikaans was spoken extensively in the wards. This was especially difficult when they started working at the hospital.

> *"The first time when I came here I just find everyone talking Afrikaans 'praat praat praat' [talk talk talk]. Do you imagine the 12 hours working you just keep quiet, not talking, just talk to the patient, but on lunch time, on handover time, busy time, they are talking their Afrikaans and you end up just keep quiet the whole day and that's not good, not enjoying working."* (Participant 1 - ENA).

Although Afrikaans is spoken extensively, one participant, a Black, isiXhosa speaking nurse mentioned that the use of Afrikaans cannot be generalised to all the wards at the hospital.

> *"It differs from ward to ward. Mainly, in Trauma, it's done in English. Or if you arrived late and they were doing it in Afrikaans, the moment they notice you are amongst, they change to English. But there are certain wards where…Medical, come to think of it, where they started in Afrikaans and they'll continue in Afrikaans. But that's mainly the older generation."* (Participant 11 - PN).

The Tshivenda speaking ENA mentioned that her relationship with her colleagues was satisfactory as she did not come to work to make friends, but to care for her patients:

> *"The relationships are fine. Cause we are not here to make friendship. We are here to help the patients. Just keep on helping your patients then you'll be fine, just keep doing your job that they don't have anything to say about you. I just do my job the way I know my job so I don't care about friendship."* (Participant 3 - ENA).

The above participant has amicable relationships with her colleagues where communication between them is mainly patient-centred.

Participants who did not understand the vehicular language felt a sense of "otherness", a feeling of not fitting in and feeling like they are unwelcome. Feelings of hopelessness emerged from most of the non-Afrikaans participants who were of the opinion that nothing can be done regarding the situation. Participants were made to feel that the Western Cape is no place for non-Afrikaans speakers.

4.3.1.4 Feeling disparate

The non-Afrikaans speaking participants of all nursing categories experienced and expressed feelings pertaining the use of Afrikaans in the wards and hospital at large; from feelings of incompetence to feeling discouraged. These feelings emanated from the language practices at the hospital. The following participant, a Tshivenda speaker, who is an ENA recalls how she would have to ask for assistance from her colleagues regarding written communication in the nurse's progress reports:

> *"It's like you don't know your job, asking everybody 'what's written here, come read here for me'. It's not good. They must change that. Write in English."* (Participant 3 - ENA).

This non-Afrikaans speaking participant's hands are tied when it comes to implementing orders first hand, because she usually has to ask someone else to translate what is written. This has left her feeling incompetent and for her the situation was not ideal:

> *"I never understand I have to ask somebody to translate. Then I'm working in that room, I have to do everything the doctor say, then you can't you have to give somebody to read it for you."* (Participant 3 - ENA).

It is the willingness of their colleagues to help that allows the non-Afrikaans speakers to be able to continue with their nursing duties. But each day is different, and this "helper" may

take on different faces each day, cementing the fact that help for these non-Afrikaans speaking nurses is not constant.

> "They are willing to help, they are willing to help whereas you know man people are different sometimes and like this and tomorrow he or she will wake up like this and she don't want to help but when its written like this that I'm covered and I'm gonna continue with my work." (Participant 1 - ENA).

> "Covered is like safe, uhm like understanding what they say, then I'm covered." (Participant 1 - ENA).

Due to the inability to comprehend notes and orders, the non-Afrikaans speaking participants have caught themselves redoing things and that has made them feel stupid.

> "You can even check for yourself the reports, it's written in Afrikaans. You can write the same thing that was written before you, because its Afrikaans. It makes me feel stupid, you see?" (Participant 6 - EN).

After being exposed to the same language practice issue in the workplace, the non-Afrikaans participants expressed feeling discouraged about anything changing. They have lost hope in the processes of the hospital being inclusive.

> *"Me, there is nothing I can change as I'm just an employee here. There is a CEO, there is a unit manager, who goes to the meeting, who do attend the meeting and stuff, and they know about the hospital policy of language. Is the one who must really really be strictly sure about the language in the ward, in their ward."* (Participant 1 - ENA).

The discouragement coming from unchanged language practices have imbued some with a sense of defeat.

> *"I don't bother anymore to ask when its written in Afrikaans because of you know mos very well that I don't understand Afrikaans so why should you write it in Afrikaans? You don't want me to do that thing mos."* (Participant 6 - EN).

Most non-Afrikaans speaking participants have also accepted the current way of things.

> "But now there isn't any other solution. Either, what I would say is the doctors or nurses at the hospital must learn to speak English. They must learn to write English….at this point we've been trying so hard." (Participant 8 - PN).

Non-Afrikaans participants voiced that they arrived into an Afrikaans speaking environment and upon their arrival they found other non-Afrikaans speakers had not complained in their time of employment.

> *"Because I came here with there was Xhosa nurses. They were comfortable with that Afrikaans thing, they never complained. So why now I came with a big drama? That's why I didn't go to the area manager."* (Participant 6 - ENA).

A non-Afrikaans speaking participant, an ENA, expressed that she had raised the matter with the manager many times, and despite the manager promising it will not continue, it carried on.

> *"Sometimes we did address with our unit manager that if they write in Afrikaans we don't understand. But it's going on, and they continue to write the same thing all over and then she said, 'Ok, it will stop', but nothing stopped. I feel like I can write in Xhosa too."* (Participant 7 - ENA).

One of the Tshivenda first language speaker participants admits that one-on-one communication for work purposes is good because she is addressed in English. However, the handovers continue to be conducted in Afrikaans.

> *"Communication in work is good, communication is good. When they are talking to me, communication in work they are good because when I ask them they gonna answer me in English…One on one communication is good, because he gonna cover me with that medium language. But in that group or in that handovers, two, three languages there so you end up not understanding what really the patient need or what really the patient's continuation is."* (Participant 1 - ENA).

The operational manager had a different view and mentioned that language differences does not affect team work of nurses as some isiXhosa speaking nurses have learned Afrikaans:

> *"It doesn't. it really doesn't. people, they pick up easy and we thought that we could 'skinner' [gossip] in Afrikaans just to find that they do actually understand what you're saying…it's the Xhosa-speaking nurses. 'So you actually can speak Afrikaans!' so they really try to understand and to learn the language. Not because its forced, but because it's used so often that people know. Ever since I started here it doesn't really have a negative impact on anybody. But we try to speak English most of the time. Even handing over in the morning. But occasionally we'll speak*

Afrikaans and then they'll remind us 'hayibo [no way] English English English. And then vice-versa. So we try to accommodate each other" (Participant 12 - OPM).

4.3.1.5 Afraid to speak up

Non-Afrikaans participants of all nursing categories expressed that they are sometimes afraid to speak up. Some feared speaking up due to the reaction they receive from their colleagues, while others feared losing their jobs if they spoke up. Some participants opted not to be vocal about their qualms regarding language.

"When you're employed, you don't want to speak too loud, or you don't want to say what you really think because you want that job. You want that job. You want that salary…and we just keep quiet and go with the flow." (Participant 8 - PN).

Further probed on keeping quiet and not wanting to lose her job, the isiXhosa speaking professional nurse replied:

"Personally I'm scared to talk about it. Everyone's scared to talk about racism. Because no-one wants to be called racist. Anything that has to do with racism in the Western Cape, you are like the worst person in the world. So I'd rather not do it all. My only solution is just to get out of here very fast. I'm regretting coming here." (Participant 8 - PN).

The abovementioned quote illustrates that language is a sensitive topic which may be closely related to issues of race. When probed on why she is scared to raise her concerns regarding language, the participant replied:

"Well, it's because... I think it's the minority and the majority thing. I so wish that I was in the clinic where most of us were Blacks and there was one Coloured person. Maybe that Coloured person would really feel the same way that we do. But now, it's their territory. So it's kind of not nice. Because when I raise something like that about race and everything, they're all going to have attitudes and it's going to be a bit rigid and it's not going to be nice. That's the whole fear. When you talk about it, they're not going to be as open." (Participant 8 – PN).

The participant, due to the fact that she considers herself to be part of a minority group working at the institution, fears the reaction or attitudes her colleagues may have towards her if she raises her concerns regarding language practices.

Even the agency nursing staff who was sought to assist raised a fear of expressing herself when she noted the linguistic system in operation in the wards.

> *"I didn't talk because it was my first day. I remember it was in Medical ward where I talk to the sister. But on these two wards, it was my first two days. So it wasn't easy at all to talk, you see?…. because I'm scared, I don't understand. It makes me deurmekaar [confused] at all you see?*" (Participant 10 - ENA).

The above agency ENA noted that the language used in the wards she was placed in was Afrikaans, however she was afraid to raise her concern on her first day in the ward. She raised the issue on her second day by approaching a PN but admits that vocalising her issue was not easy.

One participant felt very strongly that non-Afrikaans speaking students and new employees, regardless of their understanding of Afrikaans, are addressed in Afrikaans. Her response below reflects a disregard for non-Afrikaans speaking staff by Afrikaans speaking staff

> *"[I]t seems that they do it intentionally because I mean you can't just speak one word of English then you go back to Afrikaans while you see, especially when there's also a first year student, they can't speak for themselves, they're still new, they're scared of the staff. When there's a Xhosa nurse, or new nurses, they will speak this Afrikaans while they are busy handing over about the patients."*
> (Participant 6 - EN).

The same participant quoted above also had no problem vocalising her need for English to be spoken during handovers. She expressed that it was irritating to keep reminding the professional nurses to speak English especially when the professional nurses should know to accommodate everyone.

> *"For me it doesn't affect me, cause I sort them out. But some of the other nurses I don't know. Because of I can speak for myself. If I don't understand I just stop you. And say 'can you please speak English'. But that thing its irritating every time I must remind you, it's like I'm disrespecting you. Especially like in front of the nurses and then I'll be the one that says 'no I don't understand, please speak English'. As if I'm instructing you to the thing you are supposed to do."* (Participant 6 - EN).

Although this participant was not afraid to voice her concern, most of the non-Afrikaans speaking participants refused to speak up about Afrikaans being an issue for them because they were not only afraid of being labelled but they also felt that speaking up would cause them to lose their jobs. The participants felt that keeping quiet, as those before them had done, would be a better option. None of the participants provided any instances where an

Afrikaans speaker confronted or labelled them. Neither did they know of someone who had lost their job due to the language issue.

4.3.2 Theme two: Reverberations

The multicultural and multilingual nature of the hospital staff has had an impact and echoed through many of the daily nursing processes from verbal communication, nursing documentation and even interactions with the various ethnic and cultural groups. This theme speaks of the consequences that language incompatibility has on a number of aspects within the context of the hospital. These consequences were found by the participants to be directly related to the use of Afrikaans for communication purposes. According to the participants, patient care, repetition and omission of orders, a decreased desire to work, issues of respect and constant begging to be heard were all results of Afrikaans documentation and handovers.

4.3.2.1 Patient care

At the centre of all nursing duties and responsibilities lies the patient. Everything a nurse does should ultimately benefit the patient with the least expenditure of resources, which includes time. However, due to the added burden upon non-Afrikaans speaking nurses of consolidating information with other nurses, an inevitable delay is caused to delivery of patient care.

> *"I can't read Afrikaans, I can hear and then sometimes that is the order; that the patient must be done this or this so you know nothing about that and you don't do it. At the end of the day the sister will come and ask you why that thing is not done 'which thing no its not written there'. But they wrote it in Afrikaans. So it makes them to delay."* (Participant 6 - EN).

Due to some forms being in Afrikaans, some non-Afrikaans speakers have resorted to memorizing the forms, however without a comprehension of what is typed in the forms, it may have negative implications on patient care.

> *"The form I can remember it's the circulation chart. I had to ask EVERYTIME, "what does this mean, what does that mean, what does this word mean, what does that word mean?". And they explain shame, they don't get tired. And I even ask Sister: "Where's the form that is written with English?" She said she doesn't know. So we just know that ok, anyway when this is normal we have to tick here, when its abnormal we have to tick here. If now they can come and ask you just know that this is about pulse, and this is about mobility but you're not even sure cause they*

> *show you no, when its normal tick here, when its abnormal tick there. So I think it's that form and which else?"* (Participant 6 - EN).

The operational manager mentioned that in the ward she manages, documentation is mainly in English, however she concedes that even with the odd progress notes that are in Afrikaans, it may pose a risk to patients' treatment.

> *"I've seen that mostly everybody writes in English. There is the occasional one that, because Afrikaans is mos now...they're comfortable using the language and so on. Occasionally somebody would write in Afrikaans, and then the next person coming along reading whatever was written there, that makes it difficult. It can have an implication on the patient's treatment. It can have an implication on a lot of things."* (Participant 12 - OPM).

She carries on by mentioning that she is an Afrikaans speaker has no problem communicating in Afrikaans as it does not negatively affect her ability to work, however she understands how it may be difficult for one who does not understand. It is for these reasons that she promotes the use of English in her ward and is in the process of translating all forms and documents to English.

> *"Seeing that Afrikaans is my first language also... It doesn't really matter. Because I understand Afrikaans, so if you speak in Afrikaans to me, I'm comfortable - I can... Communication do take place. It doesn't even have an impact on me, so... But I can understand for somebody else, a Xhosa-speaking person, who doesn't even know what the word "verlof" means, how it can compromise patient care. There's no communication taking place, so how can you expect anyone to function like that?"* (Participant 12 - OPM).

A non-Afrikaans speaking professional nurse concurred by saying:

> *"But you get the old nurses who still feel that the medium language to communicate in is still Afrikaans. Yes, it does delay processes. Sometimes you get a patient's progress report, its written in Afrikaans. You have to call someone else to translate it for you, whereas if it was in English, you'd just continue."* (Participant 11 - PN).

The previous participant expressed that not understanding the orders and notes usually lead to nursing care being delayed. Sometimes however, the nursing care would not be done at all. This is an account of a non-Afrikaans speaking professional nurse:

> *"Firstly I would think that when you don't understand what the instructions are you will not do the instructions. That will lead up to negligence, and that is an incident. So now the patient isn't taken care of, so the patient care is not continued at all."* (Participant 8 - PN).

The non-Afrikaans speaking professional nurse participant mentions a possible legal ramification for not carrying out orders or omitting to perform a duty you were meant to. Professional negligence is a punishable offense. The reality is that when nurses do not understand an instruction, they will not comply. They are unable to comply. Some of the participants' narrations are hypothetical and anticipations of situations that may occur when the nurses do not comprehend the instructions or notes.

One non-Afrikaans speaking participant confesses to not carrying out orders if/when they are done in Afrikaans because she is of the belief that it is known that she and others do not understand Afrikaans:

> *"I don't bother anymore to ask when its written in Afrikaans because of you know mos very well that I don't understand Afrikaans so why should you write it in Afrikaans? You don't want me to do that thing mos. Cause I take it that way. You instructed me with Afrikaans which is you don't want me to do that."* (Participant 6 - EN).

Nursing is a twenty-four-hour service and it relies solely upon the ability of nurses to relay the information to the next nurse to allow continuity of nursing care. As the non-Afrikaans participants described, it becomes a difficult task to carry out duties you are not understanding on paper or in verbal handovers.

> *"Even in nursing notes nhe, you can find maybe when we hand over the previous nurse did use Afrikaans and you don't understand what is the continuation of the patient. It's difficult for me to read that thing, what am I going to continue with that thing you see."* (Participant 1 - EN).

One non-Afrikaans speaking participant mentions a possible consequence, that could occur due to omitted nursing care or delayed care – death:

> *"When you don't understand the language it's not nice. Especially the orders. You see...the patient will die or whatever because you don't follow with the orders, you see? Because of the barrier of language."* (Participant 10 - ENA).

Another concern raised by non-Afrikaans participants when they do not understand the language of communication is not being able to obtain a complete picture of the patient. Some even mention that they would know nothing about the patient except the patient's name which made caring for that patient particularly difficult.

> *"I mean like you're caring for a patient and you don't know what he's sick of. So you have to go also to check for doctors file and you can't find that file now you're nursing that patient without the nursing diagnosis and then you have to go and ask the sisters. It's written there but in Afrikaans. Some of the nurses they don't have those guts to go back to the sister because of they scared of the way they will tell them. So 'cause I think if you have to nurse your patient you must know everything about them. So we doing nursing them without knowing what's wrong with them. Because of it's there in the file but in another language. If it was written with English, then we would understand."* (Participant 6 - EN).

> *"But they say we must use medium language. That's how it's bad because some of the nurses they don't even understand one word. They get irritated."* (Participant 6 – EN).

This non-Afrikaans speaking participant, an ENA, expressed the difficulty she encounters each time she nurses a patient whose notes are in Afrikaans. At times there would be a fear of asking the professional nurses to translate because of the way they would reply, sometimes in a manner that portrays irritation.

4.3.2.2 Repetition: "I did it again"

Unable to read what the previous nurse had written, non-Afrikaans speaking nurses would unknowingly re-write what was written in the notes. At times a repetition of orders was done, as the nurse did not understand the record made.

The non-Afrikaans participants felt that documentation in Afrikaans made it hard for them to follow the exact orders.

> *"Well, most of my colleagues are Afrikaans-speaking. Which is quite difficult for me, because I don't speak Afrikaans. But I do understand it. But not to that extent. You'd find that most things are written in Afrikaans, especially with the nursing process everything is written in Afrikaans. So I would struggle to give... To render the service which I am supposed to render…. sometimes I'm not... I would do something that's been done like twenty minutes ago... I would do something that has been done, basically, without knowing it has been done."* (Participant 9 - PN).

Some non-Afrikaans speaking participants would document the same thing that was already documented.

> "*You can check for yourself the reports, its written in Afrikaans. You can write the same thing that was written before you because of its Afrikaans."* (Participant 6 - EN).

4.3.2.3 Decreased desire to work

Nursing is a passion-driven career and requires that one is passionate towards the idea of giving care to another individual. Unfortunately, the non-Afrikaans speaking participants have described their decreased desire to work and some intent to leave the profession as a result of passion that has been sapped by the constant use of Afrikaans in the workplace which gradually affects the ward milieu.

> *"At times we don't have a chance to go and check those doctor's files because of you're busy and really I didn't go back to that brown file I was talking about. So it makes you not to be in a good mood of continuing. It makes you not to be interested to come and work with that attitude you know you'll get here."* (Participant 6 - EN).

Some of the non-Afrikaans speaking participants describe the stages they went through, from being happy about being employed to dreading coming to work, solely based on linguistic differences. One participant, a professional nurse, expresses that tension sometimes exist between colleagues because of the language and racial differences and due to this she dreads going to work:

> *"At first I was happy to be employed, but now I dread coming to work. It's hard coming to work because you know that when I'm placed with this certain person this day is going to be very long. And a twelve-hour shift is quite long to be very quiet and moody and then this tension and this rigidness amongst the co-workers. So it's not nice. It's not nice at al."* (Participant 8 - PN).

When asked about who this certain person was the participant said:

> *"Because you know all your colleagues nhe, you know how each character is. Mostly the Afrikaans ladies do not want to speak English so that's why we have the tension. So you know when you're placed with that person it's gonna be a long day."* (Participant 8 - PN).

Not only do the non-Afrikaans speaking participants have a decreased desire to come to work, but it has escalated to them wanting to leave the hospital and finding alternative places of employment.

> *"It's been 20-odd years later we're still talking about Afrikaans and race and it's still the same especially in this hospital. I've even thought of resigning. Going somewhere else where I'm going to be happy. But now it's still the same."* (Participant 8 - PN).

The language practices have also caused the participant who works for an agency to cancel her shifts at the hospital. The participant experienced discomfort with working in a ward that used Afrikaans for documentation and other nursing activities. She valued working in an environment that was welcoming and when it was not, as in this instance, she cancelled her shifts.

> *"Even when they're writing entries, they're writing in Afrikaans. Everything they like to use Afrikaans. Sometimes it can cause things…like me, I did cancel my shift there, because you see, there's a lot of different things, man. It's not the same as other hospitals. We've noticed that, you're not comfortable at all, you see? You're not comfortable. You're stressed. So you can't work nicely in that situation."* (Participant 10 - ENA).

4.3.2.4 Conveying respect

A major perception described by the participants has been about mutual respect. Many feel that if you respect those around you, you will do what is necessary to make others comfortable and welcome.

> *"But as time goes on, I've learned to cope with it. And the staff, they also write in Afrikaans their own reports. But since I can read Afrikaans, to me it's a bit easier but I find it disrespectful because I also can speak Xhosa which is my first language, but I don't do that."* (Participant 8 - PN).

An Afrikaans speaking participant feels that using English as a lingua franca shows respect for colleagues.

> *"You have to stick to that because it's just showing respect to your colleagues. I hate it and I don't like it if you will carry on or continue on in Afrikaans maybe or you continue on in Xhosa."* (Participant 4 - ENA).

Despite Afrikaans being largely used at the hospital, the Tshivenda first language ENA participant acknowledged that change is slowly coming in and the hospital management is trying to be inclusive by incorporating English that non-Afrikaans speaking nurses understand.

> *"Ja as I say they are trying, they are going there. Some papers now are still written in Afrikaans, everything here in the ward some are still in Afrikaans but some they are coming in English."* (Participant 1 - ENA).

Some participants carry with them the value of respect and obedience which stems from a strong cultural upbringing that they feel asking for English to be spoken during a handover is not adhering to the hierarchy.

> *"But if they talk English, you know that you're not gonna interfere someone as they're elders, as they're sisters nhe."* (Participant 1 - ENA).

4.3.2.5 Begging to be heard

One pervasive statement that emanated from all the non-Afrikaans participants was "English please". A request that for many is uttered daily, sometimes a few times a day as a plea to understand. To understand and make sense of the patient, to understand one's colleagues and a plea to be part of the team.

> *"It affects me a lot because I end up saying 'English please' and when people are talking and you interfere just saying 'English please' you feel that you are making somewhere you are not making things sense."* (Participant 1 - ENA).

Regardless of whether the language is Afrikaans or isiXhosa, participants show that when you're working in a multilingual team, a common language is necessary as this Afrikaans speaking participant described:

> *"If we're working with the patient, then can you please speak English so that I can also understand because its nogals [somewhat] difficult if you're speaking Xhosa and I can see what you want but you are speaking Xhosa and I know your needs but I can't understand you but I can see you have a problem."* (Participant 2 - ENA).

This Afrikaans speaking participant expresses that a language which all understand, English, is necessary when working with someone who does not understand your first language. Like the isiXhosa and Tshivenda speaking participants who suggest that English be spoken for work-related activities, this Afrikaans speaking participant feels that English should be spoken.

One non-Afrikaans speaking participant relayed that even when operational managers were informed about the struggles they endured with Afrikaans, their pleas fell on deaf ears.

> *"The managers, they understand because they know Afrikaans so they don't see any difference. It's only us who's gonna see the difference…they don't even care. They say we must learn"* (Participant 3 - ENA).

The operational managers, even though they know about the issues regarding language, seem to be content about the situation as is stands. An isiXhosa speaking participant, who is a professional nurse, believes that managerial involvement should increase. According to her things are done in both English and Afrikaans in the wards because managers prefer to be neutral and not tackle the situation which negatively affects their staff.

> *"I really think they should be more involved. Now they're just content with some of us speaking English, or some speaks English and the others Afrikaans. The forms and the documentation is done in Afrikaans and English. It's like they don't want to touch, or they don't want to press the wrong buttons about not speaking Afrikaans."* (Participant 8 - PN).

Non-Afrikaans speaking participants reiterated that many times they asked for things (documentation and handovers) to change to English so they could understand, but change never came.

> *"She said she doesn't have but I said why can't you make a form with this English because we struggle now with this thing but it's never changed. So you just waste your energy of saying anything to change."* (Participant 6 - EN).

One non-Afrikaans speaking participant was of the opinion that when they were recruited, it was known that they are not Afrikaans speakers. However, they were recruited into an environment where they do not understand the language and they do not feel welcome as a result of language. This non-Afrikaans speaking participant, an ENA, expressed that inasmuch as all who are born in Africa are Africans, there are variations of the African people as evident in the different languages spoken. However, the hospital environment in which she is employed does not cater for everyone employed at the institution.

> *"The thing is they know that (mentions hospital) did employ Africans, we are all Africans but they did employ different Africans. But the thing is they know that we must use the second language or the medium language which is called English. We*

gonna end up running for a wrong thing whereas she talks a language you don't understand." (Participant 1 - ENA).

4.3.3 Theme 3: Historical influences

As all things have an origin, the participants relayed where they think the roots of the hospital's segregated practices stem. The participants named the history of apartheid, institutions of higher learning which train nurses and doctors and those in senior positions who set the ambience at the hospital as contributing factors to the language issues in wards.

4.3.3.1 Deeply-rooted: it came from the years of apartheid

Some participants appreciated the former leadership of the country and all it offered. One Coloured, Afrikaans speaking participant conveyed a sense of inclusion within the previous government as a Coloured person in the broader context of the country versus the political and social exclusion Coloureds are faced with presently.

> *"After our election in 1994 things did change a lot. Because…we can say whatever we want to say. We were under the white regime. Yes. There were a lot of things going wrong, but we had a better life."* (Participant 5 - EN).

The Afrikaans speaking participant was asked to explain what she meant by 'we had a better life':

> *"We had less corruption then, and that we were allowed to do certain things. The other thing is that, for me it just seems we go into now, with all due respect to the African people, they just seem to cater for their own people. We as the Coloured people is standing outside again. They did include us, not the way they should, but they did include us. But now we just cut outside. We are Afrikaans-speaking people, they force us now to become English people, they force the children at school to be Xhosa-speaking children. Under the white regime they just left us to speak Afrikaans and if you need to speak English, ok because we were an Afrikaans country. We, in this generation, are the people that's supposed to lead, we're the people that's supposed to make decisions".* (Participant 5 - EN).

The same participant felt that nursing underwent a change as well at the dawn of democracy:

> *"But nursing changed in 1996. It's a calling. It's a calling. But after 1996, it's no longer a calling. It became…I don't know how to explain it to you. It became like a 'beroep'[occupation]. A lot of paperwork starts…you get so little of nursing at the*

> *end of the day. Nursing care. Because it's so much paperwork. Nursing care somewhere did change."* (Participant 5 - EN).

The participant also asserts that the hospital was initially an Afrikaans-only hospital.

> *"(mentions hospital) was nog die enigste Afrikaanse hospitaal, toe skielik na 1996 toe…toe moet ons maar Engels praat." (Participant 5 - EN).*
>
> Translated version:
>
> *"[(mentions hospital) was the only Afrikaans hospital, then suddenly after 1996, we had to speak English"* (Participant 5 - EN).

Another Afrikaans first language participant reiterates that historically the hospital is Afrikaans. However, transformation measures are in place and English is promoted

> *"OK, well... (mentions hospital) is an Afrikaans hospital, but what I have seen is that we've tried to do everything in English now."* (Participant 12 - OPM).

Some participants have observed that the architectural formation of the hospital was for the intent to separate non-whites from whites.

> *"He told us that they were using the Afrikaans before, that times this side. It was the West for the white people but nothing's changed."* (Participant 6 - EN).

Another concurred:

> *"What I found out that the hospital was structured in the way that there's an East and a West side. The east side I thought was for Blacks and the West side I thought was for the boere-people. So it's just like that here in this hospital. We're just segregated and we're so separate in everything. Everything. The race is an issue."* (Participant 8 - PN).

Many of the participants – both Afrikaans and non-Afrikaans speaking - believed that the hospital's current state of language affairs stems from the historical foundations of the hospital. The current norms are blamed on the long-standing practices.

> *"I think it's the hospital policy that said you can write in whatever you want; you can say whatever you want in Afrikaans. I think this thing came back from those years of apartheid they're still using that thing because they know a lot of people they don't*

> *understand Afrikaans but they are still writing in Afrikaans in the files."* (Participant 3 - ENA).

This non-Afrikaans speaking ENA participant surmises that the current institutional language policy permits the use of Afrikaans for documentation, and this stems from the years of apartheid.

Some participants were unsure of the existence of a language policy and what it entailed. This Coloured Afrikaans speaking operational manager was asked whether she was aware of a language policy at the hospital and what it entailed:

> *"It's supposed to be English. But when I started I said that this is a historically Afrikaans hospital, so a lot of the forms are still in Afrikaans. But we are in the process of... To correct that…. Now you're asking me the question that I'm not able to... I can't answer you. I only started here in May month, so thank you for turning my attention to that! I don't know."* (Participant 12 - OPM).

A Coloured Afrikaans speaking ENA, also asked about awareness of a language policy answered:

> *"No I haven't seen any written language policy. I assume that it must be in English because we're all moving that route. It's just a matter of respect."* (Participant 4 - ENA).

A non-Afrikaans speaking professional nurse mentioned the following about the language policy:

> *"I think the hospital is on the right step, because not so long ago they introduced a policy which is inclined with that English should be used as the medium language. I think in that respect they're trying."* (Participant 11- PN).

This participant is appreciative of the efforts made by the hospital of dedicating English as the medium of communication at the hospital. The participant feels that the hospital is making strides and these, albeit small or seemingly insignificant, must be praised as it is a step in the right direction. The current language policy at the hospital stipulates that each government institution must reach a consensus as to which language(s) are used for written and oral communication.

4.3.3.2 Higher leaning: the nature of learning institutions

Institutions of higher learning where nurses and doctors are trained have come through strongly as culprits of enforcing and perpetuating the ongoing language practices at the hospital. This is because medical language is complex on its own with its own terminologies and jargon. When trained in a specific language you acquire the medical language of that particular language, making it harder to translate these intricate terms. In the clinical practice context, this translates into the doctor or nurse using the language they were trained in for communication purposes. The non-Afrikaans speaking professional nurse gives her opinion on educational background influence:

> *"I believe now it's because we were also taught in the same medium language. There's no longer that separation that you have your own class and someone else has their English class. So they have to come to the party…because I think that if at the beginning there were no two classes this would not be happening. Everyone would be taught in English, so they would know the medium language is English."* (Participant 11 - PN).

4.3.3.3 Power lies with those in higher positions

The people in top positions and those leading teams are entrusted to lead effectively and uphold everyone's interest by putting in place strategies to ensure successful socialisation of teams. It is especially those in leadership and senior positions that have been implicated by participants as those who instigate practices not conducive for multicultural teams. Doctors, operational managers and professional nurses have specifically been mentioned by the participants as those most responsible for perpetuating the use of Afrikaans during ward rounds, handovers and documentation.

> *"I don't want to talk like to discriminate other language but you find people are talking Afrikaans sometimes you don't hear what they are saying eh doctors are talking Afrikaans and you don't hear what they're saying and you just say 'English please' and you find that it is difficult for them to understand that I'm not understanding."* (Participant 1 - ENA).

A non-Afrikaans speaking participant, an ENA, mentions that doctors also convey their instructions in Afrikaans:

> *"Ah in the nursing documentation you find that they are written in Afrikaans. Doctor came and prescribe everything maybe or a patient must do this and this but it's written in Afrikaans."* (Participant 1 - ENA).

The above participant relays that the act of a doctor prescribing treatment in Afrikaans makes it an intricate task for non-Afrikaans speakers to comply and carry out orders because of a lack of comprehension.

Conversely, the operational manager stated that the doctors in her ward all spoke English. Afrikaans in her ward was not seen as an issue because it was no longer used by doctors.

> *"We are all…we've adjusted. We've all changed. Even on the doctor's rounds, they speak English as the language of choice these days. Afrikaans is no longer an issue."* (Participant 12 - OPM).

Operational managers, the people who head ward nursing teams, have been described by the participants as people who are not mindful of non-Afrikaans speakers at the hospital. The non-Afrikaans speaking EN explains that her leave forms are written in Afrikaans and she does not understand what is contained in them:

> *"How can the Afrikaans nurses stop when their boss writes our things in Afrikaans? Cause she saw nothing wrong about that. So they continue."* (Participant 6 - EN).

The non-Afrikaans speaking participant feels that if the operational manager also speaks Afrikaans, it indicates to the others that speaking Afrikaans when others do not understand is an appropriate act, and they will follow suite.

Although operational managers were mostly seen as not being mindful of non-Afrikaans speakers, this operational manager makes an observation pertaining to documents that are in Afrikaans and how the non-Afrikaans speaking nurses have come to deal with some Afrikaans documentation:

> *"Just to mention one specific thing, our duty allocation is an Afrikaans document. And, so, I've noted that you'd allocate certain duties to the nurses and maybe it's just they're so used to just signing it, they would just sign, but later on they'll go back and you'll ask, 'So why wasn't it done?' The nurses signed for it, but she never told you that she didn't really understand what she signed for. So, that's why I'm saying I'm in the process of translating it. What I've noted, people just signed and they've accepted it."* (Participant 12 - OPM).

The manager, who is newly appointed has noted that non-Afrikaans nurses have been signing the duty allocation document without comprehending that they were taking responsibility of certain duties in the ward for that day. But because they have been

accustomed to the act of just signing without comprehending, they had inadvertently left certain allocated duties undone.

The operational manager added that omitted nursing care could have major implications on a patient's treatment and impact the nurse personally.

> *"It just wasn't done. So then you would go, 'But why wasn't this done?' And they just signed without knowing what they were signing for. So the implications are huge as you can see. Also things like signing leave. Somebody told me that she doesn't know what the word "verlof' [leave] means. So we take it for granted that people would understand. And they just sign for things like that. So it does have implications."* (Participant 12 - OPM).

The non-Afrikaans speaking participants felt that if the operational manager also speaks Afrikaans, it indicates to the staff that speaking Afrikaans when others do not understand is an appropriate act, and they will follow suite.

> *"The unit manager is the one who must really really be strictly sure about the language in the ward, in their ward. But if you find them, the manager is the one who is talking that Afrikaans. What about their followers?"* (Participant 1 - ENA).

Another non-Afrikaans speaking participant notes the differing treatment the operational manager has towards non-Afrikaans speakers:

> *"The sad part is that my unit manager is a Coloured woman. She's Coloured, and she speaks Afrikaans. Her interpersonal skills…there's this thing with the clique with the Coloured thing going on, so it really doesn't affect her as much. She understands English quite fine, but there's this personal relationship she has with Coloured's and the Black people are just side-lined. When it comes to Black people she's straight forward. This same OPM (referring to the Operational Manager) doesn't have the same relationship with the Black nurses, so she becomes very, very professional and rigid when it comes to Black people. But when it comes to Coloured she has this leniency…but our views concerning language just doesn't bother her."* (Participant 8 - PN).

The above participant, a Xhosa-speaking professional nurse feels saddened by the unfairness in treatment shown by her operational manager who has close relations with only the Coloured nurses and treats the Blacks in a strict manner. Due to the operational

manager's perceived relationship she has with Coloured nurses, Black nurses feel excluded and isolated.

Despite this view of a manager, some managers are seen in a positive light. An Afrikaans speaking ENA was satisfied with the management of her operational manager as she was able to encourage team work among the nurses. The operational manager made the transition to speaking English an acceptable task and the nurses therefore had no complaints regarding the process. The participant also realises the authority the operational manager has over the team, including the authority to change ward language practices, to which the participant would oblige if she were instructed to.

> *"I think for her she was a really loving person so I can't say nothing wrong with her. Because why we worked as a team together so there were changes and we accepted that changes so I can't really have no complaints. They have the power over us working in a hospital so they have the power if they tell me tomorrow I must write English, I have to write English. They have the power over the language that we speak."* (Participant 2 - ENA).

Despite the praises to the manager that this participant has, she still writes her notes in Afrikaans:

> *"For me I'm writing in Afrikaans. I studied for nursing in English, there was also an Afrikaans class but I decided to study in English but I'm writing in Afrikaans still here in the books. So really I think if somebody don't say something. I don't know for me maybe because the way I did grow up writing in Afrikaans so for me it's easy to write Afrikaans."* (Participant 2 - ENA).

The operational manager describes how she cultivates an inclusive ward environment. As a result of her efforts, the team is cohesive.

> *"Our reports, when we hand over, it's all done in English. Because we have colleagues from different backgrounds, mostly Afrikaans is the first language of the one group and the other group is mos now Xhosa. So we try to meet each other halfway by speaking English. So we do try."* (Participant 12 - OPM*).*

Although some participants thought that Black representation in management may change language practices, even when there was a Black person in the highest leadership position, non-Afrikaans speaking participants echoed that he failed. At the time of the study the hospital had two Black females and two Black males in junior managerial positions, meaning

the position of an operational manager, but no Black representation in senior positions. Non-Afrikaans speaking participants noted that in management there was no Black representation:

> *"You'd be very surprised that most of the matrons are white or Coloured. I've never seen a Black matron at all."* (Participant 8 - PN).

> *"If there were a few Black people in management, we would probably see a difference in the language. Now it's all Coloureds. Even Mr (mentions name) is gone so nothing will be done. Having one Black face there will not do anything because one person can be easily uhm overthrown."* (Participant 8 - PN).

> *"We've been working here for too long. He was supposed to stop this thing of using Afrikaans but ja thing he failed also. He failed. Because he was supposed to correct this thing form the beginning. Maybe he understands Afrikaans because a lot of things here are still done in Afrikaans. Maybe understands but…he failed."* (Participant 3 - ENA).

These non-Afrikaans speaking participants expressed disappointment because a Black, Tshivenda speaking person once occupied the highest nursing position at the hospital, there were no changes visible at ward level.

A participant came up with some suggestions:

> *"They (the unit managers) actually have a role, because they are the…they're actually at the helm. So they see how this language barrier affects their patient care. With them there's a solution where they have to put certain measures into place, which they have done with the policy, but they have to support that with something. So they should form some sort of education that says, 'listen I know you understand certain diagnoses in Afrikaans, but this is the translation of those diagnoses in English'. They have to form some sort of team-building, because it's difficult when people see themselves as a team when they speak two languages in the same group. The manager has to create an environment where each and every one is free to be themselves but still respectful towards the other persons point of view and language".* (Participant 11 - PN).

Professional nurses have a duty and responsibility to oversee ward duties. They are also the nursing category that does end-of-shift handovers.

> *"It's the sisters that they will doing that. They will write in Afrikaans…I can't read Afrikaans."* (Participant 6 - EN).

> *"The one professional nurse is going to speak in Afrikaans and hand over the patient in Afrikaans, but fortunately because I understand, I can do the orders. But the ones that don't understand – that is the problem. Because that means that patient care is not constant at all*." (Participant 8 - PN).

These participants expressed their concern and dissatisfaction that some of the professional nurses use Afrikaans during handovers and for documentation.

4.3.4 Theme four: Language discourses

In the Western Cape there are three official languages. Throughout the years, English has maintained a neutral position albeit it also being a language of the British colonizer. Afrikaans however received a different fate and was resisted by the Black South African population. Both languages have official status, but English is the widely accepted lingua franca. Seemingly at the central hospital a "battle" of languages has ensued with everyone wanting their own language to be spoken. Some participants felt however, that a compromise is necessary for the sake of operational progression like patient care. English was deemed the suitable lingua franca as it was more widely spoken even though it is not the first language of many South Africans. Some participants felt that by virtue of living in Cape Town or calling Cape Town home, it was mandatory that you speak and understand Afrikaans.

4.3.4.1 The need for English

All the non-Afrikaans speaking participants unanimously agreed that English is the acceptable lingua franca for the workplace.

> *"I think the main language should be English, because even when you go to Jo'burg there are so many people around that speak Venda, Tswana, Sesotho, Shangaan – but everyone speaks English when they're at work. So I think that everything should be done in English."* (Participant 8 - PN).

Most of the participants recognize that at the centre of nursing, is the patient. Nursing exists because a patient exists. Therefore, all activities that take place in the hospital should ultimately benefit the patient.

> *"I say when we work different races together keep it by English then we know it's better for both if we work with patients ja. Then it's better. If we have a language that we all understand."* (Participant 2 - ENA).

Some Afrikaans-speaking participants however feel that English is taking over a bit too much and there are other solutions to address issues concerning linguistic discourse.

> *"Want as jy kyk na jou opskrifte in jou koerante, is in Engels. Alles is in Engels. Waarom nie gaan sit met die mense wat in beheer is en sê, kom ons maak die helfte in Afrikaans en die ander helfte Engels? Hoekom maak ons dit nie vyftig-vyftig nie?* (Participant 2 - ENA).

Translated version:

> *"Because if you look at the newspaper headlines, it is in English. Everything is in English. Why don't you sit with those in charge and ask them to make the one half in English and the other half in Afrikaans? Why don't we make it fifty-fifty?* (Participant 2 - ENA).

Tri-lingual ability of some participants has been advantageous as they have managed to survive the environment and perform their duties without any hitches. It has also given them the ability to be mediators.

> *"Well, being Black I understand both sides, actually, because I'm from a mixed-raced family I understand both sides. But I really, really feel for those who don't understand Afrikaans at all. Now at the moment I find that I'm the mediator because I understand both parties. Firstly, I'm in the middle. I understand Afrikaans and I understand Xhosa. So what I've tried to do is to integrate the two parties, but it's been very difficult because some of my colleagues do not want to mix with other races. They are not willing to speak English."* (Participant 8 - PN).

An Afrikaans speaking participant fluent in both English and Afrikaans expressed sympathy for non-Afrikaans speaking nurses:

> *"Only to clarify, seeing that Afrikaans is my first language also... It doesn't really matter. Because I understand Afrikaans, so if you speak in Afrikaans to me, I'm comfortable - I can... Communication do take place. It doesn't even have an impact on me, so... But I can understand for somebody else, a Xhosa-speaking person, who doesn't even know what the word "verlof" means, how it can compromise*

> *patient care. There's no communication taking place, so how can you expect anyone to function like that?"* (Participant 12 - OPM).

Non-Afrikaans speaking participants have observed that another reason why many doctors and nurses continue speaking Afrikaans, is because of low English proficiency levels due to an Afrikaans upbringing combined with Afrikaans schooling.

> *"Some of the nursing staff I see they can't write English. I've noticed that."* (Participant 4 - ENA).

> *"Documentation. That's a challenge. There are still doctors who feel that they should write their prescription in Afrikaans because they're used to that…and then you find that the very Afrikaans speaking person can't translate that in English because they're not sure what that is in English…and that also goes back to blaming the system before because they were taught in Afrikaans. So, I guess in actual fact, you have to – if that person was taught in Afrikaans – you have to go back and teach them in English so they can be better able to document what's going on."* (Participant 11 - PN).

When Afrikaans is all someone knows, that is the only language they are capable of communicating in.

> *"They were raised in Afrikaans, they were taught in Afrikaans, they even go to school tertiary in Afrikaans. That's why they. They know only that Afrikaans."* (Participant 3 - ENA).

One participant felt that even though a language policy is said to be in operation, it was not instated to appease the non-Afrikaans speaking nursing population, but it was to accommodate the vast influx of international students.

> *"(mentions hospital) is a tertiary institution. Therefore, it's an educational institution. We have international students. We have international doctors. I believe the thinking behind it was going global. We're no longer just a national hospital, but we're a global hospital where we need to accommodate everyone that comes within the premises. Not just our colleagues, who are doctors and nurses, to gain experience here."* (Participant 11 - PN).

This is the perception of a young, non-Afrikaans speaking professional nurse and provides a perspective from the younger generation.

4.3.4.2 The state of Afrikaans

Afrikaans was once the lingua franca of South Africa. Many in the Western Cape and other provinces speak this language in its pure form or the variations of the language. The hospital according to both Afrikaans and non-Afrikaans speakers, is historically Afrikaans and the tradition of Afrikaans continues.

> *"Afrikaans is such a beautiful language. It's a beautiful language. I'm a reader. I started reading at the age of four. I loved reading. I don't know… Children of today, they don't know what poems are. If they can have poems in Afrikaans. Verstaan jy? Mooie gedigte. Ek lees nog van die gedigte vir my seuntjie. [Do you understand? Beautiful poems. I still read those poems to my son.]"* (Participant 5 - EN).

Because of this great love she has for Afrikaans, this Afrikaans speaking participant feels a great deal for what seems to be the extinction of Afrikaans as evident in the younger generation.

> *"I've got that fear inside. Because I look into the Western Cape only, then you'll see that a lot of people from the Eastern Cape coming over. Those people can't speak Afrikaans. Now we had to be…there's a lot of people form Limpopo coming over. You've got that fear inside that…what if (mentions son's name) turns fifteen or sixteen, he's eleven now, and nobody will speak Afrikaans again. It's a big loss."* (Participant 5 - EN).

While some voice fears of losing Afrikaans, some are being forced to learn it simply because they are now in Cape Town.

> *"They say we must learn because we are in Cape Town, we must try to learn the language. Even the report in the morning, when they give handover they give it in Afrikaans."* (Participant 3 - ENA).

4.3.4.3 The nature of being umXhosa: Ubuntu

'Xhosa' is both a language and an ethnic group. It is the second largest ethnic group in South Africa which has its origins in the Eastern Cape province. The Xhosa people (plural: amaXhosa; singular: umXhosa) possess a deep sense of community which involves lending a helping hand to those in need which translates to 'Ubuntu'. This term, Ubuntu, reflects the caring nature which the amaXhosa embody, with the strong belief of "I AM BECAUSE YOU ARE". The Xhosa culture also recognizes the hierarchical structure within the community; males and older women are held in high regard and respect is a principle that is taught from a young age and should be bestowed upon anyone that is older or in authority.

Most of the non-Afrikaans speaking participants observed that cultural background plays a part in how engagement with linguistic differences occurs. All of the Black participants mentioned that they dare not try to change the hospital's status quo as they felt it was disrespectful and goes against their cultural values.

> *"I think as Africans, Xhosa-speaking, we have that Ubuntu culture. We care how you are. If I'm doing something I'm worried about or I care how it affects you…. how I view the Afrikaans culture is that if I'm OK, then some will just have to fall into place. Whereas if I'm me I speak Xhosa, I notice you're around, I immediately apologize and translate for you and we go on."* (Participant 11 - PN).

Some of the non-Afrikaans speaking participants felt that by even asking a team member to speak English, actually felt disrespectful, but it was imperative that they knew what the patient needed.

> *"But that thing its irritating every time I must remind you, it's like I'm disrespecting you…as if I'm instructing you to do the thing you are supposed to do."* (Participant 6 - EN).

To solve communication issues, nursing staff members have to first acknowledge their own shortcomings and apply a level of respect whilst doing so.

> *"There must be some sort of respect involved. If I can't speak English, I can't. If I can't speak Xhosa, I can't. But you must have some sort of acknowledgment and say excuse me or whatever or try another avenue to communicate to your staff…."* (Participant 4 - ENA).

Cultural differences are evident in the ways certain ethnic groups interact with each other, and viewed by another culture may be deemed unsightly.

> *"But when we speak our language amongst each other they might find that we speak a bit louder, or we're a bit rowdy; so that's that attitude towards the staff."* (Participant 8 - PN).

Non-Afrikaans speaking participants expressed that they have been restricted from conversing in their own native languages while on duty.

> *"It's like they don't want us to talk to each other because they don't understand what we are talking about."* (Participant 3 - ENA).

Even though isiXhosa is one of the official languages in the Western Cape, participants are discouraged from using it:

> *"And they don't like us to speak Xhosa. Cause it will not be nice if we write our reports in Xhosa because they're writing in their language."* (Participant 6 - EN).

4.4 SUMMARY

This chapter entailed the presentation of the findings from the study as well as the demographical data of the participants obtained during data collection. The experiences of 12 nurses, of different racial and language groups, regarding the use of Afrikaans at the hospital were described. Four themes emerged and were discussed. The participants revealed both positive and negative aspects of the current language practices at the hospital. Mostly the Black, non-Afrikaans speaking participants were negatively affected due to the use of Afrikaans for handovers and documentation which impeded the delivery of care. Certain participants, both Afrikaans and non-Afrikaans speaking, alluded to possible and current implications of language incompatibility at the hospital such as omitted patient care, delayed nursing care, division among teams, isolation and decreased desire to work with intent to leave.

Positive changes such as translation of forms and English handovers, were in effect in certain wards of the hospital which participants acknowledged as methods of mitigating the risks to patients and nurses. Some Afrikaans speaking participants commended the changes and were welcoming of transforming to English and were also welcoming of non-Afrikaans speakers in their midst. On the other end of the spectrum, there were some Afrikaans speakers who rejected the idea of English as the main language medium based on the geographical location and historical background of the hospital.

The participants revealed the necessity of language planning in institutions comprising of diverse populations.

In chapter 5 the discussion of the findings is presented.

CHAPTER 5:
DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The preceding chapters provided a background and foundation to the study, with a literature review which described multicultural nursing teams and the use of (a) language. Following were the description of research methods applied to the study and the findings. The data collected yielded four major themes: Differences which disunite, reverberations, historical influences and language discourses. This chapter contains a discussion of the study findings, as guided by the literature. It also contains conclusions drawn from the findings and recommendations.

5.2 DISCUSSION

It appears that this study was the first to explore the experiences of nurses regarding the use of Afrikaans at this central hospital. With a paucity of literature regarding the use of a South African lingua franca language amongst nursing staff or even within the multi-disciplinary team in the South African context, the researcher saw a need to explore this.

Brink *et al*. (2012:201) explain that under the discussion section, the researcher links the research problem and objectives and makes sense of the results. The research objectives are re-stated and the results are discussed with reference to these objectives.

The aim of the present study was to explore nurses' experiences regarding the use of Afrikaans for documentation and patient handovers at a central hospital in the Western Cape. With Husserl's descriptive phenomenology, the aim is to adequately describe the participants' everyday conscious experiences whilst bracketing preconceptions (Reiners, 2012:1). In this study, the researcher engaged in constant bracketing to allow the study findings to accurately describe the participants' experiences. The findings from the study relating to each objective are discussed below:

5.2.1 Objective 1: To explore how nurses experience the use of Afrikaans as it relates to documentation and patient handovers in a central hospital.

The findings of this objective will be discussed according to the main themes that emerged from the study.

5.2.1.1 Differences which disunite

From the descriptions by some non-Afrikaans speaking participants in the present study, it emerged that they felt that the use of Afrikaans during handovers and documentation isolated them from ward and nursing activities which caused divisions between (usually) Black non-Afrikaans speaking nurses and Coloured Afrikaans speaking nurses. According to the participants, Black non-Afrikaans speaking nurses felt like outsiders in the wards and felt unwelcome especially by the Coloured operational managers, who head the majority of the nursing units at the hospital. A depiction of dualism is clearly evident in documentation and handovers by the use of Afrikaans and English, which at times is not suited for all in the ward.

Clayton *et al*. (2016:13) in their study identifies the concept of "othering" that occurs in multicultural teams when language is different. Othering is identifying/noting those who are different from oneself. According to Clayton *et al.* (2016:15), the mentality of othering may cause one to assume a position of superiority or dominance, and is especially the case in multicultural/multilingual societies. The analysis of findings from a study titled 'Othering and being othered in the context of health care services', yielded that individual interactions are largely influenced by the institutional and social contexts which promote othering (Johnson, Bottorff, Brown, Grewal, Hilton & Clarke, 2004:254). In the present study, othering may be promoted by the use of Afrikaans in nursing documentation and in handovers as these occurrences tend to marginalize non-Afrikaans speakers and subsequently where non-Afrikaans speakers are marginalized and denied access to information which allows them to perform their duties. Likewise, othering may also be promoted by the use of isiXhosa in the midst of non-Xhosa speakers for handovers and activities pertaining to nursing duties and care. Afrikaans speakers may also feel othered in the broader context of society due to the rejection of Afrikaans in the public sphere (for example in institutions of higher learning). Despite maintaining its official status in South Africa, Afrikaans participants in the present study feel that its use is unfavourably dwindling.

Johnson *et al*. (2004:254) in their study mention that those in power should be involved in unmasking 'othering' practices and transform health care environments. The non-Afrikaans speaking participants in the present study have mentioned that it is especially the professional nurses, the operational managers and doctors that perpetuate the use of Afrikaans during handovers, prescriptions, doctors' ward rounds and nursing documentation which 'others' those not understanding Afrikaans.

5.2.1.2 Reverberations

The non-Afrikaans participants in the present study described how using Afrikaans for documentation and during handovers affected their ability to provide patient care. Afrikaans in documentation, as echoed by the participants in this study, affected the delivery of patient care in that instructions in Afrikaans were just ignored and not completed for a lack of comprehension of the language of instruction. Wagner *et al*. (2015:48) state that proper, effective communication increases the quality of care and patient outcomes. Poor team-work was previously identified as one of the reasons for 'missed nursing care' (Kalisch, Landstrom & Williams, 2009:3). Omitted nursing care is the omission of any aspect of nursing care, either partially or completely (Kalisch *et al*., 2009:4). Errors of omission tend to be more difficult to recognize but form the largest part of errors in nursing (Kalisch, *et al*., 2009:1). Kalisch *et al*. (2009:1) further explain that nursing care duties such as turning the patient, or administering antibiotics when omitted may decrease patients' outcomes. Acts of omissions may be punishable under law (McQuoid-Mason & Dada, 2012:210).

5.2.1.3 Historical influences

South Africa's history has had an all pervading influence on current-day South Africa. While the National Party was in rule prior to 1994, Afrikaans was used to spread nationalism and implemented a strategy of segregation (Snail, 2011:65). In the study both the Afrikaans and non-Afrikaans participants felt that documentation and handovers was done in Afrikaans because of low English proficiency levels of nurses and doctors which stem from an Afrikaans upbringing and/or the previous political regime's Afrikaans influence. It was encouraged then that Afrikaans-speaking nurses be taught in their own language (Digby, 2006:265). All the participants blamed the "system" for the continued practices of Afrikaans for documentation and handovers. Institutions of higher learning previously reserved for the White population, have been requested to transform their policies in line with the social developments that promote inclusivity post-Apartheid.

Whitehouse (2010:1) advocates for fairness in the workplace by managers or team leaders by affording team members equal opportunities. Fairness in the workplace may be deemed differently by different people, and social relationships affect one's perceptions of fairness. Managers having stronger affiliations with one language group than they do with the other may be seen as a lack of fairness. It may be translated as a lack of social justice. The Afrikaans speaking operational manager in the present study is actively involved in creating an inclusive environment by stipulating that handovers be conducted in English and she is also translating all Afrikaans documentation in English (see chapter 4, 4.3.3.1).

5.2.1.4 Language discourses

English is a widely spoken language used nationally and world-wide for communication amongst people who do not share a native language. The non-Afrikaans speaking participants in the present study constantly begged for English ('English please') to be adopted for documentation and handovers which would allow them to participate in ward activities. In a study conducted by O'Neill (2011:1124), she identified that a lack of language preparation in the clinical setting leaves the nurses who are not included, in a dangerous position where they feel not only unprepared but unsupported as well.

Some Afrikaans speaking participants, and some of their colleagues, have assisted non-Afrikaans speakers with translations and have themselves adopted a stance of speaking and writing in English.

Some Afrikaans speaking participants in this study revealed a strong fear of loss of Afrikaans, as it is currently dwindling, which is why they have made a conscious decision to hold on to it. These participants strongly felt that it was their democratic right to speak and write in Afrikaans in the workplace. The added justification was that the Western Cape is an Afrikaans stronghold, and all those who live here should be able to be conversant in Afrikaans.

5.2.2 Objective 2: To understand how the use of Afrikaans for communication influences team cohesion at the central hospital.

5.2.2.1 Differences which disunite

Most of the Black participants felt that the ward was divided due to language differences and that they were being excluded. Some participants expressed a lack of unity between Afrikaans speakers and non-Afrikaans speakers within the teams in which they worked. In a study by Kalisch and Hee Lee (2010:238) on the impact of teamwork on omitted nursing care, the results showed that collective efforts of the team and level of teamwork have an impact on the nursing care delivered. They discovered that when team cohesiveness was present, there were less cases of omitted nursing care reported.

The concept of 'othering' already reveals that there is a lack of oneness. The ones being 'othered' are usually subjected to discrimination and social exclusion among teams (Canales, 2009:19).

An effect of 'othering' as voiced by non-Afrikaans speaking participants is fear. Some Black participants expressed a fear of speaking to managers, a fear of addressing the issue of Afrikaans being used for documentation and handovers and also a fear of losing their jobs

as a result of speaking out. The Black participants in the study felt that managers treated them unfairly and differently compared to their Coloured counterparts (see chapter 4, 4.3.4.3). Similar findings emerged from Likupe and Archibong's (2013:240) study in the United Kingdom on 'Black African nurses' experiences of equality, racism and discrimination in the National Health Service. The findings from their study suggested that Black nurses experienced racism in the workplace and managers treated the British and other White nurses more favourably than they did Black nurses.

Marginalisation is an act of repelling people away toward a space that is distant from the dominant group (Beard & Julion, 2016:4). Non-Afrikaans participants felt like they were not welcome in the ward and were excluded (see chapter 4, 4.3.1.1). Beard and Julion (2016:11) recommend that the nursing profession do away with the remnants of racism and develop ways to undo racial stereotypes.

Some Afrikaans speaking participants though, were against 'othering' practices and promoted inclusive environments by speaking English. Non-Afrikaans speakers learning Afrikaans has also led to less friction between the two language groups, and therefore the 'issue' of Afrikaans did not negatively affect those who learned.

It is evident from the participants' own declarations that the issue of Afrikaans being used for handovers and documentation is confined to certain wards of the hospital and should not be generalized to the entire hospital wards. This non-generalizability does not mean, however, that the issues that may be exacerbated by the use of Afrikaans should be ignored in the wards where this problem exists.

Most of the participants alluded to the existence of generational differences (see chapter 4, 4.3.1.2) between older nurses and the newly qualified nurses. Literature identifies four generations of nurses in the workforce and how they differ. These generations are the: Silent generation (born 1925-1945), baby boomers (born 1946-1964), generation X (1965-1979) and generation Y (1980-2000) (Keepnews, Brewer, Kover & Hyun Shun, 2010:155). In a cohort study by Brunetto, Farr-Wharton and Shacklock (2012:13) findings indicated that generation Xers and Y's preferred a less hierarchical working environment compared to the baby boomers and silent generation. The cohort study also revealed that individuals from any generation are likely to resign if they are unhappy with institutional practices and policies. The different generations have quite different characteristics which may account for the differing views and opinions. In the present study, a few of the participants from both Afrikaans-speaking and non-Afrikaans speaking groups, mentioned how open and accepting the younger generation was compared to the older generation who are 'stuck in their ways'

(see chapter 4, 4.3.1.2). This may be because generation Y has been described as being more social and diverse while the silent generation showed more respect for authority, were loyal, dedicated and sacrificial (Weingarten, 2009:28). One participant in the present study pointed out that it is both an advantage and a disadvantage to have both older and younger generations, as the older generation of baby boomers can impart their knowledge to generation Y. However, the silent generation and baby boomers also carry with them unsavoury habits from the past (referring to apartheid and acts of segregation and discrimination).

5.2.2.2 Reverberations

The issue of respect was raised by all the participants. Non-Afrikaans speaking participants wondered whether they were respected by their fellow team members if these team members continued conducting ward activities in Afrikaans which meant they were excluded from partaking in ward rounds and handovers (see chapter 4, 4.3.1.1). Non-Afrikaans speaking participants felt that they sometimes irritated the professional nurses by asking them to translate notes and handovers and this often made these participants feel like they were a burden. Manser and Foster (2011:188) concur that poor communication during the handover process has negative ramifications on patient care.

Some Afrikaans speaking participants felt that mutual respect would aid in developing better relationships among multicultural groups within the nursing team (see chapter 4, 4.3.2.4).

5.2.2.3 Historical influences

The Western Cape province comprises of a large Coloured population (Statistics South Africa,2011:1). Participants in the study felt that segregation of Blacks, Whites and Coloureds began during the apartheid era and continues still especially in Cape Town (see chapter 4, 4.3.4.1). Some non-Afrikaans speaking participants feel that Cape Town is a harsh place to be for a Black person and the hospital in which they work also feels unwelcoming. Some participants felt that Coloured team members and managers do not acknowledge their presence in wards as they are ignored during handovers. Non-Afrikaans speaking participants also felt that managers, who are at the helm of nursing teams, should refrain from forming cliques with Coloured employees at their expense (see chapter 4, 4.3.4.3). With such conduct, managers were said to be encouraging divisions amongst nursing team members. Some participants, however, expressed that the managers in their respective wards were open to change in terms of communicating to teams that English must be the medium of communication (see chapter 4, 4.4.4.3). All participants from these wards felt that they had team cohesion and mutual respect with members of different

cultures and language groups. Sheehan, Robertson and Ormond (2009:25) state that leaders should themselves embody the use of inclusive language when communicating with members within their teams.

Historically, Coloureds were elevated to higher positions over Blacks purely based on their skin colour. That has caused a stereotypical mentality and attitude between Blacks and Coloureds in the Cape and is problematic to this day in Black-Coloured interactions (Brown, 2000:202).

5.2.2.4 Language discourses

As conveyed by one non-Afrikaans speaking participant, language seemed to divide rather than unite. Divisions have been brought about as a result of each language group using their own mechanisms to address language issues, such as one group choosing to stick to their own (see chapter 4, 4.3.1.1) and ignoring orders (see chapter 4, 4.3.3.1). Management, a majority of whom are Afrikaans speaking and Coloured (Hospital Administrator, 2015) seem to be complacent about the issue of Afrikaans and have neglected to address the issue of language and the effect it has on patient care and team cohesion at ward-level.

5.2.3 Objective 3: To ascertain whether the current language practices at the hospital influence the quality of patient care rendered.

5.2.3.1 Differences which disunite

Team divisions have been cited as having an impact on the type of patient care delivered. In cohesive groups, the ability of the individuals to work together in harmony translates to effective patient care being delivered. Harsh environments where employees feel disregarded, such as in the present study because of the language used, also makes these employees lose passion for the duties they perform (see chapter 4, 4.3.3.3). Dang, Bae, Karlowicz and Kim (2015:115) echo the same sentiments in their study about ‘unsafe environments’ for patients. They conclude that institutional factors such as organisational climate, have an influence on an individual’s behaviour and in turn affects quality of patient care.

5.2.3.2 Reverberations

The exchange of information in Afrikaans at the hospital has effects on care delivery. Late execution of orders because of orders being in Afrikaans, or orders missed completely pose a safety risk. Most of the non-Afrikaans speaking participants mentioned that they sometimes do not execute orders written in Afrikaans. Kalisch and Hee Lee (2010:233)

mention that omitted nursing may be used as an indicator of the quality of nursing care. The use of Afrikaans for documentation and handovers, therefore poses a risk for litigation due to negligence. Afrikaans speakers mentioned that though at times they document in Afrikaans, they would not protest to documenting in English if explicitly instructed to (see chapter 4, 4.3.3.3).

Non-Afrikaans speaking participants felt that quality and safe care was not delivered and the events of omitted nursing care posed a risk for both patients and nurses (see chapter 4, 4.3.3.1). O'Neill (2011:1125) in her study reveals that the nurses who were 'othered' feel the pressure of increasing safety to mitigate risks that could ensue if the safety of the patient is compromised. As in the present study (see chapter 4, 4.3.2.1), O'Neill's (2011:1125) participants who were internationally-recruited working in a foreign country, clarified written information with the local nurses to ensure patient safety. As with participants in the present study (see chapter 4, 4.3.2.1), O'Neill's (2011:1125) participants felt that they were deemed incompetent or slow rather than the act of clarifying being perceived as thorough or careful.

5.2.3.3 Historical influences

All disciplines involved in patient care have one common goal which is to improve, through expedited processes, patient care. An unsure nurse, or late administration of patient care, or nursing care completely omitted, affects the quality of patient care. All institutions of learning teach their pupils ways of improving the patient's condition, however, the language of instruction at the institutions of learning may make it more prone for one to speak and write in that language out of comfort due to easier expression. Some health care workers however, communicate in Afrikaans for patient-related activities without considering their colleagues who are unable or who do not have a strong grasp of Afrikaans. The lack of consideration for colleagues inadvertently puts the patient at risk because the Afrikaans speaker may not realise that they may be jeopardising delivery of safe and quality patient care. In a historical study by Brown (2000:202), he mentions that people will not perform optimally when they are pressured (intrinsically) to disprove stereotypes about their racial group. In his study, Brown (2000:203) further found that the Coloured population, expressed (when given the choice) a preference to rather interact with English-speaking White people than Blacks. While Blacks expressed a preference to interact with Coloured people than Afrikaners. Brown (2000:203) explains that this is due do a perceived threat that Coloured people have towards Blacks.

Management who are ignoring the implications of the use of Afrikaans for nursing care and documentation are playing a role in poor quality care delivered.

5.2.3.4 Language discourses

In some of the wards, as conveyed by the participants, a 'battle' between the languages has shown to cause rifts within nursing teams. These rifts at times relate to decreased quality of patient care. Participants have confessed to rather being silent the entire day if they are working with an Afrikaans speaker who also refuses to compromise concerning language. Non-Afrikaans participants felt as if their hands were tied because most of the time they are unable to perform tasks which are required of them. Once again, rifts caused by language incompatibility cannot be generalised to all wards of the hospital as some wards have transformed to promote inclusivity of all who work in a ward.

5.3 LIMITATIONS OF THE STUDY

According to Burns and Grove (2011:541), limitations are theoretical and methodological restrictions in a research study that may decrease the generalizability of the study findings.

One ward denied access as all the staff refused partaking in the study citing that they do not have 'language issues' in that ward because most of them (except two nurses) understand Afrikaans. The researcher, during the information session explained that the study was not about finding faults with the use of Afrikaans but wanted to explore the experiences of all nurses and the impact it may have on different aspects of health care delivery. The topic of language is a sensitive issue which in the South African context is closely related to issues of race and politics. It was therefore not an easy topic to explore with the participants, however the researcher managed the sensitivity by bracketing out her own preconceptions and allowing the participant to be comfortable and at ease to allow the participants' true experiences to surface. The researcher also clarified meanings of certain statements to richly describe the phenomenon

Only one operational manager was interviewed and therefore the experiences and views of other managers were not explored.Time constraints of managers limited the inclusion of more managers into the study. The inclusion of more operational managers could have included more perspectives on how managers approached a multi-lingual and multi-cultural workforce, their challenges and strategies to improve inclusion of nurses who do not understand the vehicular language used. Considering this limitation, further research may need to be done on managers as gate-keepers to information related to their practices.

The researcher also fully acknowledges the intricate nature of the study which is influenced by the strong tie language has to a persons beliefs, culture and values. The researcher therefore questions the possiblity of true bracketing and has indeed experienced the complexity of bracketing in phenemenological research.

5.4 CONCLUSIONS

It is widely acknowledged that good and effective communication amongst nursing team members is paramount to improving safe and quality care (Manser & Foster, 2011:187). Effective communication is actualised when the receiver comprehends a message the way the sender intended and it warrants an appropriate response (Maforo, 2015:4).

The findings from the present study are dual in nature; the one aspect suggests that the communication processes, currently in operation at the hospital impede the delivery of safe and quality patient care, promotes defective social relationships among nurses in a team, contributes to exclusion of those who do not comprehend the vehicular language and cause a lack of trust in management. The other aspect at play, suggests that some wards have overcome the linguistic and racial differences that exist which has cultivated improved working relationships and patient care.

With the descriptive phenomenological approach, whatever the participant relays as their experience is perceived to be a reality, and their reality guides their responses and actions (Ratcliffe, 2012:12). Non-Afrikaans participants were not only encumbered by communication challenges, but their challenges were compounded by the responses of management, which perpetuated institutional injustice. Differences that lead to these challenges may cause a delay in new staff transitioning into the ward (Allan & Westwood, 2016:2).

The question leading this research endeavour was: What are the nurses' experiences regarding the use of Afrikaans for documentation and patient handovers at a central hospital in the Western Cape?

Three distinct groups emerged from the study: Afrikaans speakers who advocated and promoted the use of Afrikaans at work, those from both Afrikaans and non-Afrikaans speakers; most of who were bilingual and some trilingual who believe in change and adapted to the environment, and non-Afrikaans speakers who were completely against Afrikaans in the workplace. Individuals' subjective experiences are their reality, and their respective perceived realities shape their world and influence their actions and decisions (Finlay, 2009:8).

Amongst themselves, the Afrikaans speaking participants varied in their views regarding the use of Afrikaans at the hospital. Some participants feared that Afrikaans was dwindling as everything in public spheres was in English. They feared that a dwindling Afrikaans will adversely affect the continuation of the language and future generations will be denied the

opportunity of speaking their fore-fathers' language. The other Afrikaans speaking participants felt comfortable with the changes and accepted that change is the only constant and should be embraced. These participants were unperturbed by the changes and felt that it conveyed respect to their fellow colleagues who did not understand Afrikaans.

The non-Afrikaans speakers were also divided in their responses regarding their feelings about the use of Afrikaans for documentation and handovers. Some participants revealed that they experienced feelings of exclusion from ward activities (handovers, hospital communique), isolation, segregation with their Coloured and White colleagues, unfairness in treatment by managers and some even intended to leave because the environment was unbearable. What was also apparent is that the non-Afrikaans participants had reached a level of complacency and dejection and they felt that there was nothing they could do to change the issue that affects their ability to execute their duties. Many of them have learned a bit of Afrikaans to allow them to blend in their new environment but still felt excluded from the team who are mostly Coloured. It seems that the 'sink or swim' mentality is fuelled by fears; fears that if they challenge the status quo of the hospital, it may impact their work life negatively.

An unintentional discovery was also made in the study; most of the participants implicated medical doctors stating that they, too, are involved in perpetuating communication difficulties. According to the participants, some doctors conduct 'doctors' rounds', which are sometimes attended by non-Afrikaans speakers, in Afrikaans and they also prescribe and write orders in Afrikaans. This practice has implications for non-Afrikaans speakers in that it limits their ability to perform their duties.

The researcher, through the data collection process, discovered that inasmuch as professional nurses have a more superior role than the other nursing categories, Black, non-Afrikaans speaking professional nurses echoed the same sentiments of exclusion and isolation as the other nursing categories. Therefore, one could infer that non-Afrikaans speaking professional nurses are unrecognised by the institutional culture of the central hospital.

5.5 RECOMMENDATIONS

The findings from the study indicate that the use of Afrikaans for communication at the hospital for handovers and documentations has negative implications for the delivery of patient care. The role of any nurse category, ultimately is to improve the patient's condition. The study also revealed a lack of cultural awareness and sensitivity of nurses.

5.5.1 Recommendation 1: Hospital-specific language policy

Implementation of a 'hospital-specific' language policy that addresses the diversity of the staff themselves and not just the patients. The current Western Cape language policy (2004:6) adopted by the central hospital gives consent for each structure within local government to implement a language policy upon reaching consensus, regarding intra-departmental oral and written communication. The hospital claims to be using this policy, however, if in fact the hospital was following the aims of this language policy, isiXhosa, as a marginalised language, would be promoted. However, quite the contrary is happening. Non-Afrikaans speakers are denied complete assimilation to the hospital due to institutional social norms that perpetuate their exclusion. Some isiXhosa speakers are also discouraged from using isiXhosa (a Western Cape official language) in the social and professional context within the hospital even though the policy states that: "no person shall be prevented from using the language of his or her preference, at any given time." (Western Cape Language Policy, 2004:6). The current language policy also does not consider the implications of promoting the use individual languages in the workplace and how it can impede patient care if all the staff do not comprehend the language. A new policy should address nursing documentation which includes but not limited to the off duty roster, hospital communique, notices and leave forms. Some of the documents that need to be transformed are essential for patient care and must be in a language that all can understand.

5.5.2 Recommendation 2: Diversity awareness training

Diversity exists based on various factors: for example culture, race, ethnicity, language, nationality, educational background, empoyment skills etc. Diversitiy awareness however is a process of recognising the differences between one and the other, acknowleding them and working to eradicate perceptions (based on differences) that impede cohesion (Jeffreys, 2008:37). Diversity awareness is beneficial for employees and employers as it increases a respect of individual differences and increases group productivity (Green, López, Wysocki, Kepner, Farnsworth & Clark, 2015:1).

Methods of diversity awareness could be workshops, where nurses share their stories and experiences which relate their different realities (of both Afrikaans speakers and non-Afrikaans speakers). Open discussions may be daunting as many participants have already raised feelings of fear, however, for real progress to occur nurses must be bold about speaking on sensitive issues that affect them. The diversity awareness training should not only be a one day session, but the institution must implement on-going strategies and training sessions because changing people's inherent behaviours will not be accomplished in one day (Green *et al*., 2015:2).

It would also be beneficial to expose undergraduate students to the diveristy awareness training in preparation of the reality that awaits them in the workplace. As mentioned above, the diversity awareness training should comprise multiple sessions and the undergraduate training period seems an ideal time to introduce concepts of diverstiy awareness and multi-cultural tolerance.

5.5.3 Recommendation 3: Initiatives for effective communication

Effective communication processes are necessary for patient safety (Manser & Foster, 2011:182) and the researcher has stressed the importance of safe practices by avoiding omitted nursing care, delayed nursing care and adverse effects related to language. The researcher gathered from her study that all the participants may not know how effective communication is achieved. Both Afrikaans speakers and non-Afrikaans speakers use language but do not assess whether the message achieved the desired outcome or response. Even when in English, communication needs to be effective by clearly conveying the message to the receiver. Classes on English proficiency may need to be introduced to produce effective communication within the team. The hospital, during the season of transformation, should engage in collaboration with linguistic professionals towards developing effective communication practices aimed at team cohesion and patient safety (Hull, 2015:32).

5.5.4 Recommendation 4: Manager training on cultivating positive interactions among diverse groups

Successful managers are aware that a certain skill set is necessary for creating an effective diverse workforce (Green *et al*., 2015:2). Managers head nursing units and teams and are responsible for creating positive social interactions among nurses. When managers themselves promote division, the team follows suite. Team cohesion promotes patient safety and safe working environments for nurses. Managers should be trained to recognise cultural biases and prejudices they may have toward a particular group and put them aside to promote unity. Managers must actively seek to create inclusive environments for all nurses in their teams. Sheehan *et al.* (2009:19) echo that team leadership is of utmost importance in developing effective team functioning. Participants in the current study felt that managers were mostly biased and treated non-Afrikaans speaking nurses unfairly. Manager training should therefore focus on motivating managers to embrace diversity and interact positively with all races and cultures (Buengeler & Den Hartog, 2015:834).

5.5.5 Future research

The following areas for future research are proposed:

- Multidisciplinary communication (with a focus on language);

- Top management attitudes towards transformation;
- The inclusivity of Black nurses in Western Cape tertiary hospitals;
- The lack of managerial diversity at the central hospital;
- Measurement of quality care in multi-lingual and multi-cultural environments;
- A study connecting the nursing profession, inter-cultural competence and linguistics;
- A study on Coloured attitudes and Black “invasion” in the Western Cape and its impact on the health institutions; and
- A similar study in other health institutions including those in the private sector.

5.6 DISSEMINATION

A copy of the study findings will be handed to the central hospital where the study was conducted and to the participants if they wish to know of the findings. The report will recommend improvements that may be made in practice. The readers will then be able to ascertain feasibility of the recommendations made. Anonymity will be assured as the name of the central hospital and participants will not be mentioned.

Furthermore, the researcher plans on submitting an article in an accredited peer-reviewed journal and the thesis will be published electronically through the university via SUNscholar.

5.7 CONCLUSION

In this chapter, the findings of the study were discussed in relation to the set objectives. A thorough exploration of the research findings was undertaken to bring about clarity to the research question, which was answered. The findings demonstrated that the use of Afrikaans for documentation and handovers does not contribute to team cohesion and the rendering of quality patient care. This could be attributed to the perceived lack of managers to enhance the implementation of language practices that accommodates non-Afrikaans speaking staff. The findings urge that necessary steps be taken to remedy the communication processes relating to nursing documentation and handovers, currently at play at the hospital. South Africa is a multi-cultural and multi-lingual nation, and diversity should be embraced at the institution, not because the law requires it, but because it will promote safe nursing practices and we are all human and endeavour to live in peace with each other regardless of the differences that exist.

REFERENCES

Allan, H.T., Cowie, H. & Smith, P. 2009. Overseas nurses' experience of discrimination: A case of racist bullying? *Journal of Nursing Management*, 17:898-906.

Allan, H.T. & Westwood, S. 2016. English Language Skills Requirements for Internationally Educated Nurses Working in the Care Industry: Barriers to UK Registration or Institutionalised Discrimination? *International Journal of Nursing Studie*s, 54:1-4.

Almutairi, A.F., McCarthy, A. & Gardner, G.E. 2015. Understanding Cultural Competence in a Multicultural Workforce: Registered Nurses' experience in Saudi Arabia. *Journal of Transcultural Nursing*, 26(1):16-23.

Antia, B.E.& Berlin, F.D.A. 2004. Multilingualism and healthcare in Nigeria: a management perspective. *Communication and Medicine*, 1:107-117.

Beard, K.V. & Julion, W.A. 2016. Does race still matter in nursing? The narratives of African-American nursing faculty members. *Nursing Outlook*, 64(6):583-596.

Berlo's Model of Comumunication. 2008. [Online]. Available: http://communicationtheory.org/berlos-smcr-model-of-communication/ [2015, November 16].

Bernard, A., Whitaker, M., Ray, M., Rockich, A., Barton-Baxter, M., Barnes, S.L., Boulanger, B., Tsuei, B. & Kearney, P. 2006. Impact of language barriers on acute care medical professionals is dependent upon role. *Journal of Professional Nursing*, 22(6):355-358.

Bischoff, A., Bovier, P.A., Isah, R., Francoise, G., Ariel, E. & Louis, L. 2003. Language barriers between nurses and asylum seekers: Their impact on symptom reporting and referral. *Social Science & Medicine*, 57(3): 503-512.

Booyens, S.W. 2004. *Dimensions of Nursing Management*, 2nd ed. Cape Town: Juta.

Braaf, S., Manias, E. & Riley, R. 2011. The role of documents and documentation in communication failure across the perioperative pathway. A literature review. *International Journal of Nursing Studies,* 48:1024 -1038.

Brink, H., Van der Walt, C. & van Rensburg, G. 2012. *Fundamentals of Research Methodology for Healthcare Professionals,* 3rd ed. Cape Town: Juta

Brink, A.J. & Dreyer, W.P. 2006. A History: 50 years on the Cape Flats. Cape Town: Cape Town Publishers.

Brown, K. 2000. Coloured and Black Relations in South Africa: The Burden of Racialized Hierarchy. *Macalester International*, 9(13): 198-207.

Brunetto, Y., Farr-Wharton, R. & Shacklock, K. 2012. Communication, training, well-being, and commitment across nurse generations. *Nursing Outlook*, 60: 7-15.

Buengeler, C. & Den Hartog, D.N. 2015. National diversity and team performance: the moderating role of interactional justice climate. *The International Journal of Human Resource Management*, 26(6):831-855.

Burns, N. & Grove, S.K. 2011, *Understanding Nursing Research. Building an Evidence-based Practice,* 5th ed. Maryland Heights: Elsevier Saunders

Canales, M.K. 2009. Othering: Difference Understand? A 10-year analysis and critique of the Nursing Literature. *Advances in Nursing Science*, 33(1):15-34.

Candlin, C.N. & Candlin, S. 2003. Health care communication: A problematic site for applied linguistics research. *Annual Review of Applied Linguistics*, 23:134-154.

Cenoz, J. 2013. Defining Multilingualism. *Annual Review of Applied Linguistics*, 33:3-18.

Clayton, J., Isaacs, A.N. & Ellender, I. 2016. Perioperative Nurses' Experiences of Communication in a Multicultural Operating Theatre: A Qualitative Study. *International Journal of Nursing Studies,* 54:7-15.

Constitution of the Republic of South Africa No. 108 of 1996. (Adopted on 8 May 1996 and amended on 11 October 1996. RSA: Constitutional Assembly.

Coovadia, H., Jewkes, R., Barron, P. & McIntyre, D. 2009. The health and health system of South Africa: Historical roots of current public health challenges. *The Lancet*, 374(9692): 817-834.

Coustasse, A., Mains, D.A., Lykens, K., Lurie, S.G. & Trevino, F. 2008. Organizational Culture in a Terminally Ill Hospital. *Journal of Hospital Marketing & Public Relations*, 18(1): 39-60.

Creswell, J.W. 2013. Research Design: *Qualitative, quantitative and mixed methods approaches*. 4th Ed. London: SAGE

Dang, E., Bae, S., Karlowicz, K.A. & Kim, M.T. 2015. Do clinician disruptive behaviours make an unsafe environment for patients? *Journal of Nursing Care Quality*, 31(2):115-123.

Department of Health (National). 2008. Patients' Rights Charter. [Online]. Available: https://www.westerncape.gov.za/general-publication/heres-what-you-need-know-about-patients%E2%80%99-rights-charter [2016, November 21].

Deumert, A. 2002. Language variation and standardization at the Cape (1880-1922): A contribution to Afrikaans Sociohistorical Linguistics. *Journal of Germanic Linguistics*, 13 (4): 301-352

Deumert, A. 2010. 'It would be Nice if they could Give Us More Language' – Serving South Africa's Multilingual Patient Base. *Social science & medicine,* 71(1):53-61.

De Vos, A.S. ed., Strydom, H., Fouche, C.B. & Delport, C.S.L. 2004. *Research at grassroots for social sciences and human service professions.* Pretoria: Van Schaik.

De Vos, A.S., Strydom, H., Fouche, C.B. & Delport, C.S.L. 2011. *Research at grass roots: For the social sciences and human service professions*. Pretoria: Van Schaik.

Digby, A. 2006. *Diversity and Division in Medicine: Healthcare in South Africa from the 1800's*. Bern: Peter Lang.

Doenges, M.E., Moorhouse, M.F. & Murr, A.C. 2013. *Nursing Diagnosis Manual: Planning, individualising and documenting client care*. 4th Ed. Bern: Verlag Hans Huber

Edmen, C. & Sandelowski, M. 1999. The good, the bad and relative, part two: Goodness and criterion problem in qualitative research. *International Journal of Nursing Practice* 5(1):2-7.

Edwards, S. & Siassakos, D. 2012. Training Teams and Leaders to Reduce Resuscitation Errors and Improve Patient Outcome. *Resuscitation,* 83(1):13-15.

Elderkin-Thompson, V., Cohen, R. & Waitzkin, H. 2001. When nurses double as interpreters: a study of Spanish-speaking patients in a US primary care setting, *Social Science & Medicine*, 52(9):1343-1358.

Finlay, L. 2009. Debating Phenomenological Research Methods. *Phenomenology & Practice,* 3(1): 6-25.

Gage, W. 2013. Evaluating handover practice in an acute NHS trust. *Nursing Standard*, 27(48):43-50.

Ganz, F.D., Endacott, R., Chaboyer, W., Benbinishty, J., Nun, M.B., Ryan, H., Schoter, A., Boulanger, C., Chamberlain, W. & Spooner, A. 2015. The quality of intensive care unit nurse handover related to end of life: A descriptive comparative international study. *International Journal of Nursing Studies*, 52:49-56.

García, M. & Cañado, M.L. 2009. Language and Power: Raising Awareness of the Role of Language in Multicultural Teams. *Language and Intercultural Communication*,5(1):86-104.

Grant, T. 2006. Problems of communicative competence in multi-cultural medical encounters in South African health services. *Curationis,* 29(4):54-60.

Green, K., López, M., Wysocki, A., Kepner, K., Farnsworth, D. & Clark, J.L. 2015. Diversity in the workplace: benefits, challenges, and the required managerial tools. [Online] https://edis.ifas.ufl.edu/pdffiles/HR/HR02200.pdf Available: [2016, November 15].

Hearnden, M. 2008. Coping with Differences in Culture and Communication in Health Care. *Nursing Standard,* 23(11):49-57.

Herbert, P.K. 1992. *Language and society in Africa*. Johannesburg: Witwatersrand University Press.

Hewett, D.G., Watson, B.M., Gallois, C., Ward, M. & Leggett, B.A. 2009. Intergroup communication between hospital doctors: Implications for quality patient care. *Social Science & Medicine,* 69:1732 – 1740.

Hindle, D., Braithwaite, J., Travaglia, J. & Iedema, R. 2006. *Patient safety: a comparative analysis of eight inquiries in six countries*. Sydney: Centre for Clinical Governance Research: University of New South Wales.

Holly, C. & Poletrick, E.B. 2013. A systematic review on the transfer of information during nurse transitions in care. *Journal of Clinical Nursing*, 23:2387-2397.

Hospital Administrator. 2015. Telephonic correspondence, 25 August.

Hull, M. 2015. Language Proficiency: A discussion of interprofessional language competencies and potential for patient risk. International Journal of Nursing Studies: http://dx.doi.org/10.1016/j.ijnurstu.2015.02.015 (unedited manuscript, accepted for publication in PDF format)

James, W. 2012. The Meaning of Race in Modern South Africa. *Focus*, 62:29-34.

Jefferies, D., Johnson, M. & Nicholls, D. 2011. Nursing documentation: How meaning is obscured by fragmentary language. *Nursing Outlook*, 59:6-12.

Jefferies, D., Johnson, M., Nicholls, D. & Lad, S. 2012. A ward-based writing coach program to improve the quality of nursing documentation. *Nurse Education Today*, 32: 647-651.

Jeffreys, M. 2008. Dynamics of Diversity: Becoming Better Nurses through Diversity Awareness [Online]. Available: http://www.nsna.org/Portals/0/Skins/NSNA/pdf/Imprint_NovDec08_Feat_Jeffreys.pdf [2016, November 15].

Jenkins, J. 2009. English as a lingua franca. *World Englishes*, 28(2):200-207.

Johnson, D.1997.*Reaching Out: Interpersonal effectiveness and self-actualization*,6th ed. Boston: Allyn and Bacon

Johnson, J.K., Arora, V.M., Bacha, E.A. & Barach, P.R. 2011. Improving communication and reliability of patient handovers in pediatric cardiac care. *Progress in Pediatric Cardiology*, 32:135-139.

Johnson, J.L., Bottorff, J.L., Brown, A.J., Grewal, S., Hilton, B.A. & Clarke, H. 2004. Othering and being othered in the context of health care services*. Health Communication,* 16(2):253-271.

Jooste, K. 2009.*Leadership in health services management,2nd ed*. Cape Town:Juta

Kahn, T. 2014. SA spurns foreign healthcare workers. Business Day live, 30 September. 1

Kalisch, B.J. & Hee Lee, K. 2010. The impact of teamwork on missed nursing care. *Nursing Outlook*, 58:233-241.

Kalisch, B.J., Landstrom, G. & Williams, R.A. 2009. Missed Nursing Care: Errors of omission. *Nursing Outlook*, 57:3-9.

Kamwangamalu, N.M. 2003. Social change and language shift: South Africa. Annual Review of Applied Linguistics, 23: 225-242.

Keepnews, D.M., Brewer, C.S., Kover, C.T. & Hyun Shun, J. 2010. Generational differences among newly licensed registered nurses. *Nursing Outlook*, 58:155-163.

Kleiman, S. 2004. Phenomenology: to wonder and search for meanings. *Nurse Researcher*, 11(4):7-19.

Levine, M.E. 2006a. Language as a barrier to care for Xhosa-speaking patients at a South African paediatric teaching hospital. *South African Medical Journal*, 96:1076-1079.

Levine, M.E. 2006b. Different use of medical terminology and culture-specific model of disease affecting communication between Xhosa-speaking patients and English-speaking doctors at a South African paediatric teaching hospital. *South African Medical Journal*, 96:1080-1084.

Liaw, S.Y., Zhou, W.T., Lau, T.C., Siau, C. & Chan, S.W. 2014. An Interprofessional Communication Training using Simulation to Enhance Safe Care for a Deteriorating Patient. *Nurse Education Today,* 34(2):259-264.

Likupe, G. & Archibong, U. 2013. Black African nurses' experiences of equality, racism, and discrimination in the National Health Service. *Journal of Psychological Issues in Organizational Culture*, 3(1):227-246.

Lincoln, Y.S. & Guba, E.G. 1985. *Fourth generation evaluation*. Beverly Hills:Sage

Lockwood, J. 2015. Virtual team management: what is causing communication breakdown? *Language and Intercultural Communication*, 15(1):125-140.

Lund, D.B. 2003. Organizational culture and job satisfaction. *Journal of Business and Industrial Marketing*, 18(3):219-236.

Macnee, C.L. & McCabe, S. 2008. *Understanding Nursing Research. Reading and using research in evidence-based practice.2nd ed.* Philadelphia: Lippincott Williams & Wilkins

Madera, J.M., Dawson, M. & Neal, J.A. 2014. Managing language barriers in the workplace: The roles of job demands and resources on turnover intentions. *International Journal of Hospitality Management*, 42:117-125.

Madonsela, S. 2012. Language as a fundamental right: How do the African languages benefit from this right? *South African Journal of African Languages*, 32(1): 91-97.

Maforo, T.M. 2015. Effective Communication. PowerPoint presentation. [Online]. Available: http://www.slideshare.net/TAURAIEMMANUELMAFORO/effective-communication-45158207 [2016, August 16].

Mannix, E. & Neale, M.A. 2005. What differences make a difference? The promise and reality of diverse teams in organizations. *Psychological Science in the Public Interest*, 6(2):31-55.

Manser, T. & Foster, S. 2011. Effective Handover Communication: An Overview of Research and Improvement Efforts. *Best Practice & Research Clinical Anaesthesiology,* 25(2):181-191.

Matua, G.A. & Van Der Wal, D.M. 2015. Differentiating between descriptive and interpretive phenomenological research approaches. *Nurse Researcher*, 22(6): 22-27.

McCormick, K. 2006. Afrikaans as a lingua franca in South Africa: The politics of change. *International Journal of the Sociology of Language*, 177:91-109.

McKenna, L.G. 1997. Improving the nursing handover report. *Professional Nurse*, 12(9):637-639.

McNair, R., Stone, N., Sims, J. & Curtis, C. 2005. Australian evidence for interprofessional education contributing to effective teamwork preparation and interest in rural practice. *Journal of Interprofessional Care*, 19(6):579-594.

McQuoid- Mason, D & Dada, M. 2012, *A- Z of Nursing law, 2nd ed*, Cape Town: Juta.

Medina, E. 2012. *Job satisfaction and employee turnover intention: What does organisational culture have to do with it?* Published Master's Degree. Columbia: Columbia University.

Meißner, A., Hasselhorn, H., Estryn-Behar, M., Nézet, O., Pokorski, J. & Gould, D. 2007. Nurses' perception of shift handovers in Europe – results from the European Nurses' Early Exit Study. *Journal of Advanced Nursing*, 57(5): 535-542.

Meyer, S.M., Naudé, M., Shangase, N.C. & van Niekerk, S.E. 2011. *The Nursing Unit Manager: A comprehensive guide, 3rd ed.* Sandton:Heinemann.

Minow, V. 2009. *Variation in the grammar of Black South African English.* Frankfurt: Peter Lang.

Mouton, J. 2014. *How to succeed in your Master's & Doctoral Studies: A South African guide and resource book*. *20th Impression*. Pietermaritzburg: Van Schaik Publishers.

Muller, M.2011. Nursing Dynamics,4th ed. Sandton:Heinemann.

Mutasa, D.E. 2012. Language policy and language use in South Africa: an uneasy marriage. *South African Journal of African Languages*, 20(3):217-224.

Mwaniki, M. 2011. Language and social justice in South Africa's higher education: insights from a South African university. *Language and Education*, 26(3):213-232.

National Language Policy Framework. 2003. Available at: http://www.dac.gov.za/sites/default/files/LPD_Language%20Policy%20Framework_English_0.pdf (18 May 2016).

Nadzam, D.M. 2009. Nurses' role in communication and patient safety. *Journal of Nursing Care Quality, 24(3):184-188.*

O'Connell, B., Macdonald, K. & Kelly, C.2008. Nursing handover: It's time for a change. *Contemporary Nurse*, 30:2-11.

O'Neill, F. 2011. From language classroom to clinical context: The role of language and culture in communication for nurses using English as a second language. *International Journal of Nursing Studies*, 48:1120-1128.

Parmegiani, A. 2008. Language ownership in multilingual settings: Exploring attitudes among students entering the University of KwaZulu-Natal through the Access Program. *Stellenbosch Papers in Linguistics*, 38: 107-124.

Plüddemann, P., Braam, D., Broeder, P., Extra, G. & October, M. 2004. Language Policy Implementation and Language Vitality in Western Cape Primary Schools. *PRAESA Occasional papers,* (15):1-64.

Polit, D.F. & Beck, C.T. 2004.*Nursing Research: Principles and Methods. 7th ed*. Philadelphia: Lippincott Williams & Wilkins.

Polit, D. F. & Beck, C.T. 2012. Nursing Research: *Generating and Assessing Evidence for Nursing Practice. 9th ed.* Philadelphia: Lippincott Williams & Wilkins.

Pringle, J., Hendry, C. & McLafferty, E. 2011. Phenomenological approaches: challenges and choices. *Nurse Researcher*, 18(2):7-18.

Probst, S. & Imhof, L. 2015. Management of language discordance in clinical nursing practice – A critical review. *Applied Nursing Research*, 30: 158-163.

Public Relations Employee, 2016. Personal interview. 13 May, [redacted] Hospital.

Ratcliffe, M. 2012. Phenomenology, Naturalism and the Sense of Reality [Online]. Available: https://philosophyofdepression.files.wordpress.com/2012/02/phenomenologynaturalismreality.pdf [2016, November 15].

Reiners, G.M. 2012. Understanding the difference between Husserl's (Descriptive) and Heidegger's (Interpretive) Phenomenological Research. *Journal of Nursing & Care*, 1(5):1-3.

Republic of South Africa. Nursing Act 33 of 2005. Pretoria: Government Printers. [Online]. Available: http://www.sanc.co.za/pdf/Nursing%20Act%202005.PDF [2016, November 30].

Republic of South Africa. Department of Health, 2012. *Policy on the Management of Hospitals*. Government Gazette no. 35101.

Republic of South Africa. 2004. *Western Cape Language Policy*. Cape Town: Western Cape Government Printer.

Ritchie, J. & Lewis, J. 2003. *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London: SAGE.

Ritchie, J., Lewis, J., McNaughton Nicholls, C. & Ormston, R. 2013. *Qualitative Research Practice: A Guide for Social Science Students and Researchers. 2nd ed*: London: SAGE

Romero, S. 2014. *Introduction to Sociology: A collaborative approach, 4th ed*. Idaho: Ashbury Publishing.

Rowe, B.M. & Levine, D.P. 2015. *A concise introduction to linguistics, 4th ed*. London: Pearson Education.

Santos, D.J.S., Palomares, N.B., Normando, D. & Quintão, C.C.A. 2010. Race versus ethnicity: Differing for better application. *Dental Journal of Orthodontics,* 15(3):121-124.

Scovell, S. 2010. Role of nurse-to-nurse handover in patient care. *Nursing Standard*, 24(20):35-39.

Searle, C. 2007.*Professional Practice: A South African Nursing Perspective, 4th ed*. Sandton: Heinemann.

Shannon and Weaver Model of Communication. 2010. [Online]. Available: http://communicationtheory.org/shannon-and-weaver-model-of-communication/ [2016, August 16].

Sheehan, D., Robertson, L. & Ormond, T. 2009. Comparison of language used and patterns of communication in interprofessional and multidisciplinary teams. *Journal of Interprofessional Care*, 21(1):17-30.

Shenton, A. K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22: 63-75

Shosha, G.A. 2012. Employment of Colaizzi's strategy in descriptive phenomenology: A reflection of a researcher. *European Scientific Journal*, 8(27):31-43.

Siemsen, I.M., Madsen, M.D., Pedersen, L.F. Michaelsen, L., Pedersen, A.V., Andersen, H.B, & Østergaard, D. 2012. Factors that impact on the safety of patient handovers: An interview study. *Scandinavian Journal of Public Health*, 40(5):439-448.

Slavkov, N. 2015. What is your 'first' language in bilingual Canada? A study of language background profiling at publicly funded elementary schools across three provinces. *International Journal of Bilingual Education and Bilingualism*, 18:1-18.

Song, S. 2007. *The Subject of Multiculturalism: Culture, Religion, Language, Ethnicity, Nationality and Race?* Cambridge: Cambridge University Press.

Snail, M.L. 2011. Revisiting Aspects of Language in South Africa during the apartheid era. *Historia Actual Online*, 24:65-91.

Statistics South Africa. 2011. [online]. Available: http://www.statssa.gov.za/?page_id=993&id=city-of-cape-town-municipality [2016, November 08]

Street, M., Eustace, P., Livingston, P.M., Craike, M.J., Kent, B. & Patterson, D. 2011. Communication at the bedside to enhance patient care: A survey of nurses' experience and perspective of handover. *International Journal of Nursing Practice*, 17:133-140

Sumbane, R. 2015. Personal communication. 27 October. Telephonic

Terre Blanche, M., Durrheim, K. & Painter, D. 2006. *Research in Practice: Applied Methods for the Social Sciences,* 2nd Ed. Cape Town: University of Cape Town Press.

Teytelman, Y. 2002. Effective nursing documentation and communication. *Seminars in Oncology Nursing*, 18(2):121-127.

Thackwell, N.D. 2014. "We waited for our turn, which sometimes never came": Registrars negotiating systemic racism in Western Cape medical schools. Master's Thesis. Stellenbosch: Stellenbosch University.

Tufford, L. & Newman, P. 2010. Bracketing in Qualitative Research. *Qualitative Social Work*, 11(1):80-96.

Van Manen M. 2007. Phenomenology of Practice. *Phenomenology & Practice*. 1:11-30.

Waddy, N.L. 2010. The fork in the road? British reactions to the election of an apartheid government in South Africa, May 1948. *Historia,*55(1):78-89.

Wagner, L.M., Brush, B.L., Castle, N.G., Eaton, M. & Capezuti, E. 2015. Examining Differences in Nurses' Language, Accent, and Comprehensibility in Nursing Home Settings Based on Birth Origin and Country of Education. *Geriatric Nursing,* 36(1):47-51.

Wa Thiong'o, N. 1981. *Decolonising the mind: The politics of languages in African literature*. London: James Currey.

Watson, R., McKenna, H., Cowman, S. & Keady, J. 2008. *Nursing Research Designs and Methods*. Edinburgh: Elsevier.

Weingarten, R.M. 2009. Four Generations, One Workplace: A Gen X-Y staff nurse's view of team building in the emergency department. *Journal of Emergency Nursing*, 35:27-30.

Western Cape Government Health. 2013. [redacted] Hospital Annual Report. [Online]. Available: https://www.westerncape.gov.za/files/tygerberg-hospital-annual-report-2013.pdf [2016, March 20].

Western, J. 2002. A Divided City: Cape Town. *Political Geography*, 21:711-712.

Whitehouse, A. 2010. The Role of Fairness in the Workplace. [Online]. Available: http://blogs.managementconcepts.com/the-role-of-fairness-in-the-workplace/#.WCgvFItZrIV [2016, November 13].

Wilkinson, J. 2000. City profile: Cape Town. *Cities*, 17(3):195-205.

World Health Organization. 2007. Communication During Patient Handovers. WHO. Geneva

Young, I.M. 1990. *Justice and the Politics of Difference*. Princeton: Princeton University Press.

Zhi-peng, R. 2014. Body language in different cultures. *US-China Foreign Language*, 12(12):1029-1033.

APPENDICES

APPENDIX 1: ETHICAL APPROVAL FROM STELLENBOSCH UNIVERSITY

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot • your knowledge partner

Approval Notice
Response to Modifications- (New Application)

06-Jun-2016
Mgoqi, Mangoyi M

Ethics Reference #: S16/03/042

Title: **Nurses' experiences on the use of Afrikaans for nursing documentation and handovers at a Central hospital in the Western Cape**

Dear Miss Mangoyi Mgoqi,

The **Response to Modifications -** ***(New Application)*** received on **23-May-2016**, was reviewed by members of **Health Research Ethics Committee 2** via Expedited review procedures on **06-Jun-2016** and was approved.
Please note the following information about your approved research protocol:

Protocol Approval Period: **06-Jun-2016 -05-Jun-2017**

Please remember to use your **protocol number** (**S16/03/042**) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.
Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel:

+27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard HREC forms and documents please visit: www.sun.ac.za/rds

If you have any questions or need further assistance, please contact the HREC office at .

Included Documents:
CV L Terblanche.pdf
CV M Mgoqi.pdf
Declaration M van der Heever.pdf
Checklist.pdf
20160602 MOD Consent form
Declaration M Mgoqi.pdf
Informed Consent General English.pdf
20160602 MOD Cover letter
CV M van der Heever.pdf
Protocol Synopsis.pdf
20160602 MOD Protocol
Application form.pdf
Declaration L Terblanche.pdf
Protocol.pdf

Sincerely,

Ashleen Fortuin
HREC Coordinator
Health Research Ethics Committee 2

Investigator Responsibilities

Protection of Human Research Participants

Some of the responsibilities investigators have when conducting research involving human participants are listed below:

1.Conducting the Research. You are responsible for making sure that the research is conducted according to the HREC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research.

2.Participant Enrolment. You may not recruit or enrol participants prior to the HREC approval date or after the expiration date of HREC approval. All recruitment materials for any form of media must be approved by the HREC prior to their use. If you need to recruit more participants than was noted in your HREC approval letter, you must submit an amendment requesting an increase in the number of participants.

3.Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the HREC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least fifteen (15) years.

4.Continuing Review. The HREC must review and approve all HREC-approved research protocols at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the HREC approval of the research expires, **it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in HREC approval does not occur.** If HREC approval of your research lapses, you must stop new participant enrolment, and contact the HREC office immediately.

5.Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the HREC for review using the current Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written HREC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the HREC should be immediately informed of this necessity.

6.Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research-related injuries, occurring at this institution or at other performance sites must be reported to the HREC within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the HRECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch Universtiy Health Research Ethics Committee Standard Operating Procedures www.sun025.sun.ac.za/portal /page/portal/Health_Sciences/English/Centres%20and%20Institutions/Research_Development_Support/Ethics/Application_package All reportable events should be submitted to the HREC using the Serious Adverse Event Report Form.

7.Research Record Keeping. You must keep the following research-related records, at a minimum, in a secure location for a minimum of fifteen years: the HREC approved research protocol and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the HREC

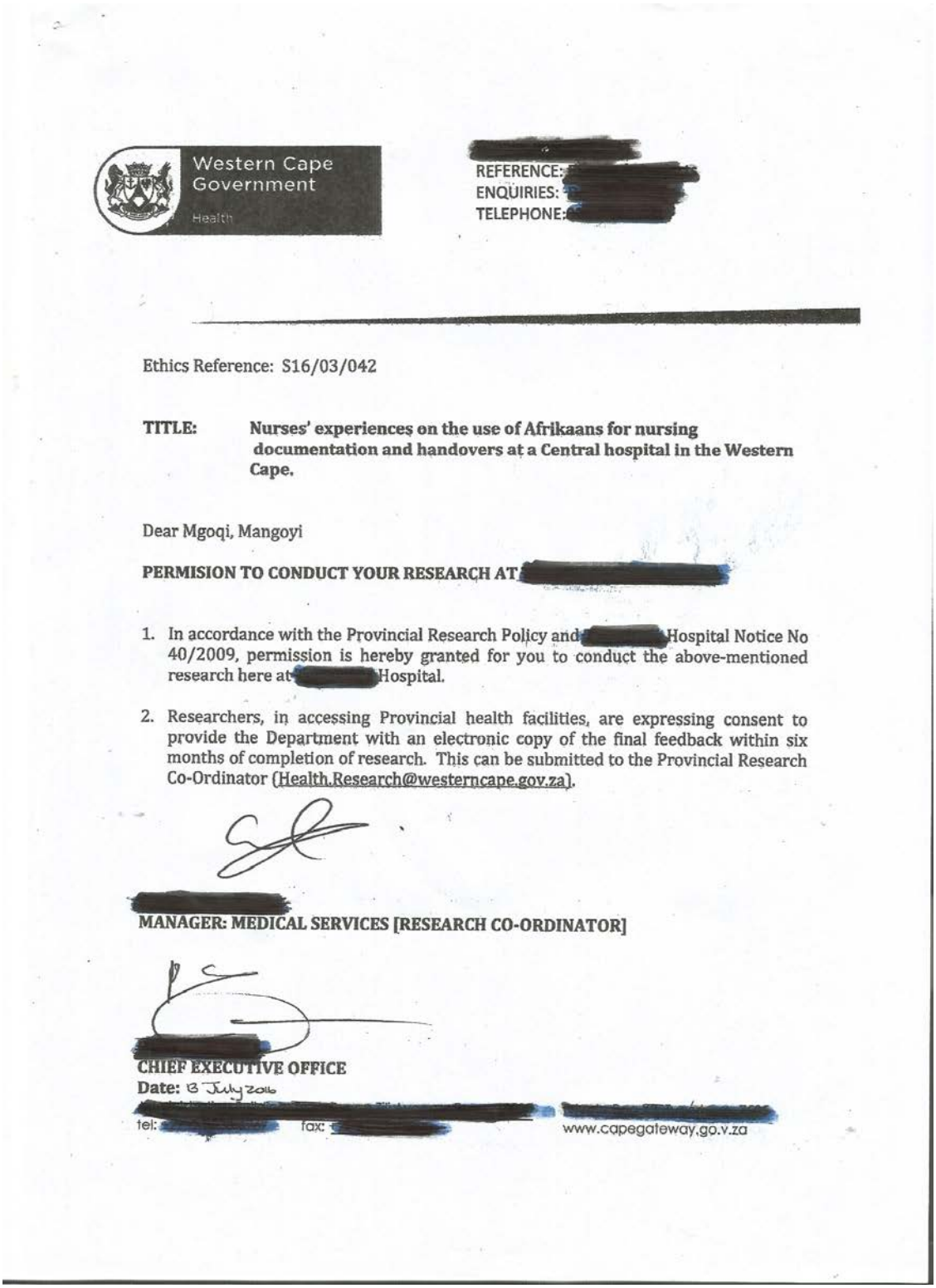
8.Reports to the MCC and Sponsor. When you submit the required annual report to the MCC or you submit required reports to your sponsor, you must provide a copy of that report to the HREC. You may submit the report at the time of continuing HREC review.

9.Provision of Emergency Medical Care. When a physician provides emergency medical care to a participant without prior HREC review and approval, to the extent permitted by law, such activities will not be recognised as research nor will the data obtained by any such activities should it be used in support of research.

10.Final reports. When you have completed (no further participant enrolment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the HREC.

11.On-Site Evaluations, MCC Inspections, or Audits. If you are notified that your research will be reviewed or audited by the MCC, the sponsor, any other external agency or any internal group, you must inform the HREC immediately of the impending audit/evaluation.

APPENDIX 2: PERMISSION OBTAINED FROM INSTITUTIONS / DEPARTMENT OF HEALTH



Western Cape Government
Health

[redacted]
REFERENCE: [redacted]
ENQUIRIES: [redacted]
TELEPHONE: [redacted]

Ethics Reference: S16/03/042

TITLE: **Nurses' experiences on the use of Afrikaans for nursing documentation and handovers at a Central hospital in the Western Cape.**

Dear Mgoqi, Mangoyi

PERMISION TO CONDUCT YOUR RESEARCH AT [redacted]

1. In accordance with the Provincial Research Policy and [redacted] Hospital Notice No 40/2009, permission is hereby granted for you to conduct the above-mentioned research here at [redacted] Hospital.

2. Researchers, in accessing Provincial health facilities, are expressing consent to provide the Department with an electronic copy of the final feedback within six months of completion of research. This can be submitted to the Provincial Research Co-Ordinator (Health.Research@westerncape.gov.za).

[redacted]
MANAGER: MEDICAL SERVICES [RESEARCH CO-ORDINATOR]

[redacted]
CHIEF EXECUTIVE OFFICE
Date: 13 July 2016

tel: [redacted] fax: [redacted] www.capegateway.go.v.za

[redacted] HOSPITAL

Ethics Reference: S16/03/042

TITLE: **Nurses' experiences on the use of Afrikaans for nursing documentation and handovers at a Central hospital in the Western Cape.**

BY _____

An authorized representative of [redacted] Hospital

NAME [redacted]

TITLE CEO

DATE 13 July 2016

APPENDIX 3: PARTICIPANT INFORMATION LEAFLET AND DECLARATION OF CONSENT BY PARTICIPANT AND INVESTIGATOR

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT: Nurses' experiences on the use of Afrikaans for nursing documentation and handovers at a Central hospital in the Western Cape

REFERENCE NUMBER: S16/03/042

PRINCIPAL INVESTIGATOR: Miss. Mangoyi Mgoqi

ADDRESS: Faculty of Medicine and Health Sciences

Stellenbosch University

Teaching Block, Second Floor

Francie van Zijl Drive

Tygerberg, 7505

CONTACT NUMBER: 082 387 6931

Dear Colleague

You are being invited to take part in a research study. Please take some time to read the information presented here, which will explain the details of this project. Please ask the principal investigator any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied and that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

- This study is undertaken with the intent of exploring the experiences of nurses regarding the use of Afrikaans during handovers and conveying of information in documentation. The study will involve 15 nurses at [redacted] Hospital, from 3 randomly chosen wards. Each individual interview will be approximately an hour and will be recorded using a tape recorder. The recordings will be transcribed and kept in a locked safe for a period of 5 years after which the recordings will be destroyed.

Why have you been invited to participate?

- Your participation in the study is requested as you are knowledgeable of the research subject being undertaken and I believe that you will make a valuable contribution to the study.

What will your responsibilities be?

- Your responsibilities will include making yourself available for the interview which will last approximately **one** hour.
- The interview will be recorded using a tape recorder and will only be accessed by the researcher, supervisor and co-supervisor.

Will you benefit from taking part in this research?

- *Taking part in the study will afford you no personal or direct benefits but your contribution will in turn contribute to the body of knowledge in the area of language use in healthcare.*

Are there any risks involved in your taking part in this research?

- *The researcher is aware that the subject matter is sensitive; however the researcher notes no apparent risks to you for taking part in the study.*
- *Coming to the interview will take some of your time which may slightly inconvenience you, however, should you incur travel costs, and it will be reimbursed.*
- *Also, no names will be used during the recordings and when reporting the findings, which means you remain anonymous and nothing will be linked back to you*

What will happen in the unlikely event of some form injury occurring as a direct result of your taking part in this research study?

- *The researcher acknowledges that the subject under study is sensitive and may evoke feelings that both researcher and yourself had not anticipated. Being aware of the sensitive nature of the subject, if you become emotionally distressed during the interview, the researcher will allow you to unpack your emotions and if you are still distressed, the researcher will assist you in receiving therapeutic counselling with ICAS (Independent Counselling and Advisory Services) and you will incur no costs as a result of counselling sessions as it is a free service.*

Declaration by participant

By signing below, I ..... agree to take part in a research study entitled *(insert title of study)*.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.

- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.
- I CONSENT TO THE AUDIO RECORDING OF THE INTERVIEW.

Signed at (*place*) ..... on (*date*) ..... 2016.

.....

Signature of participant

Declaration by investigator

I *(name)*..... declare that:

- I explained the information in this document to .....
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) ..... on (*date*) ..... 2016.

.....

Signature of investigator

APPENDIX 4: INSTRUMENT / INTERVIEW GUIDE / DATA EXTRACTION FORMS

INTERVIEW GUIDE

Section A: Demographic information:

Age:

Race:

Ethnic background:

First language:

Second language:

Nursing category:

Duration at the hospital:

Section B

1. Tell me more about yourself.
2. Tell me how you have experienced language practices at the hospital?
   (Probing words: are there positives/negatives to these practices)
3. Tell me about language used in patient documentation.
   (Probing words: understandable, relatable, standardized)
4. Tell me about language used in handovers.
   (Probing words: applicable to all present)
5. Tell me about the difficulties faced during communication.
   (Probing words: is it always clear?)
6. What is your experience of the relationship between communication among nurses and patient care?
   (probing words: influence of language on patient care quality
7. What, if anything, would you change about the language practices in the ward?
   (probing words: hospital policy, attitudes of staff, cultural tolerance, managerial support)

APPENDIX 5: INTERVIEW EXCERPT

Participant:

OK, here, personally at the ward I'm working in, I had a personal dilemma with the staff. Staffing, the allocation is different, like the Coloureds, the Blacks and the Whites - which are Boer - when you go to tea, you are separated. It's not the same. The Blacks will go to the Blacks and the Coloureds with their own race and the Boere will mix with their own. I think it's because we don't speak the same language, or we don't understand, or it's because of the history that we've been through as a country - that it's like that here because it's still very hostile and it's still a bit rigid. It's not as flexible as the rest of the society is, which is a problem.

Researcher:

So, you're saying that the hospital - including the province that the hospital is in and the Western Cape - you mentioned the language that is predominantly used is Afrikaans, and you feel that that's how the hospital is as well. Is that correct?

Participant:

Yes. What I found out that the hospital was structured in the way that there's an East and a West side. So I think that was, it is, or it was a problem back then. The East side, I thought was for Blacks, and the West side, I thought is for the Boere-people. So, it's just like that here in this hospital. We're just very segregated and we're so separate in everything. Everything. The race is an issue.

Researcher:

So you're experiencing a lot of separation at the hospital?

Participant:

Yes, that's correct.

Researcher:

You said that you are multilingual: You can speak Afrikaans, you can speak isiXhosa. You can speak English as well. But you mentioned that you can't speak isiXhosa at the hospital. Why is that? Why do you feel that way?

Participant:

Firstly, here in my ward I'm the third... We're three Blacks. So the majority is Coloureds, and we have like two Boere in a shift. I'm only limited to speak my language with the other two Black people. I can't speak Xhosa to the other races. So that is what I found out. But the majority is because the Coloureds and the blacks are the majority. They speak Afrikaans and write the reports in Afrikaans, so it's gradually acceptable. But when we speak our language amongst each other they might find that we speak a bit louder, or we're a bit rowdy; so there's that attitude towards the staff. The staff is just not integrating.

Researcher:

And then you also mentioned about tea times and the separation. How does that affect your teamwork? Nursing is a teamwork because there's continuity of care, so if you say now when you go on tea, it's separated: How does that affect you when you're working in a room with someone of a different language?

Participant:

It does affect it, because you find that us Blacks will be a bit tense, or both races will be tense with each other. Then you being with your own race, you'll be more relaxed if you are with your own race, but if you are with a Coloured or a White person, there's this tense-ness and this not a pleasant environment. But working with patients, it's a bit better. But also, it's just not nice. It's not nice at all.

Researcher:

So you're saying there's tension. How does that tension affect you? How do you work?

Participant:

Well, we're not free, firstly. I know that I'm not free in my own ward. When working with another race, you're not entirely free because you might not have the same views or the same opinions sometimes, and when you just don't mingle... You don't have that vibrance. And also, the thing is, I think it's only the... Where the hospital was situated. Because now we'll find that the majority of the patients speak Afrikaans. The Afrikaans-speaking nurses will speak Afrikaans to the patients, and the one Black person that doesn't understand Afrikaans will be side-lined and be second in the conversation, somewhat. So the relationship between the patients are also going to be a problem, because English is not first in this hospital.

Researcher:

So you're saying that even the geographical situation of the hospital affects what goes on, because most of the patients coming from outside are Afrikaans, and therefore the Afrikaans nurses are relating better with their patients while Xhosa-speaking or English-speaking nurses will be left on the side-lines?

Participant:

Yes, exactly.

Researcher:

And you had also mentioned the attitudes of the nurses that they have a certain attitude towards Xhosa-speaking nurses, because maybe you are a bit rowdy or you are loud when you speak. Where do you think those attitudes are coming from?

Participant:

I think it's because of the history of our country. Because we, us as Blacks, we've always been the minority or the oppressed part of the nation - or the oppressed race if I may place it like that. I think it's because of that, and also I would really think it's because of where we are. Firstly, there was an incident or we had an incident at Stellenbosch University. Most of our doctors are Boer, they speak Afrikaans. They're fluent in Afrikaans. They have a problem with speaking English. They find it hard to speak English. So that is a major problem. It's just where we are at this moment. This part of the area, in Stellenbosch area, here at (mentions hospital)- the majority is Afrikaans. And we know the route of everything in Stellenbosch is Afrikaans.

Researcher:

You mentioned something that I found, you know, quite painful. You mentioned that it's not nice being in the ward and you're not free in the ward. How does that make you feel that on a daily basis, you're coming to work and it's not nice and you are not free?

Participant:

At first I was happy to be employed, but now I dread coming to work. It's hard coming to work because you know that, when I'm placed with this certain person, this day is going to be very long. And a twelve-hour shift is quite long to be very quiet and moody and then this tension and this rigidness amongst the coworkers. So it's not nice at all. It's not nice.

APPENDIX 6: DECLARATIONS BY LANGUAGE AND TECHNICAL EDITORS

C/o Division for Postgraduate Studies
University of the Western Cape
Private Bag X17
Bellville 7535
South Africa

22 November 2016

To Whom It May Concern,

RE: THE EDITED MASTER'S THESIS OF MANGOYI MGOQI

I hereby acknowledge that the thesis of Mangoyi Mgoqi titled, *Nurses' experiences on the use of Afrikaans for nursing documentation and handovers at a central hospital in the Western Cape,* as the product of research towards the candidate's master's degree in the Faculty of Medicine and Health Sciences, Stellenbosch University, was edited by me. The work of editing mainly involved ensuring that the language usage and technical layout of the thesis were in accordance with the required standards.

Sincerely,

.....
David Kwao-Sarbah
Mobile: +27620716979
Email: dksarb@gmail.com

Lize Vorster Communication

To whom it may concern

This letter serves as confirmation that I, Lize Vorster, performed the technical formatting of Mangoyi Mgoqi's thesis entitled "Nuses' experiences on the use of Afrikaans for nursing documentation and handovers at a central hospital in the Western Cape." This entails complying with the Stellenbosch University's technical requirements for theses and dissertations, as presented in the Calendar Part 1 – General. Please note that this work was performed under immense time pressure, which may result in unintended inaccuracies as a consequence.

Yours sincerely

Lize Vorster
Language Practitioner

Vygie street 9, Welgevonden Estate, Stellenbosch, 7600 * e-mail: lizevorster@gmail.com * cell: 082 856 8221