

**FIRST YEAR STUDENT NURSES' EXPERIENCES OF ENCOUNTERS WITH DEATH
AND DYING OF A PATIENT DURING CLINICAL PRACTICE**

by

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submitted in accordance with the requirements

for the degree of

MASTER OF ARTS

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

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November 2014

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DECLARATION

I declare that **FIRST YEAR STUDENT NURSES' EXPERIENCES OF ENCOUNTERS WITH DEATH AND DYING OF A PATIENT DURING CLINICAL PRACTICE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



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ABSTRACT

The purpose of this study was to explore first year student nurses' experiences of encounters with death and dying of a patient during clinical practice so as to make recommendations on increase support for first year student nurses. Qualitative research which was explorative, descriptive and contextual was conducted. Data collection was done using in-depth unstructured interview. Nine participants were interviewed and data was analysed. The findings revealed that lack of knowledge, emotional trauma, low self-esteem and nutritional disorder are the results of dealing with death and dying of patients for first year student nurses. Negative attitudes of clinical professionals, shortage of staff and congested block programme were identified as some aspects worsening the situation. Incidental learning that occurs with negative experience encountered was also identified. The findings show the need for review of curriculum for first year student nurses and the need for change of attitudes of clinical professionals.

KEY CONCEPTS

First year student nurse; experience; death; dying; encounter; clinical practice

ACKNOWLEDGEMENTS

Glory be to God, the Almighty who gave me life and intellectual ability to complete this study. I give Him thanks, praise and honour.

My appreciation and acknowledgement goes to the following people:

- My supervisor, Mr D Mphuthi, for continuous guidance and support throughout my study. I really appreciate.
- My ex-supervisor who has now retired, Prof E Potgieter, you really groomed me, thank you.
- My loving husband, Mr Tumelo Molefe. You are really a pillar of my strength. You understood when I could not attend to you as I was busy immersed in the study. Thank you so much my love, I love you.
- My boy, Katlego. I could not even help you with school-work sometimes as I was also busy with my study. Thank you for understanding boy.
- My parents, parents in-law, my sister (Buang), my sisters in-law and brothers in-law.
- All my extended family members thank you for being there for me.
- The participants who agreed to be interviewed for the study. Without you guys, this would not be having this possible. Thank you from the bottom of my heart.
- The Department of Health, Gauteng, for giving me the opportunity to do the study.
- The College Principal for giving me time and permission to conduct the study.
- My editor Mr Davies Oswald who edited my final work.
- Mrs. Rina Coetzee for the professional formatting of the dissertation.

To you all, a big thank you, you contributed indirectly somehow.

God bless you all.

Dedication

I dedicate this dissertation to my loving sister Ntebaleng Nancy Modutwane, who passed away on 22 January 2013, following short illness. She was so close to me. She helped me to raise my little boy, Katlego; she was always there for him when I could not, as I was busy with my studies and work. Rest in Peace my dear sister, I will always miss you and you will be in my heart forever.

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List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immunodeficiency Virus
SA	South Africa
SAMA	South African Medical Association
SANC	South African Nursing Council
UK	United Kingdom
UNISA	University of South Africa

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CHAPTER 1

STUDY OVERVIEW

1.1 INTRODUCTION

This study aims to explore first-year student nurses' experiences of encounters with death and dying of a patient during clinical practice. The four-year diploma or degree in nursing in South Africa comprises general nursing science, psychiatric nursing science, community nursing science and midwifery as learning areas. On successful completion of the full programme the student will be awarded a professional qualification that will enable him/her to practice as a nurse. It is required by statute that all student nurses be registered with the South African Nursing Council (SANC) on commencement of training. This programme includes a theoretical as well as a clinical practice component. These are only offered by nursing schools approved by the SANC (R425, 1988, paragraph 2(a). (SANC 2005). Students are required to undertake varied clinical experiences in areas such as hospitals, clinics, community health care centres, nursing homes and old age homes, in order to gain experience in clinical practice while they are following the basic nursing programme. The need for varied clinical experiences is supported by Grealish and Ranse (2009:81) who state that the effectiveness of learning tends to be enhanced in a group setting which in essence promotes participation in activity. The purport of argument in this source, therefore, is that experiential learning is a critical component of professional practice, for example in nursing.

This chapter will give an overview of the study, whereby the objectives, aim, problem statement and brief methodology will be discussed. Also, trustworthy as well as ethical considerations will be discussed.

During clinical placements students are exposed to a variety of clinical scenarios, including the death and dying of patients. As noted in Mallory and Allen (2006:1), such exposures can be traumatic for nursing students, particularly in the first year of training; hence nursing students should certainly be offered regular psychological support during clinical placement. However, such support is not regularly available in clinical practice. Acknowledging this, Terry and Carol (2008:760) call for all experienced

nurses to offer psychological support to nursing students. They assert with conviction in this regard that good role modeling and psychological support from experienced nurses is vital for students' professional development. Germain (1980:47) observes that dying is regarded as deviant behaviour in the medical subculture. Furthermore nurses, including student nurses; tend to respond to patients' talk about dying by resorting to avoidance behaviours such as physical withdrawal, evasion or denial. Dzurec, Allchin and Engler (2007:549) found that first-year nursing students complain that they suffer from depression at work because they have to deal with the death and dying of patients in their care.

This is an essential part of their duties, however, that calls for special knowledge and skills. Communication, empathy and sympathy in clinical practice are the ultimate goals of caring for the dying person; the nurse caring for such a patient should discuss what the patient and his family know about his condition and approaching death; the nurse should consistently work supportively with the family, allowing ventilation of feelings, and should be well-informed about the relevant ethical, legal and moral issues. He or she should have respectful attitudes towards death and should raise awareness of religious and cultural issues. These statements are supported by sources reviewed in Northrup (2004:1066), Mutto and Erra'zquin (2010:1446), Ying-Chun, Pi-Yung, Chih-Yao, Hsing-Hsing, Kwua-Yun and Wen-Chii (2010:857).

According to Friedman and Friedman (2003:271), the goal of therapy administered to a dying person in clinical practice is to strengthen the meaning of life, for this itself, the search for meaning, may restore life, or at the least, enrich the meaning of terminal events, for in the face of death a person can rise to the full stature of his being. In fact, a skilled care worker can aid an individual to find his full dignity in death, if he was never able to find it in the past events of his life. Student nurses should therefore undergo training to ensure that they have good communication skills and can adequately display the qualities of empathy and sympathy that they need to deal with the death and dying of patients.

The findings and recommendations from this study may assist educators and clinical nursing professionals to develop guidelines to be applied towards increasing support for student nurses with a view to retaining their services in the nursing profession and to

prevent burn-outs to which students are prone when caring for a dying patient or when dealing with the death of a patient.

1.2 SOURCE AND BACKGROUND TO THE PROBLEM

1.2.1 Source of the research problem

The researcher lectures at a nursing college in Gauteng. The first-year student nurses are allocated to the above-mentioned array of clinical areas from college, and are encouraged to write reflective journals with regard to their experiences in the respective clinical areas where they are placed. The researcher concluded from these first-year student nurses' reflective journals that, besides other complications, students suffer from burn-outs, depression and stress as a result of exposure to the experience of patient deaths and dying.

1.2.2 Background to the research problem

The curriculum for first-year student nurses enrolled for the four-year course is congested. It consists of Fundamental Nursing Science, ethos and professional practice; General Nursing Science, Biological and Natural Science; Pharmacology and Social Science, and the approach must be the integration of the various fields of study in their clinical application. This curriculum is approved for Gauteng Nursing Colleges by the SANC (Gauteng Nursing Colleges Curriculum 2002:16). The curriculum should be implemented in the first year of study for student nurses training under Regulation R425, and the implementation should be done within an academic period of 44 weeks in a calendar year (SANC 2005, paragraph 1(i)). The result of the congested programme is that students spend less time in clinical areas, thus reducing their clinical contact with clinical educators and mentors who provide support, education, proper mentoring, and cultivation of the communication skills needed to deal with patient deaths and dying. This statement is supported by literature reviewed in Gauteng Nursing Colleges Curriculum (2002:16), which requires first-year students to spend 1000 hours yearly in general clinical practice and to devote the remaining available hours of yearly training to class attendance, tests, examinations and annual leave. Bruce (2012:1) emphasises that the theory and clinical training time should be apportioned equally (50:50) in order to adequately prepare students to provide quality nursing care, including dealing with

death and dying of patients. This is not happening presently because of the congested block programme which allows students to spend 26 weeks in theory and only 22 weeks in practical training.

Dzurec et al (2007:545-551) conducted a study at a nursing college in Ohio, USA, to explore reasons for depression among first-year student nurses. The study revealed that 53 participants attributed a depressing effect to their experience of dealing with death and dying of patients. Terry and Carrol (2008:760) endorse this finding. Furthermore, Terry and Carrol (2008:760) caution that student nurses tend to develop avoidance behaviour unless they receive support in dealing with the depressing effects mentioned. Costello (2006:594-600) concluded from a study aimed at soliciting 29 student nurses' experience at Manchester School of Nursing in the USA in regard to the said issue of death and dying that it posed a major challenge, to the extent that some candidates were too overwhelmed by the experience to continue their training. Watkins, Roos and Van der Walt (2011:1-10) conducted a study in response to the large numbers of training terminations among first-year students to explore the personal, relational and collective well-being of the said population while training at a tertiary education institution in North West Province, South Africa. Prominent among the reasons for termination were stress and burnout caused by exposure to death and dying of patients.

Carlos, Kotze and Van Rooyen (2009:5) confirm that student nurses are not provided with adequate skills and knowledge to deal with death and dying of patients. Ilhaam (2010:3) reiterates this need and stresses the urgency of remedial interventions in the clinical learning environment, as well as role modeling and pastoral care, which the source deems vital for students' personal and professional development. The researcher was persuaded by the evidence adduced above to engage in further exploration of the issue of first-year student nurses' experience of patient deaths and dying in clinical practice.

1.3 STATEMENT OF THE RESEARCH PROBLEM

It appears from current nursing literature (Dzurec et al 2007:550; Huang, Chang & Sun 2010:2281; Terry & Carol 2008:760), as well as the reflective journals of first-year student nurses, that dealing with patient deaths and dying is indeed experienced as

traumatic by students in their first year, to the extent that some terminate their training for that reason. The object of the researcher was therefore to gain independent insight into the issue at hand with a view to making recommendations relating to increased support for first-year students in order to reduce untimely termination of training.

Based on the above problem statement, the following was the aim of the study:

1.4 AIM OF THE STUDY

1.4.1 Research aim

The aim of this study is to explore and describe experiences of first-year student nurses when dealing with patient deaths and dying in order to understand their emotional responses to such experiences and make recommendations relating to increased support for the said trainees, including psychological counselling, and by such means endeavor to reduce the incidence of early termination of training. From the objective of the study, the following objectives were formulated:

1.4.2 Research objectives

The objectives of this study are to

- explore and describe first-year student nurses' experiences in dealing with patient deaths and dying in the course of routine nursing practice
- make recommendations relating to increased support for first-year student nurses with a view to increasing their capacity to cope with the clinical experience of patients' death and dying

In order to achieve the mentioned objectives, the researcher will formulate the research question.

1.4.3 Research question

The following research question was asked:

How do first-year student nurses experience their encounters with patient deaths and dying during clinical practice?

1.5 SIGNIFICANCE OF THE STUDY

The Department of Health and the nursing colleges aim to address the critical shortage of professional nurses in South Africa (SA) by retaining and training as many student nurses as possible to the requisite level of professional competence that will enable the country to cope with its onerous health burdens, which are immeasurably exacerbated by the scourge of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) (Department of Health: National Strategic Plan for Nurse Education, Training and Practice 2012/2013–2016/2017).

According to statistics released by the South African Medical Association (SAMA) (2009:1) nurse/patient ratios in public hospitals range from 1:18 to 1:44, and in isolated instances in the Eastern Cape and Gauteng, 1:50 in some general wards and 1:10 in some postnatal wards. In light of this situation, therefore, early termination of training among first-year student nurses is a just cause for grave concern, particularly since the situation can be remedied by offering adequate support that will help the affected students to cope with their clinical experience of patient death and dying.

According to Liechty (2000:252), student nurses want to be adequate transference objects for their patients. They want to be a source of comfort to dying patients and to assuage their anxiety as well as that of relatives and loved ones, thereby easing the patient's experience, as well as that of concerned parties, of the patient's departure. The object of the study under review was to make recommendations with a view to assisting the preparation and support of student nurses to become adequate transference objects for their patients as well as the relatives and other parties who take a direct interest in the patient concerned.

1.6 META-THEORETICAL GROUNDING OF THE RESEARCH

1.6.1 Meta-theoretical assumptions

The researcher align herself with meta-theoretical assumptions as stipulated by Mphuthi (2010:6) who says that a **man** is an individual, unique human being with an integrated

physical, psychological, spiritual and cultural nature; forever in contact with their surrounding and people around them. A family is viewed culturally as an organisation which comprises of the father as head, the mother as sub-head and the children as the members; in which milieu children may be socialised in a specific cultural belief system. Family also comprises extended members such as grandparents, uncles, aunts as well as cousins who also have an input into this organisation. Furthermore, **environment** is viewed as all circumstances, conditions as well changes that challenge each individual as an adaptive being. Furthermore, health is viewed as the ability of human being in adapting to the changes around him without being adversely affected. When affected, illness results, as health and illness are viewed to be on a continuum. In addition, **nursing** is viewed as the care provided to enable people to cope with or recover their health, when their health has been compromised by the disease or illness. It also adds value to the quality of life of an individual until death. In order to do this, nurses need to undergo scientific training in nursing science. **Nursing science** incorporates knowledge and the application of this knowledge is concerned with individuals, groups as well as the community, in order to make it easy for people to adapt to a changing environment.

1.6.2 Theoretical assumptions

For the purpose of this study, Maslow's hierarchy of need theory has been adopted. This theory was formulated in 1943 where Maslow looked at the pyramid of needs. In this theory, Maslow extended the idea to include observations of human's innate curiosity over the years. The researcher adapted this theory so as to be able to observe the human participants (first year student nurses) behaviour when having an encounter with death and dying. This theory is divided into five needs as follows: **Physiological needs** which are the need for oxygen, food, water and relatively constant body temperature. **Safety need**, which is safety and security need in an environment. **Need for love, affection and belonging**; this is a need whereby a person needs to be loved and have a sense of belonging. **Need for esteem** which is a need based on high level of respect from others. Self-actualisation which is a need to be who a person is born to be (Jerome 2013:39-45). Therefore, it is important for the patient and a nurse to satisfy these levels.

1.7 DEFINITION OF KEY CONCEPTS

The following terms are explained below for the purposes of this study.

1.7.1 Student nurse

An individual who is studying to achieve a professional qualification in the art and science of nursing, and who meets certain prescribed standards of education and clinical competency. A student nurse is registered as a student with the South African Nursing Council (SANC) under Section 23 of the Nursing Act (Act 33 of 2005) who will undergo training to become a professional nurse over a period of four (4) years in accordance with Regulation R425 (SANC 2005).

The curriculum content for student nurses comprises the following: Fundamental Nursing Science, ethos and professional practice; General Nursing Science; Biological and Natural Science; and Pharmacology and Social Science. The academic year for trainee student nurses extends over a period of 44 weeks of every year of study, and training includes integration in practice of the knowledge gleaned from the theoretical portion of the training in the various subject fields (SANC 2005, paragraph 6(3) (a, b, f, g and h)).

1.7.2 Experience

Experience is knowledge gained by observing or doing things (*Oxford English Dictionary* 2007:162). *Longman's Dictionary of Contemporary English* (2006:355) defines experience as the gaining of knowledge or skill which comes from practice in an activity, or from being engaged in a particular set of well-defined routines over a lengthy period. In this study experience refers to the feelings, emotions and perceptions of first-year student nurses, as well as their personal actions in dealing with patient deaths and dying in their clinical practice.

1.7.3 Death

Longman's Dictionary of Contemporary English (2006:263) defines death as the end of life of a person or an organism. Death is the cessation of all the physical and chemical

processes, that occur in living organisms or their cellular components, and in addition the permanent, not transient, cessation of electrical activity in the brain of a human being (ie. signaling the end of consciousness) (Weller & Wells 2009:155).

In this study death refers to the cessation of all the normal physiological activities of the human body, including respiration, pulse and all reflexes.

1.7.4 Dying

Dying is a poorly understood phenomenon characterised by a gradual systemic shut down, followed by an absence of criteria that define life (*Segen's Medical Dictionary* 2008:126). In addition dying can be viewed or defined as the last stage of life; a process that from a medical point of view begins when a person has a disorder that is untreatable and inevitably ends in death or the final stages of a fatal disease. The essential task of the dying person is to work through psychologic responses toward the reality of approaching death to a final and peaceful acceptance of that reality (*Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing & Allied Health* 2003:96).

In this study dying refers to the last, critical stage of a patient's life that will soon end with the cessation of breathing/respiration and pulse/heartbeat.

1.7.5 Clinical practice

Clinical practice subsists in bedside observation and professional treatment of patients (Weller & Wells 2003:107, 386).

In the study under review practice means the experience that the first-year student nurse will gain while being placed at the bedside of the patient to render nursing care in a specific accredited clinical area.

1.7.6 Encounter

Longman's Dictionary of Contemporary English (2006:334) defines an encounter as an occasion when something bad, dangerous or difficult is experienced.

An encounter in the sense referred to in this study is the situation that first-year student nurses have to contend with when dealing with patient deaths and dying.

1.8 RESEARCH METHODOLOGY AND DESIGN

Holloway and Wheeler (2006:322) note that methodology includes several subsections: deciding on the research design and methodology; implementation of the method, including data collection, sampling, detailed interviewing, and a description of data analysis. A qualitative approach was adopted for the purpose of the research under review.

1.8.1 Qualitative methodology

Burns and Grove (2005:23) explain qualitative research as a systematic, interactive, subjective approach used to describe life experiences and give them meaning. As noted by Burns and Grove (2005:24), qualitative research is derived from the naturalistic paradigm which stipulates that there are multiple interpretations of reality and the goal of research is to understand how individuals construct reality within their own context. There is no generalisation of the findings to a larger population. The purpose of qualitative research is to describe what people experience in regard to certain phenomena (Brink, Van der Walt & Van Rensburg 2006:113). Qualitative research aims to gain in-depth understanding of human behaviour and motivation, thereby answering the why and how of decision making, not just the what, where and when. It is a distinct mode of enquiry oriented towards understanding the unique nature of human thoughts and behaviours.

1.8.2 Research design

A research design is a blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings. It guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal (Burns & Grove 2005:211). According to Green and Thorogood (2004:34), a research design refers to the logic informing the study: the what, how and why of data production. Given the researcher's qualitative approach, the study under review would be explorative, descriptive and contextual (Polit & Beck 2008:759).

To be specific, then, the researcher adopted a qualitative approach to the research under review in light of the primary research question indicated above: *How did you experience patient death and dying during clinical practice?* Data collected by the researcher were intended to shed light on participants' experiences (Mactavish & Schleien 2004:126); hence the following research plan was adopted.

1.8.3 Population recruited for participation in the study

Brink et al (2008:123) define population as the group of persons or objects that interest the researcher in that they display the characteristics that the researcher proposes to study. In the present instance the population at issue consisted of first-year student nurses who were registered for the comprehensive student training programme for nurses at a nursing college in Gauteng, South Africa.

An accessible population is defined in terms of geographic location (i.e. relative proximity) (Stommel & Wills 2004:297). The study population in the present instance consisted of first-year student nurses at a nursing college in Gauteng. The proximity of the population was predicated on the fact that the problem under discussion was first identified at the said establishment, and therefore the study sample was chosen from the said population.

1.8.4 Sampling method/approach

Sampling is the process by which particular subsets of members of larger groups are selected (Stommel & Wills 2004:296) as study participants. Purposive, non-probability sampling was used in the study under review. According to Burns and Grove (2005:40), non-probability sampling means that not every member of the population can be included in the sample. Also, purposive sampling is a method that involves conscious selection of participants with specific reference to cases from which they can learn a great deal about the central focus or purpose of the study. In addition, it is the best method to gain insight into a new area of study or to obtain in-depth understanding of a complex experience or event. According to Burns and Grove (2005:353), with this method, sampling is conducted until saturation is reached. According to Brink et al

(2008:134) purposive sampling is advantageous because it allows the researcher to select the sample of the study based on knowledge of the phenomenon being studied.

Because purposive sampling is used when the researcher want situation from which she can learn a great deal about the central focus or purpose of the study, the researcher decided to select only first-year student nurses who had experienced death and dying of patients during clinical practice because these were participants who could give rich information that would be conducive to answering the research question.

1.8.5 Data collection

Stommel and Wills (2004:363) explain data collection as the systematic process of gathering all information on variables of interest with a view to addressing the relevant research questions and evaluating outcomes. According to Brink et al (2008:54), data-collection methods vary according to the design of the study. Whitney, Lind and Wahl (2008:72) emphasise that ensuring accuracy and honesty in the process of data collection is important.

According to Brink et al (2008:141), the success of a study is critically dependent on the effectiveness of the process of data collection, failing which research conclusions are easily challenged, hence selecting a suitable method is of the essence. Brink, Van der Walt and Van Rensburg (2008:141) further emphasise that data collection should be guided by five important questions: What? How? Who? Where? When?

Data collection in the present instance took the form of unstructured face-to-face interviews that were calculated to probe the relevant issues in depth (Brink et al 2008:151). Participants were required to sign an informed-consent form as their involvement was voluntary.

1.8.6 Data collection procedure

Data collection procedure subsists in the method and order of gathering information. The following procedure was adopted in the present instance: The researcher chose a quiet venue for the interview to avoid disturbances. Students are divided into groups alternating between clinical work and academic study (broadly termed “theory”) so that

the large numbers of trainees can be accommodated in the available space and an even distribution can be arranged between the two aspects of training, thus securing equal opportunities to receive all aspects of training across the board despite the material constraints of available facilities. The researcher fell in smoothly with this routine to cause the least possible disruption of the training operations generally, for example by sparing students engaged in clinical duties the inconvenience of interrupting their work to travel to the college for interviews, which were conducted in vacant classrooms to avoid disturbance. A "Do not disturb" sign was put up outside the relevant venues as further insurance in this regard.

The following interviewing skills were apposite for the purpose in hand (and the researcher gave assurances that the skills would be exercised): The researcher would not rush the interview, would arrive thirty (30) minutes before the scheduled time in order to make the necessary preparations, and would put aside an hour after the interview to make field notes, and a total of three hours overall per participant to complete the interview. The researcher further undertook to conduct interviews in a stress-free and unhurried fashion, this after contacting the prospective interviewee 7 days in advance to confirm the prospective location and the prospective interviewee's commitment to attend at the venue at the time agreed upon, as well as to allow prospective interviewees a last opportunity to air whatever queries and concerns they might have. On the day before the scheduled interview the readiness of equipment required for the occasion was checked (example: ensure that the audiotape recorder was fully functional). On the appointed day the researcher explained the purpose (including the confidentiality) of the interview and how the information gained from the interviewee would be used. The researcher arranged suitable seating for the occasion, for example: by ensuring that the researcher would not face the interviewee directly, the object being to minimise the possibility that the interview might be experienced as confrontational, and to ensure at the same time that the participant would not be able to see and thus be able to anticipate the questions in front of the researcher. Participants were required to sign informed-consent forms in anticipation of the interview.

The researcher took pains to build rapport with interviewees by explaining the purpose in hand, how long the interview would take, the fact that confidentiality would be guaranteed, that participants would be free to step away from the proceedings at any time without incurring displeasure or obligations of any kind, and other similar matters

that could be conducive to gaining the interviewee's confidence by demystifying the occasion as far as possible. Further, to avoid the possibility that the interviewee might gain the impression of a breach of confidentiality on the researcher's part a clear assurance was given that no third person (example, a moderator) would be present at the interview. This assurance and precaution was deemed necessary to avoid unease on the interviewee's part and thus possibly compromise the value of the information gained from the interview.

The researcher then asked the question unambiguously and in a neutral tone:

How did you experience dealing with death and dying of a patient during clinical practice?

The researcher encouraged participants to "tell their stories" at their own pace, proceeding with the least possible interruption. However, the researcher maintained control, for example by ensuring that participants kept their answers to the point. The researcher listened empathetically to responses to gauge the non-verbal sense of participants' communication. Verbal and non-verbal cues, including silent pauses, to encourage elaboration, were used to assist interviewees' responses. Interviewees' body language was monitored throughout for signs requiring changes in tactics (e.g. softer/bolder approach) from the interviewer's side. Interviewee's verbal response was read back at times to check accuracy of recorded version. Interviews were timed to last about 45 minutes, which was considered in keeping with the advice of Holloway and Wheeler (2006:56) about avoiding the possibility that interviewees might feel hard pressed when subjected to prolonged interview periods. Interviews were recorded in an audiotape recorder. The researcher opted to use an audio recorder due to its advantage as outlined in Brink, Van der Walt and Van Rensburg (2008:36). The advantage is that it offers to review the gathered data verbatim without having to rely on written notes.

1.9 DATA ANALYSIS

Brink et al (2008:170) explain that data analysis entails categorising, ordering, manipulating and summarising data in order to create a meaningful description. Gray (2009:499) explains that analysis means lifting significant constituent parts from the whole; further that qualitative analysis is a demanding logical process that subsists in

drawing inferences from a survey of data in order to point out significant elements. In the present instance data were duly subjected to content analysis in the process of collection to lift out significant elements (chapter 3). Recommendations were made in virtue of the analytic process as described.

1.10 TRUSTWORTHINESS

According to Speziale and Carpenter (2007:48), trustworthiness in qualitative research is concerned with rigours which, thus Holloway and Wheeler (2006:298), subsume the qualities of credibility, dependability, conformability and transferability. These are the testing criteria used in the present instance.

Credibility: Credibility is the alternative to internal validity. According to De Vos, Srydom, Fouché and Delpont (2009:345), credibility is attained by demonstrating that the participants were accurately identified and described. Polit and Beck (2008:196) note that credibility calls for persistent observation (close monitoring) throughout data collection, including triangulation, collection method and investigative procedures, as well as member checks (i.e. where data and interpretations are discussed with participants) until saturation is achieved (i.e. no further data emerge).

Dependability: Polit and Hungler (1995:362) explain dependability as stability (reliability) of data over time regardless of conditions. In the present instance dependability was assured by using an audit trail. An audit trail will allow the reader of the study to follow the decision path of the researcher and will demonstrate how the researcher reached her conclusion. Stommel and Wills (2004:288) explain that an audit trail is a systematic interlinked collection of materials and documents that is, a track record consisting of documentation that effectively creates a path of verification that enables independent or external auditors to come to comparable conclusions about the data. In the present instance the audit trail established by the researcher in the course of the study was monitored for verification by the supervisor of this dissertation at the University of South Africa (UNISA).

Confirmability: According to Polit and Beck (2008:539), confirmability refers to objectivity in the sense of agreement between two or more independent parties about the accuracy, relevance, or meaning of the data, the question decided by the parties being

that the data as recorded are an accurate reflection of the information provided by participants, and that the interpretations of those data were not figments of the inquirer's imagination. In the present instance the services of a co-coder were enlisted with a view to solidifying confirmability. In a qualitative study coding is the process of conceptualising/concretising the data (UNISA RSC201H/200:245).

Transferability: Transferability refers to generalisability of the data, that is, the extent to which the findings can be transferred/transposed with equal relevance to other settings or groups (Polit & Beck 2008:539). Generalisability in this sense could not be addressed in the present instance since the study did not extend to nursing colleges besides the setting of the study under review. However, the researcher did ensure that rich text containing densely detailed information was recorded and included in the report so that consumers could evaluate the applicability of the data to other contexts. In addition, the results of the study have been recontextualised in the literature.

1.11 ETHICAL CONSIDERATIONS

1.11.1 Ethical principles to assert for the study

Permission to conduct the study was obtained from the UNISA, Gauteng Department of Health and the Nursing College (Annexure F, G, H and I).

The researcher promised that participants' rights, wellbeing and safety will always take precedence over research objectives and that she will adhere to ethical principles of autonomy, beneficence, non-maleficence, privacy/confidentiality and justice. In this chapter, the researcher respected these rights. Autonomy was respected by ensuring that recruitment of participants was appropriate and acceptance, hence the researcher fully informed the participants about the nature of the proposed study and allowed them to voluntarily choose to participate in the study or not, without forcing them. Both verbal and written informed consent was obtained from the participants prior the interview. The researcher also advised the participants on their right to withdraw from the study if they so wish or if feel uncomfortable to continue with the interview without imposing penalties for their withdrawal or without blackmailing them or victimising them. Permission to record the interview was requested from the participants as well. The researcher adhered to the length of interview as promised. In addition consent to perform interview

was obtained prior the study and interview from the relevant stakeholders and the researcher adhered to boundaries and limitations set.

Beneficence/non-maleficence was respected by narrowly observing participants for signs of discomfort or suffering/trauma during the interview, given the sensitivity of the topic. Assurances were given that the substance of interviews would be shared with no-one besides the researcher. Participants were asked how they feel at the end of the interview. This was done to exclude any harm that could have occurred during the interview. Privacy/confidentiality was respected by ensuring that the researcher uses quiet classrooms at college and quiet private offices in hospitals. Anonymity was adhered to as researcher did not use participants' names anywhere. Only codes were used throughout. This was done to keep participants' identities a secret. In addition, the researcher ensured that she does not share the information that participants provided with anyone who is not involved in the research. The researcher also reassured participants that in case where the information needs to be shared with other health professionals for betterment of services in nursing colleges and hospitals, the researcher will first ask permission from participants before such information can be provided. Justice was respected because participants were chosen irrespective of their cultural background, gender, origin, language, age, sexual orientation or religious affiliation. No participant was provided with a different or special treatment or support from another, all participants were treated the same.

Furthermore, consent to conduct interviews was obtained from the principal of the college where participants were training, as well as Gauteng Department of Health and the UNISA. In addition, the researcher consulted nursing managers of various hospitals where participants were stationed at the time to request permission to access the hospitals where prospective interviews were to be conducted.

Ethical consideration of this study will be discussed in details in chapter 2.

1.12 CONCLUSION

This chapter outlined the source and background to the problem, as well as the purpose, objectives and significance of the study. Key concepts were explained and an overview was given. The chapter also briefly highlighted research design, method, data

collection, analysis and ethical considerations relating to the study. Chapter 2 will cover the research design and methodology.

1.13 STRUCTURE OF THE DISSERTATION

This study consists of five chapters:

Chapter 1: Study overview

Chapter 2: Research design and methodology

Chapter 3: Data analysis, results and findings

Chapter 4: Discussion of the findings and literature control

Chapter 5: Conclusion, limitations and recommendations

CHAPTER 2

RESEARCH METHODOLOGY AND DESIGN

2.1 INTRODUCTION

This chapter will discuss sampling, selection of participants, data collection, data analysis as well as trustworthiness of the research.

2.2 RESEARCH METHODOLOGY

Brink et al (2008:191) explain the research methodology as a method that informs the reader of how the investigation was carried out, in other words, what the researcher did to answer the research question(s). According to the said source this section should contain enough detail to enable another researcher to replicate the investigation. In addition, this section should consider the population, sample frame, approach and technique, sample size, data collection method and data processing and analysis. Holloway and Wheeler (2006:323) emphasise that the researcher should give reasons for using a particular methodology and research strategies and describe the procedures of collecting data.

2.3 RESEARCH DESIGN

A research design is a blueprint for conducting the study that maximises control over factors that could interfere with the validity of the findings. It guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal (Burns & Grove 2005:211).

The researcher used a generic qualitative research design which is explorative, descriptive and contextual in order to understand first year nursing students' experiences of patient deaths and dying. This decision was taken following literature reviewed in Gray (2009:166) who highlighted the following characteristics of the design followed here. It was conducted by engaging in depth with a real-life setting in order to gain a holistic overview of the situation at issue, including particulars reflecting

participants' perceptions; themes emerging from the data (verified with informants), as an endeavour generally to understand how people act and account for their actions.

According to Burns and Grove (2005:23), qualitative research is regarded as a systematic, interactive, subjective approach used to describe life experiences and give them meaning. Speziale and Carpenter (2007:21) emphasise that qualitative researchers direct their attention to human realities rather than to the concrete realities of objects. Furthermore, Speziale and Carpenter (2007:21) emphasise that researchers committed to qualitative research believe that individuals actively participate in social actions, and through these interactions that occur based on previous experiences, individuals come to know and understand phenomena in different ways. According to Speziale and Carpenter (2007:21), because people do understand and live experiences differently, qualitative researchers do not subscribe to one truth but, rather, to many truths. A qualitative approach subsists in finding ways of addressing the research question appropriately and effectively. It is upon this literature that the researcher adopted a qualitative design for this study in order to get answers to the research question:

“How did you experience patient death and dying during clinical practice”?

Information provided by participants when answering the question will enable the researcher to understand life experiences of first year student nurses in dealing with death and dying of patients because they actively participated in caring for such patients in clinical areas.

2.3.1 Population

Blanche, Durrheim and Painter (2006:133) explain population as a larger pool from which sampling elements are drawn. Brink et al (2008:123) explain population as the entire group of persons or objects that is of interest to the researcher, in other words, that meets the criteria which the researcher is interested in studying. In this study, the population that was of interest was first-year student- nurses who are doing four-year comprehensive nursing course in one nursing college in South Africa in the year 2012. The participants have had an encounter with death and dying of a patient during clinical practice. An accessible population is defined by Stommel and Wills (2004:297) in terms

of the geographic location. In this study, an accessible population was first year student-nurses at one nursing college in Gauteng, because this is where the problem was identified.

2.3.2 Sampling

Stommel and Wills (2004:296) explain sampling as the process by which particular subsets of members of larger groups are selected. In this study, non-probability sampling was used and the method that was utilised is purposive sampling. Non-probability sampling method means that not every element of the population has an opportunity for selection in the sample (Burns & Grove 2005:40). Purposive sampling involves conscious selection of participants by the researcher to include in the study. Purposive sampling is used when the researchers want those cases from which they can learn a great deal about the central focus or purpose of the study (Burns & Grove 2005:352).

In this study, the researcher explored first year student nurses experiences of encounters with death and dying of a patient during clinical practice. Participants were selected from the first year student nurses who encountered dealing with deaths and dying of a patient during their clinical practice.

2.3.3 Selection of participants

The selection was made by accepting the nine volunteers (two males and seven females) responding to an invitation addressed to first-year student nurses who had experienced patient deaths and dying in the course of their clinical duties. The researcher arranged an individualised follow-up meeting, scheduled after the college exams to avoid disruption of college operations with the volunteers for the purpose of information sharing and to secure their written consent to participation.

2.3.4 Eligibility criteria

2.3.4.1 Inclusion criteria

Burns and Grove (2005:342) define sampling criteria as a list of characteristics essential for membership or eligibility in the target population. The criteria are developed with due reference to the research problem, the purpose of the study, the literature review, the conceptual and operational definitions of the study variables, and the design. Selection took no cognisance of cultural background, gender, language, age or religious affiliation. Inclusion criteria were as indicated earlier in chapter 1.

2.3.4.2 Exclusion criteria

Holloway and Wheeler (2006:144) explain exclusion criteria as participants that are excluded- though meeting some of the inclusion criteria-might be vulnerable to be interviewed or have certain traits that might make the research problematic. The following were regarded as ineligible for the purposes of the study under review: All student nurses except those in their first year of study who had not experienced patient death and dying in the course of performing their clinical duties and had not signed written consent forms allowing participation.

2.4 DATA COLLECTION

2.4.1 Setting for data collection

Holloway and Wheeler (2006:137) explain sampling as the purposeful selection of an element of the population concerned to gain knowledge and information, the question being how to proceed with the selection process, naturally after seeking and gaining permission to access the relevant site and prospective participants for the proposed purposes, which is a significant prerequisite to protect the researcher as well as the participants (Holloway & Wheeler 2006:46).

As explained in chapter 1, the researcher selected only first year student nurses who had experience of dealing with death and dying of a patient as these were participants that could give rich information to can answer the research question. How selection of

participants was done: the researcher approached first year student nurses, explained to them that she is doing the study on experiences of first year student nurses when dealing with death and dying of a patient, and she is therefore requesting volunteers who has experience of dealing with death and dying of a patient to participate in the study. Volunteers were seen individually and privately in the office of a researcher and thorough explanation about the study was given.

2.4.2 Data collection procedure

Stommel and Wills (2004:284) note that the unstructured interview procedure used in the present instance is the least planned, most flexible method that produces the best open-ended responses. The unstructured approach was also adopted on the advice of Denzil and Lincold (2000:652) to the effect that it is best suited to securing the widest possible spread of data; and to that given by Brink, Van der Walt and Van Rensburg (2008) to the effect that it is most conducive to a face-to-face interview which enables the researcher to gauge non-verbal communication visually and listen to cues that can be gauged from participants' tone and emphases in the audio recordings. According to Holloway and Wheeler (2006:89), an unstructured interview allows an interviewer to freely ask questions in any order or sequence, depending on the responses to earlier questions. Holloway and Wheeler (2006:89) note that an unstructured interview starts with a general question in the broad area of study; hence the researcher asked the following grand-tour question: "*How did you experience dealing with death and dying of a patient during clinical practice*"? The researcher allowed the participants to share their experiences with minimal interruption.

Blanche et al (2006:299) emphasise that the interviewer should do the following during the interview: listen more and talk less, ask questions when she does not understand, follow up on what the participant says, ask to hear more about the subject, avoid leading questions, ask open-ended questions which do not presume answers, keep participants focused, ask participants to rephrase or reconstruct, tolerate silence and allow the participant to be thoughtful. That is why the researcher made use of the following probing questions in order to get better understanding and for clarity purpose:

- *Have you only had to deal with one patient's death/dying in your clinical experience?*

- *Were there differences between the first and subsequent experiences? Explain.*

Besides the above, the researcher interpolate with the following questions:

- Support questions such as *“What support did you get in the ward?”*
- Feeling questions such as *“How did you feel?”* Or *“What do you think could have been done to relieve the situation?”*

The researcher also made use of communication skills such as nodding, reflecting (i.e. pausing thoughtfully), maintaining eye contact, taking field notes relating to non-verbal communication, such as physical appearance, manner of speaking, style of interaction and emotional reactions to the fieldwork.

Interviews were done to saturation in the sense that no further information was forthcoming from the participants (i.e. from the fifth participant onwards). One of the said five was male and the rest were females, a distribution that was in keeping with the numbers of first-year students of which 100 were male and 300 female. The same female preponderance was evident in the responses to the invitation to participate in the study (i.e. 7 female and 2 male). It should be noted that no bias was shown in either recruiting students or inviting participation. At the end of the interview participants were asked how they felt. The question was asked to determine whether they were still affected emotionally by the experience they had been asked to rehearse during the interview. One of the nine participants did ask for a referral to counseling, not necessarily as a remedial measure to relieve emotional disturbance caused by the experience at issue, but as a safeguard to get closure and prevent a possible future recurrence of the same trauma as a “flashback” experience. The student later indicated with expressions of gratitude that counselling had proved most helpful.

2.5 DATA ANALYSIS

Gray (2009:499) explains data analysis as a process that involves breaking down data into smaller units to reveal their characteristic elements and structure. Furthermore, Gray says descriptions can lay the basis for analysis, but we need to go beyond description: we want to interpret, to understand and to explain. In addition, Gray mentioned that through analysis, we can also gain new insight into our data. According

to Gray (2009:499), data can be broken down into their constituent parts, and through connections made between these concepts provide the basis for new descriptions. Speziale and Carpenter (2007:96) emphasise that data analysis requires that researchers become immersed in, and thereby preserve the uniqueness of each participant's lived experience while permitting an understanding of the phenomenon under investigation. William (2010:151) emphasises that analysis begins with listening to participants' verbal descriptions, followed by reading and rereading the verbatim transcriptions or written responses. Holloway and Wheeler (2006:281) note that data analysis is an iterative activity, meaning that the researcher moves back and forth from collection to analysis and back again, refining the answers sought from the data.

According to Kovacs (2007:72), the content analysis used in the present instance entails the following: The essential meaning of the topics or subjects dealt with is extracted from the verbal and written versions of the recorded data and then separated into constituent concepts, which are then categorised into units such as ideas, themes, activities, attributes, and time or space measurements. The researcher followed the stages outlined in Holloway and Wheeler (2006:282) as follows:

- **Transcribing interviews**

The researcher transcribed the audiotape recordings made in the process of data collection in order to become fully conversant with the content and ensure its confidentiality (which could be compromised by involving third persons). A separate file was created for each of the nine respondents. Every interview was documented separately in numerical order with a front sheet reflecting the date, location and time of the relevant interview, as well as the participant's code number.

The researcher took notes to capture the flavour and behaviours expressed in participants' words, facial expressions, gestures and reactions generally. To avoid the possibility of disturbing the flow of the interview and therefore the participant's authenticity, the notes were taken immediately after the interview in the participant's presence and were duly reflected in the researcher's analytical memos.

- **Organising, ordering and storing data**

Details of time, location and attendant comments were provided with all transcripts and field notes. As noted, participants were numbered to preserve confidentiality. Data were recorded, cross-checked and labeled. All materials and files were stored in a locked closet for safety and security.

The researcher used the horizontal pass during initial process of data analysis because it is more holistic. The researcher read the data; look at themes, emotions and surprises. The researcher also did reflective and in-depth reading of the data to find supportive evidence for these themes. The researcher then re-read to identify elements that might have been overlooked. Following this, the researcher searched for possible alternative meanings and attempted to link discrepancies together.

- **Listening to and reading collected data**

As noted, the researcher used an analytical style in the instance under review, reflecting on each transcript, searching for and recording significant statements, then deleting repetitive and overlapping statements so that only invariant constituents of the phenomenon were left, then organising these into themes. In addition, the researcher included verbatim quotes from the data as these quotes from the data to capture the texture of the experience as told by the participants. Finally the researcher developed a description of the meanings of the experience.

- **Coding and categorising**

Holloway and Wheeler (2006:286) explain coding as marking sections of data and giving them labels or names. Blanche, Durrheim and Painter (2006:189) explain that coding involves applying a set of rules to recast the data in a different form. The researcher used descriptive, *in vivo* coding to explore the data, singling out words used by participants to prevent imposition of the researcher's own frame of reference/perceptions and ideas on the data. The researcher resorted to open coding which entailed labelling specific pieces of data.

- **Building themes**

The researcher started with a mass of codes that were reduced so that each one represented a specific concept. Coding was done paragraph by paragraph. The researcher took care not to impose preconceptions but to defer rigorously to ideas emerging from analysis of data gained from participants. Each note in a transcript was read and reread, observations and experiences were recalled, and the audiotape recordings were replayed to ensure familiarity with the information disclosed by participants.

As noted, tone and emphasis were gauged from listening to audiotaped interview data. The researcher made use of data reduction to reduce the volume and thereby facilitate examination. Reduction was done by subsuming new data under established themes and then adding new themes as they emerged. This process led to a reduced list of themes.

2.6 TRUSTWORTHINESS

According to Speziale and Carpenter (2007:48), trustworthiness in qualitative research is concerned with rigour or soundness, therefore with accurate representation of participants' experiences, to which end the constituent properties of trustworthiness are required, namely credibility, dependability, conformability and transferability. Speziale and Carpenter (2007:97) further emphasise that to ensure trustworthiness of data analysis the researcher needs to return to each participant and ask if the detailed description reflects the participant's experiences, hence following the interview for each and every participant, the researcher repeated what the participant said and asked the participant if that was exactly what she or he said and the participant will confirm that by affirming to the information. Speziale and Carpenter (2007:98) further recommend that the researcher should request negative descriptions of the phenomenon under investigation in order to establish authenticity and trustworthiness of the data.

In this study, the researcher ensured trustworthiness by adhering to four criteria that support trustworthiness: Credibility, Dependability, Conformability and Transferability. Holloway and Wheeler (2006:303) emphasise that credibility ensures that participants recognise the meaning that they themselves give to a situation or condition and the

'truth' of the findings in their own social context. In this study, the researcher made use of the following procedures for aiding the believability of research findings as stated by Stommel and Wills (2004:289):

- *Prolonged engagement* whereby the researcher immersed in the research process became truly engaged with the research, established valid and meaningful relationships with participants. It is therefore, the reason why the researcher consulted participants on their first month of starting the course, in January 2012 and only performed interview in November 2012 (by that time participants were exposed to clinical areas for twenty weeks, which is 800 hours) ,but continue to keep in contact with the participants during the year.
- *Peer debriefing* whereby the researcher continued to interact with experienced people such as research committee members of the college, the principal of the college, senior members of Gauteng Department of Health as well supervisors at UNISA.
- *Member checking* whereby participants were given the opportunity to validate (review, add to and revise) the reported findings that described their experience.
- *Triangulation* whereby the researcher consulted multiple sources to examine and validate conclusions about meaning, hence different sources are acknowledged in this study and recommendations of supervisors are acknowledged as they provide alternative interpretations.

Dependability was adhered by ensuring that data is organised in categories and themes. The voice-recorder, transcripts and other materials and documents used for the study were kept safe for an audit trial so that independent or external auditors can make comparable conclusions about the data. Holloway and Wheeler (2006:303) emphasise that confirmability demand intellectual honesty and openness from the researcher, hence confirmability in this study was adhered by ensuring that the data represent the information provided by the participants. Transferability was adhered by ensuring that rich text, thick descriptions and sufficient data was obtained from the participants and reported in the report so that interested others (such as Department of Health, other nursing colleges and their affiliated universities, clinical educators and clinical professionals, SANC as a registering body and community at large) can evaluate the applicability of the data to other contexts.

2.7 ETHICAL CONSIDERATIONS

2.7.1 Ethical principles to assert for the study

Permission to conduct the study was obtained from UNISA, Gauteng Department of Health and the Nursing College. The researcher hereby declares her commitment to the principle that in conducting her investigations, participants' rights, wellbeing and safety always take precedence over research objectives, in token of which four ethical principles were strictly observed in conducting the study under review: autonomy – which refers to participants' right to self-determination in the sense that participation was strictly voluntary, that is, at the discretion of the participant (Stommel & Wills 2004: 380); beneficence – by which is meant the right to protection from discomfort and harm (physical, emotional, spiritual, economic, social or legal); non-maleficence – by which is meant the fundamental obligation to “do no harm”; and justice – by which is meant fairness in the sense explained by (Burns & Grove 2005:180). Justice was conceivably compromised to some extent in the present instance in that the purposive sampling procedure applied involved conscious selection of participants, whereas to be strictly fair, all possible participants (i.e. the entire target population) would have to be given an equal chance to be included in the study. However, applying the principle too strictly in this way could also be compromising fairness in the larger sense that it might militate against achievement of the proper goal at issue, which was to home in specifically on students who had been exposed to the clinical experience of patient deaths and dying in their practical training.

2.7.2 Rights to be protected

2.7.2.1 *Protecting the rights of participants*

- **The right to self-determination**

This right is based on the ethical principle of respect for persons, which proceeds from the assumption that human beings are *ab initio* autonomous and can control their destiny, hence have an essential claim to be treated with due deference to that claim (Burns & Grove 2005:181). In the present instance the right to self-determination was served by fully informing participants about the nature of the proposed study and

deferring to their choice to participate (thereby also implying the unimpeded right to withdraw at any point in the proceedings), hence, participants' written consents were obtained before the interview. Participants were left in no doubt that they were being studied and their permission was elicited to audiotape the proceedings.

All participants participated voluntarily in the study without any coercion. Participants were informed about their right to withdraw from the study without any fear of being victimised, in view of the being students. The withdrawal from the study would not influence their academic performance.

- **The right to privacy**

Participants in a study have the right to determine the extent to which their private information will be shared with or withheld from others, hence their informed consent must be secured for any disclosure of such information, according to Gray (2009:78) not only before, but also at intervals during the interview so that ample opportunity is afforded to withdraw at any time, or to refuse to answer questions considered intrusive. In the present instance the right to privacy was protected in that confidentiality of personal information volunteered by participants was guaranteed verbally and in writing. For example, code names were used to disguise participants' identity. Brink et al (2008:30) emphasise that data collected and codes should be kept in a locked file cabinet at all times and this idea was adhered to.

- **The right to anonymity and confidentiality**

The right to anonymity and confidentiality is in line with the principle of beneficence, doing good and prevent harm. A promise of confidentiality is a pledge that any information participants provide will not be publicly reported in a manner that identifies them and will not be made accessible to others, whereas anonymity occurs when even the researcher cannot link a participant to his or her data (Speziale & Carpenter 2007:65). The researcher respected this right by keeping participants' identities secret (code names were used in the present instance). In this study, collected data were used strictly for research and were kept safely inaccessible to all other parties.

- **The right to fair selection and treatment**

This right is in line with the principle of justice. As noted by Brink et al (2008:33), participants must be selected for reasons directly related to the study problem, not because they are readily available or because the researcher likes them.

Factors ruled out as considerations for inclusion were cultural background, gender, origin, language, age, sexual orientation or religious affiliation, and participants were supported equally without respect to persons (William 2010:170).

- **The right to protection from discomfort and harm**

Categories subsumed under this rubric include emotional, social, physiological and economic discomfort and harm. Burns and Grove (2005:190) emphasise that it is incumbent on the researcher to examine the balance of benefits and risks involved in factors impinging on the study so that termination of the study can be considered if risks outweigh benefits.

Protection of this right in the present instance involved monitoring participants' behaviour for signs of discomfort or harm so that they could be referred for counseling if the need arose; furthermore assurances of confidentiality were given as discussed to protect participants against possible victimisation by superiors on grounds of their disclosures during the interviews.

2.7.2.2 Protecting the rights of the institution

The rights of the institution were protected by obtaining prior consent from the principal of the college where participants were undergoing training (see above). By the same token the researcher deferred at all times to the relevant regulatory frameworks imposed in this regard by the Gauteng Department of Health, the Ethical Committee of the College, and the Department of Health Studies Higher Degree Committee at UNISA.

2.7.2.3 *Scientific integrity of the research*

The researcher has ethical responsibilities associated with the conduct and reporting of the research. All sources consulted for the purposes of conducting the study have been duly acknowledged. The researcher hereby declares that no fabrication, falsification, forging of information or misrepresentation of what was done occurred in the process of conducting the study, nor were the design, methods and data manipulated in any way that could possibly create an unauthentic impression. Furthermore the subject matter as reported here is hereby declared free from plagiarism or irresponsible behavior such as inappropriate participation.

2.8 CONCLUSION

This chapter covered the research design and method, as well as the approach to and process of data collection. Data analysis was discussed with particular reference to content analysis. Also included were interview transcription, organising, ordering and storing of data, reviewing collected data by listening to audiorecordings and reading printouts; finally theme building was also discussed.

Particular care was taken to foster trustworthiness and authenticity. Due attention was also paid to ethical considerations, with particular reference to preservation of participants' rights, namely autonomy, beneficence, non-maleficence, privacy/confidentiality and justice. Data analysis will be covered in chapter 3.

CHAPTER 3

DATA ANALYSIS AND FINDINGS

3.1 INTRODUCTION

This chapter reviews management, analysis and the results of analysing interview data. Whereas Brink et al (2008:170) explain that data analysis entails organising and presenting data with a view to addressing research questions effectively, Gray (2009:943) comments that it is a rigorous logical process of attributing meaning to data while preserving the uniqueness of each participant's experience as reflected in the interview data. Analysis covered the identified themes and sub-themes and discussion of identified themes as well as sub-themes.

3.2 DATA MANAGEMENT AND ANALYSIS

As indicated in the previous chapter, the researcher used content analysis to analyse data collected for the study. As discussed in chapter 2, the researcher followed the stages outlined in Holloway and Wheeler (2006:282) and William (2010:139) to analyse data and these stages as explained are: Transcribing interviews whereby each file was transcribed verbatim; organising, ordering and storing data whereby the researcher used horizontal pass to read the data; look at themes, emotions and surprises; listening to and reading collected data whereby the researcher used analytical style to reflect on each transcript and searched all relevant statements; coding and categorising data; building of themes and sub-themes.

Data management was done in line with content analysis whereby codes were identified, categorised into main and sub-categories, labeled and integrated into themes to form a coherent whole. The coded data was tabulated under the headings: "themes" and "sub-themes". Identified themes and sub-themes are shown in table 3.1 and then follow the discussions.

Table 3.1: Identified themes and sub-themes

THEMES		SUB-THEMES	
1	Knowledge	1.1	Lack of knowledge
		1.2	Denial
		1.3	Empowerment
2	Emotional trauma	2.1	Unexpected event
		2.2	Terrified
		2.3	Stressed
		2.4	Insomnia
3	Low self-esteem	3.1	Feeling useless
		3.2	Not belonging
		3.3	Loss of confidence
4	Nutritional disorder	4.1	Lack of appetite

3.2.1 Theme 1: Knowledge

Du Toit and Van Staden (2000:31) observe that people accumulate facts, information and skills that are eventually formalised. Wallace (2007:15) notes that knowledge is a fluid mix of framed experience, values, contextual information, expert insight and grounded intuition that accumulates overtime in people's minds and that provides an environment and framework for evaluating and assimilating new experiences and information, thereby expanding the existing store. Naturally, knowledge in the present instance includes the first-year student nurses' experience of patient deaths and dying, which is the overriding matter at issue.

Gray (2009:341) emphasises that the researcher must make sure that participants participating in the study actually have the knowledge to be placed on record; hence selection of subjects from first-year students who had in fact experienced patient deaths and dying during their clinical engagement, including first as well as well as subsequent encounters with the phenomenon.

3.2.1.1 Sub-theme 1.1: Lack of knowledge

In this regard, Wallace (2007:46) refers to people's lack of assimilation of facts, information and skills deemed necessary for a particular purpose in that such absence of knowledge prevents them from making sense of the world (Feldman 2005:320) as a holistic mental construct and reference framework within which they can interpret and

understand events and conjunctures; it therefore also prevents them from assimilating new information constructively so that it forms part of an integrated whole.

Wallace (2007:47) affirms that a social environment has a conditioning effect on members of the society concerned in that it engages them in activities that strengthen certain purposeful impulses that serve as eternal stimuli that (Wallace 2007:181) are necessary for the proper operation of the human nervous system to the extent that without these stimuli the brain cannot reason, process information nor generate new information. In the present instance subjects' lack of knowledge is attested by the following quotes:

"I didn't know the signs of a person who is gasping or who is dying and I didn't even know what gasping is. I just relied on rumours that I once heard, that a dead person feels 'cold'."

"I was expected to provide care that I do not know."

"I had no knowledge of how to handle a dying patient. Sisters just shut us out when we ask things."

"We didn't even know that the patient has passed away as we just continue to bath him."

"I and my colleague were arguing if the patient is dead or not because we were not sure."

"I did not know how to tell the relatives that their patient is dead."

"To me, the patient was just having fits, only to find that he was actually gasping. I did not know how a patient who gasps present with."

"I was only made aware by my colleague who experienced death before, that the patient is dead."

“I was not even psychologically prepared to deal with death and dying of a patient. Sisters in the wards do not give us an opportunity to learn, they do not show us how to deal with death and dying, they do not support us. Clinical lecturers are never available. There are no counselors to help us after exposure to death. There is no debriefing.”

Death and dying are poorly understood phenomena. For instance, the basic distinction between them is that dying is a process whereas death is an event. In light of this fact it should be noted that the dying person has to work through psychological responses to the reality of approaching death to arrive at a final and peaceful acceptance of that reality (*Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing and Allied Health*). Liechty (2000:257) concurs and adds that death is a very complex symbol in the human psyche.

The study done by Germain (1980:48) revealed that although many student nurses are theoretically taught how to take care of a dying patient they are hardly exposed to actual preparation for the event, which explains why participants in the study under review indicated that they could not discern whether patients in their care were dead, moreover lacked the experience and understanding to deal with and inform relatives of patient deaths. This observation is confirmed by Mallory and Allen (2006) who note further that student nurses receive little support from clinical professionals and instructors in this regard. Terry and Carroll (2008:762) endorses the need to prepare student nurses adequately for patient deaths and dying, and Grealish and Ranse (2009:86) note that as a rule student nurses perceive situations eliciting powerful emotions as triggers for learning, but naturally tend to be troubled by severely trying situations, such as the degradation and annihilation of patient deaths and dying, which in the present instance were experienced as traumatising. The above information clearly points to an urgent need for first-year student nurses to be duly prepared for the clinical experience of patient deaths and dying.

3.2.1.2 Sub-theme 1.2: Denial

Berman, Snyder, Kozier and Erb (2008:1101) note that denial in Kubler-Ross's stages of grieving takes the form of refusal to believe that loss is happening, such refusal often being evident in the assumption of an air of artificial cheerfulness to prolong denial.

Denial is often attributable to inadequate knowledge and information about death and dying. On the part of participants, denial was evident from statements made by participants in the study under review. For example:

“I kept on arguing with my colleague that the patient has pulse, I guess I was in a denial.”

Young, Van Niekerk, and Mogotlane (2003:243) observe that extreme denial prevents sharing and discussion of unrealistic fears, thus blocking meaningful communication. Smeltzer, Bare, Hinkle and Cheever (2010:2155) assert that denial protects a person from the trauma of fully realising the painful and disturbing aspects of reality.

3.2.1.3 Sub-theme 1.3: Empowerment

According to Page and Czuba (2009:1077), empowerment is a multidimensional social process that helps people to gain control over their lives, thereby fostering power in that it extends their capacity to deploy measures that enable them to gain advantages in their interaction with others, advantages that they consider critical for their well-being on a personal as well as a communal level. It is similar to a path or journey in that it develops in due course and proceeds from the premise that power is not a finite entity but can expand indefinitely in tandem with our lived experiences rather than our preconceived notions, in token whereof it exemplifies the basic need and guaranteed right to autonomy shared by all human beings. The assertion of it tends to increase autonomy and coping skills, causing a feedback loop that further promotes autonomy and, in so doing, is likely to reduce inequalities (Tengland 2012:101). The following are quotes from participants' testimony relating to terminally ill patients:

“I have learned a lot, now I know what bacterial meningitis is, what are the signs of bacterial meningitis and I am now confident to nurse the patient with bacterial meningitis. Even in examination, I can get a distinction.”

“I am no more ignorant now, I know what to do. I also know that I am not supposed to stigmatise a sick person because after all he is still a human being. I can now treat patients with respect.”

“I think I am now empowered because now I can treat patients with respect and dignity, unlike the first time when I start the course.”

Furthermore, the statement is positively supported by Smith-Stoner, Hall-Lord, Hedelin and Petzäll (2011:274) who report that students considered caring for patients in the last part of life a momentous yet nevertheless rewarding responsibility. In addition, Vlok (2010:343) confirms that if the nurse has helped the patient to die with dignity and acceptance of his or her mortality, she will indeed experience vocational fulfillment.

3.2.2 Theme 2: Emotional trauma

Louw and Edwards (2011:425) explain emotion as a feeling that motivates, organises and guides perception, thought and action. Words such as anger, sadness, hunger, disgust, boredom, homesickness, love, curiosity, stress and jealousy are expressions that relate to emotion. *Longman’s Dictionary of Contemporary English* (2006:1130) explains trauma as damage to the mind caused by a sudden shock or terrible experience.

Emotional trauma was evident from feelings expressed by participants about their experience of deaths and dying of patients in the course of their clinical duties. Sub-themes that emerged under this rubric were signified by terms such as “unexpected event”, “terrified”, “stressed” and “insomnia”.

3.2.2.1 Sub-theme 2.1: Unexpected event

An unexpected event can be described as an incident or accident that is anomalous or fortuitous (i.e. inexplicable in terms of a foreseeable outcome of a recognisable chain of cause and effect). Such incidents impede safety investigations, inspire fear rather than mindfulness in people who do safety-critical work, make organisations more bureaucratic rather than more careful, and encourage professional secrecy, evasions and cocooning protection of the self. According to Dekker (2012:176), a safety culture is a just culture in the sense that unforeseeable events or contingencies are largely ruled out by cautious or safety conscious behaviour predicated on the vital interests of all concerned. A culture that is predicated on a sense of justice depends on the reporting of failures and problems, on openness and information sharing.

The following quotes attest participants' experiences of unexpected events or contingencies encountered in the performance of their clinical duties:

"This patient was so young, 22 years and suddenly he is no more alive!"

"The patient was a child. The mother visited and brought some fruits for the child, only to find that the child is no more alive."

"The patient was stable, ready to be discharged. The next day I was told he is in ward 10, meaning he is dead."

"Students should be given time to acclimatise themselves first before they are forced to lay corpses and students should be given a chance to observe the procedure of laying of a corpse before it is expected of us to lay the corpses. It was so soon for us to be expected to lay corpses as we were still new. Tutors must come frequently in the wards to lay corpse while we observe first!"

Friedman and Friedman (2003:272) remarked on the justifiability of unexpected events such as patient deaths and dying by postulating that some people die young and unfulfilled, hence, to those who remain behind may view this as unfair situation. Some people live longer than expected.

3.2.2.2 Sub-theme 2.2: Terrified

According to the *Oxford English Dictionary* (2007:461), the word "terrified" implies overwhelming, often paralysing fear, thus indicating that participants experienced fear after providing end-of-life care. The experience is documented as follows:

"As I close the eyes of a patient who according to me was dead, then the relative told me that I was not supposed to do that. I became more scared. When I am alone, I would be afraid when I think of that patient."

"When I lay a female corpse, I become more scared, thinking: What if I can lose my mother?"

“When we open the corpse to lay it, I got scared. I dodged by entertaining other students by talking so that they can be the ones laying the corpse. Later they called me to help them to turn the corpse. Whilst turning, air came out of the patient. I left the patient and ran away.”

“I went out, locked myself in a toilet and started to cry.”

“For a very long time I had flash-backs of the patient.”

“It was very traumatic. I called my mother and we prayed together over the phone.”

“I was shocked and I ran out of the ward without reporting to anyone. I did not come back to the ward that day.”

“I begged the sister not to let me lay the corpse as I was scared and not ready yet to lay the corpse, but she did not care, she forced me lay such corpse.”

The statement is positively supported by Parry (2011:450) who confirms that the mentorship role is critical in nurse education, failing which students may find that they lack the skills to deal with patients' death and dying and may therefore be traumatised beyond their capacity to cope with such experiences.

3.2.2.3 Sub-theme 2.3: Stressed

Stellenberg and Bruce (2007:602) explain stress as a disruption of meanings, understanding and smooth functioning with the result that harm and loss are experienced and sorrow intervenes and reinterpretation and acquisition of new skill are required. According to Swart, De la Rey, Duncan and Townsend (2008:402), stress is a set of physiological, psychological and behavioural reactions serving an adaptive function. Fermie and Shepherd (2011:143) as well as Goliszek (2003:10) enumerate the signs and symptoms of stress, including mood swings, depression, anxiety, unusual aggression, withdrawal, compulsive eating or dieting, sleeping disorder, poor mental

performance, stomach acidity, change in bowel habits, breathing problems, palpitations and migraine.

Stress reactions are exemplified in the following observations made by participants on experiencing a patient death or dying:

“I was stressed as I could not cry; I was told that nurses are not supposed to cry.”

“It was hurting and stressing to see that the patient is no more alive.”

“Sisters in the wards are very much impatient towards students, they do not understand, it is like they were never students themselves. I guess I understand why other students quit the course because I also felt the same. Even when the sister saw that I was emotionally touched by the dead of a patient, she did not care, she just said: “oh, you are crying for a dead patient”. I begged the sister not to let me lay the corpse as I was scared and not ready yet to lay the corpse, but she did not care, she forced me lay such corpse.”

Parry (2011:450) maintains that helping terminally ill patients to come to terms with the imminence of death is highly demanding and often stressful. He notes further that student nurses experience shock and panic attacks when dealing with dying patients. They feel inadequate in that they are at a loss for words in speaking to rather the relatives or the dying patient.

3.2.2.4 Sub-theme 2.4: Insomnia

Berman et al (2008:1172) describe insomnia as a sleeping disorder in the sense that the victim of the condition cannot fall asleep or achieve the sound, so-called REM sleep to the extent required for sustainable mental alertness and a sense of well-being. The researcher confirms that participants suffered from insomnia as a stress symptom after exposure to patient deaths and dying in the course of their clinical practice. The following remarks made by participants when questioned in the interviews attest this stress reaction:

“I could not sleep at nights, I kept dreaming about this patient.”

“I kept hearing this patient’s voices at night saying: ‘why did you kill me’? I felt that I killed the patient because I performed some exercises, only to find that I was not supposed to do that because the patient had Bacterial meningitis.”

“I think that this patient’s ghost is haunting me because every time I tried to sleep, I see his face”.

“It was very hard. I could not sleep. I moved out of nurses home so that I can always be with my mother”.

This reaction is confirmed by Zambrano and Barton (2011:833) who note that dealing with patient deaths and dying results in emotional reactions such as shock, sadness, guilt, stress shock, frustration and anger as anticipatory grief.

3.2.3 Theme 3: Low self-esteem

Louw and Edwards (2011:449) note that self-esteem, which ranks high on Maslow’s hierarchy of human needs, concerns personal prestige, a sense of independence, competence and self-respect that is indispensable for interpersonal relationships and mental health. Tajfel (2010:33) observes that self-esteem should be empowered by its own imprimatur and energy to justify itself. Feldman (2005:123) emphasises that unlike the self-concept, which encapsulates the overall self-image or profile – like a self-portrait in the round including personal traits in general – held of him- or herself by the person concerned, self-esteem is a valuation placed on the self by a person in virtue of a generality of impressions produced endogenously as well as in reaction to the external environment, including especially other persons.

According to Swart et al (2008:132), low self-esteem proceeds from a perceived inability to meet a self-imposed standard. Once this perception has taken root the person’s will to achieve will be undermined because the person will regard him- or herself as inherently inclined to fail.

Sub-themes: feeling useless, estranged and lacking in confidence. Each of these subthemes will be considered separately.

3.2.3.1 Sub-theme 3.1: Feeling useless

Tajfel (2010:337) explains that a person who considers him- or herself incapable of meeting goals set by the group to which he or she belongs will tend to feel useless in the group and will therefore tend to leave the group. Participants in the study at hand considered themselves to be in this category because of their perceived failure to meet the common goal of the nursing profession, which is to preserve life. They expressed this perception as indicated by the following examples:

“I felt so useless and guilty for not knowing how a dead person looks like.”

“I did some passive exercises on the corpse, thinking I am helping the patient, only to find that I am killing the patient. I feel so useless.”

3.2.3.2 Sub-theme 3.2: Not belonging

Tajfel (2010:67) explains that belonging is a process whereby a person is located within a system of social categorisation according to his own or a collective extraneous valuation. It also subsists, thus Tajfel (2010:68), in a person’s sense, born of a secure awareness, of belonging to the group concerned. That is to say, it subsists in an emotional bond that ties the person to the group. A sense of not belonging occurs when a person cannot be located in a social category as indicated above.

Participants engaged in the study at hand voiced their subjective sense of not belonging in utterances such as the following:

“I feel that I do not belong to this profession. If I do belong, then why is it that two patients – two patients died in my care?”

“I did not even perform procedure such as resuscitation to save a patient’s life because I did not know such procedure. Had I known this procedure, I

would have saved this patient's life. Now I feel that I do not belong in this profession as I cannot save life."

"I actually wanted to quit the course because I felt that I do not belong."

3.2.3.3 Sub-theme 3.3: Loss of confidence

The *Oxford English Dictionary* (2007:94) defines confidence as certainty of the ability to achieve or accomplish a feat of some sort. Loss of confidence therefore means the opposite, namely a sense of incapacity that saps or undermines the person's ability to achieve or accomplish the feat concerned. This sense of incapacity then becomes a sense of being inferior to others and of doubtful self-worth and, therefore, self-mistrust and inhibited behaviour. According to Nelson (2010:6), loss of confidence is synonymous with hopelessness, pessimism, dejection, depression, despair, disappointment, discomfiture, dismay, downheartedness, melancholy, sadness, cold feet, low spirit and the blues. Participants in the study under review vowed loss of confidence in utterances such as the following:

"I do not feel confident at all. Every time there is a patient who is dying, I make sure that I stay away. I do not feel like a nurse at all. We, students, feel useless in the wards."

"Every time I see the screen closed, I will suspect that it is a corpse and 'I take short-left'- meaning I run away or I make sure that I stay away and I do not feel like I am a nurse at all."

Mutto, Erra'zquin, Rabhansl and Villar (2010:1445) affirm that when student nurses have to take care of the dying without being briefed for the purpose, they are inclined to fall prey to bouts of anxiety emanating from a fear of death and therefore tend to shy away from dying patients, with the result that they develop a sense of inferiority and unworthiness that tends to harden as a conviction of not belonging to the profession. Kelly and Nisker (2010:426) note that students identified death of a patient as a failure to provide adequate care, with the result that they avoid reflection on death and dying and therefore fail to develop a very necessary element in the complement of professional competencies required of them. According to Peterson, Johnson

Halverson, Apmann, Chang, Kershek, Scherr, Ogi and Pincon (2010:182) student nurses who do not cope effectively with the death of their patients are inclined to become increasingly distant and uncommitted in their attitude towards and treatment of patients.

3.2.4 Theme 4: Nutritional disorder

Nutritional disorder is describe by Smeltzer et al (2010:43) as a failure of the digestive system of a human being to digest, absorb, metabolise and store essential nutrients necessary for the body processes and functions. The condition is discussed here as a psychosomatic disorder in that its physiological manifestation is largely attributable to emotional factors. Participants' testimony clearly indicated the presence of this condition among participants at the research site.

3.2.4.1 Sub-theme 4.1: Lack of appetite

Lack of appetite is described by Smeltzer et al (2010: 88) as inadequate consumption of food or calories, resulting in deficiency of vital nutrients. As indicated under the heading "Stress" above, loss of appetite, like compulsive eating and/or dieting, is often a stress signal (Fermie & Shepherd 2011:143). Heinrichs and Koob (2004:427), Tsigos and Chrousos (2002:865) as well as Bernier and Craig (2005:982) explain the effect of Corticotropin-Releasing Factor (CRF) in the brain during stress. According to these sources CRF stimulates the sympathetic nervous system, thus suppressing appetite. In addition, Smeltzer et al (2010:88) note that bodily distress causes changes in hormonal secretion that may either stimulate or suppress appetite.

The following testimony gained from a participant attests the condition as a reaction to the stressful experience of patient deaths and dying:

"I could not eat after the incident. I was even admitted and the doctor diagnosed me as having nutritional disorder."

Taking from the above statement, it means participants who are in their first year could suffer from lack of appetite by facing death and dying. This can happen where there is no adequate supervision when in the clinical area.

3.3 CONCLUSION

This chapter discussed data management, data analysis, results and findings. The researcher used content analysis as a method to analyse data. Themes that emerged during data analysis were knowledge, emotional trauma, low self-esteem and nutritional disorder. Sub-themes for knowledge were lack of knowledge, denial and empowerment. Sub-theme for emotional trauma were unexpected event, terrified, stressed and insomnia. Sub-theme for low self esteem were feeling useless, not belonging and loss of confidence. Sub-theme for nutritional disorder was lack of appetite. The next chapter will discuss research findings.

CHAPTER 4

DISCUSSION OF THE FINDINGS AND LITERATURE CONTROL

4.1 INTRODUCTION

Chapter 3 presented an analysis of collected data. This chapter deals with the findings derived from the said data. The researcher attempted to gain insight into and understanding of experiences related by participants with regard to patient deaths and dying in the course of their clinical commitments. The findings are categorised under the themes discussed in chapter 3, namely: Knowledge, Emotional trauma, Low self-esteem and Nutritional disorder, and the overall subject matter of the chapter will be presented under the headings research results, main findings of research, general findings of research and concluding statement. That is to say, the themes will be discussed under each of the headings.

4.2 RESEARCH RESULTS

Data analysis led to the following findings and results:

4.2.1 Theme 1: Knowledge

This theme revealed that participants were not aware of the signs indicating approaching death but were nevertheless expected to deal effectively with cases of patient deaths and dying. Testimony to that effect includes statements such as the following:

“I didn’t know the signs of a person who is gasping or who is dying and I didn’t even know what gasping is. I just relied on rumours that I once heard, that a dead person feels ‘cold’. We didn’t even know that the patient has passed away as we just continue to bath him. I and my colleague were arguing if the patient is dead or not because we were not sure.”

Based on the above statement, it can be assumed that clinical professionals in the wards were not supporting participants by preparing them psychologically for the stressful task of dealing with cases of patient deaths and dying. They did not offer students detailed guidance concerning the various aspects of patient deaths and dying so that the students could at least be relatively well-informed about such matters and so that professionals in turn could be informed by the students if they were traumatised by their experience of patient deaths and dying and needed to be referred for counselling. This lack of support was attested by participants' utterances. For example:

“Sisters just shut us out when we ask. Sisters in the wards do not give us an opportunity to learn, they do not show us how to deal with death and dying, they do not support us. They do not show us how to lay a corpse. Clinical lecturers are never available. There are no counselors to help us after exposure to death. There is no debriefing.”

The theme also revealed that students were not briefed about communicating with the bereaved in cases of patient deaths and dying. This fact was attested by participants as follows, for example:

“I did not know how to tell the relatives that their patient is dead”.

The above findings are supported by Kelly and Nisker (2010:422) who did research and found that many student nurses felt inadequately prepared by their curricula for experiences related to patient deaths and dying in clinical contexts. In the study done by Watkins et al (2011:4) student nurses reported uncertainty about handling situations such as patient deaths and dying, and in their ignorant state were expected to cope, with the result that they did not measure up to the requirements of their occupational conditions, which included a variety of stressful situations. In addition, Smith-Stoner et al (2011:271) note that it would behoove academic and clinical educators to be cognisant of individual differences between nursing students' perceptions of and attitudes about patient deaths and dying, and about death in the main as it would help them to deal effectively with the needs of their charges. This observation is borne out by participants' statements, for example:

“I have learned a lot, now I know what bacterial meningitis is, what are the signs of bacterial meningitis and I am now confident to nurse the patient with bacterial meningitis. I am no more ignorant now, I know what to do. I can now treat patients with respect and dignity”.

In agreement, Costello (2006:595) confirms that despite the contextual variation and complexity of good and bad experiences about death and dying, the experiences facilitate effective functioning involving the features of control, knowing the diagnosis and respecting individual dignity and autonomy. In addition, Ying-Chun et al (2010:857) observe that experiential learning as a teaching method entails giving students opportunities to experience situations actively in order to assist their personal and professional growth, for instance by becoming aware of their feelings. Shane (2011:186) notes that experiential learning provides a sounding board that enables the learner to appreciate the deeper meaning and spiritual aspects of life, thus leading to self-discovery and a confident belief in care for others as a guarantee of the continuity of life.

4.2.2 Theme 2: Emotional trauma

The researcher found that as a result of their ignorance about death and dying students failed to appreciate that death can overtake anyone at any age, young or old, and that health is by no means a fixed and self-evidently permanent state of being, but that it is subject to change that can be sudden and drastic, and that it can make life's journey very uneven at any rate. They were therefore shocked and traumatised to discover the impermanence, frailty and instability of human existence when they were confronted by cases of radical alterations in patients' health from day to day or even by the hour, as well as patient deaths and dying, in the course of performing their clinical duties. This observation is attested by statements such as the following:

“This patient was so young, 22 years and suddenly he is no more alive! The patient was a child. The mother visited and brought some fruits for the child, only to find that the child is no more alive. The patient was stable, ready to be discharged. The next day I was told he is in ward 10, meaning he is dead.”

In further corroboration, Terry and Carroll (2008:763) found that some students suffered from emotional distress and flashbacks (i.e. violently relived memories of traumatic experiences) caused by exposure to patient deaths and dying for which they were ill-prepared by their state of ignorance about such events. Hung-Lan and Volker (2009:581) adduce evidence that emotional distress in such cases may also be attributable to students' sense of failing to meet their prime objective of preserving life.

4.2.3 Theme 3: Low self-esteem

As a natural corollary of the emotional distress treated above, the theme revealed that students notably experience a sense of uselessness as a result of their perceived failure to preserve life when they encounter patient deaths and dying in the course of performing their clinical duties. Remarks such as the following attest to this experience:

"I felt so useless for not knowing how a dead person looks like. I did some passive exercises on the corpse, thinking I am helping the patient, only to find that I am killing the patient. I felt so useless."

A further corollary of low self-esteem in this theme is that students feel guilty and tend to blame themselves when a patient dies or takes a turn for the worse while in their care. Consider the following confirming statements made by participants in the study under review:

"I felt guilty for not knowing how a dead person looks like. Why is it that two patients – two patients died in my care? Then it means I am the one not doing the right thing."

As noted, students' reaction to the death of patients in their care became evident in their professed sense that they did not belong in the nursing profession and had been mistaken in choosing it as a career. Utterances to that effect included the following statements made by participants during interviews:

"I feel that I do not belong to this profession. I did not even perform procedure such as resuscitation to save a patient's life because I did not know such procedure. Had I known this procedure, I would have saved

this patient's life. Now I feel that I do not belong in this profession as I cannot save life. I actually wanted to quit the course because I felt that I do not belong."

Furthermore, student nurses lose confidence when a patient dies or the patient's condition changes while in their care. Such loss of confidence is expressed by such statements as:

"I do not feel confident at all. Every time there is a patient who is dying, I make sure that I stay away. I do not feel like a nurse at all. We, students, feel useless in the wards. Every time I see the screen closed, I will suspect that it is a corpse and 'I take short-left'- meaning I run away or I make sure that I stay away."

The above findings are corroborated by Peterson, Johnson et al (2010:181). Mutto, Erra'zquin, Rabhansl and Villar(2010:1446) observe that nurses tend to disengage from patient care and communication with the patient's family when the patient undergoes suffering, and that such withdrawal is often associated with a sense of guilt on the part of the nurse (Zambrano & Barton 2011:848).

4.2.4 Theme 4: Nutritional disorder

Stress caused by exposure to patient deaths and dying manifested in different ways, including loss of appetite. The theme revealed that participants' encounters of dealing with death and dying of patients caused stress which manifested itself by lack of appetite. This effect is evidenced by the following statement recorded during the interviews:

"I could not eat after the incident. I was even admitted and the doctor diagnosed me as having nutritional disorder."

This finding is supported by Tsigos and Chrousos (2002:865) as well as Bernier and Craig (2005:982) who explain that when a person is stressed Corticotropin-Releasing Factor (CRF) will be high, thus stimulating the sympathetic nervous system, with the result that the appetite is suppressed.

The key findings of the research are indicated below in keeping with the information given in this section.

4.2 KEY FINDINGS OF RESEARCH

The study showed that participants, when exposed to dealing with death and dying of patients during clinical practice, will present with alteration in some basic needs outlined by Maslow in Maslow's hierarchy of needs. The following needs were evident as altered:

- **Altered physiological need**

This need was identified as altered because of lack of appetite. This occurred post exposure to patient deaths and dying in the course of clinical duties.

- **Altered love and belonging need**

The need was identified as altered based on participants indicating that dealing with death and dying of a patient made them to realise that they do not belong the nursing profession.

- **Altered safety and security need**

After experiencing patient deaths and dying, participants felt that they could not safely take care of patients in their charge.

- **Altered self-esteem need**

Most participants indicated a sense of uselessness after they had been exposed to patient deaths and dying in the course of performing their clinical duties.

- **Altered self-actualisation need**

Some participants acknowledged that they experienced a loss of confidence after their exposure to patient deaths and dying.

In addition to alteration in Maslow's hierarchy of needs, the study revealed the following:

- **Emotional trauma**

Participants indicated that they had been severely traumatised by exposure to patient deaths and dying.

- **Nursing as a challenging profession**

After exposure to patient deaths and dying, participants expressed the opinion that nursing was a highly challenging profession.

- **Experience as the best teacher**

Some participants indicated that they had found their nursing practice highly informative and beneficial as an aid to gaining professional knowledge and expertise, with particular reference to medical conditions of which they had no prior knowledge when they joined the profession.

4.3 GENERAL FINDINGS OF RESEARCH

The following general findings were identified:

- **Lack of/inadequate knowledge and skills**

The study revealed that participants were not adequately equipped with the knowledge and skills needed to deal with patient deaths and dying in the course of performing their clinical duties, with particular reference to procedures such as resuscitation and laying a corpse. A vexing problem that militated against acquisition of adequate knowledge and skills in this regard was the congested block programme (chapter 1, section 1.2.2 which does not allow students to spend enough time in clinical areas).

According to the Gauteng Nursing Colleges Curriculum (2002:16), it is prescriptive for first-year student nurses to spend 1000 hours, spread over a year, performing practical clinical duties, and what remains of the year attending classes, tests, examinations, and taking vacation leave. Unfortunately the hours of practical exposure are not enough to equip students adequately to cope with patient deaths and dying since the students are in fact rank novices who need time to adjust to the conditions that typify the nursing profession, especially where the rather drastic and potentially traumatising experience of patient deaths and dying is concerned. Bruce (2012:1) takes the view that theory and practice should be divided equally in students' training programme so that they can be decently prepared for the contingencies of taking care of patients, particularly where patient deaths and dying are concerned. The present uneven allocation of 26 weeks to theoretical versus 22 weeks to practical duties poses a significant barrier to such preparation.

- **Lack of adequate supervision, mentoring and role modelling**

The study revealed that participants did not receive adequate supervision from clinical professionals as expected. There is lack of adequate mentoring and role modelling to assist student nurses to adjust and settle effectively into the routines and generally adjust to the conditions that typify the nursing profession. This statement is supported by what amounted to a *crie de coeur* (cry from the heart) from the participants, complaining that nursing professionals (sisters and lecturers) treated them with cold-hearted disdain instead of offering the guidance and instruction they truly needed in order to cope adequately with the vicissitudes of their professional task, with particular reference to patient deaths and dying.

There are only ten (10) clinical lecturers and 450 first-year student nurses at the nursing college where the study under review was done, thus amounting to a ratio of 40 students to 1 lecturer. This is not an acceptable ratio in terms of the provisions of the South African Schools Act (South Africa 1996:12) which indicates a maximum ratio not exceeding 1:30 as optimal for the purposes of effective instruction of and individualised supervisory attention to students on the part of teaching staff. Apart from the inadequate numbers of teaching staff compared to students, clinical professionals are frequently not on hand to mentor students because of the pressure of their official duties as ward sisters (these operatives are also in short supply). As noted earlier, students are

inclined to feel abandoned and therefore develop avoidance behaviour when clinical mentoring/teaching attention is wanting and they are left alone, unobserved and unsupervised (Terry & Carrol 2008:760; Carlos et al 2009:5; Ilhaam 2010:3). This was clearly the situation reflected by responses gained from participants in the study under review.

The disproportion between students and teaching staff is attributable to the high intake of first year student nurses in Gauteng Province. Gauteng department of Health mandated that there must be 10% increase in students' intake annually with a view of reducing unemployment in South Africa as well as dealing with shortage of nurses in the country, hence the said disproportion, the concomitant pressure on all concerned, and therefore the complaint registered by students concerning lack of attention from supervisory staff.

- **Lack of psychological support**

The study revealed that participants were not given psychological support following exposure to a traumatic situation. Most participants noted that they were scared, frightened, terrified, frustrated, shocked, shaking, hurting and stressed following exposure to patient deaths and dying but were never provided with any counselling or any psychological support. The researcher, being able to draw on the experience of routinely assessing students' mental and emotional status as a corollary to the task of teaching in the nursing environment where the conditions of the nursing task are particularly demanding as regards mental and emotional well-being, is confident that participants' responses indicate that they were stressed and had been experiencing trauma in the course of performing their professional task, and that the mental and emotional impact of their experience had been aggravated by being deprived of counselling or psychological support to lessen the impact of their experience (Zambrano & Barton 2011:833; Fermie & Shepherd 2011:143; Goliszek 2003:10). These authors confirm stress experienced and expressed by subjects in their studies as shock, sadness, guilt, frustration, anger, mood swings, deficient intellectual performance, and insomnia.

- **Negative attitudes of some clinical professionals**

The study revealed that negative attitudes of some clinical professionals towards participants posed a challenge leading to frustration among students and therefore becoming a contributory reason for a high incidence of students' premature termination of their course. Participants reported that clinical professionals did not listen to them, nor did they care whether students were coping; in fact the impression was relayed in their responses that the professionals disliked them. The researcher concluded that clinical professionals' behaviour ranged from indifference to fairly pronounced antipathy towards students because they simply did not realise that these junior staff members were rank novices who needed guidance and experience that had to be gained over time to adjust to conditions typifying the profession. The conclusion of the researcher is supported by Timmins and Kaliszer (2002:209) as well as Last and Fulbrook (2003:449) who affirm that tension in relationship between nurse professionals and student nurses lead to student nurses terminating the course.

The following positive finding emanated from the study:

- **Students' empowerment**

The study revealed that negative experience results in constructive incidental learning that tends to countermand the erosive effect of such experience. In the present instance some participants intimated that they had gained both theoretical and clinical knowledge from their experience of patient deaths and dying in the course of their performance of clinical duties. For example, they had become familiar with conditions and treatment thereof in terms of nursing procedures that would otherwise have remained a closed book to them, such as bacterial meningitis. They had also learned how to communicate sympathetically with terminal patients as well as relatives and families without overtly indulging in emotional displays. Responses such as these demonstrated that negative experiences are not necessarily a categorical loss because they are somehow also a profitable learning experience, as noted by participants who indicated that their experience had enabled them to nurse their patients with the requisite confidence.

The positive learning avowed by participants as a corollary of exposure to patient deaths and dying is confirmed by Shane (2011:186) who observes that rather than

eroding the meaning of life such experiences endorse it, leading to self-discovery and infusing it with spirituality and a belief that continuity of life is guaranteed by caring for others; further that repeated exposure to patient deaths and dying reduces the shock of the experience so that the nurse can retain her equanimity, thus gaining rather than losing confidence and self-esteem.

On the other hand, Kotsos (2013:09) remarks significantly in this regard that negative experiences hurt deeply, leaving a residue of disabling pain and suffering because they dominate the victim's consciousness long after their occurrence, with the result that an experience that has only taken place once may effectively be relived a thousand times in the person's mind, thus magnifying its deleterious effect.

However, the harmful effects that can normally be expected from such experiences can be turned into a positive lesson that can become a ticket to success rather than excess baggage that prevents progress.

4.4 CONCLUSION

The chapter covered the findings drawn from analysis of the data gained from the study under review and classified according to key themes and general themes, in that order. With a single exception the findings are all negative, which indicates that participants experienced patient deaths and dying as a significant, not to say formidable, challenge in the development of their careers. Conclusions, limitations and recommendations will be discussed in the next chapter as outcomes of the study.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The researcher investigated first-year student nurses' experiences of encounters with death and dying of a patient during clinical practice. The study was conducted at a nursing college in Gauteng Province in South Africa. After due investigation it is fair to conclude that participants' experiences of patient deaths and dying within the ambit of their clinical duties was almost universally negative and challenging. This finding is in keeping with the assertions of Kübler-Ross who divided the process of grieving at the prospect of imminent death into stages that are applicable to patients and those ministering to them, as well as to persons forming part of the patient's immediate circle of relatives and acquaintances. These stages include denial and isolation, anger, bargaining, depression and acceptance, in that order (Kübler-Ross 1970:76). However, one acknowledges that the process of coming to terms with death and dying is individualistic, therefore, not everyone will undergo all the stages of grieving.

The researcher decided to research the topic of responses to patient deaths and dying among first-year student nurses in view of the high incidence of termination of their contractual engagement as student nurses immediately after their placement in clinical areas. The researcher's interest stems from her engagement as a lecturer at a nursing college as noted above where she learned from her observation in clinical practice - as well as from her perusal with consent of reflective journals kept by student nurses at her behest -that students often suffered from depression, stress and burnout syndrome in the aftermath of clinical exposure to patient deaths and dying.

The objectives of the study were to

- explore and describe first-year student nurses' experiences in dealing with patient deaths and dying in the course of routine nursing practice

- make recommendations relating to increased support for first-year student nurses with a view to increasing their capacity to cope with clinical experience of patients' death and dying

These objectives were subsumed under the grand tour question: *How did you experience patient death and dying during clinical practice*? In addition, the researcher utilised the following probing questions:

Have you only had to deal with one patient's death/dying in your clinical experience? Were there differences between the first and subsequent experiences? Explain.

In addition to the above, this chapter will summarise the research methodology and design used in the study as well as interpretation of the research findings. The chapter will also discuss limitations of the study, contributions of the study, recommendations and concluding remark.

5.2 RESEARCH METHODOLOGY AND DESIGN

The researcher used a generic qualitative research design which is explorative, descriptive and contextual in order to understand first year nursing students' experiences of patient deaths and dying. The population that was of selected was first-year student nurses who are doing four-year comprehensive nursing course in one nursing college in South Africa in the year 2012 and who have had an encounter with death and dying of a patient during clinical practice. An accessible population was first year student- nurses at one nursing college in Gauteng, because this is where the problem was identified. Non-probability sampling was used and the method that was utilised is purposive sampling. Nine volunteers (two males and seven females) who responded to an invitation for an interview participated in the study. These volunteers had experienced patient deaths and dying in the course of their clinical duties. Unstructured interview procedure was used in the present instance. Interviews were done to saturation. All interviews were recorded using an audio tape recorder (voice-recorder). During the interview, both verbal and non-verbal communication techniques were used. The researcher obtained both verbal and written consent from all participants prior the interview.

The objectives of the study were met because the participants, chosen for their experience of patient deaths and dying in their first year as student nurses, confided their responses to the said experience in interviews to the effect that the researcher gained a detailed overview and in-depth understanding of the said responses, with the result that the researcher felt justified and sufficiently informed to make constructive recommendations with a view to enlisting closer support for first-year student nurses that would enable them to cope effectively with cases of patient deaths and dying in the course of performing their clinical duties, the object of such assistance being to curb the rate at which student nurses terminate their course within the first year as a result of trauma experienced when confronted by patient deaths and dying. The recommendations referred to include the following (see section 5.6).

5.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

Following data collection, analysis of data was done by using content analysis. Analysis began by listening to participants' verbal descriptions and followed by reading and rereading the verbatim transcriptions or written responses. Content analysis was used in the present instance. The researcher followed the process of transcribing interviews; organising, ordering and storing data; listening to and reading collected data; coding and categorising as well as building themes.

During data analysis, four main themes with their sub-themes emerged and these are: theme-knowledge with sub-themes lack of knowledge, denial and empowerment; theme-emotional trauma with sub-theme unexpected event, terrified, stressed and insomnia; theme-low self-esteem with sub-theme feeling useless, not belonging and loss of confidence; as well as theme- nutritional disorder with sub-theme lack of appetite. The researcher made the summary and interpretation of the research findings, based on the themes and others outside the theme. Whilst discussing the interpretation of research findings, the researcher will incorporate some of the concepts of the topic in the explanations.

5.3.1 Interpretation based on themes

5.3.1.1 Theme 1: Knowledge

The subject of patient deaths and dying is a closed book for first-year student nurses (see quoted responses of participants above) who are at a tender age and just emerging from the final stages of protective parental care and a school career when they embark on their nursing vocation. Their experience of life in the raw is therefore minimal at that stage, particularly where death and dying is concerned.

Potter and Perry (2005:573) observe that nurses need to be adequately equipped to help patients and their immediate circle of family and close acquaintances to come to terms with their imminent passing, to which end they first need to be made aware of how people normally cope with grief and loss, taking particular cognisance of the cultural beliefs and practices of those concerned. Then they have to reinforce the coping mechanisms that can be applied to constructive purpose by those concerned, and introduce new coping strategies besides, providing social support to the patient and immediate circle of significant others. Skills required by the nurse to cope with such situations include the competence to make sound clinical decisions, coordinate care and generally be well organised in all activities, communicate to best advantage, and be disciplined in her behaviour by displaying sympathy with all concerned without being swept away by excessive emotion which would render her incapable of ministering effectively to the needs of the patient and those close to him/her as his/her life ends. Student nurses therefore need adequate support to equip them to meet the demands of their task.

5.3.1.2 Theme 2: Emotional trauma

Given their lack of preparedness, participants were emotionally traumatised by the shock of patient deaths and dying, hence the researcher correctly concluded that the trauma experienced by nurses during their first year as students in the profession was attributable to their lack of experience of ministering to cases of patient deaths and dying. This conclusion is borne out by Mutto et al (2010:1445), who note that inexperience leads to a high incidence of death anxiety resulting in negative attitudes towards care for the dying among student nurses when confronted by patient deaths

and dying early in their career; also by Parry (2011:450) who note that inexperienced nurses are prone to panic attacks when they have to deal with patient deaths and dying.

5.3.1.3 Theme 3: Low self-esteem

Participants present with alteration in one of Maslow's hierarchy of need following dealing with death and dying of a patient, which is self-esteem need. They feel useless and feel that they do not belong in a nursing profession. Student nurses lost self-confidence because patients died in their care. This conclusion is also affirmed by Mutto et al (2010:1445), who said that student nurses are likely to withdraw from the care of the dying if a patient dies whilst in their care. They also limit their involvement in death-related situations. According to Parry (2011:450), first year student nurses feel inadequate when the patient dies whilst in their care. Kelly and Nisker (2010:426) affirm that first year student nurses identifies death of a patient as a failure to provide adequate care and this perception can limit students' development of empathic understanding of their patients by promoting the avoidance of reflection on events of death and dying as they are seen to constitute medical 'failure'. This conclusion is further confirmed by Peterson et al (2010:182) who said that student nurses who do not cope effectively with the death and dying of their patients are more likely to increase emotional and psychological distance between themselves and their patients by decreasing interaction with their patients.

5.3.1.4 Theme 4: Nutritional disorder

It is a confirmation that stress caused by exposure to patient deaths and dying is likely to result in loss of appetite. This conclusion was based on participants' responses. The conclusion is further affirmed by Tsigos and Chrousos (2002:869) who says that when a person is stressed, appetite is suppressed because Corticotropin-Releasing Factor is stimulated.

5.3.2 Interpretation outside the themes

- **Negative aspects**

There is no support system for participants (participants' complaints re: lack of supervision and guidance). Factors that contribute significantly to lack of support:

Attitude of some clinical professionals towards student nurses

Student nurses feel unwelcome in the professional environment of nursing because clinical professionals treat them with disdain and are reluctant to assist them where ministering to cases of patient deaths and dying are concerned. It has to be said, though, that professionals are pressured because of staff shortages.

Shortage of clinical professionals, leading to lack of supervision, mentorship and role modelling

According to Vlok (2010:68), staff shortages have negative results, including off-hand treatment of patients (as well as student nurses) by senior nursing staff because of work pressure. Such behaviour leads to dysfunctional modelling because nursing students tend to copy it by default. Shin and Rew (2010:26-30) found that student nurses felt abandoned in clinical settings when left alone, unobserved and unsupervised. This statement is confirmed by Parry (2011:450) who found that mentorship is critical in nurse education. Mentors therefore need to be supportive, understanding and be able to provide the students with the necessary skills to deal with death and dying of patients.

Congested block programme for first year student nurses at nursing colleges, leading to inadequate clinical time

The congested block programme for first-year student nurses inhibits their development, with particular reference to their capacity to cope with cases of patient deaths and dying (earlier explanation of training programme with unequal division between theory and practice. In particular see the contention by Mutto, Erra'zquin, Rabhansl and Villar (2010:1446) that changes in basic nursing education and more continuing education are keys to improving care related to patient deaths and dying).

- **Positive aspects**

Experience is the best teacher

Participants discovered a significant, not say invaluable instructive element in negative encounters. Some participants intimated that despite negative challenges embodied in their confrontations with patient deaths and dying they could take positive lessons from the experience that opened doors to success for them. This observation is echoed by Kotsos (2013:09) who notes that in many instances for which she could vouch from her personal observation, students had attested that they had derived satisfaction from the process of caring for patients *in extremis* as a result of approaching death, and had felt enriched by the inspiration they had drawn from such patients' transcendence of their suffering.

According to Mutto et al (2010:1445), being able to communicate effectively with patients facing death is a significant role that nurses need to fulfill. It has been shown that nurses with greater exposure to dying patients, more years in practice, more experience and more hours of palliative care education, tend to have more positive attitudes toward death and caring for dying patients Smith-Stoner et al (2011:274) emphasise that students viewed caring for patients in the last part of life as a big responsibility, but one that is also rewarding. According to Vlok (2010:343), if a nurse has helped a patient to die with dignity and acceptance of his or her mortality she will indeed experience vocational fulfillment. The reviewed literatures confirm that negative experience results in constructive incidental learning that tends to countermand the erosive effect of such experience. Participants intimated that they had gained both theoretical and clinical knowledge from their experience of patient deaths and dying and have learned how to communicate sympathetically with terminal patients as well as relatives. Therefore, the harmful effects can be turned into a positive lesson that can become a ticket to success rather than excess baggage that prevents progress.

5.4 LIMITATIONS

The following limitations of the study were identified:

- The study was confined to one nursing college in Gauteng Province; therefore its findings could not be extrapolated with a view to their application at nursing colleges throughout South Africa.
- The research site was a government institution and therefore left aside all private nursing colleges and nursing schools, where similar studies may produce different results.
- First-year student nurses were the exclusive target group, hence the rest of the student population remain an uncertain quantity which, if included in further studies could change the overall outcome of the investigation appreciably.
- Participants in the study were almost exclusively female, which may be statistically representative for the profession, given its low male presence. The apparently skewed gender representation is therefore not necessarily a limitation, although a male response may lead to an interesting overall outcome.
- Participants were from the same college where the researcher is currently employed, even though there was no cohesion in participation.

5.5 CONTRIBUTIONS OF THE STUDY

Despite said limitations the study has made contributions that should be documented here as worthy of emulation by the nursing college and the Department of Health to improve the quality of nursing education. The study will:

- Assist the Department of Health to increase its intake and retention of student nurses, and therefore its output of duly qualified professional nurses who would be able to fulfil their function effectively in any context, whether national or international. Moreover, increased training success and settled placement in the profession would result in a significant saving of costs as the health-care work force is strengthened and fruitless expenditure caused by trainees resiling from their contractual obligation and prematurely abandoning the nursing service is curtailed. In addition, it will be an eye-opener for the department and the college

to consider the necessity of introducing induction sessions to serve as judiciously planned preemptive counselling and thus prepare unsuspecting novices for the potentially traumatising conditions to which students will be exposed to.

- Enable clinical educators and clinical professionals to see the necessity of offering guidance and assistance to first-year student nurses that will enable them to cope effectively with cases of patient deaths and dying, particularly if professionals' assistance is planned and executed as systematically integrated in-service continuation programme.
- Assist all stakeholders involved (such as nursing colleges, universities of affiliation, SANC as a registering body, the Department of Health, and the general public) in education and training of student nurses during revision of the curriculum of first-year student nurses.
- Culminate in depositions presented to the Department of Health to solicit an increased presence of psychologists and counselors at training institutions in an effort to curb the incidence of burnout and improve morale among staff and thus reduce resignations and shore up the nursing work force.

5.6 RECOMMENDATIONS

The researcher made the following recommendations:

- That future studies be conducted in other nursing colleges of Gauteng Province, as well as colleges in other provinces of South Africa to broaden the research under review, the study at a university in North West Province being one of few local examples while the rest were mostly conducted in overseas countries such as the UK (Liverpool), Argentina, Australia, Taiwan, California, Norway and Sweden (Watkins et al 2011:1-10).
- Those studies similar to that under review be conducted in private nursing colleges and schools to determine whether experiences in the formal sector are on par with those in the private sector.
- That clinical outcomes envisaged for first-year student nurses be revised with a view to ensuring that procedures such as care for a dying patient and 'last offices' are deferred until trainees have gained more experience and are better established within and adjusted to the conditions normally encountered in the

nursing context, naturally including the task of ministering to cases of patient deaths and dying. The deferral is recommended on grounds that evidence emanating from the study under review revealed that the performance of clinical duties in cases of patient deaths and dying requires higher levels of skill, knowledge and experience than those falling within the capabilities that can be reasonably expected of first-year student nurses.

- That clinical professionals should endeavour to adopt a positive attitude towards their vocation because the negative attitude of some professionals adds up to a considerable disincentive for first-year students who have to become acclimatised to prevailing conditions within the nursing establishment, particularly where cases of patient deaths and dying are concerned. In-service training is recommended to overcome the attitudinal problems noted by participants.
- The more clinical lecturers to be employed to supervise and mentor student nurses effectively since professional nurses in the wards are too hard pressed by demands on their time to teach, mentor and supervise student nurses. Evidence adduced by the study under review indicates that shortages of staff, with particular reference to competent clinical professionals in the wards, are a serious problem that needs urgent attention.
- Since it appears that a congested block programme for first-year student nurses presents a serious problem the researcher recommends that relevant stakeholders (nursing colleges, affiliated universities, SANC and the Department of Health) revisit the curriculum prescribed for first-year student nurses with a view to enabling them to become better acquainted with and acclimatised to the routines and conditions prevailing in clinical practice by extending the periods of their engagement with clinical duties.
- Dealing with death and dying is generally stressful (Parry 2011:450), causing shock and panic attacks, as well as feelings of inadequacy in novice nursing staff who have to minister to such cases; hence the researcher's recommendation at this stage that the Department of Health employ more psychologists and counselors to provide counseling and emotional support to counter the traumatising effects experienced by student nurses when dealing with patient deaths and dying, the object being to curb the incidence of burnout and withdrawal from training, which leads to and perpetuates staff shortages and therefore lowers morale among nursing professionals.

5.7 CONCLUDING REMARKS

The researcher investigated first year student nurses' experiences of encounters with death and dying of a patient during clinical practice. The objectives were to explore and describe the experiences of first year student nurses and to make recommendations on increase support for first year student nurses with regard to dealing with death and dying of patients in clinical area.

Objectives were reached by following qualitative methodology which was explorative, descriptive and contextual. Grand tour and probing questions were asked during in-depth unstructured interview with the participants. Data collected was analysed and following data analysis, there were findings that include four main themes: Knowledge, emotional trauma, low self-esteem and nutritional disorder. These findings were also interpreted by the researcher. During interpretation of the findings, the researcher found that participants did not have knowledge of dealing with death and dying of patients; that participants were emotionally traumatised following encounter of dealing with death and dying of a patient in a clinical area; that participants presented with low self-esteem when dealing with death and dying of a patient; and that participants presented with lack of appetite following exposure of dealing with death and dying of a patient. In addition to the identified themes, the researcher also found that attitude of some clinical professionals towards participants; shortage of clinical professionals, leading to lack of supervision, mentorship and role modelling; and congested block programme for first year student nurses at nursing colleges, leading to inadequate clinical time also contribute negatively to training of first year student nurses as well as to students terminating the course.

However, not everything was negative. Nurses with greater exposure to dying patients, more years in practice, more experience and more hours of palliative care education, tend to have more positive attitudes toward death and caring for dying patients. If a nurse has helped a patient to die with dignity and acceptance of his or her mortality she will indeed experience vocational fulfillment. Negative experience results in constructive incidental learning that tends to counteract the erosive effect of such experience. Therefore, the harmful effects can be turned into a positive lesson that can become a ticket to success rather than excess baggage that prevents progress.

The research has some limitations, which include the fact that it could not be generalised as it was conducted in one nursing college of Gauteng only; it did not include private nursing colleges and nursing schools which might yield different results; it only focused on first year student nurses and excluded other levels of student nurses, hence experiences of student nurses in other levels could not be identified; few males participated in the study as compared to females. However, the study has some contributions. The study will assist the Department of Health to increase its intake and retention of student nurses. Moreover, increased training success and settled placement in the profession would result in a significant saving of costs. It will be also be an eye-opener for the department and the college to consider the necessity of introducing induction sessions. It will enable clinical educators and clinical professionals to see the necessity of offering guidance and assistance to first-year student nurses. The study will assist all stakeholders involved in education and training of student nurses during revision of the curriculum of first-year student nurses. It will also culminate in depositions presented to the Department of Health to solicit an increased presence of psychologists and counselors at training institutions in an effort to curb the incidence of burnout and improve morale among staff and thus reduce resignations and shore up the nursing work force.

The study assisted the researcher to recommend the following: that future studies be conducted in other nursing colleges of Gauteng Province, as well as colleges in other provinces of South Africa to broaden the research under review, that studies similar to that under review be conducted in private nursing colleges and schools to determine whether experiences in the formal sector are on par with those in the private sector, that clinical outcomes envisaged for first-year student nurses be revised with a view to ensuring that procedures such as care for a dying patient and 'last offices' are deferred until trainees have gained more experience and are better established within and adjusted to the conditions normally encountered in the nursing context, that clinical professionals should endeavour to adopt a positive attitude towards their vocation, that more clinical lecturers be employed to supervise and mentor student nurses effectively since professional nurses in the wards are too hard pressed by demands on their time to teach, mentor and supervise student nurses, that relevant stakeholders revisit the curriculum prescribed for first-year student nurses with a view to enabling them to become better acquainted with and acclimatised to the routines and conditions

prevailing in clinical practice by extending the periods of their engagement with clinical duties, that the Department of Health employ more psychologists and counselors to provide counseling and emotional support to counter the traumatising effects experienced by student nurses when dealing with patient deaths and dying.

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INFORMATION PERTAINING TO CONSENT FORM

I, Lebogang Lilian Molefe, a tutor at Bonalesedi nursing college and a student doing Masters in Health Science Education at the University of South Africa (UNISA), am conducting a research study, thereby requesting consent to conduct an interview on you pertaining to the study.

The title of my topic is: **FIRST YEAR STUDENT NURSES' EXPERIENCES OF ENCOUNTERS WITH DEATH AND DYING OF A PATIENT DURING CLINICAL PRACTICE**. The purpose of my research is to explore first year student nurses' experiences of dealing with death and dying during clinical practice so as to develop guidelines for educators and clinical professionals for increasing support to student nurses. The study is of importance because according to recent research studies conducted, it is noted that dealing with death and dying in health care institutions poses a major challenge to student nurses. Students become overwhelmed when dealing with deaths and end up dropping out from the course.

Kindly be informed that you have the right to choose to participate or not to participate in the study. If you agree and give consent to participate in the study, be informed that the information that you will provide will be kept confidential. The information that you will provide will be audio-taped. These will be kept locked in a safe to ensure confidentiality. Be assured that your right to anonymity will also be respected. This means that your identity will be kept a secret, your names will not be attached to the information you will give, only the codes will be used.

The interview will take approximately 45 minutes and not more than that. If at any stage, you want to withdraw from participation, you are free to do so and there will be no consequences or penalization for withdrawing. If you experience emotional or psychological distress during interview, then the interview will immediately be terminated and you will be referred for counselling if you so wish.

This study may benefit you because the researcher intends to develop guidelines to increase support to students on dealing with death and dying of a patient. The study may also help future students because they will receive improved support in the clinical setting when they have to deal with death and dying patients.

Researcher name: Lebogang Lilian Molefe

Contact numbers: (work) 011 696 8358

(Cell) 0739509009

PARTICIPANT' CONSENT FORM TO PARTICIPATE IN THE RESEARCH STUDY

I.....have agreed to participate in the research study and therefore give informed consent to the study.

I am aware of the study and its significance as it was communicated to me by the researcher that it aims to explore the experiences by first year student nurses when dealing with death and dying during clinical practice so as to develop guidelines for educators and clinical professionals for increasing support to student nurses, thus reducing student nurses drop out from the course.

I am aware that I participate freely and that I can withdraw at any time when I feel uncomfortable to continue and that no penalties will apply for such decision.

Signature of the participant

Date: _____

Signature of the researcher

Date: _____

INTERVIEW QUESTIONNAIRES

Grand tour question:

How did you experience dealing with death and dying of a patient during clinical practice?

Probing questions:

Have you only had to deal with one patient's death/dying in your clinical experience?

Were there differences between the first and subsequent experiences? Explain.



CHRIS HANI BARAGWANATH NURSING COLLEGE

Private Bag X 05
Bertsham
2013

BONALESEDI CAMPUS

Tel: (011) 696 - 8300
Fax: (011) 696 - 8400

Dr N Xundu
37 Sauer Street Bank of Lisbon
Marshall Town
2147
Dear Dr Xundu

RE- REQUEST TO CONDUCT RESEARCH

I am a Master of Arts Health studies student, College of Human Science at the University of South Africa (UNISA). As partial fulfilment for my degree, I am requesting permission to conduct a study entitled **FIRST YEAR STUDENT NURSES’ EXPERIENCES OF ENCOUNTERS WITH DEATH AND DYING OF A PATIENT DURING CLINICAL PRACTICE.** The study is a qualitative study focusing on first year student nurses who are doing a four-year diploma course under regulation R425. In- depth interview with participants will be conducted. Participation will be completely voluntary and consent forms will be signed by participants prior the interview. Participants will be informed of their rights prior the interview. The researcher promise to abide by limitations set by the department and to adhere to ethical and professional conduct of the research throughout the study. Please find attached copy of ethical clearance certificate from UNISA, copy of research questionnaires for participants, copy of consent form to be signed by participants as well as copy of approved research proposal. Thanks in anticipation of a positive response to my request.

Yours sincerely,

Mrs Lebogang Lilian Molefe

Signature.....

Date.....

Contact numbers: Work: 011 696 8358: Cell 0739509009



CHRIS HANI BARAGWANATH NURSING COLLEGE

Private Bag X 05
Bertsham
2013

BONALESEDI CAMPUS

Tel: (011) 696 - 8300
Fax: (011) 696 - 8400

The Principal
Chris Hani Baragwanath Nursing College
Private Bag X05
Bertsham
2013

Mrs Peters

I hereby apply for a permission to conduct interviews on first year student nurses who are doing four-year diploma course under regulation R425. I am presently conducting a research study under the University of South Africa (UNISA). The title of my research study is: **FIRST YEAR STUDENT NURSES' EXPERIENCES OF ENCOUNTERS WITH DEATH AND DYING OF A PATIENT DURING CLINICAL PRACTICE**. The researcher decided on this title because she has realised that most first year student nurses terminate their training immediately after their first placement in the clinical areas. The researcher did some literature review on first year student nurses' reasons for terminating the course during their first year of training and she found that most responses were that students become overwhelmed when dealing with death and dying, hence decide to leave the course.

The research will benefit the college because it will help to develop guidelines for nurse educators and clinical managers to provide support and guidelines for student nurses when dealing with death and dying of patients. The researcher promises to give feedback and results of the study to the principal and management of the college. The

researcher also promises to abide by limitations set by the college and to adhere to ethical and professional conduct of the research throughout the study. Kindly receive the followings documents for your perusal:

1. Copy of research proposal
2. Ethical clearance form from Gauteng Department of Health (Please note that agreement between Gauteng Department of Health and the Researcher document in page 3 has already been signed, scanned and e-mailed to the department).
3. Copy of research instrument
4. Copy of consent form for participants(unsigned as permission is not yet granted)
5. Copy of ethical clearance certificate, awarded by UNISA Health Studies Higher Degrees Committee, College of Human Sciences

Regards,

L.L Molefe

Lecturer, Bonalesedi campus of CHBNC

Tel no: 011 696 8358

Signature.....

Date.....



GAUTENG PROVINCE

Rip, I LIC. !Jt ' >.hJr H

CHRIS HANI BARAGWANATH NURSING COLLEGE

Private Bag X 05

Bertsham Fax: (011) 983-3091

2013

Tel: (011) 983-3000



06th June 2012

From: Mrs S Peters

Principal: Chris Hani Baragwanath Nursing College

Private Bag X 05

BERTSHAM

2013

For Attention: Ms. L.L. Molefe

Level One: Lecturer

Bonalesedi Campus

SUBJECT: AUTHORIZATION TO CONDUCT RESEARCH: BONALESEDI CAMPUS

Approval is granted for you to conduct research at the above-mentioned campus.

Please note that I do have reservations about the clear identification of the college and the campus at which the research is to be conducted.

I wish you every success with your studies.

Kind regards,

A handwritten signature in black ink, appearing to be 'S Peters', written over a dotted line.

M
Mrs S Peters

(College Principal

Chris Hani Baragwanath

Nursing College

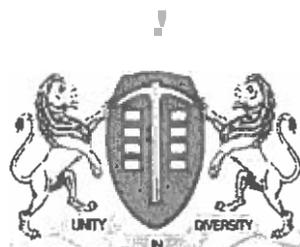
Private Bag x05

Bertsham

2013

cc:Research Committee

Annexure G



GAUTENG PROVINCE

REPUBLIC OF SOUTH AFRICA

BANK OF LISBON BUILDING
37 SAUER STREET JHB
PRIVATE BAG X085
MARSHALITOWN
Tel: (011) 355 3500
Fax: (011) 355 3675

GAUTENG DEPARTMENT OF HEALTH

RESEARCH PROPOSAL EVALUATION FORM

Researcher Name	Lebogang Lilian Molefe
Researcher's contact details	Tel: 011 6968358 Cell: 0739509009 Email: lebo.molefe@hotmail.com
Institution	University of South Africa
Research Topic	First year student nurses' experiences of encounters with death and dying of a patient during clinical practice.
Date received by the Directorate PPR	22/05/2012
Date Received Reviewer	28/05/2012
Final Review Date	29/05/2012
Date submitted to Director of PPR	29/05/2012
Research Site(s)	Bonalesedi campus of Baragwanath Nursing College
Type of research	Descriptive

CRITERIA	YES	NO	COMMENTS
1. Is this research project within the scope of the Department of Health key policy priorities/directives?	X		
2. Content of research:			
• Original work	X		
• New facts, ideas	X		
• Confirmation of uncertain data	X		
• Repetition of known data and consequently of limited importance		X	
• Insufficient research information		X	
• Confusion of topics/questions		X	
3. Is the title of the research project suitable?	X		

CRITERIA	YES	NO	COMMENTS
4. Are the objectives of the research project	X		
5. Could the objectives be limited to better focus on the project's main objective?)	
6. Writing style			
• The text of the proposal is clear)		
• The nomenclature used is correct)		
• The references used are relevant, comprehensive and accurate)		
• The spelling and grammar are correct)		
• The language needs improvement		X	
• The research proposal needs re-styling and re-writing		X	
7. Are the research methods appropriate to the study?	X		
8. Is data collection method in line with the study design?	X		
9. Does the study have ethical approval? If yes, name the ethics committee.	X		UNISA-HSHOC/26/2012
10. Is the definition and measurement of variables consistent with the scope of the proposal?	X		
11. Is the time frame of the proposal adequate to meet the objectives?)		
12. Is the method of dissemination of the results of the research project stated?)	It is recommended that the researchers specify how the results will be shared / disseminated
13. Is any possible conflict of interests clarified?	n/a		
14. Are financial implications and financial support transparent?)		

SUMMARY OF PROPOSAL

Background

Many nurses, including student nurses have difficulty in dealing with deaths (2006:23). Some students experience emotional distress and difficulty in dealing with death of a patient and if they are not given enough support from clinical education and mentors they can develop avoidance behaviours. Communication, empathy and sympathy in clinical practice are the ultimate goals when one is caring for the dying person. A dying person

should be given an opportunity to ask about death and dying. This includes dying children. The nurse caring for the dying should discuss what the child and his family knows about the condition and approaching death. The nurse caring for a dying child should work together with the family, consistently, allowing ventilation of feelings and offering support (Northrup 2004:1066). According to Friedman and Friedman (2003:271), the goal of therapy with a dying person in clinical practice is to strengthen the meaning of life. This search may restore life, if it does not restore it, then it makes for a richer meaning of the terminal events. A skilled care worker can aid an individual to find his full dignity in death, if he was never able to find it in the past events of his life. In order to assist student nurses to become comfortable in providing care to dying patients, good communication skills, empathy, and sympathy need to be taught and be instilled. The purpose of this study is to explore first year nurses experiences when dealing with death and dying of a patient during clinical practice and to develop guidelines for educators and clinical nurse professionals for increasing support to student nurses with regard to attending to the dying.

Objectives

- To describe how first year student nurses experience dealing with death and dying of patients.
- To develop guidelines for increasing support to first year student nurses with regard to dealing with death and dying of patients.

Methodology

The study will utilize qualitative, explorative, descriptive design using the phenomenological method. Participants will be First year student nurses for 2012 at Bonalesedi campus of Baragwanath Nursing College, who have had experiences with death and dying of a patient during clinical practice. They will be selected using the Purposive sampling method. Face to face unstructured in-depth individual interviews will be conducted with the selected participants, in a classroom free from noise and disturbances. They will be asked to describe verbally their experiences of their first encounters with dealing with death of a patient during clinical practice. When reporting the findings, the actual words used by the participants to describe the experiences will be used. An audio-tape recorder will be used

to capture data. Each interview recording will be transcribed verbatim. Open coding will be done and similar codes will be categorized together so as to help describing the findings more easy. Three types of codes will be used, Descriptive, Interpretative as well as explanatory codes. A computer programme, ATLAS Ti, will be used to retrieve, organize, manage and store data. The computer will have a password to prevent unauthorized usage. Data analysis will be done simultaneously with data collection.

REVIEWER'S FINAL CONCLUSION

This study will assist to adequately train student nurse to become adequate transference objects for their patients and relatives. It will also assist educators and clinical professionals to provide essential assistance for student nurses who encounter dealing with death and dying of patients in their care so as to foster positive attitudes towards end of life care and eliminate negative attitudes. This study is recommended for approval.

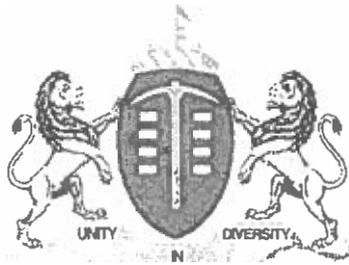
Reviewed and Recommended by



Dr Bridget Ikafe & Research and Epidemiology

Approved /not approve

CONDITIONS OF APPROVAL OF A RESEARCH STUDY PROPOSAL

**GAUTENG PROVINCE**

REPUBLIC OF SOUTH AFRICA

POLICY, PLANNING AND RESEARCH (PPR)

Enquiries: Dr 8 Ikalafeng

Tel +2711355 3500

Fax: +2711355 3675 Email: brldget.ikalafeng@gauteng.gov.za

CONTACT DETAILS	
Date	29 May
Contact number	Tel: 011 6968358 / Cell: 0739509009
Email	lebo.molefe@hotmail.com
Researcher /Principal	Lebogang lillian Molefe
Supervisor	N/A
Institution	University of South Africa
Research title	First year student nurses' experiences of encounters with death of a patient during

This approval is granted only for a research proposal submitted to GDH by Lebogang lillian Molefe entitled "First year student nurses' experiences of encounters with death of a patient during clinical practice."

Approval is hereby granted by the Gauteng Department of Health for the above mentioned research study proposal for a study to be conducted within GDH domain. Approval is limited to compliance with the following terms and conditions:

1. All principles and South African regulations pertaining to ethics of research are observed and adhered to by all involved in the research project. Ethics approval is only acceptable if it has been provided by a South African research ethics committee which is accredited by the National Health Research Ethics Council (NHREC) of South Africa; this is regardless of whether ethics approval has been granted elsewhere.

Of key importance for all researchers is that they abide by all research ethics principles and practice relating to human subjects as contained in the Declaration of Helsinki (1964, amended in 1983) and the constitution of the Republic of South Africa in its entirety. Declaration of Helsinki upholds the following principles when conducting research, respect for:

- Human dignity;
- Autonomy;
- Informed consent;
- Vulnerable persons;
- Confidentiality;
- Lack of harm;
- Maximum benefit;
- and justice

2. The GDH is indemnified from any form of liability arising from or as a consequence of the process or outcomes of any research approved by HOD and conducted within the GDH domain;

3. Researchers commit to providing the GDH with periodic progress and a final report; short term projects are expected to submit progress reports on a more frequent basis and all reports must be submitted to the Director: Policy, Planning and Research of the GDH;

4. The Principal Investigator shall promptly inform the above mentioned office of changes of contact details or physical address of the researching individual, organisation or team;
5. The Principal Investigator shall inform the above office and make arrangements to discuss their findings with GDH prior to dissemination;
6. The Principal Investigator shall promptly inform the above mentioned office of any adverse situation which may be a health hazard to any of the participants;
7. The Principal Investigator shall request in writing authorization by the HOD via PPR for any intended changes of any form to the original and approved research proposal;
8. If for any reason the research is discontinued, the Principal Investigator must inform the above mentioned office of the reasons for such discontinuation;
9. A formal research report upon completion should be submitted to the Director: Policy, Planning and

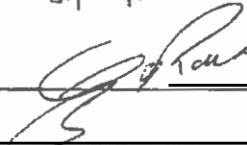
Research of the GDH with recommendations and implications for GDH, the Directorate will make this report available for the HOD.

AGREEMENT BETWEEN THE GAUTENG DEPARTMENT OF HEALTH (GOH) AND THE RESEARCHER

Suele Roux
Director: Policy Planning & Research

Date: 21/05/2012

Signature:



Name and surname of Principal Researcher

Research/Academic: Institution

Date: 04. 06. 2012

SIGNATURE

This approval is granted only for a research proposal submitted to GDH by Lebogang Lillian Molefe entitled "First year student nurses' experiences of encounters with death of a patient during clinical practice".

