

**THE EXPERIENCES OF PROFESSIONAL NURSES IN PROVIDING
COMPASSIONATE PATIENT CARE IN A PRIVATE HOSPITAL IN GAUTENG,
SOUTH AFRICA: A QUALITATIVE NARRATIVE ANALYSIS**

by

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UNIVERSITY OF SOUTH AFRICA

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FEBRUARY 2017

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DECLARATION

I declare that **THE EXPERIENCES OF PROFESSIONAL NURSES IN PROVIDING COMPASSIONATE PATIENT CARE IN A PRIVATE HOSPITAL IN GAUTENG, SOUTH AFRICA: A QUALITATIVE NARRATIVE ANALYSIS** is my own work and that the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



30 November 2016

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SIGNATURE

DATE

Leona Marianne Baker

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ABSTRACT

Compassionate care is a crucial component of patient care in nursing practice in the broad context of holistic care. However, it is seemingly difficult for nurses to identify what exactly comprises compassionate care and how to provide it to patients. The purpose of the study was to explore the experiences of professional nurses on how they provide compassionate patient care. A qualitative descriptive study design based on narrative analysis was used. Thirteen professional nurses (PNs) from a private hospital were purposefully recruited to participate. Data was collected using written stories and professional lifelines. Data was analysed using thematic and narrative analysis. The following themes were identified such as treating the patient as a whole, inadequate knowledge and skills, and barriers to providing compassionate care. Future research using quantitative approach and large samples was recommended.

Key concepts

Compassionate patient care; experiences; narrative analysis; private hospital; professional nurses.

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I dedicate this dissertation to:

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LIST OF ABBREVIATIONS

ICAS	Independent Counselling and Advisory Services
NHS	National Health System
PNs	Professional Nurses
SA	South Africa
SANC	South African Nursing Council
UK	United Kingdom
UNISA	University of South Africa
USA	United States of America
WIL	Work Integrated Learning

CHAPTER 1

ORIENTATION TO THE STUDY

Compassionate people are geniuses in the art of living, more necessary to the dignity, security and joy of humanity than the discoverers of knowledge.

Albert Einstein

1.1 INTRODUCTION

Nursing is known as the forerunner of caring professions, and this caring becomes even more important when promoting good patient care. Sitzman and Watson (2014:5) say that “caring is the essence of nursing and the most central and unifying focus for nursing practice”. Caring is used as a central point of nursing care and then if certain aspects are added, such as knowledge, listening, communication, mindfulness and compassion, patient care becomes holistic and patients benefit.

In 1849 a French protestant, Pastor Fliedner was training deaconesses in churches to do nursing and teaching as well as pastoral duties. Pastor Fliedner then travelled to Europe, United Kingdom (UK), United States of America (USA) and the Eastern countries, opening homes that were converted into hospitals and seminaries. In 1851 Florence Nightingale trained in Kaiserswerth at one of Fliedner’s hospitals/seminaries, and thereafter she became an important pioneer in the nursing profession, emulating these hospitals and taking this newly acquired knowledge first to Paris and then to England. During the Crimean War, from 1853-1856 the government of UK requested help from Nightingale to interview young women, and to train them in nursing, and then for them to go to various hospitals situated in the army camps. They went about their business of nursing, which was to keep patients clean and comfortable, as pain free as possible and make all attempts to prevent the spread of infections. These nurses were all Godly young women who were expected to treat all their patients with kindness, helpfulness and compassion. Nightingale called for all her nurses to work hard, love their patients and have the necessary knowledge needed (Facts about the Crimean War 2013:1; *Kaiserswerth yesterday and today* 2016:1; Pollard 1891:30-158).

Society recognises professional nurses (PNs) as such, and expects them to behave in a certain way. The expectation is that PNs will practice their profession in such a way that the well-being of all patients in their care will be foremost and they will be cared for in a kind, competent and humane manner by nurses who are caring and compassionate. A Code of Ethics for Nursing Practitioners is clearly stated in a revised version of the Nursing Act (2005). Apart from the fact that it states that nurses will be accountable for all acts and omissions while carrying out nursing duties, it also expects nurses to adhere to the fundamental ethical principles (South Africa 2005:section 2). The nursing profession has its own standards of professional behaviour' expectations, the way tasks need to be carried out is documented and easily accessed. According to Scammell (2014:1048), values like compassion and caring are personal values which will influence how professional nurses carry out their daily tasks. Caring for patients without compassion is in fact regarded as incompetent care.

This study was undertaken in order to investigate the experiences of PNs in providing compassionate patient care in a private hospital. A qualitative, descriptive narrative analysis was carried out to obtain written stories from the participants regarding their own experiences in the provision of compassionate patient care. In this study, literature sources outlined both the importance of this care as well as gave examples of how and why this compassionate patient care is now in question (Streubert & Carpenter 2011:364).

Research phases

This study was conducted in four phases, the first phase deals with this chapter and is indicated by the differently shaded block in Figure 1.1.



Figure 1.1 Flow of research activities in phase 1
 (Adapted from Polit & Beck 2012:61)

The first phase consisted of the planning of the study which included a literature search for previous studies which were done on the same phenomenon, identification of the research problem and its background, gaining entrance to the research site and planning the research design and method, the second phase comprised the data research method which included the population and sampling methods used, the collection of the data from written stories and a professional lifeline/timeline and ensuring trustworthiness and ethical considerations. The third phase dealt with the analysis of the stories and lifelines using thematic and narrative analysis, themes categories and sub-categories emerged, data saturation was reached and findings documented, and the fourth phase consisted of conclusions and recommendations starting with a discussion of the findings, literature control, recommendations, implication of findings on clinical practice nursing education and research and dissemination of the findings. Phases two and three cannot easily be separated as the activities occur concurrently.

1.2 BACKGROUND INFORMATION TO THE STUDY

1.2.1 Sources of the research problem

According to Polit and Beck (2012:74-75), research problems or topics often originate from the researcher's passion, interest, clinical experience, nursing literature and social issues regarding the study phenomena . The researcher has always been passionate about excellent patient care, and became inquisitive and highly concerned about the missing link of compassionate patient care as was observed in practice. According to Oosthuizen (2012:49-61), observations were made on the view that the nature of nursing care practised seems to have deteriorated in terms of nursing standards and compassionate patient care today. A comprehensive search of literature of more than 50 related articles, journal reports, books and media reports on the phenomena became a valuable source of more information. It is a notable observation that studies have been conducted in UK, USA, several European countries as well as South Africa (SA) regarding compassionate patient care with seemingly little evidence of the demonstration of improvement at implementation level (Aiken et al 2014:1824; Francis 2013:43-46; Polit & Beck 2012:74-75).

There are many literature sources on findings from enquiries into lack of compassionate care, and these sources are concluded with definite recommendations and even plans to

improve the care. Findings from a retrospective study conducted by Aiken et al (2014:1824) where data was taken from discharge notes from nine European countries showed that by cutting staff to save money, there was a negative impact on patient outcomes, and that by using more degree educated professional nurses, preventable hospital deaths are lower. Also, from findings taken from Aiken et al (2014:1824), it was shown that the organisational behaviour and retention of qualified committed staff goes a far way to improve both the quality and safety of care of patients. A systematic review was done by Foster (2014:1165) which focused on leadership styles, and found that there were certain leadership styles that were more conducive to positive outcomes in the workforce and quality of patient care than others.

It seemed that, as nurses go about their daily duties, they can do the caring part of nursing with or without compassion. There are such varied perceptions of what caring is and there is some overlap in the understanding of compassion and of caring. According to Roberts and Machon (2015:9-10), when attending to patients true caring requires the nurse to be observant, to make an accurate assessment of the patient, focus on what the patient is saying by hearing him/her, asking questions which show understanding and interest in the patient and then for the nurse to have an adequate response to the patients' needs. Caring can be healing in itself if done with presence. A nurse can be extremely empathic, but not respond to the patient's needs correctly. If the nurse acts with compassion she would want to alleviate the patients discomfort and suffering (Roberts & Machon 2015:9-10).

1.2.2 Background to the research problem

Hofstee (2006:84) explains that the background information for a study should give the readers an idea of what the study will focus on. In this study the focus is on compassionate care, how it is delivered and the reasons for the lack thereof.

Van der Wal (2006:58) defines caring as the giving of oneself in all aspects, such as the psychological self, and ethically, morally and all the spiritual and physical and learned components that make us humans. Compassion, although seemingly difficult to be understood, is however, closely related to the caring practices of nurses, which are important for the nursing profession. A study conducted by Van der Wal (2006:55) shows that factors that are erosive to caring by nurses come from both the educational setting

and the clinical situation. The following issues were found to be the culprits regarding the apparent failure of caring adequately for patients: problems within the nurses themselves such as a lack of self-knowledge and low self-esteem; not being able to prevent too much emotional involvement with their patients or, sadly, lacking therein; too big a workload causing exhaustion; insufficient knowledge in both theory and practical nursing care; administrative problems; the actual work conditions; and the patients themselves if they are deemed too difficult. Van der Wal (2006:55) further states that these factors undermine all the processes put in place for maintenance of standards of care in nursing practice.

Compassionate care is a crucial component of patient care in nursing practice in the broad context of holistic care. According to Larkin (2010:55), compassion *per se* is not about how the nurse feels about a patient who is suffering, but more about what the nurse does about it. Larkin (2010:55) defines compassion as: “a concept that asks about how to go where it hurts, to enter in places of pain, to share in brokenness, fear, confusion, and anguish”. These emotions and pain are all experienced by patients at various stages of illness. Larkin (2010:55) further states that compassion can be described “as a means of full immersion in the condition of being human”.

Nursing practice does not lie in our technical skills alone, nor does it rely only on our caring approach to our patients alone. It also lies in our ability to diagnose actual or potential threats to health and treat people in a manner that promotes health and healing. Added to that the PN must be able to deal with the responses the patient has to their own illness/disability and be able to do all of this ensuring a relationship where the patient trusts him/her. The PN must go about the business of nursing in a manner that promotes health and healing (Farrelly 2014:965).

Measuring compassion is difficult but necessary, and according to Dewar (2011:32), there are three criteria by which quality of nursing care can be measured i.e. safety, effectiveness and patient experience. The latter is further divided into two categories which are communication and compassion. There are difficulties with measuring compassion because people are not able to express what compassion means easily; it consists of many factors many of which are not able to be measured; it appears different in diverse situations and contexts and it has a different meaning to each individual so this needs to be spoken about (Dewar 2011:32).

Davison and Williams (2009:1-5) point out that there are two parts to professional caring, these are instrumental caring which consists of knowledge and acquired skills and expressive caring which is the emotional part of caring, which changes nursing actions into compassionate care. The problem comes in when educators have to measure this caring to see if the nurses are compassionate or not. The educators have to decide what compassion really is, which is difficult as it is subjective. The learned skills of nursing are about “doing” a nursing task and that the compassionate nurse is all about “being” a nurse, and that it is imperative that the patients feel that they are “cared for” and “cared about” (Davison & Williams 2009:1-5).

Six personal attributes and actions that measure the extent the nurse is present with and there for the patient are described as: compassion and love for ones fellow human beings; a goal to be a compassionate nurse on purpose; nurses getting to know the patients in their care; the nurses visible response to the patients; knowing and managing themselves in all relationships; and creating and sustaining an atmosphere where compassion can be practised. The nurse needs to choose to be present and show compassion on purpose and she/he needs to know her/himself. Educating nurses to be patient orientated and not only task orientated assists them to be present on purpose and to spark energy exchange between them and their patients. Nurses need to be able to discuss when they are overwhelmed with the suffering they are exposed to and be able to still be present and not to withdraw behind monitors and duties (Dunn 2009b:225-227).

There are many newspaper reports regarding poor quality of nursing care and few that portray nurses having values that make nursing an admirable profession and a calling. In a study done by Oosthuizen (2012:49-61) on the image of nursing in SA from newspaper reports it was found that there is a shortage of nurses, that the working conditions are not always good, and that the nurses are often not managed well and in turn they make headlines for being uncaring, not compassionate and incompetent to say the least. In the recommendations from this study mention was made of the fact that the profession itself needs to address issues and also needs to ensure positive media reporting, and that nurses need to have importance put on the values and ethos of the nursing profession during their training as student nurses before becoming PNs (Oosthuizen 2012:49-61).

Nyatanga (2013:299) states that the idea of providing compassionate patient care sounds almost *fait accompli* (a thing that has already been decided upon and leaving them with no option but to accept it) among nurses in general. However studies have highlighted that the opposite is true; “Compassion breeds compassion and the opposite is equally true”. Nyatanga (2013:299) further states that one of the key findings in the Francis (2013:43-45) report was that nurses/carers themselves did not feel their complaints were heard nor did they feel cared for by their employers. The Francis (2013:43-46) report mandated by the National Health System (NHS) in UK reported on issues of lack of compassionate patient care and the ensuing suffering of patients. In the analysis of the report, it was evidenced that a number of challenges existed such as a negative culture in the hospitals resulting in a tolerance of poor nursing standards, and no focus on the standards resulting in poor nursing performance. Other issues were passivity among leaders, difficult personnel issues and generally poor leadership from the top down. Further findings were that patients were complaining about not being heard, inadequate attention given to the continuing risk of nursing staff reduction and incorrect priorities of the board so that the resources available did not match the needs for the delivery of excellent nursing service (Francis 2013:43-46).

There was a swift response from the Nursing and Midwifery Council (2013:26-42) which promised more accountability from nurses, that nurses will put patient’s first, standards of nurses behaviour and health care will be improved, nurses will have a common culture especially that of caring, there will be effective handling of complaints, there will be openness and information given and that there will be regulation of nurses fitness to practise ongoing. However there is little proof that this did in fact happen (Nursing and Midwifery Council 2013:26-42).

There has been some talk about the six C’s that were used to drive a Compassion in Practice directive and it was put into practise by the National Health Services Commissioning Board in 2012 in UK. The six Cs comprise: care, compassion, competence, communication, courage and commitment. It is clear that an education programme together with good follow up, leadership and management is needed in order to carry out this directive. In the summary of this article it is stated that these six Cs should also be carried out by nurse researchers when dealing with research participants, leading to compassionate care for all, so that the biggest voice to be heard will be that of the patients themselves (Hardicre 2014:365-367).

Nurses need to be taught to understand and recognise the difference between routine care, empathic and compassionate care (see Figure 1.2). Post, Ng, Fischel, Bennett, Bily, Chandran, Joyce, Locicero, McGovern, McKeefrey, Rodriguez and Roess (2014:873) cite the James-Lange theory which states that the emotions will follow the actions, which is really all about faking it until you make it, as it is believed that the relevant emotions will follow the physical actions. There are some individuals who arrive for their nursing training who already have great compassion as a result of a mixture of nature and nurture, this training is more aimed at the nurses who have been identified as battling with giving empathy and compassionate care, they need cognitive training of how to get to the place where compassionate patient care becomes the norm for them and to develop this behaviour as a natural part of their nursing (Post et al 2014:873-875).

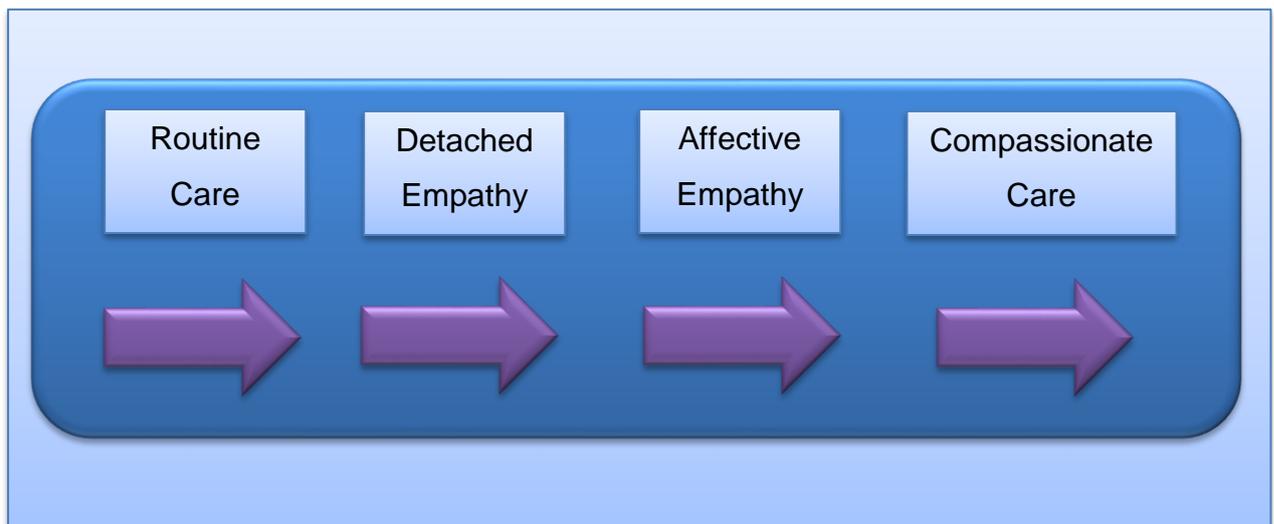


Figure 1.2 Educational steps to compassionate care

(Adapted from Post et al 2014:873)

This progression shows how nurses can be encouraged to first add empathy and then compassion to their patient care, so that it becomes compassionate care. According to (Kitson, Athlin and Conroy (2014:331-333) and Kitson, Robertson-Malt and Conroy (2013:109-111), the fundamentals of basic nursing care are evidently anything but basic and nurses should have access to a list like this, it should be part of their standard ward procedures in every unit for every patient every day:

- Safety, prevention and medication
- Communication and education
- Respiration
- Eating and drinking
- Elimination
- Personal cleansing and dressing
- Temperature control
- Rest and sleep
- Comfort which includes pain management
- Dignity
- Privacy
- Respecting choice
- Mobility
- Expressing sexuality

These are all aspects of basic physical needs and care that nurses throughout the world can relate to and, if followed, would take care of each patient as a whole (Kitson et al 2013:109-111; Kitson et al 2014:331-333).

Concern is shown by Fights (2012:5-6) as to how nursing is practised in the work place. Maintaining focus on the patient, “being present and practising active listening” is argued to help nurses achieve a balance between the documentation and the delivery of real patient-centred compassionate care. Paying attention to both what the patient is saying verbally as well as non-verbal messages will also give the nurse a lot of information about the patient and it will let the patient know that the nurse is focused on the job at hand (Fights 2012:5-6).

Research conducted by Austin (2011:158-166) from Canada showed that the barriers to nurses giving compassionate care are often systemic and not from fatigue as it is so often explained. Health care is being “McDonaldised” which is a term used by Austin (2011:159) to describe the values of corporate organisations towards efficiency and control and how nursing care cannot be measured by the same standards used for organisational success in the business world.

Debates about compassion, its meaning and how it relates to the standards of nursing care given to patients are ongoing. Van der Cingel (2009:125), from the Netherlands, explored questions and contradictions around the debate on compassion and suffering. Although compassion is important to people who are suffering, it seems not to necessarily take away suffering. In order to examine what compassion really is, it is necessary to weigh these contradictions. Van der Cingel (2009:128), further mentions that in order to feel compassion, the nurse needs to know enough about the patient to see what is of importance to the patient, and not allow any personal opinions to cloud what the best decision for the patient is. Van der Cingel (2009:125), adds that to deny providing compassionate care means you are adding suffering to suffering that already exists. Nursing has the removal of suffering as its purpose and it is almost compulsory that compassion be practised if excellence in nursing care is the goal (Van der Cingel 2009:125-128).

A study was done by Madigage (2005:55) to find reasons for problems with the delivery of patient centred/compassionate care to patients. Madigage (2005:55) showed in analysis of her study done on the "Perception of Professional Nurses on patient centred care", that there were four main areas or themes that emerged to be beneficial in providing this care which were; encouraging patient involvement, human touch from nurses including empathy and counselling, education of patients and upholding best practices in the workplace.

There are several theories in these previous studies done on why compassionate patient care is not as it should be, some almost seem to be in conflict with each other. There are some key issues which may contribute to the reasons why compassionate patient care is difficult, such as the value of nursing by PNs, compassion fatigue versus compassion energy, if compassion is inbuilt or learned and PNs caring for all cultures.

Value of nursing by PNs

Although compassion is important in a situation where there is human suffering, understanding its meaning by nurses themselves is crucial. The need to provide compassionate care is grounded in the nursing history of which Florence Nightingale (1820-1910) was a primary proponent. She encouraged holistic nursing care, including spiritual care with physical care of patients as seen in Monareng (2009:1), who also

further discusses the three dimensions of body, mind and spirit as they are depicted in a classical model developed by Stallwood (1975:1087) and described by Carson (1989:8-10), in Figure 1.3.

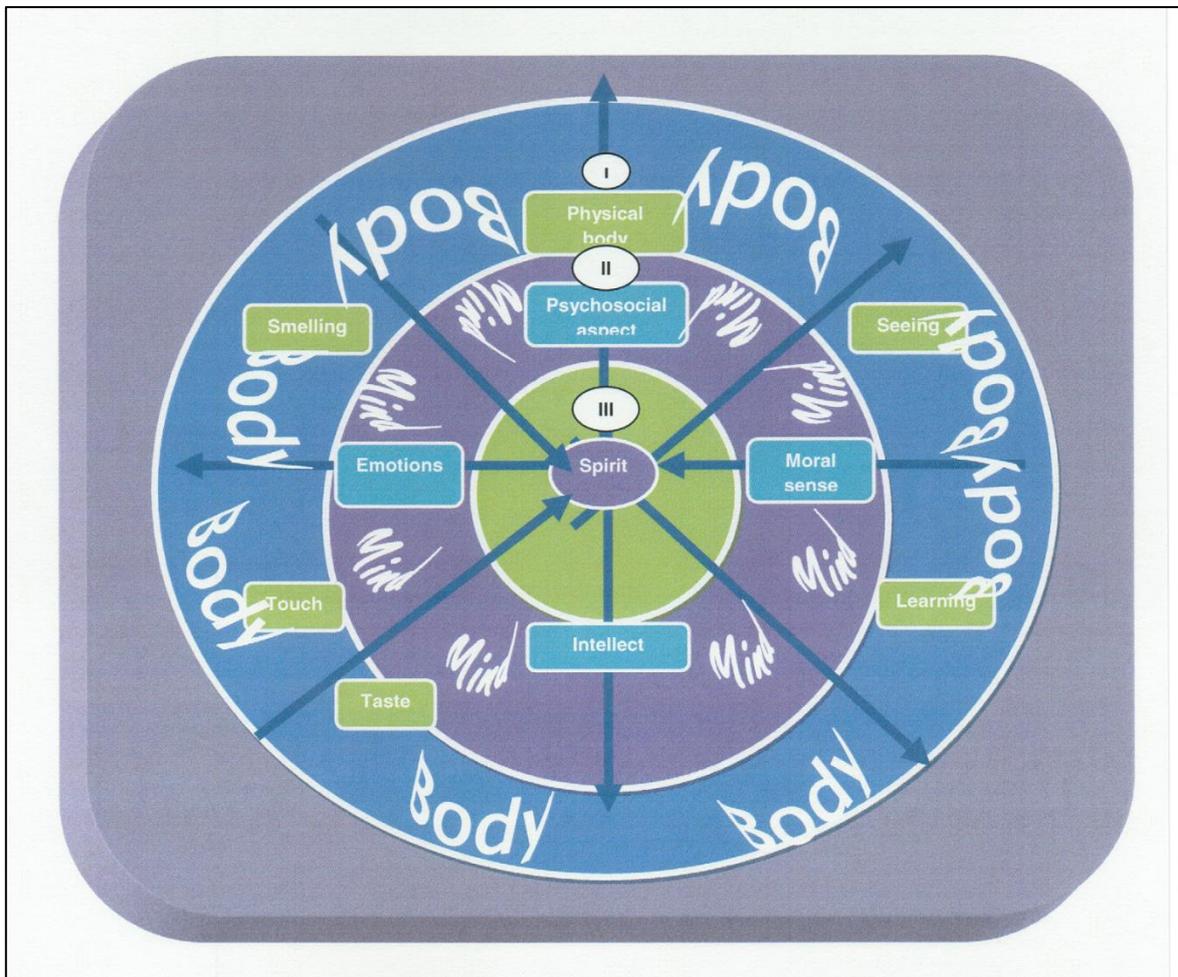


Figure 1.3 Conceptual model of the nature of humans
(Adapted from Stallwood 1975:1087)

Carson (1989:9-10) explains that this model is presented in circles that demonstrate the interrelatedness of the various dimensions. The outer circle represents the physical body, which allows the person to be in touch with the world through the senses of touch, taste, hearing, sight and smell. The body is the person seen and experienced by others, such as nurses experienced by patients as providing compassionate care or not. It is the house of the spirit because a person's human spirit does not reside in a vacuum. The body is the physical substance of a person that can be perceived in the empirical reality of displaying emotions such as being sensitive, non-judgemental and treating others with dignity. The second circle represents the mind, which is that part of a person that gives

oneself consciousness, self-identity and personality through emotions, the intellect, moral sense and the will (Carson 1989:9-10).

As a result of his more than 30 years of experience as a counsellor and a pastor, Clinebell (1992) is cited by the University of Minnesota (2016:1) as having come to the conclusion that humans have seven spiritual needs: people need to love and be loved, they need times of renewal beyond just sensory feelings, everyone needs to have a belief system that gives them hope and meaning during life's trials, they need to have a set of values and morals that guide them through life, each person needs to discover and develop their own inner self, people need to develop a sense of oneness with others and nature and all living things and every person needs their own spiritual resources that help them to heal from negative emotions like rejection, grief, guilt, unforgiveness, shame and to deepen our positive experiences of self-esteem, joy, hope and love (University of Minnesota 2016:1).

Some nurses do see value in what they do for patients, and it has been found that nurses who seem to value their work and themselves, are the ones that develop a professional identity which makes them feel like a nurse, as opposed to just working as a nurse (Pask 2003:170). Even compassion needs to be kept under constant review, making sure that one's own belief systems regarding politics, race, religion and sexual preferences and generally all beliefs, do not stand in the way of giving compassionate care to patients. A story is told by Gallagher (2013:849) who spent time as a worker at Mother Teresa's home for young homeless men dying from HIV. It was reported that these men were very depressed as they were not allowed to drink alcohol, smoke, watch TV or have any friends to visit even when they were on their death beds because Mother Theresa had very strong religious views about all social issues and very strict rules in the home for these terminally ill patients (Gallagher 2013:849).

According to Sitzman and Watson (2014:20-22), if nurses can grasp the model on caring called the Caritas Process, it will affect them on a personal and professional level. The word "Caritas" is a Latin word meaning compassion. It has ten processes that are: kindness and compassion for others; being present when dealing with patients; being sensitive to self and others; maintaining good relationships with others; giving space for positive and negative emotions; problem solving using critical thinking; transpersonal teaching and learning back and forward between self and patient; facilitation of a healing

environment; caring for all the patient's needs, mind, body and spirit with respect and dignity and being open to unknowns in other words making place for miracles to happen. Nursing would really fulfil its promise of a caring profession, giving compassionate patient care, if these were taught, and would also be of huge benefit to each individual nurse at the same time giving her a sense of value in what she is doing (Sitzman & Watson 2014:20-22).

Nurses need to value themselves, and their own health needs in order to be at their best to give compassionate patient care. A nurse's support system or a wellness programme could be put in place, so that they are able to get help when they feel like they can't cope or can't go on, as they will not be able to function well. Whether it is work related or if they are having problems at home, or health problems, nurses need to be heard and assisted. Patel (2012:1) states that the term employee wellness is still very misunderstood and when a questionnaire was put to 27 organisations, labour unions and service providers they gave 27 different definitions for employee wellness. Patel (2012:1), also cites the Harvard Business Review as defining workplace wellness as "An organised, employer-sponsored programme that is designed to support employees as they adopt and sustain behaviours that reduce health risks, improve quality of life, enhance personal effectiveness, and benefit the organisation's bottom line". In 2011 The Healthy Company Index study consisted of 101 participating companies with a combined total of 13,578 employees. The results of this study done by Patel (2012:1) show a serious picture of workplace wellness in SA: 43.4% of employees interviewed were found to have five or more health risk factors outside the healthy range; 81% of the employees did not meet recommended physical activity guidelines. In the nursing profession this percentage is one that could be significantly less, because of the amount of walking that the average nurse needs to do while carrying out her nursing duties. It was also found that 82% of the employees did not eat enough fruit and vegetables daily; 63% of the employees were overweight and 61% of them did not have the usual health risk checks like blood pressure and cholesterol checks and chronic depression was a very common chronic condition (Patel 2012:1-2).

Compassion fatigue versus compassion energy

Mendes (2014:1146) argues that compassion fatigue is the reason for nurses giving poor patient care. There are many other reasons given for compassion fatigue, one being that a nurse uses her emotional reserves when caring for patients and these need to be

refueled. The advice given is that nurses should be aware of developing compassion fatigue and plan for activities which they know will help to decompress and to reload their energy levels (Mendes 2014:1146). When one looks at how one practices care and justice or equality of care to all, it is evident that a person could become burnt out, but when compassion is practised correctly, the carer continues to blossom, and compassion fatigue would not be an issue (Frakes 2010:80).

It is stated by Dunn and Rivas (2014:48) that a principle of conduct for PNs is to go about their nursing duties with compassionate care. Findings of a study done on compassion showed that when nurses go about the business of caring for patients as their job, the emotional connection with the patients is the compassionate part of this nursing caring role (Dunn & Rivas 2014:45-48).

Burnout and compassion fatigue are closely related, but can be distinguished from one another in that burnout is gradual in onset. Hooper, Craig, Janvrin, Wetsel, Reimels, Anderson, Greenville and Clemson (2010:422) explain that it is exhaustion that affects the emotional and physical domains of individuals and can progressively worsen in response to ongoing emotionally demanding situations and take longer to resolve. Yoder (2010:191) describes burnout as a failed assertive-goal achievement response wherein individuals experience “frustration, sense of loss of control, increased wilful effort and diminishing morale”. Compassion fatigue in contrast has a swifter onset; it is a natural consequence involving behaviours and emotions resulting from wishing to relieve suffering of people (Hooper et al 2010:422). According to Yoder (2010:191), compassion fatigue can be referred to as the cost of caring, and it can be a rescue-caretaking stress response where nurses have “either turned off their own feelings” or feel anger, helplessness, guilt and distress. When compassion fatigue is given as a reason for poor nursing care, compassion energy is evidently the answer, and the way to prevent compassion fatigue. Compassion energy is achieved when a nurse connects with a patient and to do this the nurse needs to be present with the patient. Practising a higher level of consciousness by the nurse will lead to a more holistic form of compassionate nursing care. In another article written on the same subject, by Dunn (2009a:222), it speaks of compassion energy as being directly opposed to the theory of compassion fatigue. There are some opinions that compassion fatigue would not exist if nurses could tap into true compassion energy. Dunn (2009b:43-45) explains compassion energy as

something that happens when a nurse connects with a patient and this energy is mutually beneficial to both patient and the nurse.

Professional nurses could benefit from a programme designed to assist them with personal stress and fatigue like The Independent Counselling and Advisory Services (ICAS), which is a private provider of behavioural risk management services to private companies. The aim of ICAS is to improve the health and wellness of the employees in a company. Their primary goal is to inform, empower and provide the employees with the knowledge and the wherewithal to take ownership for their own wellbeing. The employee programme could be adjusted to suit nurses by consultation with them (ICAS 2016:1).

Compassion inbuilt or learned?

New developments on the definition of compassionate care by Curtis (2014:211-212) asserts that it comprises the carrying out of professional and personal values through the nurses' behaviour that demonstrates the emotional and moral dimension of caring about another person. Further, it relates to the practical dimension of caring for patients in a way that will holistically recognise and alleviate their suffering by the PNs' actions. Curtis (2014:220) argues that although student nurses are taught very early in the classroom on how to make necessary emotional and moral decisions in practice, they still experience reality shock in the clinical arena. Spending time with patients, touching them, listening to them, being present and answering their questions is often regarded by management as a waste of time and money. Curtis (2014:211-219) writes about the professional and ethical ideals that nurses are encouraged to learn, like preferring the patients, treating them with respect, dignity, listening to their concern's and choices and doing things for patients that make them feel really cared for. When a nurse sees and recognises suffering in her patient and does something to alleviate the patient's suffering he/she is practising emotional labour. This also happens when one experiences an emotion for example disgust, perhaps when a patient is disfigured, and as a choice the nurse suppresses her disgust and shows sympathy. So there is a form of acting that is either conscious or unconscious on the nurse's part that is known as emotional labour. According to Curtis (2014:211-219), there are some studies that have been done that show how important it is for nurses to be taught how to manage their emotions so that they do not harm themselves. When recognising suffering, they need to have the courage to help that person. Nurses could be shown how they will also benefit from a sense of well-being as they rise to the challenge of compassionate nursing care. Nurses need to be able to have

balance between emotional labour to their patient's and the need to care for her own emotional wellbeing. See Figure 1.4 for schematic representation of how nurses can balance their emotions when giving compassionate care (Curtis 2014:211-219).

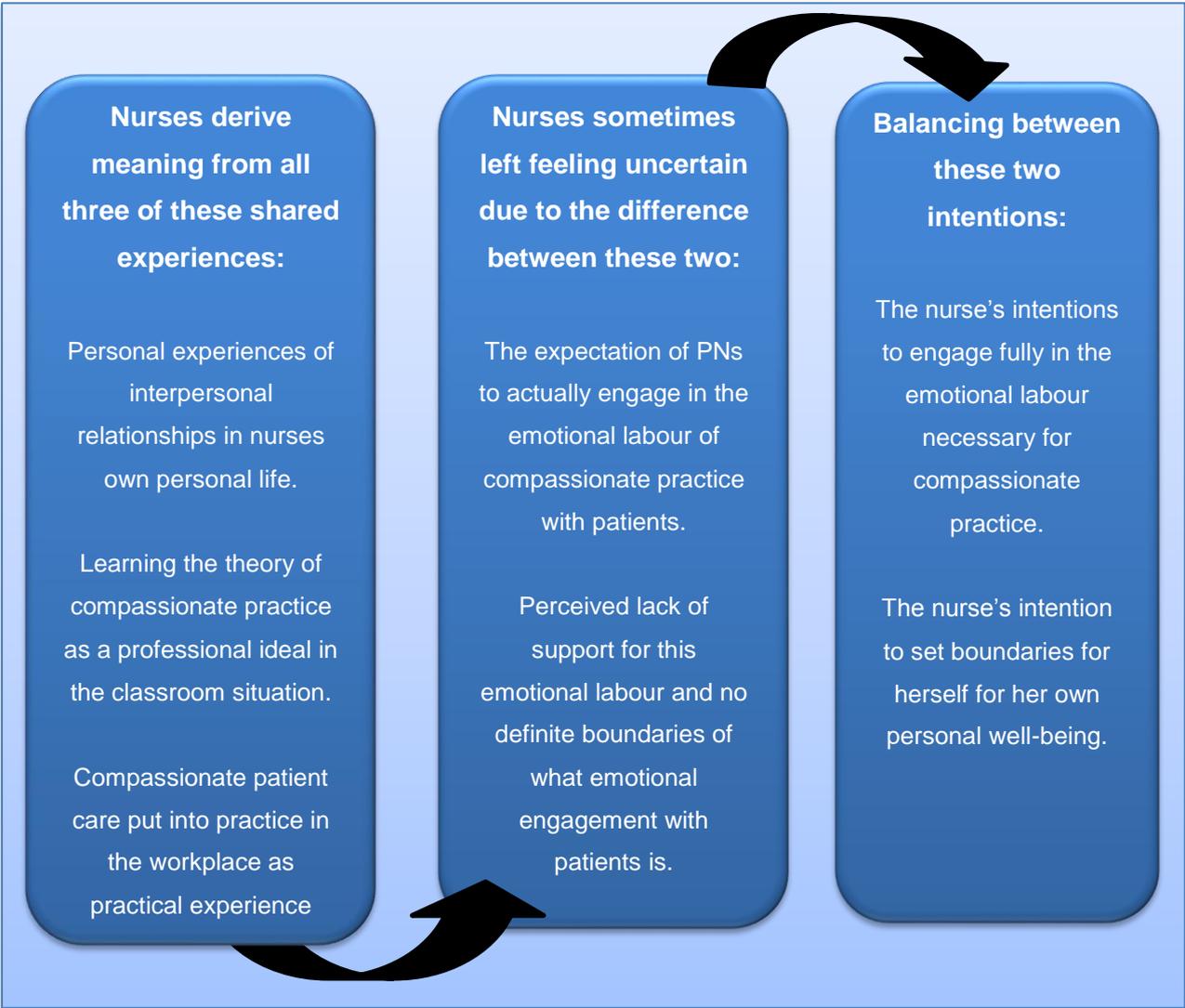


Figure 1.4 Nurses balancing emotions when practising compassionate care

(Adapted from Curtis 2014:211-219)

As Curtis (2014:211-219) points out compassionate patient care does not just happen but develops due to PNs personal experiences, theoretical and clinical learning opportunities, support from management and the nurses own intentions.

According to Straighair (2012:239), although compassion in nursing is fundamental to the nursing profession, it is subjective and not clearly defined. Bearing this in mind, suitable people should be selected to become nurses, having specific values, attitudes and interpersonal relationship skills. Correct curriculum content during nurses training can

help to develop compassion as a core nursing value. Work Integrated Learning (WIL) is a term used in the corporate environment for the marrying of the theory from classroom education with the practical education which mostly happens in the actual work situation, and is overseen by a mentor (Cooper, Orrell & Bowden 2010:1-5). Excellent clinical environment and leadership are necessary to promote compassionate nursing care, and to bring the theoretical work learnt in the classroom into practice. Combining the two forms of learning has become even more important as the nursing profession is looking at PNs having university degrees and more formal classroom education (Cooper et al 2010:1-5).

Psychology teachings are of the opinion that compassion can be developed by training the emotions, so that people don't react out of automation and previous experiences but that nurses can be taught to practise mindfulness as well as cognitive behavioural skills that would lead to compassion that is a choice and a non-reactive action (Frakes 2010:94). According to Moss (2013:2), the best period to learn a second language is before a child is eight years old as they will then be properly bilingual. A second language can be learned later in life, but then it is usually just that, a second language. We also learn our native emotional language early in life, so children that have been taught verbal and non-verbal empathy for their fellow man early in life are at an advantage when they are later in life caring for patients. However, with enough training and experience, it is possible to become an empathetic carer, it will be like having learned a second language later in life (Moss 2013:2). Some values suited for the nursing profession are learned early in life.

However Cole-King and Gilbert (2011:5-6) state that compassion is not just some feel good philosophy, but that it is the beginning of, and the benchmark for the best patient care. Compassionate care assists in the healing process for our patients, both physically and mentally, it helps them to accept disability, disfigurement and even death. If our health care institutions really encourage compassionate care, the patients' hospitalisation will be a more pleasant experience and their expected outcomes will be improved. Even the PNs will suffer less stress and burnout, therefore there will be a lower staff turnover, and job enjoyment for nursing personnel and their feeling of fulfilment will be greater. As illustrated in Figure 1.5 the most important issue is that an organisation/hospital ideally promotes compassionate care. Cole-King and Gilbert (2011:5-6) also state that guidance from good

role models, education and skill development and rewards offered for and to recognise prosocial and compassionate patient care.



Figure 1.5 Compassion for the patient operating through circles
(Adapted from Cole-King & Gilbert 2011:5)

In Figure 1.5, compassion can be shown as developing through circles, from the outside inwards. The outer circle shows the institutional/hospital environment which either promotes or prevents compassionate patient care due to its policies, standards and demands on employees. The middle circle represents the PNs who may or may not achieve compassionate care depending on their training, their own personal issues and the work environment's support system. The inner circle represents the patient who is either the receiver or not of this compassionate care (Cole-King & Gilbert 2011:5-6).

There has long been a debate on whether or not further education for nurses creates better care. The Florence Nightingale Foundation (2014:1213) states that there is a very strong argument for further education as it leads to better compassionate responses in

more educated carers as it provides a focus on holistic health care that takes the patients' needs into consideration and would directly improve good patient outcomes. Educated nurses who are more self-confident, will be more likely to deliver compassionate care as they will have good knowledge of the disease process, they will have had management training and will be better able to take leadership positions. The Florence Nightingale Foundation (2014:1213) quotes Florence Nightingale as having said "For us who nurse, our nursing is a thing which, unless we are making progress every year, every month, every week, take my word for it, we are going back". Aiken et al (2014:1824-1830) add that the more educated the PNs are the more able they will be to have critical thinking processes, management skills, will be able to delegate tasks, will be able to assess and evaluate situations in their units and be able to implement different ways of getting the job done properly. Also the patient acuity levels in the different units should be re-looked at, that is, the ratio of nurses to patients, needs to be adjusted, especially if the nurses are not able to give routine care as well as compassionate care to all of their patients routinely. It would benefit PNs if they had more education on management skills as part of this degree, as it seems that the role is becoming more and more a management position and less hands on nursing, and it has been shown earlier that the type of management affects nurses positively or negatively (Aiken et al 2014:1824-1830).

Rankin (2013:2724) says there are current concerns about the lack of compassionate care and there is much debate regarding which traits or values matter most when employing nurses. So, rather than look for specific values, the study suggests that one looks for nurses with higher emotional intelligence scores as this would indicate that these nurses would know their own values and respect the values of others in their care. They would have the reflexivity to be able to receive training and correction and this in turn would mean better compassionate care for the patients. A study was done by Rankin (2013:2717-2725), which shows that emotional intelligence has an effect on the outcomes of how well nurses treat patients with compassion. Retention of nurses in the nursing profession is not only affected by academic achievement, but also how effectively their emotional intelligence has been developed. Rankin (2013:2717-2725) further states that a lack of emotional intelligence makes nurses not to be aware of who they are, how they think and what their own values are, as well as having inadequate emotional understanding of others. There is a strong correlation between emotional intelligence, clinical practice and academic achievement in nursing students.

PNs caring for all cultures

According to Grills (2006:3-5), Western psychology is said to be quantitative, it can be measured, it is therefore empirical and focuses on natural science and African psychology is qualitative, and contextual, it uses descriptions not numbers, and focuses on human science. People's behaviour is often motivated by their culture, their beliefs, how they see and feel things and what is important to them. From this we can see that PNs need to have a basic understanding of the different cultures of their patients in order to know what matters to them and to enable them to give compassionate patient care to all (Grills 2006:3-5).

Care cannot be considered compassionate if it does not take the diversity of populations into account and if people are not respectful of the different cultures. There is no place for ethnocentrism in the nursing profession; meaning that one has a belief that one's own culture is superior to all others (Douglas, Rosenkoetter, Pacquiao, Callister, Hattar-Pollara, Lauderdale, Milstead, Nardi & Purnell 2014:109-110).

1.2.3 Research problem

According to Polit and Beck (2012:73), a problem statement clearly describes the problem and motivates the need for a study by developing a logical argument. Although a research problem is a troubling condition, the purpose of research is however to make a contribution towards solving the problem. Hofstee (2006:85) states that if there is not a problem, no new knowledge can be found. Researchers do need to state exactly what the problem is, why it is a problem, what the different aspects to the problem are, what has been done in the past to solve this problem and why has it not been enough?

Although compassion is important in a situation where there is human suffering, understanding its meaning by nurses themselves is crucial. Provision of compassionate patient care is a fundamental part of nursing. Individually, nurses have a responsibility to care and show compassion. Monareng (2009:5) lamented that absence of providing professional care without compassion can be impersonal and lead to patients feeling devalued and lacking in emotional support. The need to provide compassionate care is grounded in the nursing history of which Florence Nightingale (1820-1910) was a primary proponent. Although holistic nursing care was encouraged, integration of spiritual care

often seems as lip service (Monareng 2009:1). There is literary evidence that historically nurses incorporated compassionate care as part of their practice however, that seems to be diminishing. Nurses do still assert that their main responsibility is to care for patients which mainly is professional and maybe mechanical. It is, however, seemingly difficult for nurses to identify what exactly comprises compassionate care and or how to give it to their patients. It is in the researcher's interest to gather stories from nurses in order to gain understanding as to what exactly hinders their understanding of integrating compassionate care.

McLeod (2016:1) uses Maslow's (1943) theory of needs to show that our most basic needs are physical survival and this motivates our behaviour enormously (Figure 1.6).

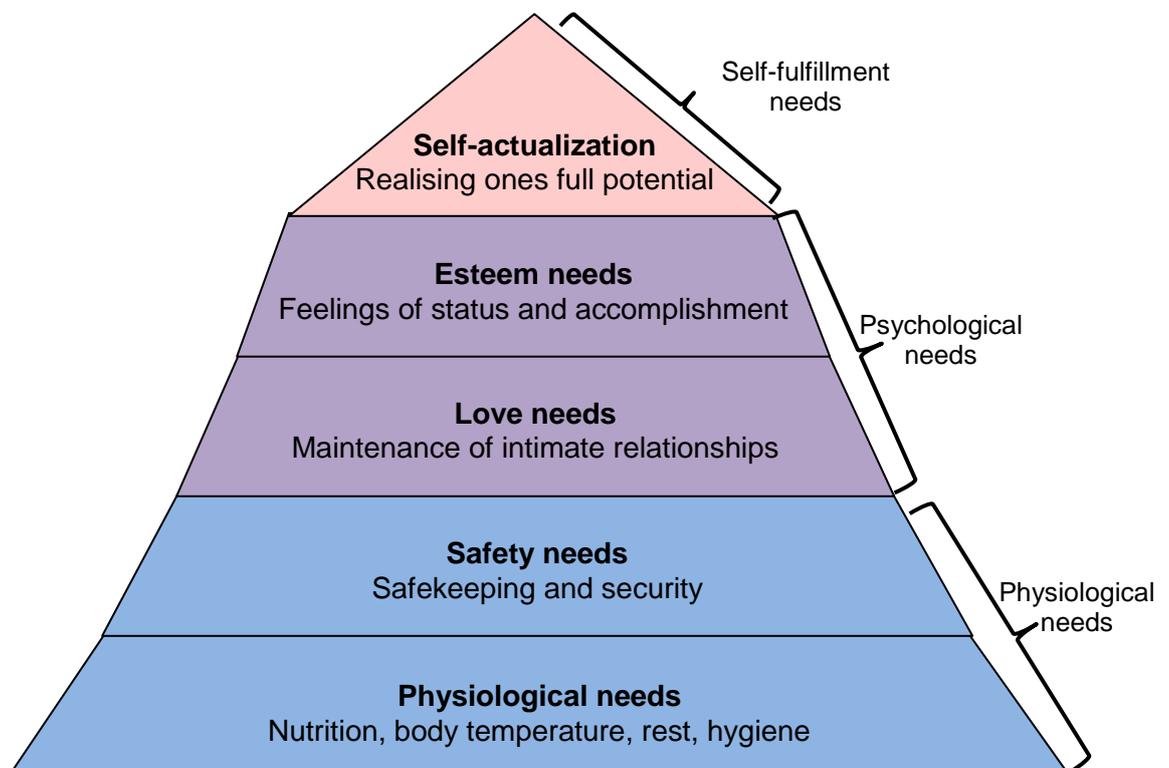


Figure 1.6 Maslow's hierarchy of needs theory

(Adapted from McLeod 2016:1)

In Maslow's Theory of needs (McLeod 2016:1) the basic needs start at the bottom and then move up to safety and security, the emotional needs and up to self-actualisation needs, and it is evident that we as human beings find it difficult to operate on the higher levels such as emotional and spiritual levels if our basic needs are not met first. This

applies to both our patient's and the nursing staff themselves. Hygiene, mobilisation, eating, vital signs and pain relief all fall under the basic physiological needs which need to be satisfied before one can move up to the higher levels of care. From this finding, it seems that basic nursing care needs to address these physiological needs for the patient's to feel comfortable and cared for. It is however intriguing that compassionate care is seen by the participants as in addition to the meeting basic physical needs of patients, when it is imperative that everything a nurse does to and for her patients is done with compassion. According to Maslow (1943), people's actions are motivated by whether their needs are met or not and the physiological needs are mentioned by all the participants first when asked how they give compassionate patient care (McLeod 2016:1).

There seem to be both internal and external barriers experienced by nurses in practice in being compassionate towards patients. This could be in relation to the perception of management on value of services versus costs, the experience of students in the classroom and the reality in the clinical environment (Van der Wal 2006:55).

The research problem was that PNs were not able to give the compassionate patient care that they did in earlier years, their understanding of this care was unclear and the reasons why they were unable to give this care were complex. Therefore, the central theoretical statement was: what are the experiences of professional nurses in providing compassionate patient care in a private hospital in Gauteng, South Africa: a qualitative narrative analysis.

1.3 AIM OF THE STUDY

1.3.1 Research purpose

The purpose of this study was to explore and describe the experiences of PNs in providing compassionate patient care in a private hospital, Gauteng, South Africa.

1.3.2 Research objectives

Bowling (2009:152) distinguishes the difference between aims and objectives as objectives being the operational tasks which one has to carry out in order to meet the aims.

The objectives of this study were to:

- Explore and describe the experiences of PNs in providing compassionate patient care in a private hospital, Gauteng, South Africa.
- Describe the reasons that hinder PNs to provide compassionate patient care in a private hospital, Gauteng, South Africa.

1.3.3 Central theoretical question (research question)

The central theoretical statement was: “Tell me, what are your experiences as PNs when you provide compassionate patient care in the units during your daily work?”

1.4 SIGNIFICANCE OF THE STUDY

Findings from this study revealed gaps on how theory learnt in the classroom is implemented in practice in terms of compassionate patient care. Therefore, these findings may be used as a spring board in the nursing clinical field to empower nurses on how to be compassionate in relation to their professional expertise. The findings may be used to further research on the phenomenon to develop and guide clinical managers and mentors on how to support nurses in practice to compassionately care for patients without waste of time and money. Professional nurses will be empowered by the findings to view the importance and impact of compassionate care as part of professional practice. In-service education for PNs on the study phenomenon can also be offered and be presented at the private hospitals for improvement of the quality of patient care with long term dividends financially and socially (Polit & Beck 2012:708).

The study has theoretical, clinical and educational significance as it will assist in identifying what factors hinder or promote provision of compassionate patient care in practice or misconceptions about the phenomenon and how it impacts on patient care outcomes that has long term benefits for hospital credibility and the nursing profession.

1.5 DEFINITION OF TERMS

Conceptual and operational concepts used in this study:

Compassionate patient care

Compassion is defined as a feeling of deep sympathy and sorrow for another who is stricken by misfortune, accompanied by a strong desire to alleviate the suffering (*Dictionary Unabridged* 2015 sv “compassion”).

According to *Free Merriam Webster Dictionary* (2014b sv “compassion”), *compassion* is defined as a feeling of wanting to help someone who is sick, hungry or in trouble.

Compassion is defined as a way of living born out of an awareness of one’s relationship to all living creatures. It engenders a response of participation in the experience of another’s sensitivity to the pain and brokenness and a quality of presence that allows one to share with and make room for the other (Dunn 2009b:42).

Compassion is defined as a strong emotion brought on by the presence of suffering that causes acknowledgement and sharing of the despair or pain of the sufferer (Kret 2011:29).

Patient is defined as a person who is physically or mentally ill, who is receiving or registered to receive medical treatment or nursing care (Freshwater & Maslin-Prothero 2005:440).

Care is defined as a procedure whereby the caregiver commits to look after the patient’s needs by making an effort to do something correctly, safely, or without causing damage; to keep someone healthy, safe, or to keep something in a good condition (Freshwater & Maslin-Prothero 2005:108).

Care is defined as the provision of what is necessary for the health, welfare, maintenance and protection of someone or something (*Oxford English Dictionary* 2002:124).

In this study, compassionate patient care refers to caring for patients by PNs in a holistic, humane, empathetic, reassuring and caring manner as part of their professional practice and not just carrying out procedures or rendering a service for remuneration only. It refers to the way in which the PNs treat their patients and whether the patients’ needs are met

with kindness and empathy, whether the care they are given is with compassion, consideration, listening skills, presence and showing concern.

Experiences

Experiences are defined as the processes of doing and seeing things and having things happen to you. It is practical knowledge, skill or practice derived from direct observation of participation in events or in a particular activity (*Free Merriam Webster Dictionary* 2014c sv “experiences”).

An experience is defined as a particular instance of personally encountering or undergoing something; the process or fact of personally observing, encountering or undergoing something (*Dictionary.com* 2015:1).

In this study, experiences refer to how PNs see and feel about the way they practice their professional work compassionately with an intention to care for their patients and meet their practical, aesthetic and or humane needs.

Private hospital

Private is defined as belonging to some particular person/s (*Free Merriam Webster Dictionary* 2014 sv “private”).

Hospital is defined as an institution that is devoted to the diagnosis, treatment, and rehabilitation of persons who are mentally or physically ill or injured (Freshwater & Maslin-Prothero 2005:280).

In this study, *private hospital* means a hospital which is not run or funded by the state but is a business owned by private people or groups, more for profit making purposes. The patients admitted to these private hospitals are usually paying large amounts of money for their care, either themselves or through their medical aid schemes.

Professional nurse

According to the Nursing Act 33 of 2005 (as amended) a *PN* is defined as a person who has satisfied the minimum educational requirements of the SANC which has led to

registration, as per guidance under section 31 of the Act, with the SANC as a qualified PN. The South African Nursing Act (South Africa 2005:6) defines a 'registered nurse' as a health care professional who has graduated from a nursing programme and has passed a national licensing examination. This person is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and is capable of assuming responsibility and accountability for such practice.

Professional nurse embodies many values present in those who pursue nursing careers, including honesty, responsibility, pursuit of new knowledge, belief in human dignity, equality of all patients and the desire to prevent and alleviate suffering (Gokenbach 2012:1).

In this study, a *PN* is a qualified professional nurse, employed by a private hospital, who utilises skills, knowledge and values as taught to provide holistic patient care to private patients, including compassionate care that cannot be quantified or an immediate monetary value put on it.

Qualitative narrative analysis

Qualitative research is defined by Burns and Grove (2007:551) as a systematic, subjective methodological approach used to describe life experiences and give them meaning.

Narrative is defined by Streubert and Carpenter (2011:41) as a data collection strategy used in place of or in addition to an interview.

Narrative analysis is, according to Streubert and Carpenter (2011:41), a research method which is the systematic study of the stories collected from participants in a study. Streubert and Carpenter (2011:41) further state that the terms story and narrative are both used to describe either the oral or written work of a person who is telling someone about events that happened to them and the consequences of these experiences.

Creswell (2013:54) defines *narrative analysis* as a specific type of qualitative design where narrative is understood as it is spoken or as written text. The participant is asked

to give an account of an event or action or series of events or actions which are then placed in chronologically order to provide meaning to the experiences.

Polit and Beck (2012:504) define *narrative analysis* as a method that focuses on the story as the object of inquiry, which is used to explore how individuals make sense of the events in their lives.

In this study, *qualitative narrative analysis* is an approach that will be used as a research design to guide data collection and data analysis.

1.6 THEORETICAL FOUNDATIONS OF THE STUDY

Qualitative studies do not necessarily use theoretical frameworks as foundation of the studies as findings from qualitative studies are often used to develop theory. However, in this study meta-theoretical assumptions were utilised to strengthen the theoretical argument and clarification of concepts. The following assumptions exposted which were epistemological, ontological, teleological and methodological assumptions.

Meta-theoretical assumptions

Meta-theoretical assumptions, according to Polit and Beck (2012:11-13), are basic principles that are assumed to be true based on logic and reason, without proof or verification.

According to Mouton and Marais (1994:14-15) *epistemological assumptions* are regarded as the embodiment of the ideal of science, namely the search for truth. In this study the findings are as a result of that interaction between researcher and participants (Polit & Beck 2012:13) In this regard, the epistemological assumptions were as follows:

- Narrative data can elicit an understanding of the meanings that PNs attach to compassionate patient care as experienced in the units and expressed in their stories.
- Theories inductively generated from data are likely to offer insight that can help researchers identify factors that may hinder or promote a demonstration of actions,

behaviour or responses related to the provision of compassionate patient care as is the case of this study.

Ontological assumptions, according to Polit and Beck (2012:13), refer to the study of being or reality. The ontological assumptions underlying this study were as follows:

- Multiple realities exist with regard to provision of compassionate patient care by PNs and these can be captured by means of qualitative narrative research.
- Reality is constructed and interpreted based on the experiences of individuals and may be expressed in written stories.

Teleological dimension is explained by Lor (2012:7) as an inclination to desire the acquisition of knowledge which stems from a fascination with occurrences. The teleological assumptions of this study were:

- Knowledge taught in the classroom can be translated or used as a guide for provision of compassionate patient care in clinical practice
- Knowledge of concepts such as compassionate care is power, so through its provision the reality of sickness, disease, depravity, suffering and pain can be changed for the better with improved outcomes.

Methodological assumptions, according to Polit and Beck (2012:13), provide the 'how' of research. In other words, how should research be planned, structured and executed to comply with the criteria of science. There is more focus on subjectivity in qualitative studies that is why it is suitable for this study. It refers to the logic of implementing scientific methods in the study of reality. Methodological assumptions regarding this study were as follows:

- Qualitative research supports naturalistic inquiry to collect narrative data on reality which is constructed by people who write about their experiences or stories on phenomena.
- Inductive reasoning in this study stems from a specific premise of the experiences of PNs to the general in which particular events as narrated and are combined into a larger whole or general statement related to compassionate patient care.

Meta-theoretical assumptions are based on a paradigm which is a world view. In this study the constructivist paradigm assumption is used as it is more suitable for qualitative narrative inquiry. The constructivist study relies on interaction between the participants and the researcher in order to understand the phenomenon which in this case is the experiences of professional nurses in providing compassionate patient care in a private hospital.

1.7 RESEARCH DESIGN AND METHOD

The research design and method was briefly outlined in this chapter to be discussed in detail in chapter 2. The study was conducted in a boardroom in a private hospital which is situated in an old suburban area, consisting mostly of middle and upper middle class citizens. The hospital has 469 beds and is close to schools, townhouse complexes, free standing homes, retirement villages, municipal offices and many shopping malls. The hospital units are varied with PNs as leaders and supervisors of care provided.

The researcher acquired permission from the Health services manager and the Hospital manager in order to conduct the study (Annexures B and C).

A qualitative descriptive research design was utilised based on qualitative narrative analysis. The universal population of this study was PNs working in private hospitals in SA. The target population for this study, as described by Polit and Beck (2012:275), was determined by the sampling criteria. The accessible population was all the PNs who were on duty on the days of the data collection. Inclusion criteria were participants who had to be above 20 years of age; all racial groups were included; they had to have at least 2 years of experience as PNs. The participants had to be PNs working in a private hospital and could be male or female. Exclusion criteria were PNs who didn't meet the inclusion criteria and who were not willing to participate in this study. Sample size was not predetermined but data was collected until data saturation. Data was collected using written narrative stories and professional timelines. Arrangements were made with the managers of the units on times of data collection and venue used, after ethical clearance and permission were obtained. Adequate needed stationary and refreshments were made available and guidance was given to the participants about the definition of the construct (Annexure D), how to complete the questions and the professional timeline

(Annexure E). The completed written narratives were collected by the researcher from the participants and the data analysis began immediately. Thematic and narrative analysis was used to analyse data. Themes, categories and sub-categories emerged from the data and the findings are presented in Chapter 3.

Trustworthiness was ensured by applying criteria of Lincoln and Guba (1985) as cited in Polit and Beck (2012:175), which are credibility, transferability, confirmability and dependability. Ethical considerations were ensured by demonstrating respect of the rights of the study institution, the rights of the participants and scientific integrity (This section is discussed in detail in chapter 2).

1.8 SCOPE OF THE STUDY

An acceptable research question should limit the scope of the study as this would lead to a trustworthy conclusion, if the scope is too broad the conclusions may be vague. As long as the study is significant, there is no reason to widen the scope (Hofstee 2006:28).

In this study the scope of the study was limited to PNs who were employed at the private hospital where the study was conducted and who were available on the day that the study was conducted.

1.9 STRUCTURE OF THE DISSERTATION

The dissertation consisted of four chapters, see Figure 1.7.

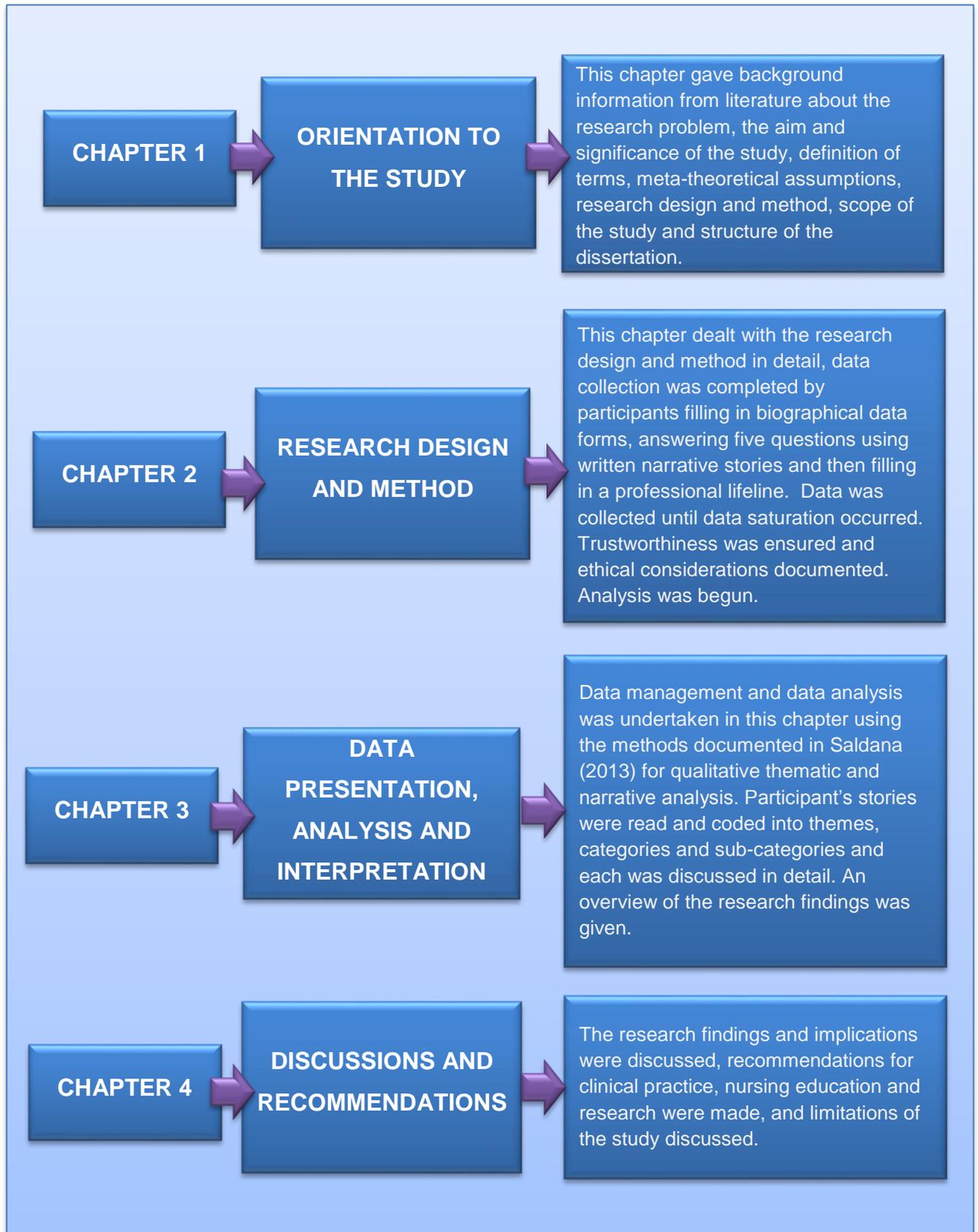


Figure 1.7 Structure of this dissertation

1.10 CONCLUSION

A comprehensive literature review was undertaken of at least 50 articles, and previous studies and books were looked at in order to gain background information on the phenomenon. This chapter further presented the study phases, the research purpose, objectives and the central theoretical statement and the significance of the study was discussed. Meta-theoretical assumptions were highlighted for conceptual clarity. A brief introduction of the research design and method, the scope of the study, ensuring trustworthiness and ethical considerations were introduced. Chapter 2 will present discussion on the qualitative narrative analysis research method and design.

CHAPTER 2

RESEARCH DESIGN AND METHOD

Caring healing consciousness calls forth the concept and practice of being mindfully present – holding compassion equanimity and a non-judgemental stance.

Jean Watson

2.1 INTRODUCTION

A guide, a recipe or a map is needed in order to reach a conclusion in a study and the research design and method in this study are the map which is used to draw conclusions about the study phenomenon. The findings and conclusions made can then be understood, and either accepted or rejected based on the map of how the researcher arrived there. The entire success of this study hinged around the design and methods that were used (Hofstee 2006:107).

In this study, a qualitative and descriptive research design using the qualitative narrative analysis approach was used. This analysis method enabled the researcher to analyse beyond what is documented in the stories as data, and to see the meaning of what is being said from the participants own worldview (Yardley 2006:1-13).

The design was chosen for this study as it allowed the researcher to listen to the human participants as they wrote down stories of their own experiences in clinical practice concerning the study phenomena and then to make sense of, or identify meaning attached to these experiences. Specific reference is given to the study research setting, design, research method, ensuring trustworthiness as well as the ethical considerations.

This study was conducted in phases, the second phase in Figure 2.1 applies to this chapter and is shaded differently.

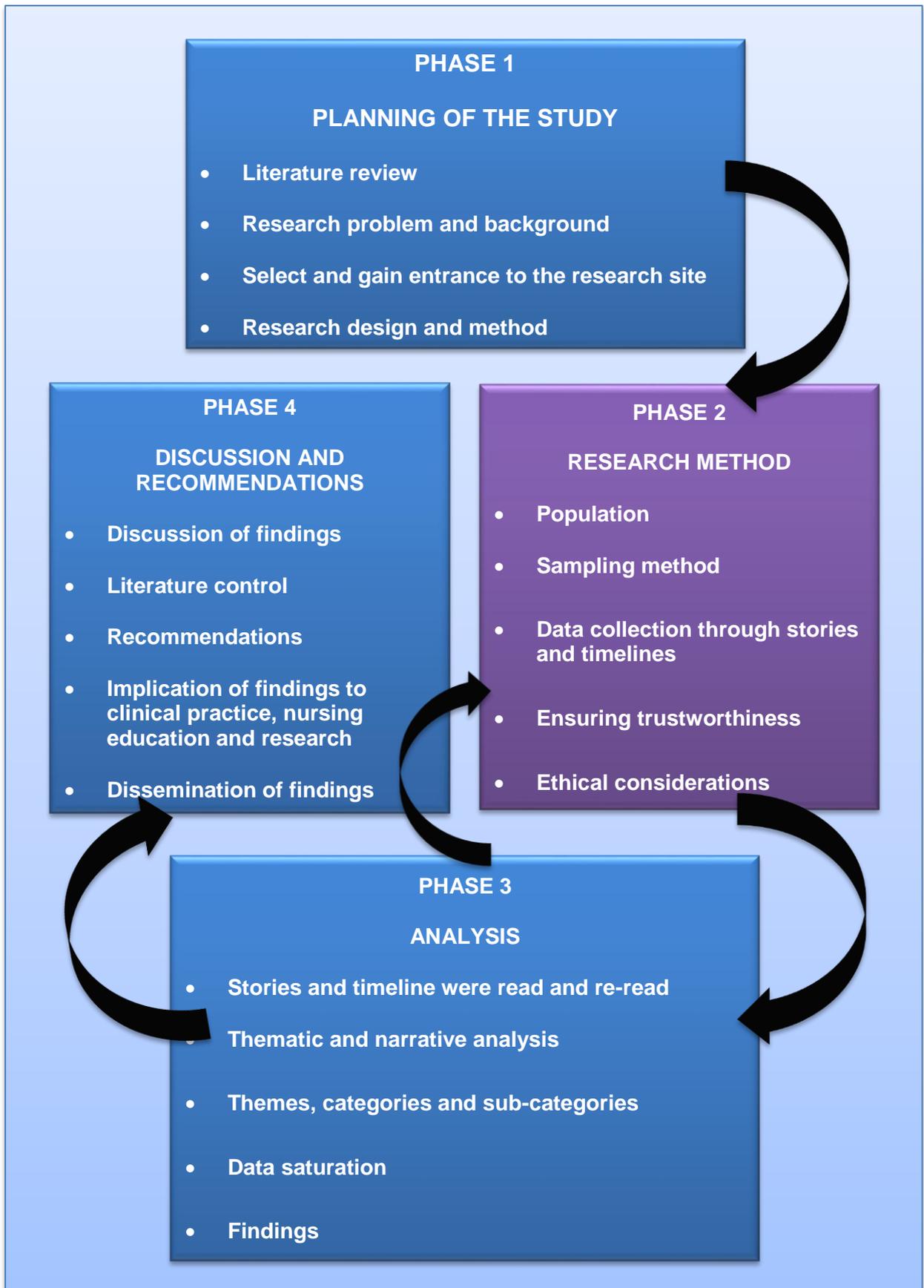


Figure 2.1 Flow of research activities in phase 2
(Adapted from Polit and Beck 2012:61)

In this phase research methods, population, sampling techniques were examined, data collection of written stories and professional timelines was undertaken. Trustworthiness was ensured and ethical considerations taken into account and presented in Figure 2.1.

The central theoretical statement of this study was: “Tell me, what your experiences as PNs are when you provide compassionate patient care in the units during your daily work?”

According to Grove, Burns and Gray (2013:138-140), objectives of a study need to be clear and to the point. In the case of a qualitative study, the objectives were guided by the study purpose and had a broader focus.

The objectives of this study were to:

- Explore and describe the experiences of PNs in providing compassionate patient care in a private hospital, Gauteng, South Africa.
- Describe the reasons that hinder PNs to provide compassionate patient care in a private hospital, Gauteng, South Africa.

These objectives guided the researcher in the subsequent research processes.

Research setting

Research settings are specific places or physical locations where the study is conducted or data collection occurs. In-depth qualitative study is likely to be done in a naturalistic setting or field which is an uncontrolled, real life situation or environment. Conducting a study in a natural setting means that the researcher does not exercise control over or change the environment. Such settings can be at people’s homes or places of work (Burns & Grove 2007:29-30; Polit & Beck 2012:57). The study took place in the boardroom attached to the Health services manager’s offices, in a 469 bedded private hospital situated in the Gauteng province of SA.

The different units were manned by different categories of nurses, with at least 3 to 4 PNs on duty at a time to provide leadership. The patient turnover comprised of long term and short term intakes with units specialising in surgery, medical, oncology, cardiology,

orthopaedic, maternity, paediatric, gastro-enterology, medical, surgical and trauma ICU's and trauma emergency services. The participants interviewed were recruited from different units.

2.2 RESEARCH DESIGN

A *research design* is defined as an overall plan for addressing a research question, including specifications for enhancing the study's integrity (Polit & Beck 2012:741). It is the section in which the methods used are applied to explore and answer the research question (Hofstee 2006:113). In addition for further clarity Grove et al (2013:195) define a *research design* as the outline for conducting the study that assures control over aspects that could hamper the trustworthiness of the study findings. It leads the way in the planning and execution of the study in order to achieve the most credible findings.

The reasoning behind choosing a qualitative, descriptive narrative design, was that a quantitative study would not be able to answer the study question of a human phenomenon such as compassion as it cannot be reduced to a mathematical formula. This design assisted the researcher to enter into the world of the participants who provide care to patients and to understand the basic processes of human behaviour and response to illness and suffering (Streubert & Carpenter 2011:3). Although the design is not rigid, the researcher started by arranging interviews with participants, and they were asked to give a written stories, in reply to five questions of how they have been able to give or not give compassionate care to their patients.

- **Qualitative paradigm**

According to Polit and Beck (2012:736), a paradigm is a method of viewing a natural phenomenon and contains philosophical assumptions that directs ones method of inquiry. It is a specific way of looking at a phenomenon in the world (Grove et al 2013: 702) and Bowling (2009:467), add that it is as a set of ideas or theories about a phenomena under analysis. Qualitative research is a method to describe life experiences from the perception of the persons involved. Grove et al (2013:57) report that qualitative research is a way to give meaning to subjective human experiences as well as acquire understanding of phenomena to guide nursing practice.

Qualitative research is a general term used for research methodologies that aims to describe and explain a person's lived experiences, their behaviours, interpersonal interactions and social contexts without the use of statistical procedures or being able to put numbers to the research, rather through written data or spoken words. Alpaslan (2014:2-5) further explains that qualitative research is an inductive process, the data will inform the researcher, it is an open ended process, and it develops as the research continues. The researcher that decides on the qualitative method is interested in what the participant's experiences are, and the meaning he/she makes from these experiences.

General characteristics of qualitative research:

- It is often necessary to combine several data collection strategies or of analysis, which is called triangulation.
- The research design is often adaptable, able to be adjusted to new information received as the study progresses.
- It is usually holistic, the researcher endeavours to understand the whole of peoples's experiences.
- The researcher tends to become extremely involved which makes critics of this paradigm to label it as subjective in nature.
- The researcher is actually the research instrument.
- The analysis of the data collected is usually ongoing in order to facilitate strategies for going forward as well as to know when data saturation has been reached, which is determined by the fact that no new information emerges from the participants (Polit & Beck 2012:487).

Justification for use of the qualitative paradigm

As with all research designs, the qualitative method of inquiry in this study, had relevance because of the nature of the topic and research questions to be addressed.

- It provided a way to investigate subjective human experiences in a natural setting. This study could be useful to practicing nurses, as evidence based practice is important for better health outcomes (Polit & Beck 2012:487-488).

- Qualitative enquiry is holistic in nature as it attempts to understand the experiences of people wholly. In this study it allowed for a deep reflection of the PNs stories on how the provision of patient care led to the wholeness of humans which included the mind, body and spirit (Monareng 2009:4).
- In the use of this paradigm, only the researcher was in a position to be able to be the voice for the participants, however, bracketing was applied throughout to prevent the researcher from allowing her own opinions to influence findings.
- This approach was not rigid, the researcher based the enquiry on the views of the participants which were not initially known to her. The study was emergent, it kept on changing and developing as the researcher reflected on what had been presented (Polit & Beck 2012:487).

Challenges on the use of the qualitative paradigm

- Data was collected from PNs who may have been sensitive and made mistakes in reporting their sometimes forgotten stories which could make some of the findings trivial (Polit, Beck & Hungler 2006:15).
- However, the researcher tried to achieve objectivity, and to avoid her own biases which could have crept into the analysis and the way of stating the findings and could impact on the conclusion (Grove et al 2013:598).
- Another challenge of qualitative narrative analysis as was experienced by the primary researcher was that both the written interviews and the analysis of the data were time consuming and became emotionally draining (Madrigal & McClain 2012:3-4). Although samples were small, data was comprehensive and cumbersome during analysis (81 pages).

Although the qualitative paradigm has some disadvantages it has been found to be useful in naturalistic environments like nursing.

- **Descriptive paradigm**

The main objective of descriptive research in this study was the accurate portrayal of nurse's circumstances through narrative stories, to determine the frequency with which certain phenomena occur. The purpose of a descriptive study is to describe and document aspects of a situation as it naturally occurs, and sometimes to serve as a

starting point for hypothesis generation or theory development (Polit & Beck 2012:226,725). According to Burns and Grove (2005:45), the purpose of descriptive research is to describe phenomena in real-life situations. In this study it was used to generate knowledge and concepts and topics about which there was limited research as the PNs' own stories had not been adequately heard.

- **Qualitative narrative research**

Narrative research refers to a qualitative approach that concentrates on stories from participants as the object of analysis (Polit & Beck 2012:735). It is described as a qualitative way of formally analysing data which includes stories (Grove et al 2013:700).

Narrative analysis is a specific type of qualitative design where narrative is understood as it is spoken or as written text. The participant is asked to give an account of an event or action, or series of events or actions which are then chronologically ordered to provide meaning to the experiences (Creswell 2013:54). It focuses on the story as the object of inquiry, which is used to explore how individuals make sense of the events in their lives (Polit & Beck 2012:504). Trahar (2009:1) states that Narrative Inquiry is a type of qualitative research that comes from both interpretive hermeneutics as well as phenomenology. Narrative analysis has been influenced by many disciplines such as philosophy, psychotherapy, psychology and sociology.

- **History of narrative analysis**

Narrative analysis developed as a form of qualitative research in the early 20th century. Narrative inquiry can use the spoken or written word. Narrative inquiry was first used in the early 1980's by the field of knowledge management. The narrative method of research utilises the idea that knowledge is kept in stories which can be told or re-told, remembered and kept in memories and retrieved when needed. The way knowledge is shared is primarily through the narrative, either written or spoken, so knowledge management and the narrative are interdependent (Durque 2010:1-2; *Introduction to knowledge management* 2016:1-5).

There is a swing towards using the narrative in conducting research and in the analysis of research because there is much reflexivity practised in these postmodernist times, so

there is more emphasis on developing the self. This leads to more emphasis on individuals and their behaviour and not just about examining social structures. There is much more literature on understanding the self, and the reflexivity leading to self-discovery. There are also therapeutic benefits for the storyteller as he/she learns more about him/herself as the story is being told. Narrative analysis highlights both what is being said and how it is being told, and it gives the researcher more vital detailed information (Johns Hopkins School of Public Health 2008:5-7).

As with the way narrative research is done and analysed, there are also some differing opinions on the history of narrative research. Andrews, Squire and Tamboukou (2008:3-18) argue that most of the present day narrative research is found in two academic moves which are the humanist approach which developed after World War 2 and focuses on individual human stories; the second is poststructuralist which became evident in the late 1970's and is more concerned about the content of the story and the way it is structured. Although there are differences in the two moves, there is also some common ground, both humanist and poststructuralist moves are often used to see narratives as resistance to existing structures of power. Andrews et al (2008:3-18) further state that a difference within narrative research is whether one focuses on the retold stories of past events that happened to the storyteller, or experience centred stories that the narrator tells which may be more general and actual or even imagined, things that might have happened to the narrator or he/she might even have heard about these events having happened to someone else. Another field which narrative research looks at, apart from the event or experience centred approaches, is the stories that address social codes and conduct of groups of people. Researchers could be interested in how the individual feels or experiences the life events, or more interested in how the stories affect society at large, but some types of narrative analysis are interested in both of these.

Application of narrative research in this study

This design was applicable to this study, although the researcher was looking at individuals' stories, she looked for a common thread, themes and categories that developed when nurses experienced the same emotions or attributed the same meaning to an event. Then the stories became relevant to the community of PNs and their professional practice. There are also some questions as to how the audience has an effect on the storyteller and thus the story, this is why the researcher asked the

participants to write their stories down with patients as recipients of care and audiences of that care. It can be accepted that narrative research is multi-faceted and multi levelled and can be used across many disciplines including nursing as an in-depth form of research (Andrews et al 2008:3-18).

What separated narrative analysis from other types of qualitative research designs in this study was its broad idea that PNs most effectively made sense of their world by building and telling their written stories. They were able, by telling stories, to understand events and situations that allowed them to link their internal world of need and intention to the external world of their own visible actions as they provide compassionate patient care (Polit & Beck 2012:504). The powerful effect of the PNs' stories was in the transportation that the story teller had to "mentally transport" the reader of the texts into the world that was created by them. There was power in the stories that were narrated by the participants and even had the ability to change the opinions of the readers through the written word (Jones 2014:994-997). Using the narrative approach in this study assisted the researcher to emphasise how absolutely important the actual stories of the PNs were to be told as was experienced. The emphasis in the narrative approach was on the analysing of the content of the stories to identify meanings attached to them in terms of what hindered them or enabled them to provide compassionate patient care (Bowling 2009:422). This finding concurs with Trahar (2009:1) who explains that narrative inquiry comes from the fact that we humans understand and explain our lives and our experiences through stories and that we can give our lives meaning through them. Based on the findings of Trahar (2009:1), the researcher realised that the narrative written information that was gathered was after the experiences of the highs and lows of the PNs as they endeavoured to provide compassionate patient care that gave meaning to what had happened in their interaction with patients.

Use of qualitative narrative research in this study had no clear starting or finishing point, as there were no set rules regarding tools or materials that the researcher used. However, the researcher has chosen this method in an attempt to bring many layers of meaning in answer to the research question. It was not only about the stories, but how they were told, why were they being told, what meaning they had to the PNs who were telling them but what significance it has to the nursing profession at large. It helped the researcher to understand and perhaps explain the research question to other colleagues (Andrews et al 2008:3-4).

2.3 RESEARCH METHOD

Research method refers to the whole blueprint to be used for a study, from the statement of the research problem to the strategies for the data collection and analysis. It refers to the process or development of plans for actually carrying out the exact steps of the study (Grove et al 2013:195, 707).

Research methods in this study referred to techniques and processes that the researcher used to structure the study and stated how to gather and analyse data in a systematic way (Polit & Beck 2012:741). The flow of the activities of this study referred to implementation of the research method as *Research method* in qualitative research is mostly constructivist because humans are complex, and the truth often consists of the sum of many realities. In-depth information from the stories collected offered relevant information regarding this complicated phenomenon which was revealed in the findings (Polit & Beck 2012:14-15).

2.3.1 Population

Population is defined as all the individuals having some common characteristic, as in this study it refers to all PNs in private hospitals (Polit & Beck 2012:738). It is all the elements, be it individuals or objects that meet the same criteria for inclusion in a study (Grove et al 2013:703). Population and sample are evidenced in Figure 2.2.

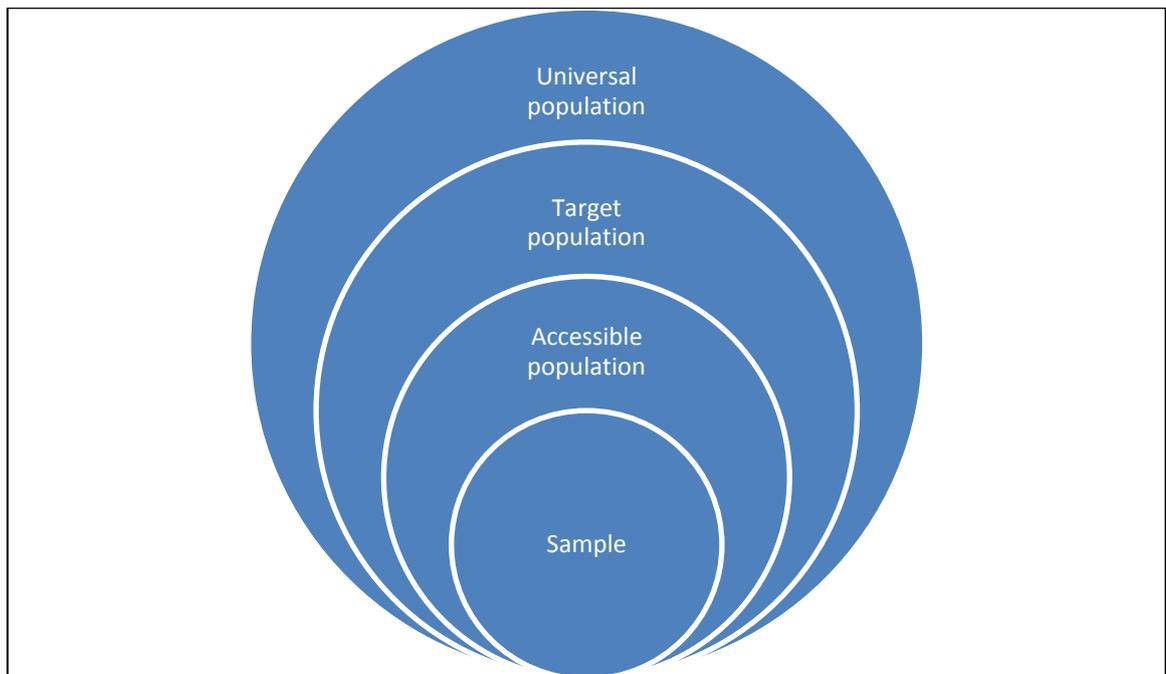


Figure 2.2 Population and sample

(Adapted from Grove et al 2013:352)

The universal population of this study was all PNs who work in private hospitals in SA. The target population was the entire population of PNs who work in the private hospital where the study was conducted and were eligible to take part in the study and to whom the findings will be contextualised. The accessible population for this study was the PNs who were available and willing to participate in the study, and met the study sampling criteria (Polit & Beck 2012:744,719) on the days when data was collected.

Inclusion study criteria is defined by Burns and Grove (2007:542) as characteristics that the participants must possess to be included as part of the target population for this study.

Inclusion criteria in this study:

- Participants had to be above 20 years of age.
- All racial groups (White, Black, Coloured and Indian) were included.
- They had to have at least 2 years of experience as PNs.
- PNs working in a private hospital.
- Male or female PNs.

Exclusion criteria is defined by Burns and Grove (2007:539) as those elements that could cause a person to be excluded from taking part in a study.

Exclusion criteria in this study:

- PNs who do not meet the requirements of the inclusion criteria.
- PNs who are not willing to participate in this study.

The thirteen participants all met the inclusion criteria.

2.3.2 Sample

Qualitative researchers select a sample of individuals who will have much rich information regarding the question of the study. Some individuals will be able to give many examples of incidences, so a small number of participants can yield a large sample for analysis (Polit & Beck 2012:515). Sample is defined by Burns and Grove (2007:554) as a subset of the population that was selected to take part in the study.

There are two criteria mentioned by Polit and Beck (2012:527), adequacy and appropriateness which were used when trying to evaluate the sample that was used for this study:

Adequacy was achieved when there was enough data and the type of data was rich enough. When data saturation was reached at the thirteenth interview, and there were no new themes, categories or concepts being raised, then the sample was deemed adequate.

Appropriateness refers to the methods that the researcher uses to select the sample, and in this study participants that were information rich and had experience of the phenomenon under study, and were able to leave the unit for the time it took to do the study, were identified and interviewed (Polit & Beck 2012:527).

The sample of PNs that were included in this study met the inclusion criteria.

2.3.3 Sampling and sampling method

Sampling is the process whereby a portion of the population is selected to represent the entire population (Polit & Beck 2012:742) which is elaborated by Grove et al (2013:708) saying that it also refers to the choosing of groups of people, events, behaviours and or other components with which to carry out a study.

Purposive sampling method was used as this allowed the researcher to ask the most conveniently available people working at the nearest private hospital (Polit & Beck 2012:276). The *purposive sampling* method was appropriate to recruit participants as they were known to be rich with information to answer the research question because of their experience from working with patients.

Sampling size was not predetermined but narratives or stories were read until no new information emerged from the participants, and the same themes were re-occurring and data collection stopped at the thirteenth written narrative (Polit & Beck 2012:517-521).

2.4 DATA COLLECTION

Data collection is defined as a process of gathering information which was appropriate to address the research questions and objectives (Polit & Beck 2012:725). This study was conducted in the natural setting of the PNs at the hospital where they are employed and were able to feel relaxed and write freely.

2.4.1 Data collection approach and method

Data was collected by using an interview guide (Annexure E) to illicit stories that were written narratives of experiences of PNs as they provided compassionate care to patients. The grand tour question was broken into five open-ended questions that had no pre-established answers, and the participants answered in writing using narrative descriptions of their own choice (Polit & Beck 2012:721 & 736).

The following five questions were asked of the participants:

- In your own words, what is your understanding of giving compassionate patient care?
- How do you provide compassionate patient care?
- What are your experiences in providing compassionate patient care as a professional nurse, in terms of your highs and lows?
- Write down your experiences of providing compassionate patient care in the last week. Use the questions How? When? Who? What? Where?
- Has your compassionate patient care changed over the years and if so how and why?

These questions assisted the researcher to keep focus on eliciting concise information to answer the research question. An interview guide was used not for face to face interview but participants had to write their stories.

2.4.2 Data gathering method

There were no formal structured questions, but an interview guide (Annexure E) with open-ended questions was used to collect data. It had three sections as follows:

Section A was the collection of biographic data.

Section B was a set of five open-ended questions derived from the central theoretical statement or the grand tour question (see section 2.4.1). Each participant was asked to write their own stories guided by the questions in this section of the interview guide.

Section C was the professional nursing timeline which represented their nursing career as PNs in the form of a graph (Annexure E).

Timeline/professional lifeline

The timeline is defined by Saldana (2013:26) as a graphical representation of a period of time, on which important events are marked. It was a graph with years of experience on the horizontal and an indication of highs and lows of each PNs personal work experience

as they provided compassionate patient care on the vertical. The terms timeline and professional lifeline were used interchangeably.

Bracketing

Bracketing was used to put the researchers own experience and understanding of the study phenomenon aside. Researchers in qualitative studies needs to practice *bracketing*, which refers to introspection of one's own biases that often come from one's own history and preconceptions (Polit & Beck 2012:740).

The researcher applied bracketing during the interviews with the participants, in order to avoid subjectivity and contamination of data with own perceptions (Streubert & Carpenter 2011:34). There was no conversation with the participants apart from the explanations needed to sign consent, fill in the forms for biographical data, questions and the timeline. There was no discussion regarding what the researcher knows about the experience of the phenomenon that is being studied (Grove et al 2013:687). However, there was some interaction between the researcher and participants when they needed to fill in the professional lifeline as they did not know what it was.

Tufford and Newman (2010:80-81) argue that the researcher is the instrument for analysis in all phases of a qualitative study, which unavoidably causes the transference of all sorts of preconceptions from the researchers own past and this may affect how data is collected, understood and presented. Bracketing was nonetheless the method used to lessen the potential harmful effects of unrecognised presumptions on the researchers side, the rigor of the study was increased by the appropriate use of bracketing. It encouraged the researcher to reach deeper levels of thinking across all the stages of the study, which also enhanced the insight of the research as well as produced more accurate and more complex findings. Tufford and Newman (2010:84-85) further state that bracketing is not a once-off event of setting preconceptions aside, but it is a process of self-discovery, using self-examination, whereby buried emotions and experiences might surface (Tufford & Newman 2010:80-85).

2.4.3 Data collection process

Data collection is a process of collecting information which will enable the researcher to answer the research question and study objectives (Polit & Beck 2012:725). In this study the researcher did not pretest before the day on which the study was carried out. The following resources were given to the participants in the process to facilitate data collection.

- A leaflet with the definition of the study construct, information about the study with consent and confidentiality forms for participants to sign, and a three part interview guide for participants to fill in.
- The forms were placed in a plastic folder, with a pen, an eraser, a pencil, a sharpener, and extra pages in case they were needed when writing stories, as well as a chocolate with thank you written on it.

Pre-interview arrangements

The researcher reviewed the topic in the literature briefly and compiled a page of the definition of the major construct which was compassionate care. The managers as gatekeepers where the potential participants worked were informed of the dates and times. Entry and access into the research setting was negotiated with the appropriate authorities with permission granted in writing (Annexure C). The researcher arrived early on the day of data collection to prepare the environment to ensure privacy, quietness and comfortable sitting and writing arrangements. According to Monareng (2009:138-139), it is the responsibility of the interviewer to create a suitably comfortable and conducive environment in which the participants were able to write their stories without interruption and noise. The role of the researcher in this study was to ensure that the writing of the narratives was managed successfully.

Introduction of self and the study purpose

During the introductory stage of the interview sessions, the researcher welcomed the participants and explained the ethical issues as stated in the informed consent form and study information leaflet. The general purpose of the research, the specific purpose of the narratives and possible benefits such as improvement of provision of compassionate care

to patients were explained. Each participant was then given a consent form to complete (Annexure D) and also a list of definitions of the study construct. The approximate duration of the sessions was confirmed with the participants which varied from 30-60 minutes with an average of 45 minutes each.

The researcher used the arranged venue that was provided by the hospital management to interview the PNs. It was quiet and the Health service manager's secretary ensured there were no interruptions. The unit managers, as gatekeepers, allowed the participants to take turns to come up to take part in the study when the units were not so busy.

Data collection procedure

The participants were interviewed on paper, a few at a time as they relieved one another. There was a manager who was a gate keeper and assisted the researcher to coordinate which PNs were able to be available. Attention was paid to eligibility issues, their comfort and refreshments were offered. The researcher introduced herself to break the ice and put the participants at ease. They were asked to first read and sign the consent and confidentiality forms, as well as read the definitions of words used in the questions. Then they were asked to fill in a biographical data form in the interview guide under section A (Annexure E) and they were asked to write their stories of their experiences of giving compassionate patient care with examples. These stories were led by five open-ended questions that were on the section B of the interview guide (Annexure E). After writing their stories, they were then asked to draw a professional lifeline on the graph to show their nursing high and low points on section C of the interview guide (Annexure E). No names or personal information were on the completed forms of the interview guide for the sake of confidentiality, so that their stories could not be linked to their name. The completed forms were coded by the researcher for easy linkage of data. The researcher commenced to read the narratives for data analysis from the first story in order to identify emerging themes, categories and subcategories, and to be able to establish when data saturation occurred.

2.4.4 Data management

Data management refers to the way the data is managed as well as how the data is kept safe once collected. The management and analysis started simultaneously when data collection began. It was important to keep the separate forms which were filled in by each participant together, and given a code, so that the forms were not mixed up. Also the filled in forms need to be put in a safe place and kept locked up for confidentiality (Grove et al 2013:531).

In qualitative studies there is some overlap between data management and data analysis. Data management refers to the reduction of the data into manageable portions, and data analysis to the task of organising the parts of the data into a meaningful pattern allowing understanding of the data collected (Polit et al 2006:388). The difference between data management and data analysis, according to Polit and Beck (2012:562), is that in qualitative research data management is “reductionist” involving reducing masses or large amounts of data into smaller sections, and that data analysis is “constructionist” which means placing these sections together to make sense out of the data.

2.4.5 Data analysis

Data analysis was undertaken to condense, organise and give meaning to data (Grove et al 2013:690). Data analysis is the methodological organisation and fusion of research data, and the testing of research theories using that data (Polit et al 2006:460). Although in qualitative studies we do not test theories and hypothesis, findings contribute to theory development.

The purpose of data analysis was to provide structure that helped the researcher to draw out sense and meaning from the data. It was a challenging process because it could not be done in a linear fashion and there were no formulas that could be followed, so it was more difficult and time consuming. It was necessary to read and re-read a large amount of written data (total of 81 pages) to make sure that the meaning was clear and concise. The large amount of the original narrative data needed to be reduced and summarised for reporting purposes (Polit et al 2006:380-381).

The analysis of the data included a written biographical data form, the actual written stories of each participant in order to answer the five questions about compassionate patient care, as well as a professional lifeline which each participant filled in. Thirteen participants who were all female took part in the study as data saturation occurred at the thirteenth interview. The biographical data is presented in Table 2.1.

Table 2.1 Biographical data

Professional nurse	Race	Age group	Level of education	Experience period as PN	Unit
1	Indian	20-30	Diploma in General Nursing	4 years	Surgical
2	White	31-40	BCur Degree	16 years	Surgical
3	White	41-50	Diploma in General Nursing	19 years	Other
4	Black	31-40	Diploma in General Nursing	2 years	Medical
5	White	51-60	Diploma in General Nursing	30 years	Surgical
6	White	41-50	Diploma in General Nursing	29 years	Surgical
7	White	31-40	Diploma in General Nursing	6 years	Paediatrics
8	White	31-40	Diploma in General Nursing	20 years	Other
9	Black	41-50	Diploma in General Nursing	5 years	Oncology
10	Black	41-50	BCur Degree	20 years	ICU
11	White	31-40	Diploma in General Nursing	13 years	Surgical
12	Indian	31-40	BCur Degree	10 years	Other
13	White	60+	Diploma in General Nursing	36 years	Medical

When drawing up the biographical data form, other was used in case there were any PNs in units not initially known to the researcher. From the data it was seen that there were PNs who marked other as they worked in the Emergency Services, the Education and Clinical training departments.

Data analysis approach

The narrative approach, descriptive research was chosen for this study as it encouraged the researcher to understand what the participants were saying as they wrote their stories down. The researcher needed to make sense of what was actually been said, by grouping the data into similar themes and categories (Yardley 2006:1-13; Saldana 2013:9).

In this study, the researcher needed to be aware of how she understood, and more importantly how she failed to understand what the participants were saying or trying to

say in their written stories. According to Andrews et al (2008:24-25), in this study the researcher formed a crucial part of the data. After the data was collected, she deciphered the data for meaning which was crucial to the success of the study. It was up to the researcher to examine herself and account for her own impact on the work produced as described earlier when bracketing was discussed (Andrews et al 2008:24-25).

The analysis process was very active and interactive as the researcher engaged with the data in search of meaning attached by the participants regarding this study's phenomena. The researcher scrutinised their stories repeatedly to become familiar with them, and to understand the full meaning of their experiences. Saldana (2013:131) argues that there are no general rules about how to scrutinise or study stories. Saldana (2013:131) adds that stories express a type of knowledge that distinctively describes human experiences with meaning attached to them. This process was supported by Polit and Beck (2012:557) who cite Morse and Field (1995) saying that during the process of analysing data, the researcher sees how the data fits together, the hidden becomes obvious, and the significance of the data is linked to the antecedents (Polit & Beck 2012:557). Three participants answered some questions in Afrikaans as they were not comfortable to express their emotions in English; these were translated into English by the researcher.

When coding the stories the analyst looked at each story as a whole as well as the individual elements within the story. The stories will form themes and the analyst was able to put the stories into categories. Polit et al (2006:383-384) points out four intellectual processes that do play a role in the analysis of qualitative data which are comprehending, synthesising, theorising and re-contextualising.

The researcher read and re-read the data and became "fully immersed" in the data until some meaning was attached to some of the repeated words or phrases in the narratives. This process of labelling words or phrases is called coding. As codes were repeatedly identified in the data, themes, categories and sub-categories began to emerge (Grove et al 2013:280-281). Inductive reasoning was used to make inferences on the findings. Narrative data collected from the participant's stories was analysed qualitatively to identify prominent themes, categories and sub-categories (Saldana 2013:137-139).

A theme is the outcome of coding which happens during repeated analytical reflection of the data. As a novice researcher, every sentence that is written by the participants needed

to be coded, as it was only with experience that the researcher was able to know immediately which data was relevant and which was not applicable or redundant. Thematic analysis was used as an analysis method to search for the relationships between domains and how they were linked to, in this case the provision of patient care (Saldana 2013:14 & 17).

After re-reading the written transcripts many times three themes, seven categories and ten sub-categories were identified after seven sub-categories were collapsed (Table 3.1).

There are four different models of narrative analysis according to the classical contribution of Riessman (2005:1-7) which are thematic, structural, interactional and performative analysis. In this study, thematic analysis was the model of choice based on Riessman (2005:1-7)'s narrative analysis approach. Thematic analysis is when more emphasis is placed on what was said in the story than how it was said. Riessman (2005:2) defines thematic analysis as one of the most common forms of qualitative data analysis. The model puts emphasis on pinpointing, examining, and recording theoretical patterns or themes within data. Themes are described as similarity of concepts across data sets that are important to the description of a study phenomenon associated to a specific research problem or question. This model allowed the researcher to identify common themes in the participant's stories.

According to Polit and Beck (2012:562), thematic analysis often uses two principles. The first one is the similarity principle, which looks for information in the data with similar meanings; the other is the contrast principle which looks at what makes information different from the other themes, categories and sub-categories. Another step during the process of thematic analysis is when the researcher counts the number of times the same theme crops up in the data, this is referred to as quasi-statistics, and gives validation to the themes as it can be proven that a topic crops up many times (Polit & Beck 2012:562-563).

The thematic analysis method was used during analysis to find out what each PN is saying, by going through the stories and seeing what helps or hinders the attempts of participants to give compassionate patient care. Data analysis started simultaneously with data collection. The following process based on the guidance of Riessman (2005:18-20) was followed:

- The researcher first looked at the large volumes of data (68 pages of written stories and 13 timelines) and summarised it into manageable chunks by highlighting important words and phrases and concepts.
- The stories were read over many times from the first one to the thirteenth story in order to identify the major themes, categories and subcategories.
- Themes, categories and sub-categories were identified from words, sentences, paragraphs, page by page and throughout the whole document using different colours of highlighters. (Saldana 2013:2-4).
- As stories were completely initially read over a period of three days and constantly re-read when needed, themes and categories emerged until a point of data saturation was reached when no new themes or categories were identified. It was the beginning of the coding process.
- Similar concepts were pinpointed and grouped together as identified per question answered
- The three C's of data analysis which are coding, categorising and concepts, were undertaken after all the necessary data was collected. .
- During the coding process, some of the codes that seemed less relevant were dropped, leaving only a list of important categories.
- Re-reading again, the researcher re-examined all the categories and from this list a list of concepts was developed from which meaning was attributed to the data (Riessman 2005:18-20)

There were a number of challenges experienced during data analysis using the narrative approach, the researcher was dependent on what the storyteller chose to say and chose not to say and how they wanted to be seen in the story. According to Hunter (2010:45), the story told could even be based on the storyteller's perception of what happened and not an actual real event. It was not an easy or simple task to analyse the participant's personal stories of their own experiences in clinical practice, however the researcher handled the participants and their stories with dignity and respect (Hunter 2010:44-50).

Stories are subjective, and they do not actually represent the person's life exactly as it was lived, but are told to us from what and how the storyteller chooses to remember and interpret. In this study the participants were made to feel totally relaxed and believed that

their voices were important to hear. The researcher searched for ambiguous meanings and tried to pick up hidden meanings in written expressions. The narrators were not made to feel like the researcher had more knowledge than them on the subject and the participants felt that they were going to assist in finding the truth about the phenomenon. The researcher needed to be reflexive and did not just report what was written, but attempted to interpret from her own experiences in her nursing career and really delve into how these interpretations came about (Etherington 2000:1-8).

2.5 TRUSTWORTHINESS OF THIS STUDY

Trustworthiness is defined as the degree of confidence, credibility and authenticity that qualitative researchers have in their findings. It is assessed by using the criteria of credibility, transferability, dependability, confirmability and authenticity as proposed by Lincoln and Guba (1985), cited in Polit and Beck (2012:745). There are many arguments for and against using validity in qualitative research but no real conclusion, except to say that the term rigor or trustworthiness seems to be becoming the accepted term to be used by qualitative researchers (Polit & Beck 2012:582-583).

Streubert and Carpenter (2011:48) argue that there is no one set of criteria regarding trustworthiness that works exactly for every study. Also, that the rigor of a qualitative study is demonstrated when the participant's experiences are accurately portrayed and represented in the study. In other words the worth of a study is referred to as rigor which means the endeavouring for excellence in research through the use of discipline, meticulous observance to detail, and stringent accurateness (Grove et al 2013:708).

Rigorous qualitative researchers are regarded as open minded and they show methodological accuracy, strict adherence to a philosophical perspective, thoroughness in collecting data, attention to all of the data in the analysis process, and self-understanding (Grove et al 2013:58).

Ensuring trustworthiness

Trustworthiness as originally developed by Lincoln and Guba (1985) is a combination of credibility, transferability, confirmability and dependability (Polit & Beck 2012:175) therefore in this study, the following criteria were ensured:

- *Credibility* is a gauge used for evaluating integrity and quality in qualitative studies and is ensured by making sure that the research methods are applied as planned. Confidence in the truth of the findings is enhanced by using participants who have personal experience in the phenomenon and the researcher's interpretation and presentation thereof (Polit & Beck 2012:175, 584-585 & 724).

In this study the accuracy and the credibility of the study findings was enhanced by the fact that all participants were PNs with a minimum of 2 years' experience and most had many more years of experience in units in private hospitals. The researcher has nursed for 40 years and has experience of the phenomenon being studied from having held positions in many different hospitals and types of units, as well as experience in teaching nursing and patient education. The following were used as quality enhancing strategies when collecting the data:

- *Prolonged engagement* refers to spending enough time collecting data to ensure that there are rich, in-depth stories to provide the correct information and to reach data saturation. The participants were encouraged to write as much as they liked, no time limit or amount of writing was specified and they were offered extra sheets of paper so that they could express their feelings fully. Persistent observation refers to the focus the researcher places on the questions around the study phenomenon and this was encouraged by asking the participants five relevant questions which they were allowed to answer as they pleased. The researcher did not lead them in any way and only talked to them if they had a question.
- *Reflexivity* strategies refers to the fact that the researcher has their own background and set of values which must not be made known to the participants. In this study there was very little conversation with participants before or during the study and all the questions were asked and answered in writing. The researcher was careful to remain reflexive and use bracketing throughout the analysis of the data into themes and categories to avoid misinterpreting what the participants have said. Bracketing is a process whereby the damaging effects of one's own preconceived ideas and previous experiences need to be put aside and the data collected be allowed to speak for itself (Tufford & Newman 2010:80).
- *Data triangulation* refers to the use of many data sources for the purpose of validating the conclusions to be drawn from the analysis of the data. In this study

there was use made of triangulation by using a biographical data questionnaire, asking five questions in writing that required answering in the narrative, as well as a professional lifeline which was drawn to depict highs and lows in the PNs nursing careers. This was done to prevent the bias that can come from using single method studies (Polit & Beck 2012:586-590).

- *Transferability* was ensured by reporting the findings clearly so that the steps followed can be audited and can be transferred to other settings (Polit & Beck 2012:175). According to Streubert and Carpenter (2011:49), transferability means that the study findings will have some meaning to other PNs in similar situations.

The findings from this study were made known to the Health service manager and management of the hospital where the study was done, and the PNs who took part in the study, as well as to all other interested parties.

- *Confirmability* refers to being as objective as possible by using bracketing so that the study findings are derived from the participants' information and the contents of this study and not from the researcher's bias or pre-conceived ideas (Polit & Beck 2012:175). Confirmability was ensured by leaving an audit trail, which in this study, was the accurate recording of the participants written stories. Another researcher would be able to follow the research steps or replicate the study in a different but similar context. In other words the researcher showed how she came to the conclusions she did and a second researcher should come to the same conclusions (Streubert & Carpenter 2011:49).
- *Dependability* is a gauge for measuring integrity in qualitative studies, it refers to the stability of the data over time and was enhanced in this study by being diligent in reporting every step of the research process (Polit & Beck 2012:175, 725).

The researcher asked herself how dependable the results of this study are. According to Lincoln and Guba (1985), cited by Streubert and Carpenter (2011:49), there can be no dependability without first ensuring credibility. Streubert and Carpenter (2011:49) further state that triangulation also contributes to the dependability of a study. Credibility was ensured, as stated earlier and triangulation was used in this study.

- *Authenticity* is defined as the extent or degree to which qualitative researchers fairly and faithfully show a range of different realities or truths in collecting,

analysing and interpretation of the data they have collected during the study (Polit & Beck 2012:720).

In this study authenticity was achieved as the participants real experiences were described and the actual tone of the participants feelings emerged as the stories were analysed and reported on, more understanding of the phenomenon emerged (Polit & Beck 2012:585).

2.6 ETHICAL CONSIDERATIONS

Ethics is defined as a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants and the organisation where the study was carried out. (Polit & Beck 2012:150-152). According to Hofstee (2006:210), the scientific community are the people who decide what counts as morally acceptable conduct in science, and these codes of conduct are enforced by the various associations, societies and universities. Ethical issues occur as a result of interaction with people, either during data collection or when findings are made public. Researchers must guard against their own search for the truth harming other people.

Adams (2008:177) gives a description of bioethics as being a caring way of attempting to understand what it means to be a human being and what exactly it means to act morally correctly, this includes what value life has, and what it means to an individual to be a human.

Ethical consideration in this study related to the protection of the rights of the study institution, participants and scientific integrity.

Protection of the rights of the study institution

The relevant ethical clearance (Annexure A) allowed the researcher to conduct the study. This was obtained from the University of South Africa (Unisa), issued by the Higher Degree Committee of the Department of Health Studies. Relevant permission from the management of the hospital where the study was conducted was requested (Annexure

B), and obtained (Annexure C). The findings from this study was disseminated to the management of the hospital where the study was conducted.

Protection of the rights of the participants

Informed consent is defined as participants knowing that participation is voluntary. They must be given enough information so that they fully understand what it is that is expected of them. They were assured that they could stop taking part in the study at any time without being questioned. In qualitative studies the consent needs to be explained as being ongoing for the duration of the study as very often, as data collection takes place the study questions may change and evolve (Polit & Beck 2012:157-158). The rights of the participants were protected by obtaining informed consent from the participants who willingly volunteered (Annexure D). An information leaflet about the study was given to each participant to ensure that they were well informed to make an informed decision to participate or not to. The participants who were willing to partake then signed this form to give permission to participate in the study, this included sections both on consent and confidentiality (Annexure D). Unlike a quantitative study, one cannot be sure what information will come to light in the participant's story, so privacy was upheld (Streubert & Carpenter 2011:91).

There is always the possibility of harm when dealing with people. In this case the likelihood of harm is less than in clinical trials, but there is always the possibility of emotional hurt when people are asked to deal with emotional issues (Hofstee 2006:119). In this study, the researcher took reasonable precautions to protect the participants and not cause any harm to anyone. However, two of the participants seemed to be a little emotional after writing down the stories and the researcher allowed them to talk further about their emotions and how they feel, until they had been understood. They were distressed as they felt they were not able to give compassionate patient care as they would like to.

Confidentiality and anonymity was ensured when handling the participants written stories by not using their names during the briefing session. The information written by the participants was kept under lock and key to ensure confidentiality of their opinions. All their stories as well as notes were kept in a locked drawer after completion of the study, to which only the researcher had access. These written stories and all forms filled in by

the participants will be destroyed one year after completion of the study (Polit & Beck 2012:162). Participants were told not to mention patients by name when writing their stories, and the researcher did not use names on the stories, patient and participant's anonymity was thus maintained (Streubert & Carpenter 2011:91).

The Belmont Report was published in 1979 after the United States Department of Health, Education and Welfare asked the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research to give guidelines regarding ethical conduct for researchers. The Summary of the Belmont Report gives three standards of ethical conduct that researchers need to base their research on which are beneficence, respect for persons, human dignity and justice which were also ensured in this study (United States of America. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979:1-10).

Beneficence makes researchers aware to ensure that participants and/or others that come after them experience long term benefits. At the same time researchers have an obligation to practise non-maleficence which means not causing harm, risks and discomfort to the participant's. Sometimes it is easy to protect participants from physical harm, but the researcher needs to be aware of the possibility of psychological and emotional damage depending on the nature of topics investigated. Qualitative studies are often more probing the researchers need to be sensitive to the participant's feelings and emotions. In this study the participants were writing down their own stories freely with no disturbance, and no one apart from the researcher was able to read these stories. In this study there will be some benefit as the findings might be used in planning of future education and training of nurses both in the classroom and in practice.

Respect for human dignity this refers broadly to self-determination which is the choice to take part in a study or not, or to terminate participation at any point. There was no money offered for any participation. The second part of respect for human dignity was the fact that people have a right to know everything about the study, any possible risks and/or benefits to the participant. These points were taken care of as the participants were able to give informed consent empowered with all the information that was needed about the study.

Justice was the third standard of ethical conduct from the Belmont Report and it included both fair treatment of the participants and their right to privacy. If there had been eligible participants who did not want to participate in this study, they would have been treated in a non-judgemental manner. Recruitment and selection of participants was not exclusive to one group of people, all PNs were welcome (Polit & Beck 2012:152-156).

In this study the researcher did not talk much before the study as she did not want to cause any contamination of the findings except to explain the process of how data was going to be collected and explaining the use of the data collecting instrument. The participants were greeted warmly and made to feel at ease and comfortable, given a brief explanation, and then they were given the paper work.

Scientific integrity

Scientific integrity was maintained as care was taken to avoid research misconduct, by acknowledging all sources cited and referred to while presenting the arguments and writing the research report. Paraphrasing information was used so that the voice of the researcher could be heard and to avoid plagiarism. All possible ethical pitfalls were taken into consideration to ensure that fabrication and falsification of data does not occur as only actual data was used. The researcher utilised bracketing when analysing the narratives to prevent her own opinion, experiences and pre-conceived ideas from interfering with the reporting of the study at all its stages (Polit & Beck 2012:167-171).

2.7 CONCLUSION

This chapter discussed the research design and methodology used in this study. This included the setting, population, sampling and sample, data collection and analysis, and the measures that were taken to ensure trustworthiness and ethical considerations.

Chapter 3 describes the data analysis and interpretation.

CHAPTER 3

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

The most important thing to remember about compassion is that it requires removing yourself from the center of your universe, and placing another in that spot.

Bruce Korbelik

3.1 INTRODUCTION

Data refers to facts that are collected during a research study. Qualitative analysis involves the integration and synthesis of non-numeric data that are then reduced to themes and categories through the process termed coding. Researchers draw conclusions to give meaning and make sense out of research results (Brink, Van der Walt & Van Rensburg 2012:58). Data analysis is carried out in order to reduce, organise and to make sense of and give meaning to the data (Grove et al 2013:691). Schmidt (2012:192) states that qualitative data analysis involves description, data reduction, analysis and interpretation. It is crucial that large amounts of data be made simple to ease analysis especially in a qualitative study. Simplification of data is referred to as data reduction. The study findings presented were based on the analysis and interpretation of data obtained from thirteen research participants who were purposefully selected. Narratives or stories which provided the required information to answer the research question and objectives were analysed.

This study was conducted in phases and the third block, which is shaded a different colour, applies to the activities covered in this chapter (Figure 3.1).

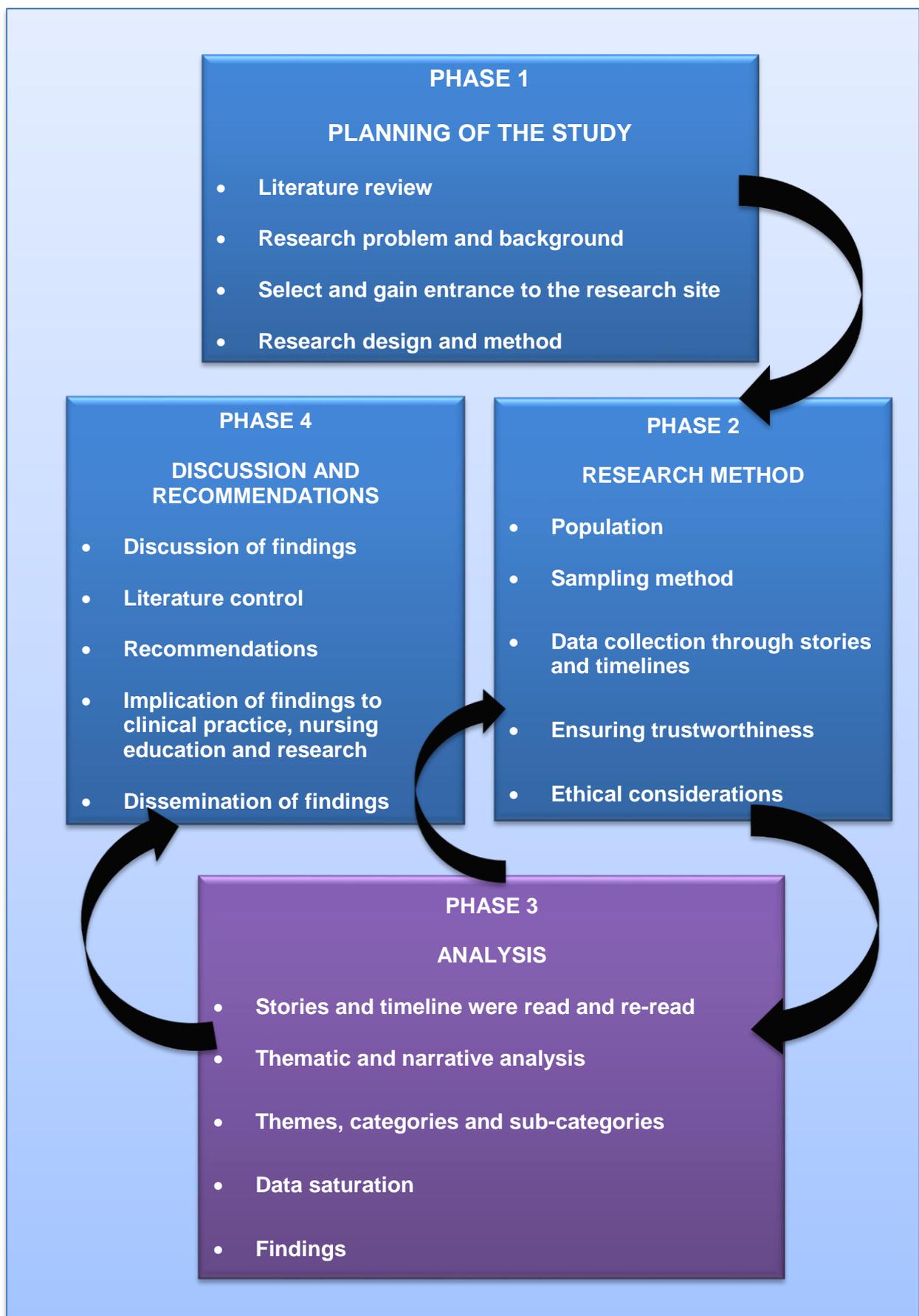


Figure 3.1 Flow of research activities in phase 3
(Adapted from Polit & Beck 2012:61)

At this stage data analysis was done using thematic and narrative analysis. As the participants finished writing their stories, the researcher would read what they had written, and it very quickly became evident that many of the participants were saying the same thing, therefore data saturation was reached by the time thirteen participants had given their stories. Stories were read and re-read until themes, categories and sub-categories were identified. No changes were necessary to the data collection strategy, the participant's answered the questions asked adequately. Findings were tabled and described and analysed in detail. The questions which the participants were asked are in the interview guide (Annexure E, Section B), they were asked to include actual stories as well, and for written answers to five questions.

3.2 PRESENTATION OF FINDINGS

Table 3.1 Summary of themes, categories and sub-categories

MAJOR THEME	CATEGORY	SUB-CATEGORIES
1 Treating the patient as a whole	1.1 Physical needs of patients	1.1.1 Basic nursing care
	1.2 Emotional needs of patients	1.2.1 Therapeutic communication
	1.3 Spiritual needs of patients	
	1.4 Support system for patients	1.4.1 Family and friends support
2 Inadequate knowledge and skill	2.1 Participants feeling inadequately prepared	2.1.1 Skill level and practice and further education
3 Barriers to providing compassionate care	3.1 Emotional needs of participants	3.1.1 Balancing of home and work life
		3.1.2 Atmosphere in the unit
	3.2 Workload	3.2.1 Support from management
		3.2.2 Too much paper work
		3.2.3 Shortage of staff and resources
		3.2.4 Dealing with complaints from patients and family

Table 3.1 shows a tabled version of the themes, categories and sub-categories generated from the participants stories. These will each be discussed in more detail under research findings.

3.3 RESEARCH FINDINGS

The presentation of the findings of this study began first with that of the participant's biographic data and then the data from the questions asked and the timeline.

3.3.1 Participants' biographical data

The biographical information obtained from the demographic record in the interview Guide (Section A of Annexure E) covered aspects such as race, age, marital status, level of education, years of experience as a PN and the type of unit the PN was working in at the time of the study as depicted in Table 2.1 in Chapter 2. The biographical data was further converted to percentages for better understanding of the parameters, see Table 3.2. Parameter refers to a distinctive characteristic of a population (Polit & Beck 2012:737).

Table 3.2 Biographical data in percentages

Parameter	Value	Frequency	Percentage
Race	White	8	61.5
	Black	3	23.0
	Indian	2	15.5
Age	20-30	1	7.66
	31-40	6	46.2
	41-50	4	30.8
	51-60	1	7.66
	60+	1	7.66
Marital status	Married	8	61.5
	Single/divorced/widowed	5	38.5
Level of education	Diploma in Nursing	10	76.5
	Degree in Nursing	3	23.5
PNs years of experience	2-10 years	5	38.5
	11-20 years	5	38.5
	21-30 years	2	15.5
	31-40 years	1	7.5
Unit working in	Medical	2	15.5
	Surgical	5	38.5
	ICU	1	7.5
	Oncology	1	7.5
	Paediatrics	1	7.5
	Other	3	23.5

From these tables, it was evidenced that 8 (61.5%) PNs were white which evidenced the dominant cultural group, 8 (61.5%) were married and 5 (38.5%) had at least 10 years' experience as PNs. The majority 10 (77%) PNs were over 30 years and under 50 years of age, most PNs 10 (76.3%) have a Diploma in Nursing, not a degree and they all work in various types of units.

The race of the PNs seemed relevant as most of the participants were of the same race as the patients. The issue of cultural competence is imperative so that PNs can treat all patients amicably regardless of colour. This finding is supported by Campinha-Bacote (2011:1-4) who posits that when nurses are well trained and able to truly give compassionate patient care they will automatically have respect for all differences in people like race, gender, religion and anything else. They will also easily make meaningful connections with their patients.

Only one of the PNs was under 30 years of age which indicates that the PNs interviewed have some experience and are more mature. After investigation of the relationship between nursing experience and quality care, it was found in a study conducted by Hill (2010:4) that the amount of years in nursing definitely has a positive effect on the quality of competent compassionate patient care provided, as experience which comes with age and years of nursing, increases nursing and life skills, giving nurses more understanding and maturity to handle clinical situations. Despite the age of PNs, there are other barriers in the findings which also come into play when providing compassionate care.

Many of the participants 8(38%), who said their compassion levels had fluctuated or improved, mentioned that their own age and maturity had an impact on them being more compassionate towards their patients then when they first started nursing:

One of the participants responded that:

“Ja dit het definitief verander. Soos wat ek ouer geword het en my eie kennis en verwysing raamwerk verbreed het, het my meegevoel verdieper. Sekere gebeure in my persoonlike lewe, soos die gebore van my kinders, afsterwe van m pa, ens het my persoonlik laat groei en kon ek die nuwe ervarings gebruik in my ongang met my pasiënte.” (P3).

[Translated: “Yes it definitely changed. As I got older and my own knowledge and framework of reference widened, my compassion deepened. Certain things that happened in my personal life, like the birth of my children and the death of my father etc., caused me to have personal growth and then I could use these new experiences while interacting with my patients.”]

These PNs mentioned that they only developed the conceptualisation of the provision of compassionate care as a result of years going by with episodes of pain, suffering, and illness of themselves or loved ones. This is confirmed by Post et al (2014:875) who cite the psychologist Carl Jung referred to the “wounded healer” as the health care worker who has experienced some severe illness or suffering him or herself as having more empathy and compassion towards his/her patients thereafter Further study in this area would be recommended to find out how this can be taught to neophytes without them or their families having to experience trauma themselves first in order for them to learn compassion (Post et al 2014:875).

This participant placed her compassion very low on the professional lifeline chart, when she started nursing and wrote:

“Compassionate was low in early profession.” Then, in reply to the question whether her compassion has changed over the years, her reply is a great example of PNs own life experiences affecting their compassion: “My compassionate towards patients has changed for the better because of the experiences I have had as a person, very sick at the point of death made me realise that care that I offer needs to be accelerated with compassionate. Being in bed, hopeless and all you hear is strange voices and sounds in your surroundings, made me realise that these patients goes through the same experiences. That changed the way I view a patient.” (P10).

There is not a definite link between the PNs being able to provide more or less compassionate care whether they are married, single or divorced, however there appears to be a huge impact on their ability to provide compassionate care if they are experiencing personal problems including the situation and atmosphere in their homes. PNs have the stress of hectic work schedules and still have to go home and deal with more life situations. Simmons (2012:25-26) points out that shift work and long working hours can upset sleep and rest patterns and PNs may even find their health affected in the long run.

Added to this is the never ending possible stream of problems at home like financial shortages, marital or partner problems, household chores, further studies and parents and/or children to care for.

Most PNs interviewed did not have university degrees. It is essential to raise the level of education for all categories of nurses. The Institute of Medicine (2011:5-27) contributes to this finding by saying that among many other traits, PNs need to have excellent critical thinking skills, which they will learn while being educated further. The basic education for all nurse categories needs to be excellent, but there must also be a push for continuous lifelong learning by the nursing profession for all. This will develop better ability of PNs for coordinating compassionate care, understanding real quality standards, systems thinking and organisation thereof, and the understanding of policies of both the nursing profession and the business which employs them.

The suitability of certain personalities to certain types of units is something management should be aware of. In this study, most of the PNs 5(38.5%) were working in surgical wards, although each unit would have its own stressors, perhaps the hectic pace of a surgical unit is the reason for the PNs in the study's stress levels being high. One of the participants mentioned that she prefers not to work in wards where there are a lot of terminally ill patients, because she becomes too emotional:

“For example I worked with a patient who was last stage in cancer. I nurse that patient with dignity, listen for all he wanted, the last day was hard he last breath I was there I washed patient tagged him, and had to run to sluice to go and cry cause it was to hurtful I was very compassion and still am that why I can't work in a medical, cancer ward.” (P1).

It has been shown in a study done by Stokowski (2015:1-2) that different personalities can affect the job satisfaction of a nurse as well as affect their levels of compassion fatigue, and then their ability to give compassionate care to their patients and even in the long run the turnover of nurses in an institution. Findings from tests done on different specialties showed the PNs in different units needed different character traits.

3.3.2 Themes, categories and sub-categories

Table 3.1 shows the themes, categories and sub-categories which the researcher generated from the most frequently given answers to the questions answered by the participants and the timelines, and the interpretation thereof. The themes will further be discussed with references being made to the literature that was reviewed on the phenomenon under study (Annexure D; Sections B & C).

A theme is defined as a recurring regularity of concepts or pattern emerging from the data that is being analysed (Polit & Beck 2012:570). There are various definitions of the word theme by different sources, but generally it means it is a phrase that identifies what a section of data means. Saldana (2013:175-176) defines a theme as an abstract concept that brings meaning to data and identity to a recurring experience and its variant presentation. A theme captures and brings together the experience into a meaningful whole. Saldana (2013:175-176) further states that the terms themes and categories are often used interchangeably and a more definite definition of the word theme used in qualitative research, is that it is an abstract unit that brings sense and identity to a recurring experience (Saldana 2013:175-176).

Thematic and narrative analysis was used to analyse data with an outcome that assisted the researcher to put the data into themes, categories and sub-categories, this was achieved by using the most frequently used statements from the participants' replies to the questions asked. A category is defined as a class or division of people, objects or things that have particular shared or similar characteristics (Table 3.1). Each theme, category and sub-category will then be discussed in more detail.

3.3.2.1 Theme 1: Treating patients as a whole

This is the first of three major theme's that was identified because of its significance and recurrence in the data and came from the first two questions asked in the interview guide.

Most health care professionals are keen to deliver outstanding care services to their patient's in a dignified and compassionate environment. They seek to meet each patient's physical, mental, emotional and spiritual needs from a place of dedication and

commitment (Roberts & Machon 2015:1). Treating patients as a whole was a theme that recurred almost in all the transcripts. Nine of the thirteen participants in this study mentioned that the way to give compassionate patient care is to treat the patient as a whole, and some of the participant's verbatim written answers are given. One of the participants answered the question of her understanding of giving compassionate patient care with great insight as according to the following excerpt:

"Compassionate patient care requires a holistic approach. It is one of the strengths of the nursing profession. It is also very personal and subjective. It is the ability to focus on another person's needs and channeling your emotion into an active response to maintain their dignity. It is a complex combination of attributes and qualities namely empathy, sensitivity, and non-judgmental attitude and the ability to care about the wellbeing of others." (P13).

According to Monareng (2009:2), holism emphasises that an integrated whole has a reality that is bigger than the sum of its parts. Monareng (2009:2) further states that when holistic care is applied to the Western health care system, it supports an approach that includes all aspects of bodily, psychosocial and spiritual human functions. Wholeness entails activities by nurses that facilitate a healthy balance between the physical and psychosocial aspects of the person, thus promoting a sense of being treated as an individual and well-being. Applied to this study findings, compassionate care encompasses activities, which will empower both nurses, and patients with coping strategies to transcend the present situation, discover meaning and purpose, and experience connectedness with other human beings and the environment in a meaningful way (Monareng 2009:2).

"It is to look after your patient in a whole. Not to just nurse his/her diagnoses for instands [instance] if patient comes for a hysteroscopy just to look after her emotional status. You must also consider the family in patient care especially with a dying patient and with other diagnoses, because it can have an influence on her/his care especially at his/her home. It can also mean you have empathy with your patient. You cannot have sympathy, because you do not know all the circumstances of your patient." (P2).

"Giving care to patients as a whole. Sometimes 'being there' emotionally means more to a patient than actual physical care. Compassionate patient care is

putting yourself in the patients' shoes and thinking of how you wanted to be treated if it was you that were in the same position." (P8).

"Giving compassionate care to patient is taking a patient as a whole. Patient, as you care for them, (body, soul, mind) and the spiritual aspect as well. Compassionate care is being empathetic, sympathetic as though you are lying in that bed where the patient is." (P10).

These findings which were written down by the participants in the study, concur with the figure that was presented by Stallwood (1975) and cited by Carson (1989:8-10), in Figure 1.3 on the concept of wholeness. There is an understanding of human beings that says that they are connected in body, mind and spirit. In applying it to the western health care context, it supports a health care approach that incorporates all aspects of bodily, psychosocial and spiritual human functions as described by Monareng (2009:2) depicted in Figure 1.2 in Chapter 1.

Farrelly (2014:965) cites Nightingale (1859) as saying that nature alone can cure, and what nursing can do to help this process, is to get the patients in the best possible condition so that nature can act upon them. Farrelly (2014:965) further cites Henderson (1960) as saying the most important function of the nurse is to assist a patient to do those activities which contribute to his/her health, to recovery or a peaceful death. Also that the patient's would be able to do these functions for themselves, if they were well enough, so the goal is to get them to that place of independence as quickly as possible again (Farrelly 2014:965). This kind of care which is not only biomedical in nature but is that of treating a patient as a whole by combining qualities of humane compassionate care of mind, body and spirit. Under theme one the following patient care needs were identified and described as categories:

Category: Physical needs of patients

McLeod (2016:1-2) cited Maslow (1943) as saying that to really find out what motivates people, he noted that all people have needs which they need to quench and these needs can be listed in importance. He also believed that unless the basic needs were met, the person could not progress to the next, higher level. As humans our most basic needs are our own physiological needs which we require for survival. According to Maslow's

hierarchy of needs theory, a physical need is something critical to the survival of the human body. These needs are listed as oxygen, food, water, temperature control, rest/sleep, sex and shelter. McLeod (2016:1-2) further adds that individuals cannot move to the next level if these basic needs are not met. It is important for nurses to see that if patient's basic needs to feel physically comfortable, are not met, they will not be able to feel secure in the nurse's care especially if they are not able to do these basics for themselves.

Competent nursing care includes performing a set of care tasks, assessing the patient as well as attending to their needs. Patients can feel uncared for due to division of care tasks during delegation by PNs of tasks to nurses. It is sensible to delegate tasks like washing and feeding, but the PNs then spend less time with the patient's so might miss subtle clues about a patient's other needs beyond physical, such as touch, therapeutic communication and sharing concerns. More weight is now placed on academic learning when PNs are students, as it is necessary to prepare them for managing multifaceted medical conditions, it must, however, remain important to teach the core nursing care skills such as providing humane and compassionate care.

One participant expressed meeting of physical needs as:

“Assisting patient with meals, hygiene, mobility if possible ensure caring.” (P9).

Professional expertise when dealing with physical needs of patients is basic care which needs to be coupled with humane care without extra time. According to Scammell (2014:1048), values based nursing education are the standard in UK and the students need to unpack their personal values about people and care so that they don't learn only what to do, but the significance of how these basic nursing care tasks are done. Even though PNs are sometimes pushed to the limit with the workload being very high and not enough staff to cover all the patient's needs, the importance of basic needs being met cannot be over-emphasised. This emphasis on basic needs of patients being met with compassion and care would also address the problem of nursing been seen as more technological and less hands on. If more rigorous and carefully monitored system with checks and balances were put in place patient satisfaction would also improve dramatically, and the balance between well-educated theoretically trained nurses who

remain relevant in the practical situation would be addressed (Kitson et al 2013:109-111; Kitson et al 2014:331-333).

There is sometimes too much emphasis placed on the theoretical knowledge rather than the provision of care to patients that translates to being compassionate as one participant who works in a paediatric unit noted:

“Always providing quality nursing care, playing with the kids and interacting with parent, supporting and ensuring patient and parents are comfortable, physically and emotionally. Ensuring that the nursing regime is followed, eg. Mouth care, medication, health education and comfort.” (P7).

Sub-category: Basic nursing care

To advocate excellent basic nursing of patients it is imperative that it is known exactly what is meant by basic nursing. Nursing is defined very well, as the protection, encouragement, and optimisation of health and abilities, avoidance of illness and injury, enabling of healing, easing of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, groups, communities, and populations (*What is nursing?* 2016:1). General basic care of patients is accepted as hygiene, rest, sleep, exercise, oxygen and elimination, and communication and advocacy for and with patients all need to be done with co-ordination with other health care workers, for every patient until they no longer require this assistance. However, the humane aspect of care such as quality of presence should always be integrated in patient care (South Africa 2005).

The following participant understood caring for a patient by saying:

“Caring for a patient in full. Not only physically but also emotional support. You as a nurse will put yourself or a loved one in the patient’s shoes and you will care for them the same way you will care for the people you love. The patient should be able to trust you, as the nurse because they are in your hands and you will possibly see them at the most vulnerable times.” (P11).

Hygiene

Hygiene is defined as cleanliness that supports and assists health and well-being, especially of a personal nature. It is the PNs responsibility that all the patients have access to hygiene and if they cannot do this for themselves that the nurses will assist them do it for them (*Helping patients with personal hygiene* 2016:1). The following excerpt brings about an understanding that the participants know how to provide compassionate care therefore, the gap that exists between what they know and what is done in reality could be due to some other factors.

“By making patients aware that we are there to make life easily for them. Helping them in feed, bath, walk and listen when they talk and try to understand their point of view.” (P4).

“Supporting the patient is important, comforting the family giving a true, strustworth [trustworthy] information assisting patient with meds, hygiene, mobility if possible ensure caring.” (P9).

It is interesting that some participants mention to care if possible. This findings brings evidence that nurses might be looking at provision of care when carrying out routine tasks as an added responsibility. All the basic hygiene needs which need to be done on a daily basis, can be done in a way that brings hope and assurance to the patients, if done in a compassionate and caring manner.

Eating

It is essential that all patients are well fed and hydrated at all times, not only because it is what every person’s physical body requires, because the patients are ill they might need more specialised nutrition to promote healing. Hospitals have nutritionists who are able to assist with the nutritional requirements of all patients.

“By making patients aware that we are there to make life easily for them. Helping to feed, bath, walk and listen when they talk.” (P4).

“Being able to assist with basic needs whilst they are admitted like feeding, ensuring comfort during their stay.” (P12).

It is important for patients to maintain independence however, there are many reasons why they are unable to feed themselves which are both physical and cognitive. If feeding needs are identified and properly managed from admission the patient's nutritional intake will be improved and their overall health will be better. It is also an ideal opportunity for nurses to interact with patients and check on whether they are improving or not (Feeding Patients who cannot feed themselves 2013:1). Although the participants noted eating as a basic need of a patient is important to respect the cultural and religious preferences patients have regarding food as this will show caring from the nurse. From the participants' stories it seems that basic nursing duties and those of the mind and spirit of the patient are separate, competent compassionate patient care would address this gap.

Vital signs

Vital signs refers to the measuring of the signs of life, the important functions which tell you whether a person is alive or healthy. Nurses need to document these vital signs of the patients, which is their pulse rate, respiratory rate, temperature and blood pressure (*Merriam-Webster Dictionary 2016, sv "vital signs"*).

"What must be done to show we care by ensuring patient intake and output is monitored? Ensure vital signs chart. Nursing in a clean and safe environment. Hygiene of patient is meant. Helping to feed." (P4).

Nurses need to have a deeper insight on what they are doing and why (*Vital signs 2016:1*). The participant's replies to the question as to how they provide compassionate care shows a lack of understanding of compassionate patient care as many of them did not include observations of the patient's mood and emotional state in the routine checks. The timeous response and referrals by PNs if any vital signs were abnormal, would be viewed as compassionate care.

Pain relief

The assessment of pain and treatment thereof remain subjective, as the definition highlights that pain is whatever the person who is experiencing it says it is. PNs in hospital situations need to guard against pre-judging whether the person experiencing pain has

actually got as much pain as they say they have. All health professionals need to be guided by their ethical principles when attending to their patient's needs (Bernhofer 2011:1).

This is supported by an excerpt from participants who said:

“Give medication pain relief explanation on what being done and why holding patient hand, hugging patient if needed, feeling empathetic, just listening to patient.” (P1).

Wells, Pasero and McCaffery (2008:1) argue that despite the fact that a large percentage of hospitalised patients experience pain either acute postoperatively or chronic pain from chronic diseases like arthritis, many patients complain after discharge as they feel their pain was inadequately managed. It is important for all PNs to be aware that uncontrolled pain has many effects on the patient body, including slowing down the healing process due to suppression of the immune system, as well as cardiovascular, gastrointestinal and renal complications. Apart from these physiological problems, when a patient experiences pain which is not managed, it leads to stress and even possibly depression and reduces patient satisfaction (Wells et al 2008:1). Participants expressed an understanding on some elements of compassionate care such as touch and empathetic listening.

Category: Emotional needs of patients

Emotions are defined by Hume (2016:2-3) as intense feelings towards something or someone, they usually occur when you are happy about something, or upset by something or someone or really afraid. Sometimes it is as if we all expect people to not show emotions as it is what we believe is the opposite to being rational. Emotions are part of life and both patients and the PNs are subject to many emotions on a daily basis. Emotions are often seen as being negative, but the truth is they help us to understand what a person is going through. Patients will differ in how they feel regarding the care they receive and attitudes of staff members will also have an impact on this perception (Hume 2016:2-3). A participant who, after her general nursing diploma, did a year of psychiatric training at a mental health care facility, expressed that:

"I did my psychiatric nursing at the age of 21. I then discovered that physical care is not the only care patients, or a person being ill, needs. They need emotional support. Being caring and compassionate in performing my duties as a nurse is the most important point of my day. The patient needs to feel that I am caring, and actually wants to do what I am supposed to do with or at the patients' bedside. I have always been compassionate about caring for my patients. I have a long history of working with oncology patients and their family's and here compassionate care counts 110%." (P8).

This participant's response captured the essence of compassionate care, it is interesting to note that she is still fairly young (31-40yrs) however, having a psychiatric background seems to have better empowered her to address compassion. This is emphasised by the Florence Nightingale Foundation (2014:1213) who state that education and compassion balance each other and are not contradictory and that nursing is a combination of theoretical knowledge, compassion and practical expertise which is what provides excellent compassionate patient care.

Another participant learned through making a connection with her patient she was able to practice compassionate patient care:

"I looked after a patient in Midstream Mediclinic Hospital in ICU, a day before that the patient was very noisy, and talking too much. In my heart I thought I wouldn't stand such a patient. The following day I was allocated to the same patient I greeted the patient, and as usually very loud he started talking. Deep in my heart I was asking myself when on earth will he stop talking. That was his personality. I could not change him. Then, something deep inside stirred me to start asking how was he admitted to the hospital and why was he in ICU [intensive care unit]. His story was deeply moving, the patient came in very sick was diagnosed with hyperthyroidism. Became unconscious, was intubated and mechanically ventilated. Prognosis was very poor. Then it took 3 weeks interventions for him to start getting better and the day I looked after him was almost a month in hospital. His excitement and noisy was an indication that he is grateful to be alive. His kids are small. If I did not ask him of who he was, I wouldn't have known why the guy is so noisy and excited. I became empathetic, look him as an individual patient and become more companionate as I cared for him that day." (P10).

Although most of the participants mention the need for emotional support, it is however not always evident how it is done. These two participants were able to translate this emotional support to compassionate care. The value given by a nurse's supportive care should not be underestimated. Mendes da Mata (2014:951) reports that a patient's feelings and attitudes can positively or negatively affect the course of their illness, and their outlook can also affect their behaviour, especially towards their treatment and any health care interventions. Mendes da Mata (2014:951) states that for a nurse to be able to fulfil her duty of caring, she needs to have the capability to listen to patients, comprehend how they are feeling, and offer appropriate support.

Subcategory: Therapeutic communication

Medical Dictionary (2009a:1) defines, in combination with *Mosby's Medical Dictionary* (2009), therapeutic communication as taking place when a health care professional is interacting with a patient. The nurse uses verbal and non-verbal communication to ensure that the patient has a better understanding of what is taking place in the hospital and that the patient feels re-assured regarding his/her own comfort, safety, health and general well-being. The nurse uses approaches during the communication to foster a feeling of trust, respect and acceptance in the patient (*Medical Dictionary* 2009a: Sv "therapeutic communication"). In this study this category was exemplified as follows:

"For example in a month we work with a lot of new or expecting mother who had a miscarriage. I as a professional [professional] nurse go talk to her comfort her at time I also cry with them cause when you listen to and even though you have not experice [experienced] it yourself, if you got compassion it breaks you and if patient know some is listen and just give them support and hug make them feel a little better. In my point of view compassion must come from the heart, it like love" (P1).

Based on research findings from a study done by Sherko, Sotiri and Like (2013:1-9), there is a difference between therapeutic and non-therapeutic communication. Therapeutic communication builds a good relationship with the patient, and requires practice and non-therapeutic communication will hamper effective communication. Therapeutic communication involves asking patients appropriate questions, providing needed information to the patient, paraphrasing to make sure you understood what the patient said, clarifying to see whether the patient has understood you correctly. Some examples

of non-therapeutic communication would be asking the patient private questions, giving personal opinions, changing the subject, giving automatic replies, incorrect assurances, showing disapproval, defensive responses, becoming aggressive and or arguing with the patient. Therefore, therapeutic communication seems to be well aligned with compassionate care and non-therapeutic communication defeats the object (Sherko et al 2013:1-9).

Therapeutic communication was well demonstrated by the response of this participant:

“Is the patient complaining about bad service just because it is her perception that the care is not good, or is there another problem, like poor pain management, worries about relatives at home, financial difficulties etc. Listening to what the patient says. What is the patient really asking? Is the patient really complaining or is he working through his own emotions. Reflecting on what the patient says by asking am I right to say that you need this and this? Or do I understand you correctly that you want this? Reading body language. Is the posture open or close, does the patient show symptoms like enduring pain.” (P3).

Grimsley (2016:1) states that communication takes place whenever there are two or more people together. Communication is all about the giving and receiving of information between people and it may refer to verbal or non-verbal. Interaction with patients, and communicating with people who are sick, suffering or in pain is often a challenge to care givers. Some patients may be misunderstood which may impact on how care is given. It is understandable that some patients may be difficult to treat but according to the Patients' Rights Charter a patient must always be treated with respect and dignity (Health Professionals Council 2008:1-3).

The following participant is aware of the importance of effective communication:

“In the morning when I report on duty – I introduce myself in order for the patient to know who is taking care of him/her that particular day. Then I identify them, whatever I will be doing to the patient, I will have to explain to them the reason why I am doing it. Communication is very important in provision of compassionate care. I will also let the patient be at liberty to ask questions as the day progress.” (P10).

Empathy

Empathy involves not only understanding your patient's feelings but the ability to make the patient aware that you understand how they are feeling. Teaching strategies for nurses to learn empathy need to be creative and first take into account what the nurses own perceptions and attitudes towards patients are (Webster 2010:87-94).

When asked what they understand about providing compassionate care these participants had the following to say:

“Giving compassionate patient care is all about the empathy. Interacting with the patient irrespective of gender, raise [race] and status, holistically giving nursing care to everyone in health care service, firstly with assessmens [assessments] that will tell you the needs of the patients and put all the problems in your shoes and that will help you to carry out the tasks and will motivate and encourage to go extra mile.” (P9).

“Giving care to patients as a whole. Sometimes being there emotionally means more to a patient then actual physical care. Compassionate patient care is putting yourself in the patients' shoes and thinking of how you wanted to be treated if it was you that were in the same position. Emotional care. The way you are doing, giving care to your patient. The way in which you express yourself verbally toward the patient. Just being there for your patient.” (P8).

Although the concept empathy seems to be understood it is not yet certain how effectively it is as the negative media reports seem to overshadow those of nurses being caring and compassionate (Oosthuizen 2012:49).

Eye contact

Making the right amount of eye contact is very important when communicating with patients. Too much can make a patient feel uncomfortable and dominated, especially in some cultures, and too little may make you seem like you are not interested in your patient. The right amount of eye contact when talking to a patient is between 30% and 60%, and always more when you are listening than when you are talking (Kinsey Goman 2014:1-2).

The following participant seemed very aware of the importance of eye contact:

“Looking the patient in the eye, facing them will give them a feeling that you are listening and in fact hearing what they are saying. Because I think as a professional nurse you may be able to realise the patient is trying to tell you something whereas as a student you may not understand it.” (P5).

Keeping eye contact is an important virtue on how people are valued. Often nurses who have a busy schedule and many administrative tasks to do, may not be able to provide this kind of care. Many participants mentioned the provision of compassionate care to be challenging.

Touch

Touch is an extremely important part of non-verbal communication. As with eye contact, the touch must be appropriate as there can also be cultural issues around touch. The key is to be informed, know your patient, and be culturally competent. Touch must always be light, maybe on the hand or the shoulder and never be for too long. The right amount of touch is re-assuring whereas too much can be seen as being over familiar and this is an important aspect of communication with as well as listening and attending to patients (Royal College of Nursing 2016:1-3).

The following participants stated how they used touch:

“You can have compassion for your patient by touch especially or to have eye contact with you patient.” (P2).

“Ask and mean, a patient how they are feeling, emotional, not just physical. Talking to a patient while you are performing duties around the patients bed. Give a patient time to express his or her feelings, and reflect on that feelings. The touching of a patients hand, just giving time to talk to your patient. I always talk to my patients while I am busy around their beds, and while I am preforming my duties in the patient’s room.” (P8).

The real life experience of the late Ken Schwartz who was a health care lawyer gives credibility to the importance of touch, ten months before his death he said that his: “ordeal has been punctuated by moments of exquisite compassion. I have been the recipient of an extraordinary array of human and humane responses to my plight. These acts of kindness – the simple touch from my caregivers – have made the unbearable bearable.” (The Schwartz Center for Compassionate Healthcare 2016:1).

Acceptance

There must be no judgement of patients based on anything they do or who they are and many participants mentioned this. Treating patients with a non-judgement and accepting attitude needs to be inculcated from early years of nursing training and re-enforced with in-service education programmes (South Africa 2005).

“Compassionate care in short should be holistic. Patient centredness should also play a role where you do not only focus on the disease process but on a patient being an individual with different needs from other patients. As a professional you will put yourself in their shoes and do what is right for the patient as an individual. You do not blame and shame or be judgmental toward patients especially if the condition was acquired through sexual contacts, for example sexual transmission diseases.” (P10).

Patients need to be accepted in spite of their social state, religion, sexual orientation, political affiliation and beliefs. This needs to be brought to the attention of all nurses as the Batho Pele White Paper states: “Improving the public service delivery is not a one-off exercise. It is an ongoing and dynamic process, because as standards are met, they must be progressively raised. This document marks only the first stage in that process. There is a great deal to do, and progress will sometimes be frustratingly slow; but the task is one of the most worthwhile and rewarding that the public service faces, and the need is urgent, so there is no time to lose” (South Africa 1997:30).

Emotional counselling

Emotional counselling covers a range of talking type therapies, given by trained practitioners, either short or long term in an effort to improve a patient’s coping

mechanisms and well-being especially if they are going through a tough time due to a life changing diagnosis. It is very important that the counsellor and the patient make a good connection and that the patient wants to work with the counsellor (Counselling in Primary Care 2016:1).

The following participant recognised the need for a referral for her patient:

“You can have compassion for you patient by touch especially or to have eye contact with your patient. With instands [instance] with a patient going throw [through] an emotional ordeal you can arrange for some counselling for instants with amputation of a leg.” (P2).

Professional counsellors can help patients to address a definite problem, make decisions, the acceptance of a diagnosis, handling of crises, to work through conflict, improving relationships, in short anything that the patient would like help with is available, and there are many techniques used by the counsellor to affect this help (Counselling in Primary Care 2016:1).

Category: Spiritual needs of patients

According to an article by the University of Minnesota (2016:1) patients own spiritual resources help them to heal from negative emotions, and a belief system can give them hope and meaning. The following participant seemed to understand this need:

“I admitted an elderly gentleman to my unit after he had a fall in which he sustained a head injury with possible femur/pelvis fracture. He subsequently developed a bronchopneumonia which aggravated his pre-existing CCF. The gentleman was very ill and realised that his life expectancy was nearing its end. In spite of the fact that he had been a good Christian his whole life, he was very frightened and needed constant reassurance and affirmation of his beliefs. He feared being left alone and the staff spent a lot of time comforting him. The family also needed support and comfort emotionally as they tried to deal with the possible negative outcome and loss of their loved one.” (P13).

Monareng (2009:5) argues that the idea of holistic nursing care necessitates that nurses should understand the interconnectedness of the physical, psychological/emotional,

social, cultural and spiritual realms and treat their patients with all these aspects in mind. To meet the needs of patients holistically and to assist them to understand their circumstances, spiritual care should be integrated as part of physical, emotional and social care which alludes to all the elements of compassionate care. Some participants talked about the PNs needing to be present which is supported by Monareng (2009:7), who comments that if nurses feel that they are not able to provide spiritual nursing care fully, they can still meet their patients' spiritual needs by being present and listening to their anxieties regarding their illness, pain and suffering which is understood as being part of compassionate care (Monareng 2009:5-7).

Spiritual counselling

It has been found that giving patients spiritual counselling improves their spiritual health, which in turn leads to an overall health improvement. If patients' spiritual needs are not met their medical issues don't end after discharge from hospital, often sending them back to hospital, at greater cost for themselves, their family and the hospital itself. If spiritual counselling can be given by professional people, like a pastor, often this spiritual healing will also help with physical healing (Chang 2014:1-3).

Some participants were well aware of their role of spiritual counselling and without formalised training they do provide it based on their own experiences and background:

“One day I came to work and the patient shout and say I want to die, I want to die. I immediately left what I was doing and went to patient, close the curtains, took a chair, hold the patient's hand and ask if there is any way I can make it better for her. She went to talk about it. Patient told me how she was diagnose with cancer, bipolar and feels like she cannot take it anymore and want to end her life. I gave her time to say what she needed to say and allow her to cry and tells her it is okay. I started asking her about her family, if she think they miss her while in hospital or if she miss them also. I made her understand that they need her to fight the sickness to be better for them, we hugged and she was happy we had a talk. And I show sympathy, care, compassion.” (P4).

This response gives evidence that nurses are aware of their patients spiritual needs however, the counselling happened by accident. Spiritual care as part of holistic care is often neglected and spiritual counsellors could also be called in as a referral.

Category: Support system for patients

Family needs are varied, but generally when someone is hospitalised their role becomes another family member's role. In order for these family members to cope, they need to be informed about the patient's diagnosis, prognosis, estimated length of time in hospital and possible fears need to be addressed, and necessary health care education given. On discharge patients families need to be given some health care advice and education, such as to be aware of limitations the patient may have and reasons for certain restraints to be observed, as well as details for follow up visits (*Impact of illness on the family* 2016:1). Patient and family centred care and engagement has become a more talked about topic as the benefits of including family and friends support has been recognised as important. Questionnaires have been developed to evaluate whether family support is encouraged and valued in a hospital setting (Agency for Healthcare Research and Quality 2013:1-3).

These participant's stated how they would attempt to put family members at ease:

"Compassionate care extends to the significant others especially with regard to critical illness, where families are devastated because of the condition of the patient. Compassionate care will include support such as counselling and a talk to families to know where they are at. Compassionate care in short should be holistic."
(P10).

And further on this, the same participant added:

"I will explain the progress of the patient to significant others within my scope, things that I am unable I will refer the family to the doctor for detailed report." (P10).

"Realise that their changing health status can be overwhelming and offer patients and families repeated explanations. Including the family in the patient care helps to prevent the buildup of conflict and allows all to support the patient positively."
(P13).

Even though PNs are busy they need to make time to answer the family's questions with empathy, understanding, respect and concern. When a person is ill the family is equally affected. Compassionate care needs to be extended to the family. Caring about their family will have positive health outcomes on the patient to. If PNs cannot answer

questions or deal with family they need to refer them to the patient's doctor, or for counselling. Working with families and friends is not easy as the strain of illness and of not knowing what is happening to the patient can put stress on the most devoted relationships. All of this requires skilled, thoughtful and compassionate support on the part of the PNs (Physant 2013:8).

Subcategory: Family and friends support

Support from family participation and partnering with the nurses will have an impact on the well-being of patients. Nursing in the 70's was very different as family were seen as an interference, however through research it has been found that family participation is imperative to the patients recovery. According to the Institute for Patient and Family centered care (2016:1), the PN needs to be understanding as both patients and family might go through many emotions while dealing with the illness and all it entails.

Many participants noted how important the participation of family and friends is in the recovery of their patients was:

“Seeing how patient is if need assistance, need someone to talk to. Be there for family and friends as well if patient know family and friends are fine patient is calm.” (P1).

“Talking to patient with dignity to show respect. Showing respect by respecting their family. By involving family in the care of the patient. By showing empathy and sympathy while caring for the patient. By allowing family to participate in caring of patient. By allowing family to participate in caring of patient. By allowing them to visit patient. Sometimes we provide compassionate to family as well cause it feels like they need someone to blame while their family is sick. I keep my cool and understand their pain and if it makes them feel better that they shout it okay with me” (P4).

Not all patients have family, or perhaps they live far away, or the patient might have lived with someone for years and are not married. The patient him/herself, if mature, well enough and competent should always be given the opportunity to make their own decisions regarding who is involved in their health care. The definition of the word family

refers to two or more people who are related, this relationship could be biological, legal or emotional (Institute for Patient and Family Centered Care 2016:1).

3.3.2.2 Theme 2: Inadequate knowledge and skill

Inadequate knowledge and skill affects the delivery of compassionate patient care.

The professional lifeline was helpful in identifying the highs and low in the PNs nursing career. Some of the lows were as a result of challenges in the units, the PNs need good decision making and problem-solving skills and clinical ability for them to feel competent. These timelines were part of the Interview Guide (Annexure E; Section C) and their interpretation was implied on the identified themes and categories.

The Florence Nightingale Foundation (2014:1213) addressed the issue of education for nurses to investigate whether having degree educated PNs directly improved the numbers of good patient outcomes or not. Theoretical knowledge is likely to impact on PNs ability to provide compassionate care as it cognitively empowers them with abstract knowledge that can be applied in practice to improve psychomotor ability.

Category: Participants feeling inadequately prepared

Health care is an ever changing environment and nurses need the kind of education that prepares them for the changes and trials that lie ahead. This preparation needs much more than just the gaining of knowledge and expertise during the formal education of the nurses.

Educated nurses will question purely task orientated care programmes and will be more inclined to focus on patient centred holistic health care by taking patient's needs into account. Educated nurses are prepared to be self-confident and they are critical thinkers who will be likely to deliver compassionate care. Their training empowers them with knowledge of the disease process, management and leadership skills to mentor neophyte nurses on desirable nursing practice (Florence Nightingale Foundation 2014:1213).

One participant put it in a nutshell:

“For some people, compassion is a natural disposition. For others, it slowly emerges with life experiences and the realisation that we are all vulnerable to life’s uncertainties. I personally feel that compassion isn’t something a person knows, it is something a person feels. Having said that there are a few factors that can influence the amount of compassion shown namely the age of the care-giver; whether they have children or not; whether they have elderly parents. These life experiences often heighten one’s sense of compassion or allow you to relate to your patient on a personal level.” (P13).

This participant did not view compassion as part of training but as a feeling of a person. This is contradictory to the fact that studies show that training can improve compassionate patient care (Florence Nightingale Foundation 2014:1213).

Subcategory: Skill level and practice and further education

The true test of nursing care is at the point of contact with the patient. It appears as if not enough consideration has been given to the practical application of this knowledge and skills at the patient’s bedside. The ability of the nurse to have knowledge and skill and to respond with dignity, respect, empathy, compassion and good communication are just as important. The development of this package in a nurse, requires good mentorship and good role models as well as much experience in a range of practical learning opportunities. Participants expressed lack of education as a contributing factor to the conceptualisation of what compassionate care is and how to provide it (Sturdy 2013:17).

When asked to write about their highs and lows in the provision of compassionate care one participant noted:

“My lows was where I was not working in a unit that I felt comfortable in. Where I possibly felt unexperienced in and where I was put in situations where I did not have much experience in.” (P11).

This participant stated what education has done for her:

“Soos wat my ervaringsveld vergroot het en my kennis toegeneem het en ek verdure [verderer] studie gedoen het, het my vermoë om te kommunikeer verbeter. Kennis in die veld waarin ek werk maak dat ek sekere simptome kan verstaan en verklaar en soms ook kan voorspel, wat dit makliker maak om te verstaan hoe die siektetoestand verloop en daarom kan ek meer compassion met die pasiënt hê.”
(P3).

[Translated: “As my field of experience widened and my knowledge increased and I studied further, my ability to communicate to improved. Knowledge in the field that I am working in has enabled me to recognise and understand certain symptoms, and sometimes to predict certain symptoms which makes it easier for me to understand how the illness will progress and therefore I can have more compassion for the patient.”]

According to this participant there is a need for further education over and above the basic nursing education. According to Farenden (2013:13), when discussing the future of nursing, in order for PNs to be competent to carry out safe and effective compassionate care there must be an understanding of what is expected of these nurses. There is a need for support in terms of training, professional development and supervision. There must be clear standards and policies available to all nurses to guide this practice. The work environment must provide an open culture where staff feel supported and can raise concerns and these need to be dealt with adequately. Equipment needs to be sufficiently modern, in good working condition and staff need to be properly trained in the use thereof (Farenden 2013:13).

3.3.2.3 Theme 3: Barriers to providing compassionate care

A barrier is defined by the Oxford English Dictionary (2002b:62) as anything that obstructs or hinders passage, access or progress.

Barriers in the provision of compassionate patient care in a study done by Bartol (2014:1-2) were identified as lack of understanding of teamwork, personal barriers in the nurses and organisational barriers. The results of this study were similar in that barriers cited that

prevent compassionate care were found to be personal, organisational and inadequate skill and knowledge.

Category: Emotional needs of participants

The lack of emotional investment during nursing, changes what should be a caring experience into a burden, just a job. Yet emotional involvement can also become emotionally exhausting. Van der Wal (2006:63) is of the notion that there is no definite evidence that shows whether or not nurses who make compassionate connections with patients experience the same levels of dissatisfaction as those nurses who appear distant or even uncaring (Van der Wal 2006:63).

One participant expressed on paper that:

“When you go home after a shift and there was a moment where you know you made a difference in someone’s life, a patient a family member. It is always difficult to do this when you yourself as a nurse is going through a difficult time personally. You need to be able to put your life on hold while you are working with a patient.” (P11).

It can be emotionally exhausting, some nurses do see value in what they do for patients. It has been found that nurses who seem to value their work and themselves, are the ones that develop a professional identity over time which makes them feel like a nurse, as opposed to just working as a nurse (Pask 2003:170).

PNs will not be able to give compassionate patient care if they are not well or if not taking care of themselves.

Participants reported that they felt challenged to give patients the care they need if they fell tired:

“I also struggle with highs and lows if you are also going through an emotional ordeal like you and your husband having a fight at home or you are hardling [hardly] having sleep for not sleeping at night. It also gets difficult as your compassionate tank get exhausted and emptied out and you do not have any compassion left to give to a patient.” (P2).

Compassion fatigue in nurses is given as one of the reasons for poor patient care. There are many reasons given for compassion fatigue, one being that a nurse uses her emotional reserves when caring for patients and this emotional tank needs to be refueled. The advice given is that nurses should be aware of developing compassion fatigue and plan for activities which they know will help to decompress and to reload their energy levels before they are in an emotional low crises (Mendes 2014:1146).

Subcategory: Balancing of home and work life

There are economic and other pressures on nurses as many have to run a home, see to children and all the activities that go with that as well as work full time.

Participants backed this up with the following comments:

“Possibly had ups and downs from being a student nurse I had a lot of compassion but my own life situation as well as work environment at times made it more difficult to have compassion.” (P11).

“But hospital nursing hours is too long, the money and sometime feeling of being unappreciated as well from being blue eye bushed tailed (the participant means a bright eyed and bushy tailed youth) when student and first 3 years of nursing it changed a little, cause family and cost living go high and then need to look for better position and hours but I still very compassionate and love my job. Still couse [because] still early days” (P1).

Nurses could be shown how they will also benefit from a sense of well-being as they rise to the challenge of compassionate nursing care. Nurses need to be able to have balance between emotional labour to their patients and the need to care for her own emotional wellbeing (Curtis 2014:211-219). According to the Registered Nurses Association of Ontario (2016:1-2,) nurses battle with work-life balance because of the type of the job having long hours and shift work. Nurses are expected to embrace a caretaker’s role and many don’t look after themselves and they put others before themselves.

Subcategory: Atmosphere in the unit

Although the manager has the responsibility of the unit, he/she also sets the tone for the atmosphere in the unit, commonly friction between employees can affect the working relationships which has an effect on the provision of compassionate patient care.

Participants mention this:

“Your highs and lows also get influenced by your co-worker for instance if your unit manager is having a positive outlook it will change your outlook and compassion to giving more and to give less.” (P2).

“I would say I have experienced lows in providing compassionate care due to external circumstances- like being overworked due to staff shortages, lack of resources, poor management. All these place an added stress on nurses and distracts them from providing holistic and compassionate care. Politics amongst nurses can be so frustrating at times- and can side track nurses from providing optimal and compassionate care for their patients.” (P12).

The atmosphere in the workplace is considered healthy if staff display teamwork. PNs show positive, courteous and respectful behaviour while spending time with their patients. Staff are not rushing all the time and have time to help their patients and each other (Registered Nurses Association of Ontario 2016:1-2).

Category: Workload

It seems that the workload of PNs has increased as the job has become much more multi-dimensional, and a higher expectation is placed on the PNs. According to Farenden (2013:13), having too few nurses with the correct training on duty will lead to poor patient care. What happens if the number of nurses in relation to the amount of patients is not sufficient, the nurses prioritise what they can do, then patients will go unwashed and many other needs will not be attended to.

Most of the participants interviewed spoke about the workload affecting compassionate care:

“Obviously a heavy work load can negatively affect the dispensing of compassionate patient care so a fine balance needs to be maintained.” (P13).

“Negative influences are time constraints, bureaucratic paperwork, workload and technological dominance. These often take priority over holistic care which creates a difficult ethical and moral dilemma with regard to service provision and compassionate care. Being able to provide compassionate patient care definitely leads to greater job satisfaction and less burnout.” (P13).

Lack of time for many reasons relating to general workload problems seemed to be something that most of the participants in the study mentioned:

“During my years after being a student as R/N it has become more difficult due to lack of time and amount of written documents that need to be done. This distracts you from some real issues the patient may have. For example if a patient has a lot of pain and you want to find out if there are other problems at home/disfigurement issues it sometimes get missed because of time you cannot spend with your patient.” (P5).

Research conducted by Austin (2011:158-166) from Canada showed that the barriers to nurses giving compassionate care are often systemic and not from fatigue as it is so often explained. Austin (2011:159) further describes the values of corporate organisations towards efficiency and control and how nursing care cannot be measured by the same standards used for organisational success in the business world.

Sub-category: Support from management

A review was done which focused on management styles, and found that there were certain management styles that were more conducive to positive outcomes in the workforce and quality of patient care than others (Foster 2014:1165; Aiken et al 2014:1824).

Some participants mentioned lack of support from management:

“The highs and lows is also bepaal deur the matrons and the work they sent to the ward that they expect to done by a certain time.” (P2).

[Translated: “The highs and lows are also determined by the matrons and the work they send to the ward and that they expect this work to be done by a certain time.”]

“I would have to say that my compassionate nursing care has wavered over the years not by choice- but due to external circumstances eg. Frustrations from senior management, being over worked where the patient nurse ratio was not right, also instances where you don’t have the resources to provide total care- it is in those instances that compassionate care is challenged.” (P12).

This is a defining moment in nursing. Nursing has changed and will continue to do so, but never before have there been so many negative media stories about nurse’s lack of compassionate patient care. Nursing leaders need to be more visible and more outspoken than ever before. Nursing leaders need to hear the voice of the nurses, and the patients and be heard at the board level of private hospitals (Sturdy 2013:6).

Subcategory: Too much paper work

Most of the participants also complained that there is a lot of paper work to be done in the units and they do not have time to be compassionate. One of the participants reports that:

“It also become more difficult to give compassion to your patient in the ward as your time get less to be by your patients’ bedside and to do more and more paperwork.” (P2).

“Die groot problem wat my tans en die afgelope paar jaar verhinder om nog steeds passievol te verpleeg is al die papierwerk. Verpleging is deesdae n papier oorlog. Ons moet al hoe meer dokuments invul by elke pasient dat dit net nie meer moontlik is om langs pasient te staan nie. – Dus meer papierwerk en admin as basiese verpleegkunde. (P6).

[Translated: “A big problem that affects me now and has done for a few years, and prevents me from still nursing with compassion is all the paperwork. Nursing today is a paper war. We must fill in more and more documents for every patient, so that it is not still possible to be there for the patient. Thus, more paperwork and admin than basic nursing care.”]

In a longitudinal study conducted by Paperwork burden (2013:1) it was reported that paperwork doubled from 2008-2013 in the health care environment. Three quarters of nurses who were asked in that study how paperwork affected them, said that it prevented them from giving compassionate patient care while they were busy with the paperwork. It is an interesting finding to note that nurses seem to view compassionate care as separate from their professional care of patients.

Subcategory: Shortage of staff and resources

Findings from a retrospective study conducted by Aiken et al (2014:1824), taken from discharge data from nine European countries showed that by cutting staff to save money, there was a negative impact on patient care outcomes. Also it was shown that the organisational behaviour and retention of qualified committed staff was noted to contribute to the improvement of both the quality and safety of care of patients.

Some participants cited staff shortages as affecting their ability to give compassionate patient care:

“Being over worked and not having enough nursing staff does take a lot out of you. Unfortunately the patients are the ones who will suffer.” (P11).

“I would say I have experienced lows in providing compassionate care due to external circumstances- like being overworked due to staff shortages, lack of resources, poor management. All these place an added stress on nurses and distracts them from providing holistic and compassionate care.” (P11).

When one looks at how one practices care and justice or equality of care to all, it is evident that a person could become burnt out, but when compassion is practised correctly, the carer continues to blossom, and compassion fatigue is not an issue (Frakes 2010:80).

Some participants pointed out that some nurses lose compassion over time due to circumstances in their hospital or unit:

“In ‘n privaat hospital is dit egter n bietjie moeiliker, daar is groot beklemming op koste besparing en dokumentasie. Daar word verwag dat meer gedoen word in minder tyd. Ons werk ook nie meer met personeel wat gebore is vir die beroep nie, maar met mense wat verpleeg net as ‘n beroep en om geld te verdien. Dit maak dit baie moeilik om passievol te wees as daar nie baie mense om jou is wat ook so passievol is nie.” (P6).

[Translated: In a private hospital it is, however, a little more difficult, there is large emphasis placed on cost saving and documentation. There is an expectation that more must be done in less time. We also no longer work with staff who are born for the profession, but people who do nursing as a job and to earn money. This makes it very difficult to be compassionate if there are not many people around you who are also compassionate.”]

The provision of compassionate care is much more than the competent performance of clinical skills; and that it involves a “doing role” and a “being role”. Davison and Williams (2009:3-4) cite the National Nursing Research Unit (2008) as stating that patients consider it essential that they are “cared for” and “cared about” for continuation of compassionate patient care.

In earlier years it seemed as if nurses only went into nursing because they wanted to. With unemployment figures being higher, young girls might enter the profession for economic reasons. This is the reason why the recommendation made later calls for nurses to be screened before being allowed to even enter the nursing profession.

“Compassionate [compassion] was low in early profession.” (P10).

This PN told me she just came nursing because it was a job and she didn’t enjoy it initially.

There seem to be many young ladies interested in nursing but various factors prevent them from entering the profession: heavier workloads, lack of nursing schools and universities offering Nursing Diplomas and Degrees, lack of training of enrolled nurses who are not able to function well, high stress in PNs not being addressed, high turnover

of staff and added to that is a 55% of PNs in a study done in the United States in 2013 are retiring soon (White 2016:1).

Sub-category: Dealing with complaints from patients and family

It is a common phenomenon for patients to complain about services rendered. Because of nurses being at the patient's bedside all the time they are the common recipients of complaints. It call for maturity on the part of the PN to deal with these complaints in a professional manner. According to Royal College of Nursing (2016:1) when dealing with patient/family complaints, it is important that the nurse listens carefully to the complaint and is not dismissive. If the complainants feel they have been heard, and that there is going to be some form of action or corrective procedure taken it will more than likely diffuse their anger.

Participants did seem to battle with handling of complaints:

"Patients as customers are always right but in other terms this provoke the compassionate to nursing care given, because you will care for patient for a while, but the family and patients not appreciating what you do, and what I realised with family sometimes they look for mistakes unnecessary. We had a patient who complained of hip pain to the doctor while the wife was visiting and the wife told the doctor that he felt [fell] and that was a surprise to us, when we try to find out the story, the wife verbalised that she found the husband on the floor the previous day, but she did not report the issue immediately until the doctor came the following day for rounds, and the patient also never reported, so we were embarrassed because we were assisting patient day out to the bathroom and, the other day there comes a white sister, the patient explained to her he did not fell, he was but by the cot side when he comes out of the bed and we were supposed to right [write] incident and root cause ardises [root cause advise]." (P9).

"Compassionate was very high when patient has an appreciating attitude towards the care and I remember looking after a patient who told me I pay you for the service that you are rendering. True enough but my salary did not come straight from his pocket if that's what he meant. He pays the institution and there after salaries are distributed. Such a patient, no matter the good I did, he felt he deserved it because of the money he was paying." (P10).

It seems that certain patient characteristics, which make them seem difficult, have a definite effect on the caring aspect of the nurse towards the patient. However it has also been found that situational issues like workload, lack of time, stress and perceived less important patient requests, also contribute to the nurse feeling that the patient is moaning or being difficult. PNs need to guard against “punishing” the so called difficult patients and use caring behaviour not avoidance, ignoring, admonishing or being uncaring (Van der Wal 2006:72).

3.3.3 Participants’ professional Lifeline

The participants were asked to look at a graph and to plot how they provided compassionate care from the time they became PNs up currently. The results of the graphs drawn by the PNs were summarised and put in table form (Table 3.3) and then converted into percentages in a table (Table 3.4).

Table 3.3: Levels of compassionate care based on the professional lifeline

Participants	Declined over years	Improved over years	Went up and down ended up nearly the same	Stayed nearly the same
1	x			
2	x			
3			x	
4				x
5	x			
6	x			
7		x		
8		x		
9	x			
10		x		
11	x			
12				x
13		x		

It is interesting to note that some of the participants understanding of the phenomenon declined over the years, these PNs seemed to lose their zeal and value for the profession. Many factors may come into play to bring about this perception. However, those PNs who indicated an improvement in how they became compassionate in caring for patients, attributed it to be related to their personal experiences with illness and hospitalisation.

Table 3.4 Professional lifeline in percentages

Parameters	n	Percentage
Compassion declined over years	6	46.5
Compassion improved over years	4	30.5
Compassion went up and down now nearly the same at beginning	1	7.7
Compassion stayed nearly the same over the years	2	15.3
Total	13	100.0

Table 3.4 shows that from the professional lifeline 6 (46.5%) of the PNs interviewed said that their feeling of compassion towards patients had declined over the years of working as a PN. Compassion had improved over the years for 4(30.5%) and 2(15.3%) felt their compassion had stayed the same. Only 1 (7.7%) indicated continuous fluctuation of compassionate care and was affected by personal challenges. This does indicate, from reading the stories in conjunction with the lifeline, that many of the PNs interviewed felt that they were not able to give compassionate care as they would like to due to various reasons beyond their own control. The PNs who complained that their compassion had declined or gone up and down over the years cited a number of barriers, both internal and external, as the reasons for this happening. The lifeline was a visual representation of the actual stories by the PNs

3.4 OVERVIEW OF RESEARCH FINDINGS

Interpretation in this study was a process of making sense of the outcomes of this study and exploring their implications to practice, education and research by nurses. There were no fixed rules in the summarising. Interpretation of this study was an iterative process, meaning it happened simultaneously with the reading and re-reading of the data as the themes and categories emerged. As the researcher became truly immersed in the

data, a process called incubation occurred which is also known as “living in the data”, as she attempted to draw the real meaning from the meaning units. It was necessary for the researcher to practice bracketing throughout this process to avoid contamination of the findings (Polit & Beck 2012:576). It was up to the researcher to make use of enough and suitable evidence (Hofstee 2006:147).

Thematic and narrative analysis was applied as guided by Saldana (2013:1-41). Interpretation of the data followed the following five interpretive aspects as stated by Polit et al 2006:411-413):

- *The credibility of the findings*, was evidenced by the fact that a reasonable amount of meaning quotes were utilised for analysis. The researcher could make sense of the written stories although they had many grammar and spelling mistakes. The responses from the participants to the research questions was satisfactory.
- *The extracted meaning of these findings*, was a natural outflow from the analysis of the data. In this study the analysis occurred as the researcher made sense of the data during the coding. The themes and categories naturally took shape, the data was read and re-read, and it was not necessary to dig for more meaning than what was evident. The PNs spoke with one voice as most of them cited the same barriers to giving compassionate patient care, and the reasons for waning compassion were similar. There was no mis-understanding and the meaning from their stories was obvious and clear, even though two participants answered some questions in Afrikaans, as the researcher is bilingual.
- *The importance of these findings*, was really apparent as despite much previous research on the phenomenon, the provision of compassionate patient care remains an everyday for both nurses and patients. Although reasons for the deterioration of compassion provided is evident in the literature sources, there is not much evidence of change in practice for many reasons cited as barriers. The findings add value to the conclusions of previous studies and to scholars who are interested in the phenomenon. The findings were helpful in developing recommendations that will assist addressing the barriers that prevent PNs from providing meaningful compassionate patient care. Recommendations were added for future studies to further clarify and simplify the phenomenon. Findings from this study will be disseminated by presentations and conferences to like-minded

groups, in-service education in private hospitals and through the writing of an article for publication.

- *The transferability of the findings.* Because of the small sample size, the findings cannot be transferable to the other institutions except to the study context. The research process followed was richly described and therefore the study can be replicated.
- *The implications of these findings* referred to impact on clinical practice, education and research for nurses. However, use of larger populations using the quantitative approach could add other information about the study phenomenon. Further research should be undertaken to measure the suitability of young men and women to the nursing profession (Polit et al 2006:411-413).

From the PNs' stories it was evident that every one of them is fully aware and was able to verbalise exactly how to care for their patients' needs physically, emotionally and spiritually as well as the inclusion of family members. It was however noted that they seemed to find it difficult to differentiate aspects mentioned under emotional and spiritual needs and they viewed them as the same. Further detailed information about the analysis and interpretation process done has been described already.

3.5 CONCLUSION

In this chapter and phase, data management and analysis were discussed. From the data, major themes, categories and sub-categories were identified. These were discussed in more detail, interpreted and validated with literature. The findings of this study were further summarized and interpretive aspects were included in the research overview.

Chapter 4 will discuss the conclusion from the findings as well as the limitations, recommendations and implications

CHAPTER 4

DISCUSSIONS AND RECOMMENDATIONS

Compassion is not religious business, it is human business, it is not luxury, it is essential for our own peace and mental stability, it is essential for human survival.

Dalai Lama XIV

4.1 INTRODUCTION

In this chapter the research findings were discussed as conclusions which were derived from the meaning PNs attached to the questions they were asked. The analysis of their written stories about their experiences of providing compassionate patient care led to the emergence of three major themes which were treating patients as a whole, how inadequate knowledge and skill and barriers to providing compassionate care. Recommendations and implications to nursing practice, education and further research were alluded to (Grove et al 2013:590).

This study was conducted in phases and the fourth block, which is shaded a different colour, applies to the activities of the phases covered in this chapter (Figure 4.1).

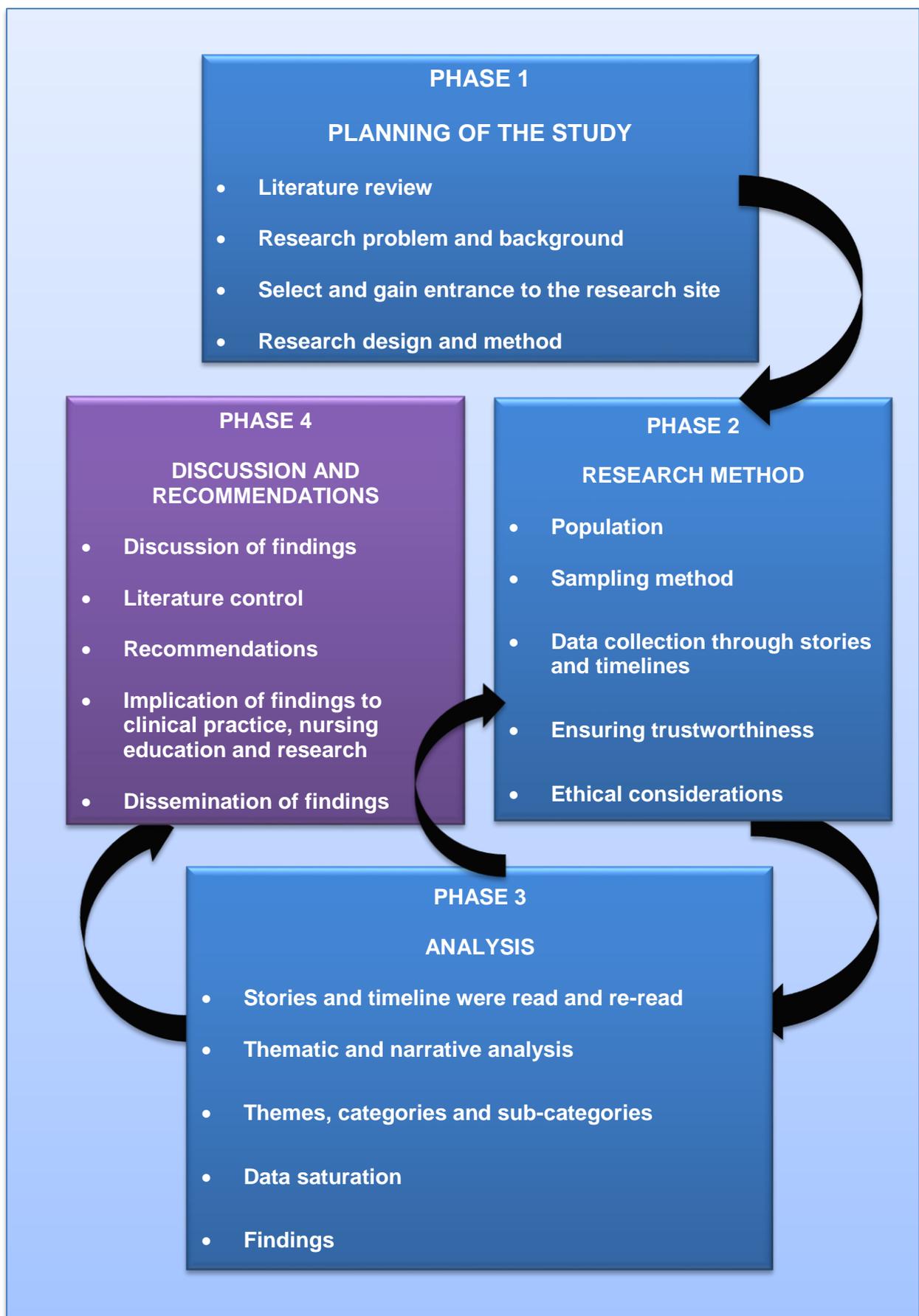


Figure 4.1 Flow of research activities in phase 4
 (Adapted from Polit & Beck 2012:61)

In this phase of this study, discussions of the research findings was undertaken with literature control and limitations of the study were highlighted. Ways of communicating the findings to the interested parties were stated, recommendations implications of the findings on the future of nursing in clinical practice, education and further research was discussed.

The purpose, research question and objectives of this study were indicated to align the ensuing discussions.

The *purpose* of this study was to describe the experiences of the participants in their provision of compassionate patient care on a daily basis.

The *objectives* of the study were to:

- Explore and describe the experiences of PNs in providing compassionate patient care in a private hospital, Gauteng, South Africa.
- Describe the reasons that hinder PNs to provide compassionate patient care in a private hospital, Gauteng, South Africa.

The *central theoretical statement* for this study was: What are the experiences of professional nurses in providing compassionate patient care in a private hospital in Gauteng, South Africa?

4.2 DISCUSSION OF THE RESEARCH FINDINGS

Discussion of these research findings were embedded in the identified themes from data analysis. The themes were treating patients as a whole, inadequate knowledge and skill and barriers to providing compassionate patient care.

4.2.1 Treating patient as a whole

Treating patients as a whole is a fundamental feature of the nursing profession and is what compassionate patient care is about. It means not just looking at the disease or illness, but the patient as a whole. Good nurses were historically noted by Florence Nightingale as those who treat patients with dignity and not as objects (Pollard 1891:81-

94), as pointed out in her classic life story. Today good nurses would be measured not only by their qualifications, although they do require these, but by the evidence of their compassionate patient care. According to Monareng (2009:2), holism emphasises that an integrated whole has a reality that is bigger than the sum of its parts. Monareng (2009:2) further explains that when holistic care is applied to the Western health care system, it supports an approach that includes all aspects of bodily, psychosocial and spiritual human functions. When health care settings are deficient in compassionate patient care, this means that the very best patient outcomes cannot be expected. Patients would have better outcomes if treated as a whole, this in turn has a long term impact on time and costs for the organisation. Compassionate care is not only a science where routine holistic patient care is expected, it is also as important to be aware of being present and available to and for the patient whatever that means to him/her during their illness. No one nurse can be perfect in doing all of this perfectly all the time, but the goal should always be to attempt to get there. In this study it appears that most of the participants were aware of what should and needs to be done to be a compassionate nurse although the gap still exists between what they know and the reality of what happens (Post et al 2014:878).

Scammell (2014:1048) reports that the professional nursing code of practice has been re-examined in UK and USA and this needs to be done in all countries. Examining the nursing Code is only a guide, and it largely depends on the PNs personal values as to whether they are going to embody the professional Code which is the correct standard of nursing to be adhered to. Most nurses enter nursing with excellent intentions of caring, they feel that they can identify with the professional values and standards. However, it depends on each PNs interpretation of words; for instance competency might mean getting the job done, yet it is not compassionate care if the job is done but there is no emphasis on how the job was done. It also takes personal resilience for PNs to continue giving compassionate patient care if this type of care is not supported by all the members of the health care team. Education of how to provide compassionate nursing care is as important as what to do (Scammell 2014:1048). Private hospitals don't have the numbers of patients that state hospitals do, which should make it possible to provide holistic care.

4.2.2 Inadequate knowledge and skill

However, the knowledge and skill that nurses acquire from education programmes is necessary to enable the nurse to treat patients scientifically as well as humanely.

Van der Wal (2006:72) states that if you want nurses to become compassionate in their caring they need to be mentored in a compassionate manner themselves, so that their own professional development cannot be compromised, but will be strengthened by the situation they are working in. Van der Wal (2006:72) further adds that the nursing education received by PNs while training will facilitate changes in their attitude, but it will not always be in the direction which would be conducive to better compassionate care on their part. According to Van der Wal (2006:72), if the following are included in nursing education it would offset the factors that would possibly erode the provision of compassionate care such as the encouragement of academic, emotional, social and spiritual intelligences. Nurses should be encouraged to truly emotionally connect with their patients (Van der Wal 2006:72).

Education in relation to compassionate care seem to fit very well together as evidenced in the writings of the article by the Florence Nightingale Foundation (2014:1213). Whereas it is argued by Buchanan (2013:17) in an article entitled “Too posh to wash? It is indicated that nurses with degrees are not as good in the practical situation because they think of themselves as being too good to do some of the more menial tasks. Buchanan (2013:17) further asks whether our nurses today are overqualified and possibly undertrained. Based on the present training for degree purposes, nurses spend at least 50% of their time in the practical ward set up with mentors. There seems to be a fine line between the professional practice of PNs and the provision of humane care. This challenges how holistic care should be provided. In addition to compassion, plenty of skills are necessary to become a competent PN, which include the assessment of patient’s health status, as well as picking up any early signs of deterioration, and to be able to then take appropriate action as well as timeous referrals, these are all of utmost importance without ignoring the human aspect.

According to the Florence Nightingale Foundation (2014:1213), more theoretical knowledge enables the PN to give compassionate care that is more up-to-date and even more meaningful. When this theoretical knowledge is combined with the correct practical

application of the art of nursing it becomes acceptable nursing care. The more nurses are well trained and mentored on the provision of compassionate care, patient health outcomes and quality of life improves (Florence Nightingale Foundation 2014:1213). Although advances in medical technology keeps patients living longer, the quality of care provided remains a concern, and so does the quality of life for the patients. According to Buchanan (2013:17), nurses need to be prepared with additional skills and knowledge for a larger number of elderly patients with a multitude of comorbidities and the training and values required for the future of nursing and the best outcomes for the patients in their care. However, there are many nurses who care and are compassionate to patients and this is not necessarily learnt from nursing programmes. Background, family values and personal experiences together with the correct education and training ensure competent compassionate PNs.

Sturdy (2013:6) attempted to put the future of nursing into perspective in an article which attempted by examining nursing as a profession clearly and objectively. As expressed in the ensuing debate nursing seems to have hit an all-time low as the public is able to cite more and more cases of poor nursing care, particularly in the media. Many people in our communities are wary of going to health care services because of their own and relative's bad experiences in hospital, having been treated without dignity and respect.

4.2.3 Barriers to providing compassionate care

When reading the stories given by the study participants it was clear that they all knew how to provide compassionate patient care, but the implementation was a different story. The application of this care was hampered by many factors, as will be briefly discussed. Most PNs reported experiencing emotional stress themselves, this seems to be a challenge that managers should treat compassionately. Cornwell and Goodrich (2009:1-5) report that nurses are exposed to emotional trauma from fellow human beings being in pain, suffering, having terminal illnesses and dying, on a daily basis. PNs develop their own coping mechanisms, some more effective, healthy and appropriate than others. These nurses who do not find effective coping skills will experience higher stress and even burnout. Nurses feeling stressed is reportedly higher in health care situations than in the general working population.

Dunn and Rivas (2014:48-49) maintain that a compassionate nurse is able to discern when patients are upset and empathies with their distress, recognise both positive and negative effects and be moved through the feeling of care and compassion to lessen or relieve their suffering. Positive emotions expected to be displayed are love or concern, however negative emotions are dismay or anguish over the suffering of another. Compassion becomes the driving force behind caring and supports the interactive process in the connection between the nurse and patient letting a balance of energies take place. Compassion is one of the essences of care (Dunn & Rivas 2014:48-49).

In this study, it was evidenced that the participants interviewed were moved to want to provide compassionate care for their patients and appeared frustrated by barriers both within and without themselves.

In a debate posed by Cole-King and Gilbert (2011:6), they argue that if cost-efficiency is the main measurement for human resources quality assessments, then it is easier for managers to persuade themselves and others that they are creating highly efficient health care facilities. This environment can be unpleasant and exhausting to be in, both for the patients and staff. When nurses are burdened and anxious about work pressure and achieving targets, they are more likely to perceive high acuity patients are a source stress and pressure. This was alluded to by participants as these patients demand more care, time and attention and are often referred to as “difficult patients”. Cole-King and Gilbert (2011:6), further say that as nurses are pushed for time and battling to meet the demands of documentation and administration tasks, it becomes easier for nurses to overlook the needs of patients who are quiet, undemanding and perhaps not as complicated. Both of these scenarios, the high acuity and the quiet patients, make it more difficult for PNs to behave compassionately towards these patients. These statements are not criticisms levelled against nurses, but merely well-known observations of how they work under pressure in a non-compassion-facilitating environment and this is supported by the findings in this study. In the real world where health care must become a competitive business, especially in the private sector, cost-saving and targets are extremely important. Health organisations run the risk of creating unhappy, defensive, burntout staff members who cannot provide compassionate care as they would like to, and who prematurely long only for retirement (Cole-King & Gilbert 2011:6).

It was remarkable that four of the participants in this study mentioned that they really felt much more compassion for their patients after they had either experienced a serious illness, or someone close to them became ill or died. This finding is supported by Post et al (2014:875), stating that a psychiatrist who was treating patients with depression didn't ever feel he connected with his patients until he suffered from a severe bout of depression himself. The psychologist Carl Jung referred to the "wounded healer" as the health care worker who has experienced some severe illness or suffering themselves as having more empathy and compassion towards his/her patients thereafter (Post et al 2014:875).

Nurses share some of the most challenging and often life changing moments with patients and their families. This exposes a range of different emotions and feelings, between nurses, patients, families and colleagues. Sitzman and Watson (2014:85) point out that feelings can't be correct or incorrect, they are just feelings, and that the way we respond to these feelings is important. It is an important fact that we have free choice whether to respond to patients with thoughtfulness and compassion or not. Sitzman and Watson (2014:85) state that nurses need to know that their own personalities are not based on their feelings, but that feelings will change over time and can be managed. The same applies to the patients, that their feelings will come and go. If they are nursed within a non-judgemental, compassionate environment where they feel accepted and respected, and are able to express positive and negative feelings and they feel they are heard, this will truly allow them to connect with the nurses and in turn for the nurses to connect with them. An analogy is given of someone trying to grasp and hold on to clouds as they float by, the futility of this allows one to realise how fleeting feelings are. They are merely feelings, good or bad, and should be useful to learn from and grow as a person, but not hung on to (Sitzman & Watson 2014:85-86). In this study a few of the participants mentioned their feelings, and whether or not they felt compassion, it is clear that the participants do not view compassionate patient care as part of their holistic patient care but merely an add on if there is time for it in their busy schedule.

4.3 LIMITATIONS OF THIS STUDY

Limitations refer to design or methodology characteristics which affect the interpretation of the findings of the research. They are the reason for not being able to generalise the findings, resulting in the prevention of practical application of the findings, because of the

initial choices the researcher made regarding the design and the steps taken to ensure adequate trustworthiness (University of Southern California 2016:1).

The major limitation of this study, as is in most qualitative studies, is that because the sample size is small, it will be impossible to generalise the findings to larger populations or other contexts. As the data analysis was done the researcher saw sample deficiencies. A purposive sample method was used which could have limited access to informants that are more rich with information to answer the study questions. Written stories may be exaggerated, untrue or some aspects forgotten or not well expressed which could have been a shortfall. These limitations were taken into consideration during data analysis (Polit & Beck 2012:60-65). Exaggeration occurs when participants might make the events or the outcome thereof out to be more significant than they actually were when they happened (University of Southern California 2016:1-5). English language was noted to be a challenge for some of the participants as evidenced by many spelling and grammar mistakes in the written stories.

4.4 RECOMMENDATIONS AND IMPLICATIONS

The most important reasons for making recommendations in this study, was that they are meant to be supportive and also give direction to nurse managers for the long-term application of change in the provision of compassionate care. Review of literature, and adequate cited examples from literature were important and together with the data analysis led to guide and inform planning for the future of nurses training (Streubert & Carpenter 2011:315). Recommendations were made based on the conclusions drawn from the findings, and was achieved by adding some information from the findings of literature sourced on the same topic. (Grove et al 2013:597).

Recommendations were based on the findings for further improvements in clinical practice, nursing education and advanced research.

4.4.1 Clinical practice

Based on the responses of the participants who struggled with issues like burnout, stress and compassionate fatigue, it is recommended that hospitals put employee's wellness programmes in place. Nurses should be able to consult with these services in order to be

able to provide compassionate patient care. Nurses require appropriate mentoring on the conceptualisation and practical application of compassionate care, and that high technology does not have to translate as low care (Davison & Williams 2009:3-4).

In practice nurses need to be aware of their own values, professional values and how to balance them while respecting the values of the patients. Although provision of compassionate care may mean different things to different nurses as evidenced in the findings, compassionate nurses should tailor their behaviour to meet the needs of their patients. Compassion should be encouraged and exemplified as a virtue that goes beyond physical care. Encouragement of staff members to engage in therapeutic communication human to human, not nurse to patient (Cornwell & Goodrich 2009:2-6).

4.4.2 Nursing education

Educating nurses to be patient orientated and not task orientated assists them to be present and to spark energy exchange between them and their patients. Nurses need to be taught to nurse with intention, in other words on purpose to be compassionate, kind and respectful. This means he/she needs to know him/herself and know how to be present and available to the patient's. Educators could consider using a narrative-centred curriculum to encourage patient centred care. This curriculum should focus on looking for, listening to, responding to, thinking about and interpreting all the work situations and personal stories of students, patients and teachers (Dunn 2009b:224-227).

To counter the erosive effects on caring, Van der Wal (2006:70-73) made recommendation that nursing education should focus on developing emotional, social and spiritual intelligences of nurses. Nurses should be taught to develop their various intelligences such as IQ (intelligence quotient) and EQ (emotional quotient). There is also a need to equip nurses to be able to engage in appropriate social interactions, requiring an improvement in inter-personal relationship skills with one another and with patients in order to create a positive atmosphere in the units. (Van der Wal 2006:55-73).

New emphasis needs to be placed on training nurses to understand and recognise the difference between routine care, empathic and compassionate care as evidenced in Figure 1.2 in Chapter 1. Post et al (2014:873) recommend that nurses can be encouraged to first add empathy to their routine care, and then compassion to their patient care, so

that it becomes compassionate care. They need to know the importance of progressing past the routine care stage, the understanding that this routine nursing care is only a beginning, albeit very important to do correctly. However, they are to be given the tools of how to achieve this progression from routine to compassionate patient care. It is pointed out in a study done by (Post et al 2014:873-875) that routine care could be a first step of education for nurses, progressing to detached empathy which is really just sympathy, then to affective empathy which is when the nurse understands what the patient is going through, to full compassionate care which entails wanting to alleviate the patients suffering in totality. The performative analysis method of narrative analysis will be useful later after the findings are made known to nursing training institutions. One could use role play when educating students regarding the giving of compassionate care to their patients and this would make it fun as well as help the students to remember what is being taught.

A programme such as WIL would be an investment in the future good of the nurses, the hospital where they are employed, local communities and humanity as a whole due to incorporation and sharing of academic, practical and life's general knowledge skills, and the development of future generations of confident, skilled, critical thinking, professional, community minded nurses equipped and competent with enough knowledge and correct attitudes to lead nursing onward and upward in the face of continuing change. These would be the ideal outcomes of WIL (Cooper et al 2010:1-5). Role play can be useful for training nurses to enact how they would practice compassionate care in the ward setting.

4.4.3 Advanced research

Recommendations and considerations for further research could include:

- The development of a multi-faceted measuring instrument, which would include psychometric questions to see whether new recruits are suited to the nursing profession before they even are admitted to commence training.
- A similar study, but with enrolled nurses could be repeated, as it appears they are doing more of the hands on caring duties, to see if their experiences differ from PNs, and to see if they experience the same barriers to providing compassionate care. The PNs are often not the main care givers, unless they are in specialised

units like ICU and High Care, many of them are no longer involved in the actual hands on nursing activities (University of Southern California 2016:1-5).

- Interviews with the board of directors in a private hospital, to establish how much control they have over the actual nursing model used, or whether the nurse managers are allowed to choose the best nursing models based on how compassionate care is provided.
- A quantitative study, with large samples carried out in state hospitals to see what the differences are between compassionate care in state and private hospitals which may lead to the development of hypotheses.
- A comparative study between the different groups of privately owned hospitals to enlarge the generalisation of this study to all private hospitals, because of differences of nursing care models, acuity and ratio of differing nurse categories.

4.4.4 Reflections of the researcher about her journey on this study

Conducting this study was exciting as I did it after retiring from nursing practice. It has always been my concern that the level of compassionate care that was given in the olden days is fast disappearing from the health care arena. I understand that there have been many changes in health care and for that matter in the world and that change will always be with us, but I question whether all the changes are for the better. The choice of this study construct was because of how I saw compassionate patient care change during my forty year nursing career and my previous experiences as a patient.

This study started with a research proposal. Gaining entry to the research site was difficult, but with persistence permission was granted. I had two supervisors who guided me expertly, especially on the use of the narrative approach. I didn't conduct face to face interviews, but collected data from written stories and this was a new field for me especially in trying to be as objective as possible. Analysing the data was an elaborate experience but was well handled because of the rich, in-depth information provided. It was the first time I had used timelines about the professional experience as nurses. It reminded me of my own personal professional experience of highs and lows in providing compassionate patient care. It was heart-breaking for me when I was no longer able to provide the level of care I used to. One of the lows that really stood out for me the most in my nursing career was when I was in a heavy medical ward late in my career, with too few nurses to be able to give proper physical care to the patients who needed assistance. An elderly lady's son commented that his Mom was smelly and he wasn't used to seeing

her like that, she was a patient that required help with her personal hygiene. Writing up the report took some time of being away from my family, but was possible with their love, support and understanding. I learnt a lot about research and developed an interest to further my studies despite my age.

4.5 DISSEMINATION OF FINDINGS

A plan was put in place to disseminate the findings of this study by making available a copy of the research report to the managers of the study institution with the possibility of conducting in-service education in private hospitals. Writing of research papers for publication in credible journals will be undertaken as well as possible presentation of this paper at relevant nursing conferences (Polit & Beck 2012:167-171). The findings from this study may be shared with important stakeholders that are involved in the training of nurses, such as the South African Nursing Council (SANC), the Department of Health and the World Health Organization (WHO) and nursing colleagues as this may assist them in modifying their policies and training curriculum of nurses of different categories. There was free dissemination of the research findings through in-service education and the writing of papers for publication

4.6 CONCLUSION

In this chapter the findings of this study were discussed with literature control applied. Recommendations and implications were related to clinical practice, education and further research in nursing. Dissemination of findings was made to interested health care providers.

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ANNEXURES

ANNEXURE A

ETHICAL CLEARANCE FROM THE DEPARTMENT OF HEALTH STUDIES, UNISA



**UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE**

REC-012714-039

MSHDC/345/2014

Date: 26 November 2014 Student No: 4374-249-1
Project Title: The experiences of professional nurses in providing compassionate patient care in a private hospital in Gauteng, South Africa: a qualitative narrative analysis.
Researcher: Leona Marianne Baker
Degree: MA in Nursing Code: MPCHS94
Supervisor: Prof LV Monareng
Qualification: D Litt et Phil
Joint Supervisor: -

DECISION OF COMMITTEE

Approved

Conditionally Approved

Prof L Roets
For CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

L. Roets (Prof)

MM Moleki
Prof MM Moleki

ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE B

LETTER REQUESTING PERMISSION TO DO A STUDY

I made an appointment with the chief Matron at a private hospital, Gauteng; I went to see her in April 2015. The Chief Matron told me to send an email requesting permission to do the study to Matron E Le Roux which I did, see copy of the email sent to her below.

I attached my letter from Unisa to say I had been approved to do this study: **THE EXPERIENCES OF PROFESSIONAL NURSES IN PROVIDING COMPASSIONATE PATIENT CARE IN A PRIVATE HOSPITAL IN GAUTENG, SOUTH AFRICA: A QUALITATIVE NARRATIVE ANALYSIS**

Matron le Roux then sent me an official Netcare form which I had to submit together with the Ethical Clearance Certificate and the Research Proposal for the study. I later received a document from the hospital granting permission for me to conduct the study there, this letter is Annexure C.

Leona Baker [<mailto:cottageco@mtnloaded.co.za>]

Sent: 02 March 2015 07:38 PM

To: 'estelle.leroux@netcare.co.za'

Cc: 'Monareng, Lydia'

Subject: Permission to do a study

Dear Matron le Roux,

I spoke to the matron in charge today and she gave me your email address.

I would like to request permission to do my study for my master's degree at the hospital, see attached letter to this effect.

Attached please also see my ethical clearance certificate which I received after completing my research proposal, as well as a copy of the actual research proposal.

With regards

Leona Baker

LM Baker

ANNEXURE C

LETTER OF PERMISSION TO DO A STUDY FROM THE HOSPITAL



Netcare Unitas Hospital

Tel: +27 (0) 12 677 8000
Fax: +27 (0) 12 664 6225
Clifton Avenue, Lyttelton, Centurion, South Africa
PO Box 15123, Lyttelton, Centurion, 0140, South Africa
www.netcare.co.za

21 May 2015

LETTER CONFIRMING KNOWLEDGE OF CLINICAL MEDICATION OR NON-MEDICATION RELATED TRIAL RESEARCH TO BE CONDUCTED IN THIS NETCARE FACILITY

Dear Leona Marianne Baker

RE: THE EXPERIENCE OF PROFESSIONAL NURSES IN PROVIDING COMPASSIONATE PATIENT CARE IN A PRIVATE HOSPITAL IN GAUTENG, SOUTH AFRICA: A QUALITATIVE NARRATIVE ANALYSIS

We hereby confirm knowledge of the above named research application to be made to the Netcare Research Committee and in principle agree to the research application for Netcare Unitas Hospital, subject to the following:

- i) That the research may not commence prior to receipt of FINAL APPROVAL from the Academic Board of Netcare (Research Committee).
- ii) A copy of the research report will be provided to Netcare once it is finally approved by the tertiary institution, or once complete.
- iii) Netcare has the right to implement any Best Practice recommendations from the research.
- iv) That the Hospital Management reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects / Netcare or should the researcher not comply with the conditions of approval.

We wish you success in your research.

Yours faithfully



Robert Jordaan
Hospital Manager

21/05/15

Date

Netcare Hospitals (Pty) Ltd T/A Netcare Unitas Hospital
Directors: J du Plessis, S Chetty, R H Friedland, K N Gibson
Company Secretary: L Bagwandeem
Reg. No. 1996/006591/07

ANNEXURE D

CONSENT AND CONFIDENTIALITY FORMS FOR STUDY PARTICIPANTS

Dear Participant

I am a master's student (43742491) in the Department of Health Studies in the College of Human Sciences at the University of South Africa (UNISA).

I would like to invite you to voluntarily participate in a research study entitled "The experiences of professional nurses in providing compassionate patient care in a private hospital: a qualitative narrative analysis".

The purpose of this study is to explore and describe your experiences in a story or narrative way, recording how you were able, or not able to provide compassionate patient care in the units where you work.

I request that you participate in a more or less one-hour interview, with a possible follow-up only if needed. With your permission, I would like to obtain anonymous biographical data from you and then ask various questions relating to compassionate patient care. I would like you to write down your answers/stories as I would need to analyse this data later. I will then ask you to complete a nursing career lifeline, showing the highs and lows in providing compassionate patient care.

Your identity and any information you disclose will be anonymous and treated with high confidentiality. Your stories will be kept under lock and key by the researcher and only the study supervisor will be able to see this information. The stories will be destroyed a year after completion of the study and no identifying information will be disclosed with the publication of the research findings.

Kindly be informed that you need not have any fear of victimisation or judgement by your participation in this study.

The benefit of this study is that the findings will help contribute in improving the quality of patient care provided.

Selection of a private venue and possible timeframes for the interview will be discussed with you. You have the right to refuse to continue with the interview or withdraw from the research study at any time if you so wish or feel uncomfortable. Your help with this research study, will however, be greatly appreciated.

If you are willing to participate, please sign the attached consent and confidentiality forms.

Thank you for your assistance in this regard.

Consent Form:

I..... (Full name)

Telephone number.....Date.....

I hereby consent to Leona Baker asking me questions concerning her study, which she has explained to me. I voluntarily agree to an interview and to answer biographical questions and give written stories regarding my experiences as a professional nurse in providing compassionate patient care in a private hospital.

I know that I have the right to withdraw from this study at any time, without any fear of victimisation.

.....
Signature study participant

.....
Signature researcher

Study Supervisor: Professor LV Monareng (012-4296059)

Confidentiality Form

I..... (Full name)

Telephone number.....Date.....

I hereby consent to Leona Baker collecting both verbal and written data from me as I understand that my identity and all my responses will be kept completely anonymous and confidential.

The forms which I will fill in today will be kept under lock and key by Leona Baker and the contents thereof only indulged to her study supervisor. All forms and stories will be destroyed after one year.

I know that I have the right to withdraw from this study at any time, without any fear of victimisation.

.....
Signature study participant

.....
Signature researcher

Study Supervisor: Professor LV Monareng (012-4296059)

DEFINITIONS OF COMPASSIONATE PATIENT CARE

Compassion is a way of living born out of an awareness of one's relationship to all living creatures. It engenders a response of participation in the experience of another's sensitivity to the pain and brokenness of the other and a quality of presence that allows one to share with and make room for the other (Dunn 2009:42).

Compassion is defined as a feeling of deep sympathy and sorrow for another who is stricken by misfortune, accompanied by a strong desire to alleviate the suffering (*Dictionary Unabridged* 2014 sv "compassion").

According to *Free Merriam Webster Dictionary* (2014 sv "compassion"), *compassion* is defined as a feeling of wanting to help someone who is sick, hungry or in trouble.

Compassion is a strong emotion brought on by the presence of suffering that causes acknowledgement and sharing of the despair or pain of the sufferer (Kret 2011:29 cites Morse, Bottorff, Anderson, O'Brien & Solberg 1992).

Patient is defined as a person who is physically or mentally ill, receiving or registered to receive medical treatment or nursing care (Freshwater & Maslin-Prothero 2005:440).

Care is a procedure whereby the caregiver commits to look after the patient's needs by making an effort to do something correctly, safely, or without causing damage; to keep someone healthy, safe, or to keep something in a good condition (*Blackwell's Nursing Dictionary* 2005:108 sv "care").

Care is the provision of what is necessary for the health, welfare, maintenance and protection of someone or something (*Oxford Dictionaries* 2015 sv "care").

In this study, *compassionate patient care* refers to how you interact with your patients who are suffering, in a holistic, humane, empathetic, reassuring and caring manner as part of your professional practice and not just the carrying out of procedures or the rendering of a service. It refers to the way in which you treat your patients and whether the patients' needs are met with kindness and empathy or not.

The researcher would like to know about your experiences in providing compassionate patient care.

ANNEXURE E

INTERVIEW GUIDE

THE EXPERIENCES OF PROFESSIONAL NURSES IN PROVIDING COMPASSIONATE PATIENT CARE IN A PRIVATE HOSPITAL IN GAUTENG, SOUTH AFRICA: A QUALITATIVE NARRATIVE ANALYSIS

INSTRUCTIONS

All information herewith provided will be treated confidentially. It is not necessary to indicate your name on this questionnaire

1. Answer all questions by providing an “X” in the box corresponding to the chosen alternative
2. Hand in the questionnaire and the written narrative to the researcher immediately after completion

SECTION A: BIOLOGICAL DATA

1	Today's Date <table border="1" data-bbox="593 1115 1102 1232" style="margin-left: auto; margin-right: auto;"> <tr> <th colspan="2">Day</th> <th colspan="2">Month</th> <th colspan="2">Year</th> </tr> <tr> <td style="width: 20px; height: 20px;"></td> </tr> </table>	Day		Month		Year								<input style="width: 100px; height: 20px;" type="text"/>			
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4	Masters in Nursing																
5	Other (please specify)																

ANNEXURE F

EXAMPLE OF COMPLETED INTERVIEW GUIDE (PARTICIPANT 13)

INTERVIEW GUIDE

**THE EXPERIENCES OF PROFESSIONAL NURSES IN PROVIDING
COMPASSIONATE PATIENT CARE IN A PRIVATE HOSPITAL IN GAUTENG,
SOUTH AFRICA: A QUALITATIVE NARRATIVE ANALYSIS**

INSTRUCTIONS

All information herewith provided will be treated confidentially. It is not necessary to indicate your name on this questionnaire

1. Answer all questions by providing an "X" in the box corresponding to the chosen alternative
2. Hand in the questionnaire and the written narrative to the researcher immediately after completion

SECTION A: BIOLOGICAL DATA

1	Today's Date	<table border="1" style="margin: auto;"> <tr> <th style="padding: 2px;">Day</th> <th style="padding: 2px;">Month</th> <th style="padding: 2px;">Year</th> </tr> <tr> <td style="text-align: center; padding: 2px;">17</td> <td style="text-align: center; padding: 2px;">08</td> <td style="text-align: center; padding: 2px;">2016</td> </tr> </table>	Day	Month	Year	17	08	2016										
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1	Single/ divorced/ widowed																	
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5	Indicate your nationality		
	1	White	<input checked="" type="checkbox"/>
	2	Black	<input type="checkbox"/>
	3	Coloured	<input type="checkbox"/>
	4	Indian	<input type="checkbox"/>
	7	Other (please specify)	<input type="checkbox"/>
			<input type="text"/>
6	What is your highest professional qualification?		
	1	Diploma in general nursing	<input checked="" type="checkbox"/>
	2	Degree in Nursing	<input type="checkbox"/>
	3	Honours degree	<input type="checkbox"/>
	4	Masters in Nursing	<input type="checkbox"/>
	5	Other (please specify)	<input type="checkbox"/>
			<input type="text"/>
7	What unit are you currently working at?		
	1	Medical	<input checked="" type="checkbox"/>
	2	Surgical	<input type="checkbox"/>
	3	Oncology	<input type="checkbox"/>
	4	Maternity	<input type="checkbox"/>
	5	Theatre	<input type="checkbox"/>
	6	ICU	<input type="checkbox"/>
	7	Casualty	<input checked="" type="checkbox"/>
	8	Paediatrics	<input type="checkbox"/>
	9	Other	<input type="checkbox"/>
			<input type="text"/>

INTERVIEW GUIDE

SECTION B:

QUESTIONS TO BE ANSWERED IN WRITING BY PARTICIPANTS PLEASE

1 In your own words, what is your understanding of giving compassionate patient care?

Compassionate patient care requires a holistic approach. It is one of the strengths of the nursing profession. It is also very personal & subjective.

It is the ability to focus on another person's needs & channelling your emotion into an active response to maintain their dignity. It is a complex combination of attributes & qualities namely empathy, sensitivity, a non-judgemental attitude & the ability to care about the well being of others.

2 How do you provide compassionate patient care?

Compassionate care is a careful balance between maintaining objectivity & yet connecting emotionally.

Always act & speak with respect & kindness. Show the patient that they have your full attention.

Raise personal issues in an environment that respects the need for privacy.

Take the time to listen to their concerns & use language that they can understand.

Realise that their changing health status can be overwhelming & offer patients & families repeated explanations.

Ensure the patient's comfort by small acts of kindness eg adjusting their pillow, enquiring about a photograph.

Including the family in the patient care helps to prevent the build up of conflict & allows all to support the patient positively.

Compassionate care adds to the patient's well being & their adherence to treatment.

3 What are your experiences in providing compassionate patient care as a professional nurse, in terms of your highs and lows?

For some people, compassion is a natural disposition. For others, it slowly emerges with life experiences & the realization that we are all vulnerable to life's uncertainties. I personally feel that compassion isn't something a person knows, it is something a person feels.

Having said that, there are a few factors that can influence the amount of compassion shown, namely the age of the care giver, whether they have children or not, whether they have elderly parents. These life experiences often heighten one's sense of compassion & allow you to relate to your patient on a personal level.

Negative influences are time constraints, bureaucratic paperwork, workload & technological dominance. These often take priority over holistic care which creates a difficult ethical & moral dilemma with regard to service provision & compassionate care.

Being able to provide compassionate patient care definitely leads to greater job satisfaction & less burnout.

4 Write down your experiences of providing compassionate patient care in the last week. Use the questions How? When? Who? What? Where?

I admitted an elderly gentleman to my unit after he had had a fall in which he sustained a head injury with possible femur/pelvis fracture. Fortunately the latter proved NAD. He subsequently developed a broad pneumonia which aggravated his pre-existing COPD. The gentleman was very ill & realized that his life expectancy was nearing its end. In spite of the fact that he had been a good Christian his whole life, he was very frightened & needed constant reassurance & affirmation of his beliefs. He feared being left alone & the staff spent a lot of time comforting him. The family also needed support & comfort emotionally as they tried to deal with the possible negative outcome and loss of their loved one.

Compassionate care was given in providing for his physical comfort but perhaps more importantly, his & his family's emotional needs.

5. Has your compassionate patient care changed over the years and if so how and why?

I feel that I have always been a very compassionate person. It is the reason I entered the profession in the first place.

I do feel, however, that my life experiences have added to my growth & development as a care giver. The birth of my child definitely heightened my sensitivity & made me more empathetic. Also having elderly parents myself has made me more attune to the needs & fears of the elderly. Obviously a heavy work load can negatively affect the dispensing of compassionate patient care so a fine balance needs to be maintained.

Skilful use of compassion depends on humans having evolved to interact & understand the minds of others.

INTERVIEW GUIDE

SECTION C: PROFESSIONAL NURSING LIFELINE

Introduction and explanation of the lifeline:

This lifeline represents your nursing career as a professional nurse.

The numbers at the bottom of the graph are the number of years you have been a professional nurse.

The horizontal line across the middle is neutral, above the neutral line are your high or good experiences in providing compassionate patient care, the better the experience the higher your graph should go.

The part below the middle horizontal line represents the low points of your nursing career specifically relating to how you experienced giving compassionate patient care.

