



SECTION 2
MANUSCRIPT:
EXPLORING RESILIENCE IN NURSES CARING
FOR OLDER PERSONS

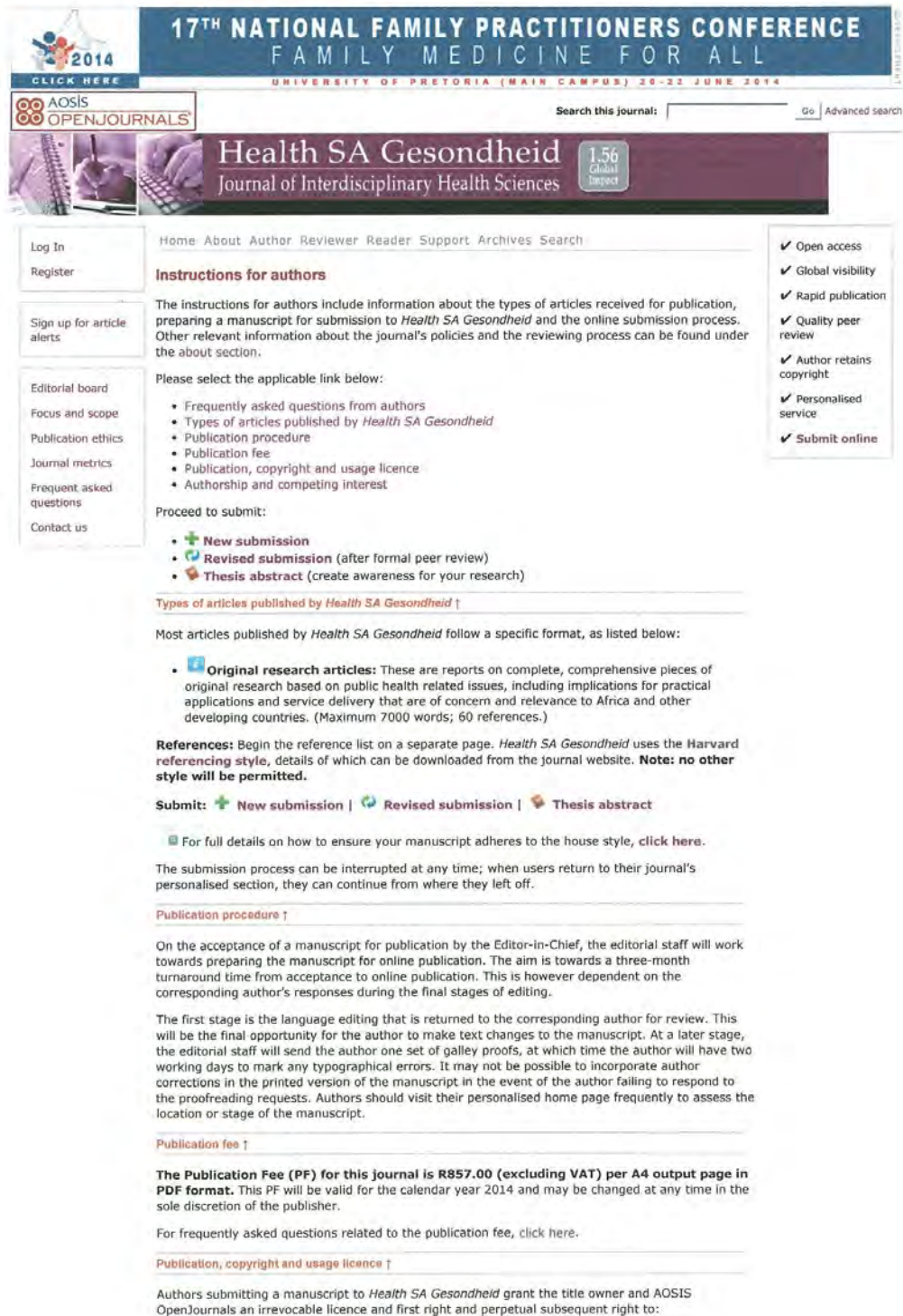


To be submitted to “Health SA Gesondheid”
(Please see Section 1: 1.13)

Health SA Gesondheid: Instructions for authors

For authors

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Please select the applicable link below:

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- Types of articles published by *Health SA Gesondheid*
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- Publication, copyright and usage licence
- Authorship and competing interest

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- **Thesis abstract** (create awareness for your research)

[Types of articles published by Health SA Gesondheid ↑](#)

Most articles published by *Health SA Gesondheid* follow a specific format, as listed below:

- **Original research articles:** These are reports on complete, comprehensive pieces of original research based on public health related issues, including implications for practical applications and service delivery that are of concern and relevance to Africa and other developing countries. (Maximum 7000 words; 60 references.)

References: Begin the reference list on a separate page. *Health SA Gesondheid* uses the Harvard referencing style, details of which can be downloaded from the journal website. **Note: no other style will be permitted.**

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All co-authors (collaborators) share a degree of responsibility for articles they collaborate on. Hence, if an individual is unwilling to accept appropriate responsibility for a manuscript's contents, the individual should not be a co-author.

A 'co-author' is defined as any person who has made a significant scientific contribution to the work reported and who shares responsibility and accountability for the results. We advise that authorship credit should follow and be based on:

1. substantial contributions to conception and design, acquisition of data or analysis and interpretation of data
2. drafting the article or revising it critically for important intellectual content
3. final approval of the version to be published.

Include a statement in the manuscript specifying the actual contribution made by each co-author with their affiliation at the time of the study and completion of the work. Contributions made by each of the authors listed, can follow the example below (please note the use of author initials):

J.K. (University of Pretoria) was the project leader, L.M.N. (University of KwaZulu-Natal) and A.B. (Stellenbosch University) were responsible for experimental and project design. L.M.N. performed most of the experiments. P.R. (Cape Peninsula University of Technology) made conceptual contributions and S.T. (University of Cape Town), U.V. (University of Cape Town) and C.D. (University of Cape Town) performed some of the experiments. S.M. (Cape Peninsula University of Technology) and V.C. (Cape Peninsula University of Technology) prepared the samples and calculations were performed by C.S. (Cape Peninsula University of Technology).

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Where an author gives no competing interests, the listing will read 'The authors declare that they have no financial or personal relationship(s) that may have inappropriately influenced them in writing this article.'

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Health SA Gesondheid: Original research articles

Original research: Empirical Research

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The screenshot displays the journal's homepage with a banner for the 17th National Family Practitioners Conference. The journal is identified as 'Health SA Gesondheid: Journal of Interdisciplinary Health Sciences' with a 1.56 Global Impact factor. Navigation links include Home, About, Author, Reviewer, Reader, Support, Archives, and Search. A sidebar on the left offers options like Log In, Register, Sign up for article alerts, and Editorial board. A 'Print page' button is visible. The main content area is titled 'Index:' and lists 'Cover page' and 'Article structure'. The 'Cover page' section explains the compulsory cover letter format and lists required elements: Article title, Significance of work, Full author details, Corresponding author, Authors' contributions, and Summary. A note states that a statistical consultant's letter is required upon submission. The 'Article structure' section specifies the submission language as English (UK) and provides detailed guidelines for the title, abstract, and structured abstract (Background, Objectives, Method, Results, Conclusion).

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Cover page

The format of the **compulsory cover letter** forms part of your submission and is located on the first page of your manuscript and should always be presented in English. You should provide all of the following elements:

- Article title:** Provide a short title of 50 characters or less.
- Significance of work:** Briefly state the significance of the work being reported on.
- Full author details:** Title(s), Full name(s), Position(s), Affiliation(s) and contact details (postal address, email, telephone and cellular number) of each author.
- Corresponding author:** Indicate to whom all correspondence should be addressed to.
- Authors' contributions:** Briefly summarise the nature of the contribution made by each of the authors listed, along the lines of the following: *J.K. was the project leader, L.M.N. and A.B. were responsible for experimental and project design. L.M.N. performed most of the experiments. P.R. made conceptual contributions and S.T., U.V. and C.D. performed some of the experiments. S.M. and V.C. prepared the samples and calculations were performed by C.S., J.K. and U.V. wrote the manuscript.*
- Summary:** Lastly, a list containing the number of words, pages, tables, figures and/or other supplementary material should accompany the submission.

A letter from a statistical consultant needs to be presented upon submitting your article to this journal. Ensure that this letter is uploaded in Step 4 of the online submission process.

Article structure

Submission language: English (UK)

Title: The article's full title should contain a maximum of 95 characters (including spaces).

Abstract (first-level heading)

- Do not cite references in the abstract.
- Do not use abbreviations excessively in the abstract.
- The abstract should be written in English.
- The abstract should be no longer than 250 words and must be written in the past tense. The abstract should give a succinct account of the objectives, methods, results and significance of the matter. The structured abstract for an Original Research article should consist of five paragraphs labelled Background, Objectives, Method, Results and Conclusion.

- Background:** *Why do we care about the problem?* The context and purpose of the study (what practical, scientific or theoretical gap is your research filling?).
- Objectives:** *What problem are you trying to solve?* What is the scope of your work (a generalised approach, or for specific situation). Be careful not to use too much jargon.
- Method:** *How did you go about solving or making progress on the problem?* How the study was performed and statistical tests used (what did you actually do to get the results). Clearly express the basic design of the study, name or briefly describe the basic methodology used without going into excessive detail. Be sure to indicate the key techniques used.
- Results:** *What is the answer?* The main findings (as a result of completing the above procedure/study what did you learn/invent/create?). Identify trends, relative change or differences on answers to questions.
- Conclusion:** *What are the implications of your answer?* Brief summary and potential implications (what are the larger implications of your findings, especially for the problem/gap identified in your motivation?).

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Introduction (first-level heading)

The Introduction contains two subsections, namely the background section and the literature review.

- **Problem statement (second-level heading):** The setting section should be written from the standpoint of readers, that is, without specialist knowledge in that area and must clearly state and illustrate the Introduction to the research and its aims in the context of previous work bearing directly on the subject. The setting section to the article normally contains the following five elements.
 - **Aims of the study/Key focus (third-level heading):** A thought-provoking introductory statement on the broad theme or topic of the research.
 - **Background (third-level heading):** Providing the background or the context to the study (explaining the role of other relevant key variables in this study);
 - **Trends (third-level heading):** Cite the most important published studies previously conducted on this topic or that has any relevance to this study (provide a high-level synopsis of the research literature on this topic).
 - **Research objectives (third-level heading):** Indicate the most important controversies, gaps and inconsistencies in the literature that will be addressed by this study. In view of the above trends, state the core research problem and specific research objectives that will be addressed in this study and provide the reader with an outline of what to expect in the rest of the article.
 - **Definition of key concepts (third-level heading)**
 - **Contribution to field (third-level heading):** Explanation of the study's academic (theoretical and methodological) or practical merit and/or importance (provide the value-add and/or rationale for the study).
- **Literature review (second-level heading):** The literature review is the second subsection under the Introduction and provides a brief and concise overview of the literature under a separate second-level heading, e.g. literature review. A synthesis and critical evaluation of the literature (not a compilation of citations and references) should at least include or address the following elements, ensure these are in the literature review. Define conceptual (theoretical) definitions of all key concepts; A critical review and summary of previous research findings (theories, models, frameworks, etc.) on the topic; A clear indication of the gap in the literature and for the necessity to address this void; and A clearly established link exists between formulated research objectives and theoretical support from the relevant literature.

Research method and design (first-level heading)

This section should include:

- **Design (second-level heading):** Describe your experimental design clearly, including a power calculation if appropriate. Note: Additional details can be placed in the online supplementary location.
- **Materials (second-level heading):** Describe the type of organism(s) or material(s) involved in the study.
- **Data collection method/Procedure (second-level heading):** Describe the protocol for your study in sufficient detail (clear description of all interventions and comparisons) that other scientists could repeat your work to verify your findings.
- **Data analysis (second-level heading):** Describe how the data were summarised and analysed, additional details can be placed in the online supplementary information.
- **Context of the study (second-level heading):** Describe the site and setting where your field study was conducted.

Results (first-level heading)

This section provides a synthesis of the obtained literature grouped or categorised according to some organising or analysis principle.

Tables may be used and/or models may be drafted to indicate key components of the results of the study.

- Organise the results based on the sequence of Tables and Figures you will include in the manuscript.
- The body of the Results section is a text presentation of the key findings which includes references to each of the Tables and Figures.
- Statistical test summaries (test name, p-value) are usually reported parenthetically in conjunction with the biological results they support, use SI unit.
- Present the results of your experiment(s)/research data in a sequence that will logically support (or provide evidence against) the hypothesis, or answer the question, stated in the Introduction.

All units should conform to the SI convention and be abbreviated accordingly. Metric units and their international symbols are used throughout, as is the decimal point (not the decimal comma).

Ethical considerations (first-level heading)

Articles based on the involvement of animals or humans must have been conducted in accordance with relevant national and international guidelines. Approval must have been obtained for all protocols from the author's institutional or other relevant ethics committee and the institution name and permit numbers provided at submission.

- **Potential benefits and hazards (second-level heading):** What risks to the subject are entailed in involvement in the research? Are there any potential physical, psychological or disclosure dangers that can be anticipated? What is the possible benefit or harm to the subject or society from their participation or from the project as a whole? What procedures have been established for the care and protection of subjects (e.g. insurance, medical cover) and the control of any information gained from them or about them?
- **Recruitment procedures (second-level heading):** Was there any sense in which subjects might be 'obliged' to participate – as in the case of students, prisoners, learners or patients – or were volunteers being recruited? If participation was compulsory, the potential consequences of non-compliance must be indicated to subjects; if voluntary, entitlement to withdraw consent must be indicated and when that entitlement lapses.
- **Informed consent (second-level heading):** Authors must include how informed consent was handled in the study.
- **Data protection (second-level heading):** Authors must include in detail the way in which data protection was handled.

Trustworthiness (first-level heading)

This refers to the findings of the study being based on the discovery of human experience as it was experienced and observed by the participants.

- **Reliability (second-level heading):** Reliability is the extent to which an experiment, test, or any measuring procedure yields the same result on repeated trials. Without the agreement of independent observers able to replicate research procedures, or the ability to use research tools and procedures that yield consistent measurements, researchers would be unable to satisfactorily draw conclusions, formulate theories, or make claims about the generalisability of their research.
- **Validity (second-level heading):** Validity refers to the degree to which a study accurately reflects or assesses the specific concept that the researcher is attempting to measure. While reliability is concerned with the accuracy of the actual measuring instrument or procedure, validity is concerned with the study's success at measuring what the researchers set out to measure. Researchers should be concerned with both external and internal validity. External validity refers to the extent to which the results of a study are generalisable or transferable. Internal validity refers to (1) the rigor with which the study was conducted (e.g. the study's design, the care taken to conduct measurements, and decisions concerning what was and wasn't measured) and (2) the extent to which the designers of a study have taken into account alternative explanations for any causal relationships they explore. In studies that do not explore causal relationships, only the first of these definitions should be considered when assessing internal validity.

Discussion (first-level heading)

This section normally contains the following four elements. It is suggested that sub-headings are used in this section:

- **Outline of the results (second-level heading):** Restate the main objective of the study and reaffirm the importance of the study by restating its main contributions; summarise the results in relation to each stated research objective or research hypothesis; link the findings back to the literature and to the results reported by other researchers; provide explanations for unexpected results.
- **Practical implications (second-level heading):** Reaffirm the importance of the study by restating its main contributions and provide the implications for the practical implementation your research.

Limitations of the study (first-level heading): Point out the possible limitations of the study and provide suggestions for future research.

Recommendations (first-level heading): Provide the recommendations emerging out of the current research.

Conclusion (first-level heading)

This should state clearly the main conclusions of the research and give a clear explanation of their importance and relevance, with a recommendation for future research (implications for practice). Provide a brief conclusion that restates the objectives; the research design; the results and their meaning.

Acknowledgements (first-level heading)

If, through your study, you received any significant help in conceiving, designing, or carrying out the work, or received materials from someone who did you a favour by supplying them, you must acknowledge their assistance and the service or material provided. **Authors should always acknowledge outside reviewers of their drafts and any sources of funding that supported the research.**

- **Competing interests (second-level heading):** A competing interest exists when your interpretation of data or presentation of information may be influenced by your personal or financial relationship with other people or organisations that can potentially prevent you from executing and publishing unbiased research. Authors should disclose any financial competing interests but also any non-financial competing interests that may cause them embarrassment were they to become public.

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- **Authors' contributions (second-level heading)*:** This section is necessary to give appropriate credit to each author, and to the authors' applicable institution. The individual contributions of authors should be specified with their affiliation at the time of the study and completion of the work. An 'author' is generally considered to be someone who has made substantive intellectual contributions to a published study. Contributions made by each of the authors listed, along the lines of the following (please note the use of author initials):

J.K. (University of Pretoria) was the project leader, L.M.N. (University of KwaZulu-Natal) and A.B. (University of Stellenbosch) were responsible for experimental and project design. L.M.N. performed most of the experiments. P.R. made conceptual contributions and S.T. (University of Cape Town), U.V. (University of Cape Town) and C.D. (University of Cape Town) performed some of the experiments. S.M. (Cape Peninsula University of Technology) and V.C. (Cape Peninsula University of Technology) prepared the samples and calculations were performed by C.S., J.K. (Cape Peninsula University of Technology) and U.V. wrote the manuscript.

References (first-level heading)

Begin the reference list on a separate page with no more than 60 references. *Health SA Gesondheid* uses the Harvard referencing style, details of which can be downloaded from the journal website. **Nota: No other style will be permitted.**

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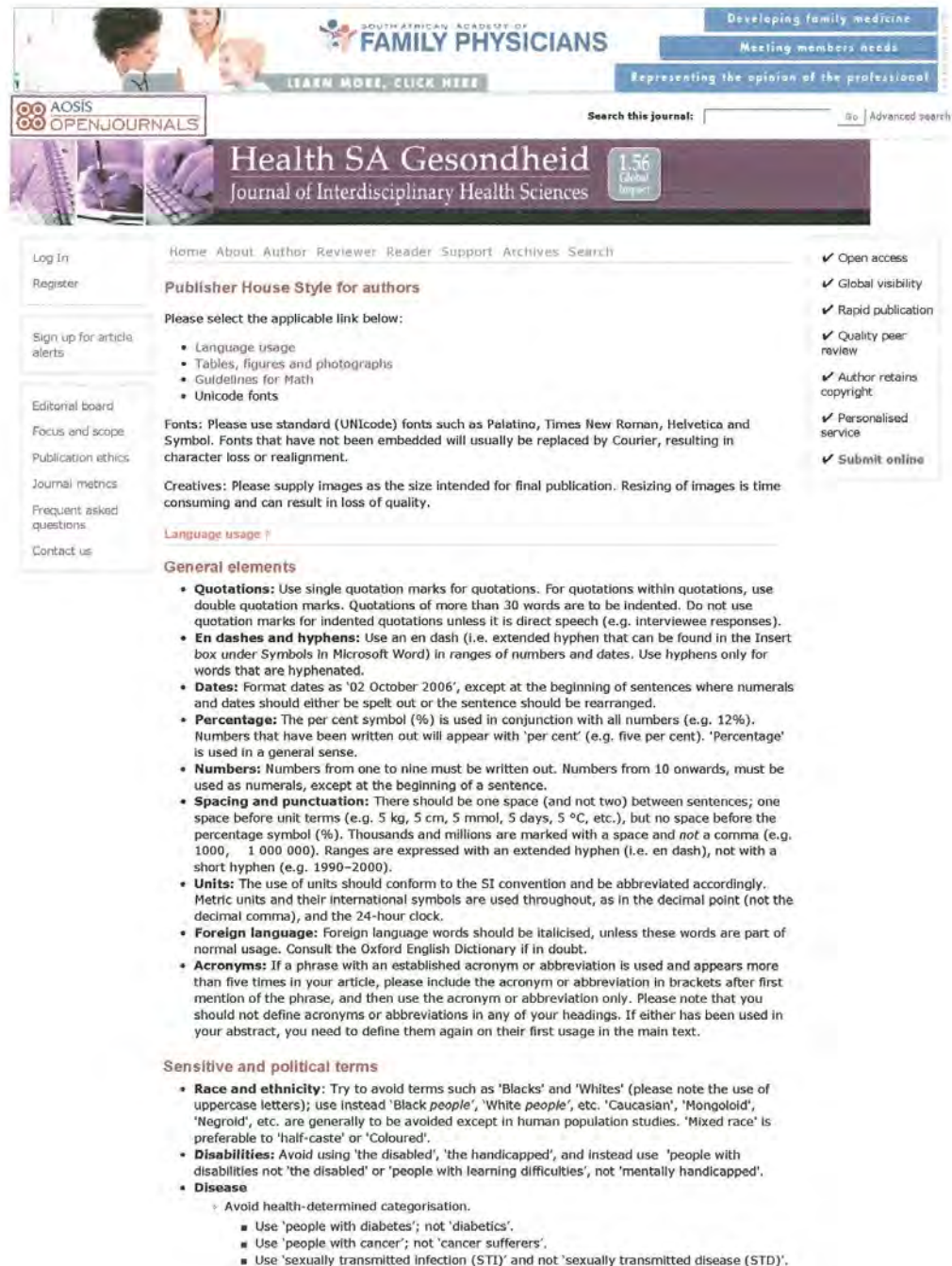
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The screenshot shows the website for the South African Academy of Family Physicians (SAAFP) and the journal Health SA Gesondheid. The header includes the SAAFP logo and tagline 'Developing family medicine. Meeting members needs. Representing the opinion of the professional.' Below this is the journal's title 'Health SA Gesondheid' and 'Journal of Interdisciplinary Health Sciences'. A search bar is present. The main content area is titled 'Publisher House Style for authors' and includes a list of links for authors, a section for fonts and symbols, and a section for general elements. The 'General elements' section contains detailed guidelines on quotations, dashes, dates, percentages, numbers, spacing, units, foreign language, and acronyms. A 'Sensitive and political terms' section provides guidance on race and ethnicity, disabilities, and disease.

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Creatives: Please supply images as the size intended for final publication. Resizing of images is time consuming and can result in loss of quality.

[Language usage ?](#)

General elements

- Quotations:** Use single quotation marks for quotations. For quotations within quotations, use double quotation marks. Quotations of more than 30 words are to be indented. Do not use quotation marks for indented quotations unless it is direct speech (e.g. interviewee responses).
- En dashes and hyphens:** Use an en dash (i.e. extended hyphen that can be found in the Insert box under Symbols in Microsoft Word) in ranges of numbers and dates. Use hyphens only for words that are hyphenated.
- Dates:** Format dates as '02 October 2006', except at the beginning of sentences where numerals and dates should either be spelled out or the sentence should be rearranged.
- Percentage:** The per cent symbol (%) is used in conjunction with all numbers (e.g. 12%). Numbers that have been written out will appear with 'per cent' (e.g. five per cent). 'Percentage' is used in a general sense.
- Numbers:** Numbers from one to nine must be written out. Numbers from 10 onwards, must be used as numerals, except at the beginning of a sentence.
- Spacing and punctuation:** There should be one space (and not two) between sentences; one space before unit terms (e.g. 5 kg, 5 cm, 5 mmol, 5 days, 5 °C, etc.), but no space before the percentage symbol (%). Thousands and millions are marked with a space and *not* a comma (e.g. 1000, 1 000 000). Ranges are expressed with an extended hyphen (i.e. en dash), not with a short hyphen (e.g. 1990–2000).
- Units:** The use of units should conform to the SI convention and be abbreviated accordingly. Metric units and their international symbols are used throughout, as in the decimal point (not the decimal comma), and the 24-hour clock.
- Foreign language:** Foreign language words should be italicised, unless these words are part of normal usage. Consult the Oxford English Dictionary if in doubt.
- Acronyms:** If a phrase with an established acronym or abbreviation is used and appears more than five times in your article, please include the acronym or abbreviation in brackets after first mention of the phrase, and then use the acronym or abbreviation only. Please note that you should not define acronyms or abbreviations in any of your headings. If either has been used in your abstract, you need to define them again on their first usage in the main text.

Sensitive and political terms

- Race and ethnicity:** Try to avoid terms such as 'Blacks' and 'Whites' (please note the use of uppercase letters); use instead 'Black people', 'White people', etc. 'Caucasian', 'Mongoloid', 'Negroid', etc. are generally to be avoided except in human population studies. 'Mixed race' is preferable to 'half-caste' or 'Coloured'.
- Disabilities:** Avoid using 'the disabled', 'the handicapped', and instead use 'people with disabilities' not 'the disabled' or 'people with learning difficulties', not 'mentally handicapped'.
- Disease**
 - Avoid health-determined categorisation.
 - Use 'people with diabetes'; not 'diabetics'.
 - Use 'people with cancer'; not 'cancer sufferers'.
 - Use 'sexually transmitted infection (STI)' and not 'sexually transmitted disease (STD)'.

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- Avoid phrasing that dehumanises a patient. Many authors use *case* (instance of a disease) when they mean patient (i.e. the person or individual who is ill with the (disease)).

• AIDS

- Ensure that 'AIDS' is used for the disease and 'HIV' for the virus, e.g. do not use 'AIDS carrier', 'AIDS positive', 'AIDS virus' or 'catching AIDS or HIV/AIDS' (avoid using the solidus here).
- 'AIDS sufferer/victim' is inappropriate; use 'people with AIDS'.
- Refer to 'people who practise high-risk activities' and not '*high-risk groups*'.
- The expression 'full-blown AIDS' is unnecessary if the correct distinction has been made between HIV and AIDS.

• Male versus Female

- 'Male' and 'female' are *adjectives*, so be careful to use them as such (i.e. a *male* patient and a *female* frog, but a 35-year-old *man*, a French *woman* and a group of 25 *men* and 35 *women*).

• Sexuality: Avoid the terms '*homosexual activities*' (if achievable within the manuscript's context, specify which activity is being referred to, especially when dealing with medical research.) Avoid using '*homosexuals*' (specify homosexual men or homosexual women).

• Gender: Use gender neutral nouns. Avoid the use of 'man' if not specifically referring to men; for example:

- for 'men' use 'humans'
- for 'man-kind' use 'the human race'
- for 'men-power' use 'workforce'
- for 'man-made fibre' use 'synthetic fibre'

• 'He/she', 'him/her' and 'his/hers': For 'he/she', 'him/her' and 'his/hers' rather use 'he or she', 'her or him', 'his or hers' (without a solidus) or change to plural 'they'. Use inclusive pronouns: use 'he or she', or rephrase the sentence (rephrasing to the plural form often works):

X ... *Any observer* of changes in publishing technology will perceive that *he* has need of...

✓ ... *Observers* of... will perceive that *they* have...

Beware of referring to people with stereotypical pronouns (e.g. 'the doctor treated *his* patient'; 'the secretary tidied *her* desk').

• Geography

- The terms *Third World*, *poor countries* and *underdeveloped countries* should be avoided.
- *Developing* or *non-developed country/society* is better, but it is best to specify countries or regions instead.
- *Western society* and *Western World* should only be used in relation to geography; otherwise, use *developed world/society* or, even better, specify the countries themselves or the region.

Tables, figures and photographs †

In Step 4 of the online submission process, upload all tables, figures, images, and supplementary files. Tables should be saved and uploaded as separate Excel (.xls) files with no more than 10 figures and tables in total per article. Ensure that all personal identifying information is removed from the supplementary files as indicated in the provided instructions. All captions should be provided together on a separate page. Tables and figures should use numerical numbers.

- **Organise your visual presentation:** Once you have read through the analyses and decided how best to present each table or figure, think about how you will arrange them within the article. The analyses should tell a 'story' that leads the reader through the steps needed to logically answer the question(s) that you as author are posing in the Introduction. The order in which you present the results can be as important in convincing the readers as what you actually are saying in the text.
- **How to refer to tables and figures in the text:** Every figure and table included in the paper *must* be referred to in the body of the text. Use sentences that draw the reader's attention to the relationship or trend you wish to highlight, referring to the appropriate figure or table only in parenthesis e.g.:
 - Germination rates were significantly higher after 24 h in running water than in controls (Figure 4).
 - DNA sequence homologies for the purple gene from the four congeners (Table 1) show high similarity, differing by at most 4 base pairs. (Avoid sentences that give no information other than directing the reader to the figure or table, e.g. Table 1 shows the summary results for male and female heights at Bates College.)
- **Abbreviation of the word 'Figure':** When referring to a figure in the text, the word 'figure' is never abbreviated as 'Fig.'; the same rule applies to the usage of 'table'. Both words are spelled out completely in descriptive legends.
- **How to number tables and figures:** Figures and tables are numbered independently, in the sequence in which you refer to them in the text, starting with Figure 1 and Table 1. If, in revision, you change the presentation sequence of the figures and tables, you must renumber them to reflect the new sequence.
- **The acid test for tables and figures:** Any table or figure you present must be clear, well-labelled, and described by its legend to be understood by your intended audience without

reading the results section. That is, it must be able to stand alone and be interpretable. Overly complicated figures or tables may be difficult to understand in or out of context, so strive for simplicity whenever possible.

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 - the results that are being shown in the graph(s), including the summary statistics plotted
 - the organism studied in the experiment (if applicable)
 - a context for the results: the treatment applied or the relationship displayed, etc.
 - location (*only* if a field experiment)
 - specific explanatory information needed to interpret the results shown (in tables, this is frequently done as footnotes)
 - culture parameters or conditions if applicable (temperature, media, etc.)
 - sample sizes and statistical test summaries, as they apply

Do not simply restate the axis labels with a 'versus' written in between.

Example: Figure 1: Height frequency (%) of White Pines (*Pinus strobus*) in the Thorncrag Bird Sanctuary, Lewiston, Maine, before and after the Ice Storm of 1998. Before, $n = 137$, after, $n = 133$. Four trees fell during the storm and were excluded from the post-storm survey.

Column Titles

Table Legend

Table Body (Data)

Footnote

Lines demarcating

TABLE 4: Leaf dry weights of three pea varieties grown at different temperatures.

Variety	Temperature (°C)		Days after sowing		
	Mean	HE	40	55	70
EC-12876	18	35	0.40 [*]	3.88 [*]	0.17 [*]
P-116	22	38	0.52	0.43 [*]	0.20
T-165	25	38	1.35 ^{***}	5.35 [*]	4.20

Source: Smith et al. (1998), *Journal of Agricultural Research* 120: 1-10.
 * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.
 HE = Heat event (introduced at weekly intervals).
 EC-12876 is a variety of pea grown in 1998.
 P-116 is a variety of pea grown in 1998.
 T-165 is a variety of pea grown in 1998.
 All data are based on the mean of three replicates.
 All data are based on the mean of three replicates.

Note: Questions frequently arise about how much methodology to include in the legend, and how much results reporting should be done. For laboratory reports, specific results should be reported in the results text with a reference to the applicable table or figure. Other than culture conditions, methods are similarly confined to the Methods section.

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Books	In-Text Example	Reference List Example
Single Author	(Doss 2003)	Doss, G., 2003, <i>IS project management handbook</i> , Aspen Publishers, New York.
Two Author	(Laudon & Laudon 2003)	Karskens, G., 1997, <i>The rocks: Life in early Sydney</i> , Melbourne University Press, Carlton. Laudon, K.C. & Laudon, J.P., 2003, <i>Essentials of management information systems: Managing the digital firm</i> , Prentice Hall, Upper Saddle River, N.J.
Three authors	In-text: Initially (Coveney, Ganster & King 2003) In-text: thereafter (Coveney et al. 2003)	Coveney, M., Ganster, S. & King, D., 2003, <i>The strategy gap: Leveraging technology to execute winning strategies</i> , Wiley, Hoboken, N.J.
Corporate author	In-text: Initially (Department of Foreign Affairs and Trade 2002) In-text: thereafter (DFAT 2002)	Department of Foreign Affairs and Trade, 2002, <i>Connecting with Asia's tech future: ICT export opportunities</i> , Economic Analytical Unit, Commonwealth Government, Canberra.
Book Editor	(ed. Shaw 2003)	Shaw, M.J. (ed.), 2003, <i>E-business management: Integration of Web technologies</i>

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	Shaw (ed. 2003:87) indicates that '... Current essays edited by Shaw (2003) suggest ...	<i>with business models</i> , Kluwer Academic, London. Schuman, N.A., 2001, Psalm 91: Tekst, context, en een diversiteit aan herlezingen, in P. Post, G. Rouwhorst, T. Sheer, R. Sleensma, & L. Tongeren (eds.), <i>Jaarboek voor liturgieonderzoek deel</i> , vol. 17, pp. 237-256, Groningen, Instituut voor Liturgiewetenschap. Spieckermann, H., 2003, Hymnen im Psalter – Ihre Funktion und ihre Verlässe, in Zenger, E. (Hrsg.), <i>Ritual und Poesie</i> , pp. 90-136, Freiburg, Herder. Hudson, W. & Bolton, G. (eds.), 1997, <i>Creating Australia: Changing Australian history</i> , Allen & Unwin, Sydney. Howard, S., 1998, 'Verbal Protocol Analysis', in B. Henderson-Sellers, A. Simons & H. Younessi (eds.), <i>The open process specification</i> , pp. 272-274, Addison Wesley, Sydney. Johnston R.B., Mak H.C. & Kurnia S., 2001, 'The contribution of Internet Electronic Commerce to advanced supply chain reform - a case study', in S. Barnes & B. Hunt (eds.), <i>E-Commerce and V-Business</i> , pp. 232-249, Butterworth-Heinemann, Oxford.
Book collection/ One volume of multi-volume work	(eds: Hudson & Bolton 1997) Hudson and Bolton (eds. 1997:32) stated that '...'	
Chapter: single author	(Howard 1998)	
Chapter: three authors	In-text: Initially (Johnston, Mak & Kurnia 2001) In-text: thereafter (Johnston et al. 2001)	
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Article cited in a book		Oppenheim, P.L., 1981, 'Power politics', <i>Journal of Power Engineering</i> 1(3), 19-26, quoted in Strong, K., 1985, <i>Advances in power engineering</i> , Springer-Verlag, Berlin, p. 70. Dyson, G.G.H., 1977, <i>The mechanics of athletics</i> , 7th edn., Homes and Meier, New York.
Second, further or revised editions		Cohen, J., 1977, <i>Statistical power analysis for the behavioural sciences</i> , rev. edn., Academic Press, New York.

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Translated works		Bakhtin, M., 1984, <i>Rabelais and his world</i> , transl. H. Iswolsky, Indiana University Press, Bloomington. Izudinova, S.V., 1977, <i>A few months with the Boers: The war reminiscences of a Russian nursing sister</i> , transl. C Moody, Perskor, Johannesburg.
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Works by different authors—same family name—same year	A. Carter (1999) proposed that class size seriously limited creativity in the lower school. Further investigation proved there were notable weaknesses in this claim (Carter, T 1999). Note: As a general rule, it is advisable to paraphrase in this instance. Group dynamics has been identified as ... (Johnston 1993). Or A recent theory (Johnston 1993:5) on group dynamics states that '...'	Carter, A., 1999, <i>Issues in Australian education</i> , Cherokee Publications, Brisbane. Carter, T., 1999, <i>Creativity in the classroom</i> , Watkins & O'Hara Publishers, Darwin.
Second or later edition with an author		Johnston, K., 1993, <i>Surviving the first year experience</i> , 2nd edn., Macmillan, Melbourne.
Several sources are cited at once	Bradford (1992), Curtis (1983), and Graham (1997) all agree ... Or Recent studies (Bradford 1992; Curtis 1983; Graham 1997) agree that ...	Bradford, C., 1992, <i>Genre in perspective: A whole language approach</i> , Bookshelf, Gosford. Curtis, A., 1983, <i>Practical math for business</i> , Houghton Mifflin, Boston. Graham, A., 1997, <i>Managing more postgraduate research students</i> , Oxford Centre for Staff Development, Oxford.

Non-English journal article		Give the original title, as well as an English translation in brackets. Ising, M., 2000, Intensitätsabhängigkeit evozierter Potenzial im EEG: Sind impulsive Personen Augmenter oder Reducer? [Intensity dependence in event-related EEG potentials: Are impulsive individuals augmenters or reducers?]. <i>Zeitschrift für differentielle und diagnostische Psychologie</i> 21, 208-217.
Back dating articles		The volume number should be provided in Arabic numeral, without the preceding abbreviation "v", "vol." or "Jrg." . Full page numbers must be given. If the date or place of publication is missing, the abbreviation "n.d." is used instead of referring to the date of publication and "s.l." instead of referring to the place of publication. The date is placed in square brackets if the date of publication is known to the user but is not explicitly mentioned in the book or journal. Pont, A.D. [1978], Die herderijike brief van die sinode van 1837. <i>HTS</i> 34(4), 91-105.
Supplement journal		Fisk, B.N., 2001, 'Do you not remember? Scripture, story and exegesis in the rewritten Bible of Pseudo-Philo'. <i>Journal for the Study of the Pseudepigrapha</i> , suppl. ser. 37.
Proceedings Published Conferences, seminars and meetings	In-Text Example (Eidenberger et al. 2002)	Reference List Example Eidenberger, H., Breiteneder, C. & Hitz, M., 2002, 'A Framework for Visual Information Retrieval', in S.-K. Chang, Z. Chen & S.-Y. Lee (eds.), <i>Recent advances in visual information systems: 5th international conference, VISUAL 2002 proceedings</i> , Hsin Chu, Taiwan, March 11-13, 2002, pp. 105-116.
Unpublished material Unpublished conference paper	In-Text Example (Fitzsimmons 2005)	Reference List Example Fitzsimmons, D., 2005, 'Who chooses who belongs: Tactics and strategies and migrant literature', paper presented at the AULLA & FILLM conference, James Cook University, Cairns, 15-19th July.
Theses and Reports	(Rouse 2002)	Rouse, A.C., 2002, 'Information technology outsourcing revisited: success factors and risks', PhD thesis, Dept. of Information Systems, University of Melbourne. .
Encyclopedias and Dictionaries	In-Text Example (Karlof 2002)	Reference List Example Karlof, B., 2002, 'Benchmarking', in H. Biddell (ed.), <i>Encyclopedia of information systems</i> , Academic Press, New York, vol. 1, pp. 65-80.
Newspaper Print unattributed	In-Text Example (Sydney Morning Herald 7 March 1994:8)	Reference List Example 'UNSW gains top ranking from quality team', Sydney Morning Herald, 30 February, 1994, p. 21.
Print attributed	(Barker 2004)	Barker, G., 2004, '\$54m Deal To Heat Up Broadband War', <i>The Age</i> , Business, 24 February, p. 2. Donaghy, B., 1994, 'National meeting set to review tertiary admissions', Campus News, 3-9 March, p. 3.

Online	(Varghese 2004)	Varghese, S., 2004, 'The Linux desktop is here', <i>The Age</i> , viewed 1 March 2004, from http://www.theage.com.au/articles/2004/02/13/1076548215848.html .
Magazine Single author	In-Text Example (Knight 2004)	Reference List Example Knight, W., 2004, 'How to second guess the next hack attack', <i>New Scientist</i> , 24 January, p. 19. Note : Always evaluate information found in magazines for 'scholarliness'—including bias, validity, trustworthiness of the authors etc. Magazines are not generally considered scholarly pieces of work for research.
Software		
Named author	(Rawson-Tolley 2005)	Rawson-Tolley, R., <i>Animal Shelter Manager</i> , computer software, viewed 11 January 2005 from http://sheltermanager.sourceforge.net .
No named author	(OpenOffice.org 2005)	<i>OpenOffice.org</i> , computer software, viewed 11 January 2005, from http://www.openoffice.org .
Corporate publisher	(MATLAB 2003)	MATLAB version 6.5.1, 2003, computer software, The MathWorks Inc., Natick, Massachusetts. 1. Title of software - in italics: <i>MATLAB</i> 2. Version of software: version 6.5.1, 3. Year of publication: 2003, 4. Identifier: computer software, 5. Publisher: The MathWorks Inc., 6. Place of publication: Natick, Massachusetts
World Wide Web Document on the WWW (author/sponsor given but not dated)	According to Greenpeace (n.d.), genetically modified foods are ... or Greenpeace (n.d.:1 of 2) recommends that 'fewer genetically ...' (Arch & Lefourneau 2002)	Greenpeace n.d., <i>The future is GE free</i> , viewed 28 September 2005, from http://www.greenpeace.org.au/ge/farming/canola.html . Note: The title of a webpage is treated like the title of a book. It is written in italics in the reference list.
Identifiable, personal author		Arch, A. & Lefourneau, C., 2002, 'Auxiliary Benefits of Accessible Web Design', in <i>W3C Web Accessibility Initiative</i> , viewed 26 February 2004, from http://www.w3.org/WAI/ibase/benefits.html .
E-book	(Eck 2002)	Eck, D.J., 2002, <i>Introduction To Programming Using Java</i> , 3rd edn., OOPWeb.com, viewed 26 February 2004, from http://www.oopweb.com/java/Documents/IntroToProgrammingUsingJavaVolumeFrames.html .
E-journal: single author	(Lenoir 2003)	Lenoir, L., 2003, 'Response of the foraging behaviour of red wood ants (<i>Formica rufa</i> group) to exclusion from trees', <i>Agricultural and Forest Entomology</i> 5(3), 183-189, viewed 10 September 2003, from http://www.blackwell-synergy.com/links/doi/10.1046/j.1461-9553.2003.00175.x/full .
E-journal: three author	(Mueller et al. 2003)	Mueller, J.K., Heckathorn, S.A. & Fernando, D., 2003, 'Identification of a chloroplast dehydriol in leaves of mature plants', <i>International Journal of Plant Sciences</i> 164(4), 535-542, viewed on 10 September 2003, from http://www.journals.uchicago.edu/IJPS/journal/no.s1v164n4/164053.html .

E-journal: Abstract and more than 6 authors	(Wolter et al. 2003)	Wolter, B.F., Ellis, M., Corrigan, B.P., DeDecker, J.M., Curtis, S.E., Parr, E.N. et al., 2003. 'Effect of restricted postweaning growth resulting from reduced floor and feeder-trough space on pig growth performance to slaughter weight in a wean-to-finish production system', <i>Journal of Animal Science</i> , (abstract), vol. 81, viewed 11 September 2003, from http://buffy.lib.umn.edu.au/2148/as/abs/2003/a0340836.htm...
Other References		
CD-ROM	(World Atlas & Almanac 1995)	<i>World Atlas & Almanac</i> , 1995, CD-ROM, Mindscape Inc., Novato, California, USA.
Video & Audio Recordings: Named	(<i>Grumpy meets the orchestra</i> 1992)	<i>Grumpy meets the orchestra</i> , 1992, video recording, Australian Broadcasting Corporation, Sydney. Featuring the Sydney Symphony Orchestra.
Video & Audio Recordings: Named performer	(Sangare 1997)	Sangare, O., 1997, 'Dugu Kamalamba', in <i>The divas from Mali</i> , audio CD, Network Medien GmbH, D-60316 Frankfurt. Track #10. 1. Author (performer): Sangare, O., 2. Date (year): 1997, 3. Title (piece) - in single quotes: 'Dugu Kamalamba', 4. Title (collection) - in italics: <i>The divas from Mali</i> , 5. Identifier: audio CD, 6. Publisher: Network Medien GmbH, 7. Place: D-60316 Frankfurt. 8. Qualifier: Track #10.
Personal Communication: Individual	- When interviewed on 15 May 2001, Mr R. Forbes stated... OR - Mr R. Forbes confirmed his statement by fax on 15 May 2003... OR - The statement claimed that Marlians had landed in Moonee Ponds (R. Forbes [Australian UFO Society] pers. comm., 15 May 2003). Not included in the Reference list.	
Personal Communication: Email	(Minthorpe 2002)	Minthorpe, R.Q., 2002, e-mail, 26 November, minthorpe@scrappgemback.com.au 1. Author: Minthorpe, RQ 2. Date (year): 2002, 3. Identifier: e-mail, 4. Date: 26 November, 5. Address: minthorpe@scrappgemback.com.au
Personal Communication: Lectures	"There is no need to panic", stated Mr R. Forbes at his public lecture on 18 May 2003... OR - The Chair (Seminar on the Moonee Ponds Phenomena 11 June 2003) drew attention to the unexplained spontaneous combustion of Mr Ron Forbes...	

	Not included in the Reference list.	
Maps: Print	(Viking O'Neil 1991:32-33)	Viking O'Neil, 1991, <i>Australian Road Atlas</i> , 10th edn., Penguin Books Australia, Melbourne, pp. 32-33. 1. Author: Viking O'Neil 2. Date: 1991. 3. Title - in italics: <i>Australian Road Atlas</i> , 4. Edition: 10th edn, 5. Publisher: Penguin Books Australia, 6. City: Melbourne, 7. Pages: pp. 32-33.
Maps: Online	(maps.com 1999)	maps.com, 1999, <i>Bhutan</i> , viewed 11 September 2003, from http://www.maps.com/cgi-bin/search/hyperseek.cgi?search=CAT&Category=Asia%3ABhutanP&Qualifier= 1. Author: maps.com, 2. Date: 1999. 3. Title - in italics: <i>Bhutan</i> , 4. Viewed: viewed 11 September 2003, URL: from http://www.maps.com/cgi-bin/search/hyperseek.cgi?search=CAT&Category=Asia%3ABhutanP&Qualifier=
Government Media Releases	(Alston 2003)	Alston, R., (Australian Minister for Communications, Information Technology) 2003, <i>Australian Government to ban spam</i> , media release 122/03, National Office for Information Economy, Canberra, viewed 23 July, from http://www.nole.gov.au/publications/media_releases/2003/jul/spam.htm
Government media releases	According to the Commonwealth Scientific and Industrial Research Organisation (CSIRO) (1997-2004:5 of 12), 'the benefits of the new sheep weighing technology ...'	Commonwealth Scientific and Industrial Research Organisation (CSIRO), 1997-2004, <i>Revolutionary sheep weigher on trial</i> , media release Ref PRO 4_168, 15 Sept 2004, viewed 16 September 2004, from http://www.csiro.au/index.asp?type=mediaRelease&id=sheepweigher&style=mediaRelease
Government publication and regulations	(Department of Education, Science & Training 2000)	Department of Education, Science & Training, 2000, <i>Annual Report 1999-2000</i> , AGPS, Canberra. Department of Immigration and Multicultural Affairs 2001, <i>Immigration: Federation to century's end 1901-2000</i> , Statistics Section, Business Branch, Department of Immigration and Multicultural Affairs, Canberra.

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Legislation	Queensland Government, 1962, <i>Queensland State Liquor Act</i> , Author, Brisbane. Note: Author refers back to the sponsor who is also the publisher.	
Standards	Standards Association of Australia, 1997, <i>Australian standard: Pressure equipment—manufacture</i> , (AS4488-1997), Standards Australia, North Sydney.	
Patents	Tan, I.S. & Arnold, F.F., (US Air Force) 1993, <i>In situ molecular composites based on rigid-rod polyamides</i> , US patent 5 247 057.	
Or		
	Tan and Arnold (1993, n.p.) protected their ideas by ...	
Brochure	New South Wales Dept of Primary Industries 2005)	New South Wales Dept of Primary Industries, 2005, <i>Saltwater recreational fishing in New South Wales: Rules & regulations summary</i> , brochure, NSWDP, New South Wales. Include as much information as available. The publisher's name may be abbreviated if it is also the author.
To cite a work reproduced in a book (image, poem, painting etc)	De Kooning's 1952 painting 'Woman and Bicycle' (Hughes 1980:295) is an example of ...	Hughes, R., 1980, <i>The shock of the new: Art and the century of change</i> , British Broadcasting Corporation, London.
Study Guide (author known)	Reports by Hallinan (2000) indicate that ...	Hallinan, P., 2000, <i>EDFD48102 Development and disability: Study guide</i> , Central Queensland University, Rockhampton.

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	Or	
Study Guide (author unknown)	Similarly, Hallinan (2000:66) reported that '...' (Central Queensland University (CQU) 2000) has suggested that ...	Central Queensland University (CQU), 2000, <i>EDE48201 Development and disability: Study guide</i> , Author, Rockhampton.
	Or	
Tutorial/workshop handout (unpublished)	Findings from a 1999 study indicate that '...' (Central Queensland University (CQU) 2000:5). The importance of aerobic exercise ... (The respiratory system 2000).	The respiratory system, Tutorial handout distributed in the unit, HHM72160 Human anatomy, Central Queensland University, Gladstone on 2 March 2000. Note: No italics nor quotation marks are shown because class handouts are unpublished sources.
	Or	
Lecture notes (unpublished)	Aerobic exercise is valuable because of its '...' (The respiratory system 2000:1). Thompson (2001) found that the first teaching day may result in mixed emotions for many first year teachers.	Thompson, R., 2001, The first day experience, Lecture notes distributed in the unit, EDED48314 Professional practice III, Central Queensland University, Bundaberg on 21 April 2001.
	Or	
The Bible	It has been found that beginner teachers, on their first day in the class room, will '...' (Thompson 2001:1). These particular lines (Psalm 23:6-8) refer the reader to...	Note: Bible references are not included in a reference list.
Atlas (with an editor)	The position of the new city is to be in south-east Queensland (ed. Eales 2003, Map 34).	Eales, S. (ed.), 2003, <i>The Jacaranda atlas</i> , 3rd edn., John Wiley & Sons, Brisbane.
Atlas (with no editor)	The position of the new city is to be in south-east Queensland (<i>The Jacaranda atlas</i> 2003, Map 34).	<i>The Jacaranda atlas</i> 2003, 3rd edn., John Wiley & Sons, Brisbane.

Abbreviations:

Abbrev.	Meaning
art.	article
app.	appendix
c.	about, approximately (from Latin <i>circa</i>)
cf.	compare (from Latin <i>confer</i>)
ch.	chapter
col., cols.	column(s)
div.	division
ed., eds.	editor(s)
edn.	edition
<i>et al.</i>	and others (from Latin <i>et alii</i>)
fn., fnn.	footnote(s)
ill., illis.	illustrator(s)

I., II.	line(s)
MS., MSS.	manuscript(s)
n., nn.	Notes
n.d.	no date
n.p.	no place
p., pp.	page(s)
para., paras.	paragraph(s)
pl.	plate (photograph)
pl., pls.	part(s)
rev.	revised
ser.	series
suppl.	Supplement
transl.	Translated
vol., vols.	volume(s)

Abbreviations for Bible Books (as recommended by NTSWA English):

Use abbreviation of Bible Book when in parenthetical citation [example: (Mt 28:19)], but the full book name when in a sentence [example: According to Matthew 28:19]

Gn	Ex	Lv	Nm	Dr	Jos	Jdg
Rt	1 Sm	2 Sm	1 Ki	2 Ki	1 Chr	2 Chr
Exr	Neh	Es	Job	Ps	Pr	Ec
Can	Is	Jr	Lm	Ezk	Dn	Ha
Jl	Am	Ob	Jnh	Mi	Nah	Hab
Zph	Hg		Zch	Mi		
Mt	Mk	Lk	Jn	Ac	Rm	1 Cor
2 Cor	Gl	Eph	Philp	Col	1 Th	2 Th
1 Tm	2 Tm	Tr	Phlm	Heb	Ja	1 Pt
2 Pt	1 Jn	2 Jn	3 Jn	Jude	Rv	

Abbreviations for Bible Books (S A Academy of Science and Art, Afrikaans):

Gen	Exs	Lev	Num	Deut	Jos	Rig
Rut	1 Sam	2 Sam	1 Kon	2 Kon	1 Kron	2 Kron
Esra	Neh	Est	Job	Ps	Spr	Pred
Hoogl	Jes	Jer	Klaagl	Eseg	Dan	Hos
Joel	Am	Ob	Jona	Miga	Nah	Hab
Self	Hag	Sag	Mal			
Matt	Mark	Luk	Joh	Hand	Rom	1 Kor
2 Kor	Gal	Ef	Fil	Kol	1 Tess	2 Tess

1 Tim 2 Pet	2 Tim 1 Joh	Tit 2 Joh	Filem 3 Joh	Heb Jud	Jak Op	1 Pet
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Other resources:
<http://www.fc.unsw.edu.au/onlibref2.html>
<http://www.lib.monash.edu.au/tutorials/citinc/harvard-government.html>
http://www.lib.unimelb.edu.au/cite/harvard_dis/index.html#Example
http://www.usq.edu.au/library/help/referencing/harvard.htm#Books_print_and_online

Exploring resilience in nurses caring for older persons

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ABSTRACT

Background: A shortage of nurses is experienced in aged care as these nurses experience adverse working conditions. Resilience might empower these nurses to survive, thrive and even flourish. A paucity of research exists regarding resilience in nurses caring for older persons.

Objectives: The purpose of this research was to investigate the level of resilience in nurses caring for older persons, and to explore and describe their strengths and coping abilities, in order to formulate recommendations to strengthen resilience in nurses caring for older persons.

Method: An explorative, descriptive design with multiple phases was used. An all-inclusive sample of nurses caring for older persons in an urban setting in the North West Province was used. During phase one (sample size n=43) the level of resilience, demographic information and narratives were obtained. During phase two (sample size n=17) focus group interviews were conducted. The quantitative data was analysed using descriptive statistics and the qualitative data using content analysis.

Results: The participants had a moderately high to high level of resilience. Participants did experience adverse working circumstances and they needed resilience due to a need for balance, the emotional nature of the work, work ethics and the work environment. Nurses caring for older persons use personal, professional, contextual and spiritual strengths to handle adverse working conditions.

Conclusion: Recommendations to strengthen resilience in nurses caring for older persons were formulated in phase three of the research, focusing on strengthening nurses' personal, professional, contextual and spiritual strengths in order that they can handle adverse workplace conditions.

Key words: resilience, nurses, caring, older-persons, strengths

OPSOMMING

Agtergrond: 'n Tekort aan verpleegkundiges word in bejaardesorg ervaar aangesien hierdie verpleegkundiges ongunstige werksomstandighede beleef. Veerkragtigheid kan moontlik hierdie verpleegkundiges bemagtig om te oorleef, te gedy en selfs te floreer. 'n Gebrek aan navorsing bestaan aangaande veerkragtigheid in verpleegkundiges wat ouer persone versorg.

Doelwitte: Die doel van hierdie navorsing was om die vlak van veerkragtigheid in verpleegkundiges wat ouer persone versorg te ondersoek, om hul sterktes en hanteringsvermoëns te verken en te beskryf, om sodoende aanbevelings te kan formuleer wat veerkragtigheid versterk in verpleegkundiges wat ouer persone versorg.

Metode: 'n Verkennende, beskrywende ontwerp met verskeie fases is gebruik. 'n Alles-insluitende steekproef van verpleegkundiges wat ouer persone in 'n stedelike gebied in die Noordwes Provinsie versorg, is gebruik. Gedurende die eerste fase (steekproefgrootte n=43) is die vlak van veerkragtigheid, demografiese inligting en verhale verkry. Tydens fase twee (steekproefgrootte n=17) is fokusgroep-onderhoude gevoer. Die kwantitatiewe data is ontleed met behulp van beskrywende statistiek en die kwalitatiewe data met behulp van inhoudsontleding.

Resultate: Die deelnemers het 'n matig hoë tot hoë vlak van veerkragtigheid getoon. Deelnemers het ongunstige werksomstandighede ervaar en hulle het veerkragtigheid nodig as gevolg van die behoefte aan balans, die emosionele aard van die werk, werksetiek en die werksomgewing. Verpleegkundiges wat ouer persone versorg gebruik persoonlike, professionele, kontekstuele en geestelike sterktes om die ongunstige werksomstandighede te hanteer.

Gevolgtrekking: Aanbevelings om veerkragtigheid in verpleegkundiges wat ouer persone versorg te versterk is in fase drie van die navorsing geformuleer met die fokus op die bevordering van verpleegkundiges se persoonlike, professionele, kontekstuele en geestelike sterktes sodat hulle die ongunstige werksomstandighede kan hanteer.

Sleutelwoorde: veerkragtigheid, verpleegkundiges, omgee, ouer persone, sterktes

INTRODUCTION

In the introduction the background to the research is provided, including the statement of the problem. A brief overview of relevant literature is also provided.

Background and statement of the problem

Key focus

The paucity of research regarding the resilience of nurses caring for older persons confirms the need to explore the resilience of these nurses as well as to explore how their resilience can be strengthened.

Background

The steady increase in the older population (Velkoff & Kowal 2007:3) and the alarming shortage of qualified and experienced nurses to care for them (Jackson, Mannix & Daly 2003:45) require urgent attention. According to the National Institute on Aging (NIA) (2007:7), it is estimated that in 2030, thirteen per cent of the total world population will be aged 65 and older, an estimated total of one billion older persons worldwide. These estimates indicate that one in every eight people on earth will be aged 65 and older by 2030 (NIA 2007:2). The South African population is also ageing. It is projected that by the year 2030 more than twelve per cent of the South African population will be aged 60 and older (Velkoff & Kowal 2007:11). These projections estimate that there will be about 4.8 million older persons in South Africa by the year 2030 (Velkoff & Kowal 2007:22). Statistics South Africa conducted a countrywide census in 2011 and according to the results of this census, the population aged 65 and older increased from 4.8% in 1996 to 5.3% in 2011, accounting for a total number of 2 765 992 older persons in 2011 (StatsSA 2011:1).

Because of this steady increase in the older population, more nurses are needed to provide in their needs. Although we need more nurses to care for the growing numbers of older persons, Oulton (2006:34S) states that an unparalleled worldwide shortage of nurses is experienced because of both supply and demand factors. The diminished supply cannot meet the enhanced demand (Oulton 2006:34S). An enhanced demand for nurses is experienced because of hospital patients needing more acute care, a movement from hospital to home-based and community

care, infectious diseases, for example Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), tuberculosis and malaria, an increasing older population, globalization, the growth in the private sector and the trust the community places in nurses (Oulton 2006:35S). On the other hand, we find that the diminished supply of nurses is caused by the nursing workforce that is growing older, less candidates apply for nursing training, adverse working conditions including extreme workloads, insufficient support personnel, violence, stress, burnout, salary disputes and limited participation in making decisions as well as variation in the way human resources are managed (Oulton 2006:35S).

It seems that the nursing shortage is also experienced in South Africa. The statistics of the South African Nursing Council (2013b) indicate that there is only one qualified nurse for every 203 persons in South Africa. According to the 2013 statistics, there is currently one registered (professional) nurse for every 411 persons, one enrolled (staff) nurse for every 831 persons and one auxiliary (assistant) nurse for every 780 persons in South Africa. Contributing to the nursing shortage in South Africa is the high emigration rate amongst nurses. According to Oosthuizen and Ehlers (2007:14), the worldwide shortage of nurses creates job opportunities for South African nurses overseas and South African nurses decide to emigrate because of low salaries, poor working environments, extreme workloads, lack of personal development and promotion opportunities and inadequate security and safety experienced. George, Quinlan, Reardon & Aguilera (2012:2) add that South Africa experiences a shortage of health care staff and that the Department of Health stresses the need to employ more personnel.

Jackson *et al.* (2003:42) confirm that all nursing disciplines are presently influenced by nursing shortages, including residential aged care facilities providing high care services. Older persons in residential aged care facilities need progressively more advanced nursing care and the need for qualified and experienced nurses has never been bigger (Jackson *et al.* 2003:45). Published information about the shortage of nurses caring for older persons in South Africa is scarce. The researcher can confirm, from previously working as a manager of a retirement village in an urban setting within the eastern portion of the North West Province, that a shortage of professional nurses, enrolled nurses and auxiliary nurses willing to care for older persons, is evident.

Regardless of the shortages and high turnover rates, we still find nurses who choose to remain in nursing and manage to cope and survive and even flourish under the often difficult workplace

conditions experienced (Koen, Van Eeden & Wissing 2011:1; Jackson, Firtko & Edenborough 2007:1), which implies that there must be something that keeps them there. One of the factors that might play a role in retaining nurses in care of the aged may be the resilience of these nurses. According to Edward and Hercelinskyj (2007:240), knowledge of resilient behaviour can empower nurses to handle workplace stress and prevent burnout. Taking this literature into account, it seems that resilience might also contribute to the ability of nurses to remain in the nursing profession and be willing to care for older persons.

Trends in research on resilience in nurses

Research relating to resilience in nurses has been done using different measuring instruments (Gillespie, Chaboyer & Wallis 2007:130-132), and in a variety of settings (Hart, Brannan & De Chesnay 2012:6-7). Gillespie, Chaboyer and Wallis (2007:131-132) refer to five different instruments that have been used to measure resilience in different contexts and populations: the ‘Resiliency Attitudes Scale’ that measures seven components of resilience; ‘the Ego-Resilience Scale’ that assesses resilience in people living near warfare regions; the ‘Connor and Davidson Resilience Scale’ that measures resilience across various community samples of grown-ups; the ‘Brief Resilient Coping Scale’ that measures a predisposition towards coping and adaptation and lastly the ‘Resilience Scale’ that identifies the degree of individual resilience that improves adjustment. According to Ahern, Kiehl, Sole and Beyers (2006: 103) the ‘Resilience Scale’ is the best instrument to use when studying resilience in adolescents because of the psychometric assets of the instrument and the fact that it can be used for various age groups.

As mentioned above, research relating to resilience has been done in a variety of settings, with different populations and with different age groups. Ablett and Jones (2007:733-734) performed a qualitative study to describe palliative nurses’ work experiences and to understand the aspects that enhanced their resilience and lessen the effect of occupational stress. The findings of their study can be used to enhance resilience during training especially ‘hardiness’ and a strong ‘sense of coherence’ and by introducing change gradually and sensitively because resilient staff might react differently to change (Ablett & Jones 2007:739).

Gillespie, Chaboyer, Wallis and Grimbeek (2007:427) used a correlational cross-sectional survey design amongst operating room nurses to examine the relation of the following variables: perceived competence, collaboration, control, self-efficacy, hope, coping, age, experience, education and years of employment, to resilience. Resilience was explained by the following

five variables at statistically significant levels: hope, self-efficacy, coping, control and competence indicating that hope, self-efficacy and coping were the strongest, but no statistical significance was shown with regard to nursing experience, education and years of employment (Gillespie, Chaboyer, Wallis & Grimbeek 2007:427,435). Strategies that enhance resilience can be formulated taking these variables into account and in the process contribute to the retention of operating room nurses (Gillespie, Chaboyer, Wallis & Grimbeek 2007:427).

This research was followed by another study (Gillespie, Chaboyer & Wallis 2009:968) to identify the level of resilience in a random sample of operating room nurses in Australia. The Connor-Davidson Resilience Scale was used. The results of the study indicated that age, experience and education seems not to be responsible for resilience in operating room nurses and that younger nurses that receive enough support may flourish in the operating room (Gillespie *et al.* 2009: 968).

Similar research have been conducted by Mealer, Jones, Newman, McFann, Rothbaum & Moss (2012:292) amongst intensive care unit (ICU) nurses, Hart *et al.* (2012:1), who conducted an integrative review on the resilience in nurses and Zander, Hutton & King (2013:17-18) who found that resilience has been proposed as an essential coping strategy for nurses that work in challenging contexts, for example paediatric oncology.

Benchmark research was done on the resilience of professional nurses working in public and private hospitals as well as in primary healthcare clinics in South Africa. Koen, Van Eeden and Wissing (2011:3) established the prevalence of resilience in professional nurses, while Koen, Van Eeden, Wissing and Du Plessis (2011:106) explored how resilient professional nurses manage to stay resilient and what prevented the less resilient professional nurses from being resilient and Koen, Van Eeden, Wissing and Koen (2011:643) formulated guidelines to develop resilience in professional nurses.

According to the abovementioned research, professional nurses are emotionally exhausted, experience low job satisfaction and leave the nursing profession although there are those that decide to stay in nursing and survive and even flourish despite difficult workplace circumstances (Koen, Van Eeden & Wissing 2011:1). Koen, Van Eeden, Wissing and Koen (2011:643-652) formulated guidelines with strategies to enhance resilience and psycho-social well-being in professional nurses based on previous qualitative research on resilience in professional nurses that worked in private and public healthcare facilities in South-Africa.

Although these research findings provide a strong foundation regarding resilience in professional nurses in this setting, these authors recommended further research regarding the resilience of professional nurses working in other health care settings (Koen, Van Eeden & Wissing 2011:10). The guidelines that were formulated to strengthen resilience in professional nurses can be used fruitfully by all professional nurses but they are not focused enough on the practicalities that nurses caring for older persons have to deal with.

Flowing from Koen's work, the RISE study (Strengthening the resilience of health caregivers and risk groups), was developed (Koen & du Plessis 2011:3). This study is grounded on the premise that despite the difficult working conditions that nurses experience, some of them manage to remain in nursing and even flourish while they still provide healthcare of high quality to their patients (Koen & du Plessis 2011:4). The RISE study acknowledges that there is a shortage of research regarding the concept of resilience and the strengths and coping abilities that enable health caregivers to stay loyal to the nursing profession and handle the workplace difficulties experienced (Koen & du Plessis 2011:4). Koen and du Plessis (2011:4) recommend further investigation into the resilience of health caregivers and risk groups. Such research might explore how the resilience of health caregivers and risk groups can be strengthened by means of a 'comprehensive, multi-faceted approach' (Koen & du Plessis 2011:4).

While this valuable research regarding resilience in professional nurses can be considered, there still seems to be a scarcity of research regarding the resilience of nurses caring for older persons globally as well as in South Africa. The only article that was found during the literature search on resilience in nurses caring for older persons, was an article by Cameron and Brownie (2010:66) regarding how the resilience in registered nurses (professional nurses) caring for the aged can be enhanced.

The results indicated that nurses caring for older persons experience and enhance resilience through clinical knowledge, skills and expertise; providing knowledgeable, competent, holistic care; making a positive difference; physical and psychological support from colleagues including sharing experiences, chances for self-reflection, debriefing and relief of stress through humour; being optimistic; ensuring a work-life balance by giving attention to exercise, rest, personal interests and networks for social support as well as long-term relationships with older persons and their families (Cameron & Brownie 2010: 66-70).

The research that was conducted by Cameron and Brownie (2010) regarding enhancing resilience in registered nurses caring for older persons in high-care residential aged care facilities provided valuable information on how resilience is enhanced by these nurses. However, this research only included registered nurses and not enrolled nurses and auxiliary nurses. Those authors also did not investigate the level of resilience in these nurses. Although important information was provided on how resilience is enhanced by these nurses, no recommendations were formulated on how to strengthen resilience in nurses caring for older persons, indicating the ‘gap’ in the knowledge base regarding the resilience of nurses caring for older persons as well as the need for recommendations to strengthen resilience in nurses caring for older persons.

Purpose and objectives

In this study, a sub-study within RISE, a very specific research problem could be identified. This is that there is a steady increase in older persons worldwide (Velkoff & Kowal 2007:3) as well as in South-Africa (Velkoff & Kowal 2007:10-11) who need nursing care. At the same time there is a worldwide shortage of nurses (Oulton 2006:34S) as well as in South Africa (SANC 2013b). This limits the number of nurses available to provide care for the older person. Jackson *et al.* (2003:42) confirm that the nursing shortage is also prevalent in care for older persons. A shortage of nurses is also experienced by the facilities providing care to older persons in this urban setting within the eastern portion of the North West Province where the research study was conducted. This shortage can personally be confirmed by the researcher who worked as a manager of a retirement village in this setting for five years. Available literature indicates that the resilience of nurses might play a critical role in their decision to stay in nursing and, especially in this instance, in older person care. Jackson *et al.* (2007:1) furthermore confirm that when nurses actively take part in the improvement and enhancement of their own resilience to minimise their susceptibility to workplace difficulties, they can contribute to improve the general healthcare situation. Nurses caring for older persons might use a variety of strategies to develop resilience in response to workplace difficulties experienced (Cameron & Brownie 2010:70). However, the level of resilience of nurses caring for older persons, as well as what strengths and coping abilities they used, were unknown, leading to the following research questions:

- What is the level of resilience in nurses caring for older persons?

- What can be learned about the strengths and coping abilities of nurses caring for older persons?
- What recommendations can be formulated from the findings to strengthen resilience in nurses caring for older persons?

The purpose of this research was thus to investigate the level of resilience in nurses caring for older persons. The intention was further to explore and describe their strengths and coping abilities in order to formulate recommendations from the findings to strengthen resilience in nurses caring for older persons.

Definition of key concepts

Resilience

Is the human ability to deal with, rise above, be strengthened by, and even be changed by experiences of hardship, including natural disasters as well as those caused by man (Grotberg 2001:76). In this study resilience referred to the ability of nurses caring for older persons to cope and even flourish under adverse working conditions in order to provide quality care to older persons.

Nurse

According to the Nursing Act (33 of 2005), a nurse is a person registered with the South African Nursing Council in order to practice nursing or midwifery (South Africa 2005). Different categories of nurses are registered with the South African Nursing Council, namely auxiliary nurses, staff nurses and professional nurses. In practice as well as in literature a professional nurse is also referred to as a registered nurse and a staff nurse is also called an enrolled nurse and an auxiliary nurse is also called an assistant nurse. In this study all these categories of nurses provide care to the older person.

Older person

According to the Older Persons Act (13 of 2006), an older person is seen as a person that is 65 years old or older when referring to a male and 60 years of age or older when referring to a

female (South Africa 2006). In this study the older person is any person older than 60 years of age that is being cared for by a nurse.

Contribution to the field

The contribution of this research is embedded in the possible benefits for the nurses and for the older persons. The nurses will benefit from this study if they could be empowered to be more resilient when caring for older persons. The recommendations to strengthen their resilience could enable them to survive, cope and even flourish in the adverse working conditions they experience while caring for older persons. The older persons would benefit from this study indirectly. If nurses could be empowered to be resilient, they would be able to survive in nursing and remain in their jobs caring for older persons.

Literature review on resilience

Different definitions of resilience can be found in the literature including ‘a personality characteristic that moderates the negative effects of stress and promotes adaptation’ (Wagnild & Young 1993:165); ‘Resilience embodies the personal qualities that enable one to thrive in the face of adversity’ (Connor & Davidson 2003:76); ‘Resilience refers to a person’s ability to adapt successfully to acute stress, trauma, or more chronic forms of adversity’ Rutter (2006) (cited by Wagnild 2011:12). According to the Concise Oxford English Dictionary (2011:1224) a resilient person is ‘able to withstand or recover quickly from difficult conditions’. Resilient people can ‘bounce back’ from hardship and continue with their lives (Dyer & McGuinness 1996:276). Reich, Zautra & Hall (2010:4), confirm that resilience means that a person can successfully adjust to hardship. Fredrickson, Tugade, Waugh & Larkin (2003:373) assert that a series of psychological advantages for everyday life as well as in coping with crisis situations are connected to resilience. These definitions indicate that higher levels of resilience might empower nurses caring for older persons to cope and survive.

According to Fletcher and Sarkar (2013:12, 14) ‘adversity’ and ‘positive adaptation’ form the basis of most definitions of resilience and resilience is needed to handle different difficulties ranging from problems encountered daily to big life-changing events and that the positive adjustment must be in accordance with the difficulty experienced. This is confirmed by Jackson *et al.* (2007:1) who state that ‘Resilience is the ability of an individual to positively adjust to adversity’ and Herrman, Steward, Diaz-Granados, Berger, Jackson & Yuen (2011:258) that

resilience refers to ‘positive adaptation’ or to be able to sustain or resume mental health although ‘adversity’ is experienced. Earvolino-Ramirez (2007:76) adds that the quality of ‘bouncing back’ and going forward in life after difficulties is evident in resilience. Adversity differentiates resilience from other personality characteristics or social organizational practices and successful coping, control and ‘positive adaptation’ are important results of resilience (Earvolino-Ramirez 2007:78). Tugade and Fredrikson (2004:331) contend that individuals with high levels of resilience experience positive emotions during stressful situations. Pooley and Cohen (2010:34) formulated a new definition of resilience: ‘...the potential to exhibit resourcefulness by using available internal and external resources in response to different contextual and developmental challenges’.

According to Pooley and Cohen (2010:34) resilience is a ‘multidimensional’ and ‘multi-level’ construct. The following **antecedents** of resilience were identified by Gillespie, Chaboyer & Wallis (2007:126-128) ‘adversity’, ‘interpretation as traumatic’, ‘cognitive ability’ and ‘realistic world-view’. According to Earvolino-Ramirez (2007:78) and Fletcher and Sarkar (2013:15), the main antecedent of resilience seems to be ‘adversity’.

Defining **attributes** for resilience identified by Earvolino-Ramirez (2007:76-77, 81) include ‘rebounding’ / ‘reintegration’; ‘high expectancy’ / ‘self-determination’; ‘positive relationships’ / ‘social support’; ‘flexibility’; ‘sense of humour’ and ‘self-esteem’ / ‘self-efficacy’. Gillespie, Chaboyer and Wallis (2007:127-130) added that ‘self-efficacy’, ‘hope’ and ‘coping’ materialized as defining attributes of resilience during their analysis of the concept.

Fletcher and Sarkar (2013:15) assert that the main **consequence** of resilience is ‘positive adaptation’. This is supported by (Earvolino-Ramirez 2007:78) who asserts that ‘effective coping’, ‘mastery’, and ‘positive adaptation’ are important consequences of resilience. Gillespie, Chaboyer and Wallis (2007:127) added that ‘integration’, ‘control’, ‘adjustment’ and ‘growth’ emerged as consequences of resilience in their study.

According to Fletcher and Sarkar (2013:15), researchers distinguish between protective and promotive factors and explain that protective factors protect the individual from the possible negative consequence of an experience whereas a promotive factor may produce benefits. Resilience as a trait is recognised as a protective factor (Fletcher & Sarkar 2013:15). Resilience as a trait acknowledges that people may be born resilient (Jacelon 1997:128) but Gillespie, Chaboyer and Wallis (2007:124) disagree and state that resilience appears to be a process that

can be developed at any age and it is not an inborn personality characteristic. According to Jacelon (1997:128) resilience has been acknowledged as a collection of ‘traits’ as well as a ‘process’ whereby people react to incentives from the environment. This is confirmed by Fletcher and Sarkar (2013:15) who state that resilience has been considered to be a personality characteristic as well as being perceived to be a process.

Fletcher and Sarkar (2013:16) draw attention to the fact that a mounting body of evidence suggests that resilience and coping are conceptually dissimilar constructs. Resilience controls how an experience is assessed and coping refers to the tactics engaged following the assessment of a traumatic event, concluding that resilience is the collaborative influence of personality characteristics inside the setting of the stress process. ‘Psychological resilience is defined as the role of mental processes and behaviour in promoting personal assets and protecting an individual from the potential negative effect of stressors’ (Fletcher & Sarkar 2013:16).

According to Fletcher and Sarkar (2013:17), more than a dozen resilience theories were offered by different researchers during the last thirty years. According to the mainstream of these theories resilience change over time and is seen as a dynamic process and most researchers acknowledge the fact that inside the process, the interaction between a wide variety of aspects establish if a person show resilience (Fletcher & Sarkar 2013:17).

The metatheory of resilience and resiliency has the potential to be applied to a variety of stressors, difficulties and life experiences as well as at different levels of analysis (Fletcher & Sarkar 2013:17). According to Fletcher and Sarkar (2013:17), Richardson (2002) describes the history of research regarding resilience as occurring in ‘waves’. During the first wave, the resilient qualities (protective factors) of people that responded in a positive way to difficult circumstances were explored (Fletcher & Sarkar 2013:17; Richardson 2002:307-308). During the second wave, resilience was described as a ‘disruptive’ and ‘reintegrative’ process (Richardson 2002:307) of coping with stressors, hardship, change or opportunity (Fletcher & Sarkar 2013:17; Richardson 2002:307-308). The third wave explored the force that drives a person to grow through hardship and trouble towards self-actualization (Fletcher & Sarkar 2013:17; Richardson 2002:307-308).

According to Fletcher and Sarkar (2013:17), the resilience model is one of the main contributions of Richardson (2002) and Richardson, Neiger, Jensen & Kumphier (1990). According to the resilience model, the resilience process starts with a state of physical, mental

and spiritual equilibrium also referred to as ‘bio-psycho spiritual homeostasis’ or ‘comfort zone’ (Fletcher & Sarkar 2013:17; Richardson 2002:310-311). If a person has inadequate resources (protective factors) to safeguard him against stressors, hardship or life experiences, disruption from this state of equilibrium occurs but after a while a person that experienced disruption will adjust and the reintegration process will begin (Fletcher & Sarkar 2013:17). One of four outcomes may follow this process: ‘resilient reintegration’ (additional protective factors are obtained from the disruption and an advanced level of homeostasis is obtained), ‘homeostatic reintegration’ (the disruption caused the persons just to stay in their ‘comfort zones’ and ‘just get past’ the disruption), ‘reintegration with loss’ (the disruption caused a loss of protective factors and a lower level of equilibrium or homeostasis); and ‘dysfunctional reintegration’ (the disruption caused the people to turn to destructive activities for example drug abuse) (Fletcher & Sarkar 2013:17).

According to Richardson (2002:319), the metatheory of resilience and resiliency incorporates a number of theories from different disciplines as well as theories of life. The resilience process is inspiring and implies that stress and change may lead to growth and develop more resilient virtues or protective factors while the process of disruption and repetition refers to the ups and downs of life that are experienced by most people (Richardson 2002:319). Richardson (2002:319) concludes that in order for development and reintegration to occur, energy is needed, coming from both inside the person and from outside sources of strength and maintains that resilience can be applied in the practice of everyday life, providing hope and enhancement of self-efficacy. Fletcher and Sarkar (2013:17) propose that new theories of resilience based on original research need to be formulated taking into account the mounting body of evidence suggesting that resilience and coping are conceptually different constructs.

RESEARCH DESIGN AND METHOD

Research design

An explorative, descriptive design with multiple phases was used in this study. Both quantitative and qualitative approaches were utilized to answer the research questions and reach the research objectives. The research was conducted in three phases in order to reach the objectives of the study. Figure 1 outlines the explorative, descriptive design with multiple phases that was followed in the study.



Figure 1: Outline of the explorative, descriptive design with multiple phases.

Research method

Table 1 gives an outline of the research method in each phase, linked with the objectives. The research method includes the population and sample, data collection and data analysis. The sample includes the sampling method and sample size. Following table 1, the context of the study will highlight the setting in which the study was conducted.

Table 1 : Outline of the phases, objectives, steps, population and sample, data collection and data analysis.

PHASE 1				
Objective	Step	Population and sample	Data collection	Data analysis
Objective 1: To investigate the level of resilience in nurses caring for older persons.	Step 1: Collection of demographic information. Step 2: Investigating the level of resilience.	Population: All categories of nurses, namely professional nurses, enrolled nurses and auxiliary nurses caring for older persons in facilities or in the community, in an urban setting within the eastern portion of the North-West Province. Sample: An all-inclusive, voluntary sample of nurses (n=43).	*Demographic information form *Resilience Scale	Descriptive statistics using: * SPSS statistical programme *Resilience Scale User's Guide
Objective 2: To explore and describe the strengths and coping abilities of nurses caring for older persons.	Step 3: Exploring personal strengths, managing to cope, what makes it worthwhile and managing to be resilient.	Population All categories of nurses, namely professional nurses, enrolled nurses and auxiliary nurses caring for older persons in facilities or in the community, in an urban setting within the eastern portion of the North-West Province. Sample: An all-inclusive, voluntary sample of nurses (n=43).	Narratives	Content analysis
				
PHASE 2				
Objective 2 (Continue): To explore and describe the strengths and coping abilities of nurses caring for older persons.	Step 4: Verifying findings from narratives, exploring why resilience is needed and what advice can be given.	Population: All categories of nurses, namely professional nurses, enrolled nurses and auxiliary nurses caring for older persons in facilities or in the community, in an urban setting within the eastern portion of the North-West Province. Sample: An all-inclusive, voluntary sample of nurses (n=17).	Focus group interviews	Content analysis
				
PHASE 3				
Objective 3: To formulate recommendations from the findings to strengthen resilience in nurses caring for older persons.	Step 5: Formulate recommendations.	Conclusions and results of the demographic information forms, Resilience Scales, themes identified from narratives and focus group interviews, as well as relevant literature, were brought into relation with one another, integrated, and used to formulate recommendations.		

Context of the study

The setting was an urban setting within the eastern portion of the North West Province. The setting included seven community facilities providing care to older persons that gave written consent for participating in the research. The facilities that participated in the research included one service centre for the aged providing home-based care, three old age homes, one retirement village, one facility that provides care and rehabilitation to older as well as disabled persons and one facility caring for older persons in a residential home setting.

Materials

During phase one, three types of data were collected. During step one, a demographic information form, Annexure H, was used to collect the following demographic information from the participants to enable the researcher to contextualise the findings: employment status, marital status, age, gender, home language, highest level of education, nursing title and number of years caring for older persons. This enabled the statistical consultant to determine whether associations between certain aspects of the Resilience Scale and the demographic information existed.

During step two, the level of resilience in participants was investigated using a reliable and validated self-report instrument, the Resilience Scale, Annexure I, (Wagnild & Young, 1993:165; Wagnild 2011:22), with permission from these authors (Annexure C). The Resilience Scale consists of 25 items (Ahern *et al.* 2006:111) that measures the construct resilience. A seven point (1-7) Likert scale (Ahern *et al.* 2006:112) is used where 1 indicates 'Strongly Disagree' and 7 'Strongly Agree' (Wagnild & Young 1993:168; Wagnild 2011:122). All the items are formulated in a positive manner and portray the words that the participants used in the original study (Wagnild & Young 1993:168). The scoring of the Resilience Scale will be discussed in the results section of the article (see Section 2: Quantitative results and discussion; and in Section 2: Table 5). The reliability and validity of the Resilience Scale will also be discussed in the results section of the article as well as in rigour (see Section 2: Quantitative results and discussion; Section 2: Rigour).

During step three, the strengths and coping abilities of the participants were explored by asking them to write narratives. According to Polit and Beck (2012:735), a narrative is a qualitative approach where the centre of attention is on stories as the object of the investigation. The

decision to use narratives was made because when individuals write stories, they are able to make sense of their world and they convey these meanings by the building and rebuilding of the stories (Polit & Beck 2012:504). The writing of the narratives will be discussed in detail in this article (Section 2: Data collection procedure).

During the second phase, step four, focus group interviews were conducted with all the participants who were willing to participate. Conducting the focus group interviews and the questions asked will be discussed in detail in this article Section 2: Data collection procedure).

All the above mentioned phases and steps followed contributed to the reaching of step 5.

Data collection procedure

The researcher obtained ethical approval from the North-West University (NWU) under the RISE study (Annexures A and B). Before the commencement of data collection, the researcher gained entry to the facilities (Botma, Greeff, Mulaudzi & Wright 2010:203) by contacting the managers and / or chief professional nurses of the different facilities. The written consent of the managers and / or chief professional nurses was obtained (Annexure D). The researcher then identified a ‘go-between’ at each facility to connect the researcher with the nurses at the facility (Botma *et al.* 2010: 203). This person was the manager or chief professional nurse that arranged with the nurses of each shift to be available at the date, time and venue as arranged in order for the researcher to explain the research to the nurses, obtain their permission and to collect the data.

The managers or chief professional nurses had ensured that comfortable, private venues were selected at each facility, where there were no interruptions (Botma *et al.* 2010:203). Conference rooms, sitting rooms or an office were used. The researcher welcomed the nurses and thanked the manager or chief professional nurse for the arrangements. Informed, voluntary consent from participants was then obtained. The participants were given an opportunity to select a file containing the following:

1. An information page explaining the purpose and objectives of the research, (Annexure G).
2. Section A: Demographic information form, (Annexure H).
3. Section B: The Resilience Scale, (Annexure I).

4. Section C: Writing of narrative (story), (Annexure J).
5. An envelope with a checklist printed on top, to ensure that the nurses hand in all the data collection instruments.

All the data collection instruments of each participant were marked with the same number in order for the researcher to link the demographic information form, Resilience Scale and narrative of each participant. No form of identification was required from the participants. This was to ensure that the data was anonymous. The researcher explained all the documents to the participants in English as well as in Afrikaans as needed. The participants were asked to read through the documents and asked if they had any questions. The researcher was available to answer any questions.

During this first phase of the research, the participants were requested to complete Section A: the Demographic information form, Section B: the Resilience Scale and Section C: Writing of narrative. Regarding the writing of the narratives, the following was requested from the participants:

Dear nurse,

Nurse Dawn is a young nurse that would like to care for older persons. She would like to learn from all the experience you have gained while caring for older persons. Please write her a letter in which you tell her about your personal **strengths**, how you manage to **cope** while caring for older persons, what makes it **worthwhile** for you and how you manage to be **resilient** while caring for older persons.”

The following prompts were given on the top of each page in English as well as in Afrikaans:

- My **personal strengths** that enable me to care for older persons are.....
- This is how I manage to **cope** while caring for older persons....
- The following makes it **worthwhile** for me to care for older persons.....
- This is how I manage to be **resilient** while caring for older persons....

The participants were given enough time to complete the documents and hand them back to the researcher. The researcher collected all the envelopes containing the data collection instruments

and kept them safely for data analysis. Some of the participants on night duty requested to write the narratives during the night and in those instances the researcher collected the envelopes the following day or as soon as possible.

The participants that participated in phase one of the research, were all invited by the researcher to participate in a focus group interview. The date, time and venue of the focus group interview were given to them. The researcher explained to them that the focus group interview would be voice recorded (Botma *et al.* 2010:214).

The focus group interviews were conducted during phase two. The choice to use focus group interviews was made to further explore the strengths and coping abilities of nurses caring for older persons as well as to explore the reasons why nurses caring for older persons need to be resilient. Practical arrangements such as the date, time and venue (Botma *et al.* 2010:212) were made well in advance, and appointments were arranged with the help of the manager or chief professional nurse (Botma *et al.* 2010:203). The manager or chief professional nurse at each facility ensured that a private, comfortable venue was arranged where there were no interruptions (Botma *et al.* 2010:203) and where the door could be closed. Two of the focus group interviews were conducted in offices, one in a conference room / activity room and one in a private hall.

The researcher prepared an interview schedule for the focus group interviews Annexure L, and made preparations for voice recording (Botma *et al.* 2010:212). The researcher gave each participant a copy of the interview schedule containing the rules as well as the interview questions and read the interview schedule before the focus group interview started (Botma *et al.* 2010:212). It was explained in English as well as in Afrikaans as needed.

The following information was written on the interview schedule that was given to the participants before the focus group interview started: the purpose of the research, the participants and what was expected from them, the fact that they voluntarily participated, a reminder that they will receive no money for participating, the fact that the focus group interview will be voice recorded, a reminder that they may withdraw at any time and the provision of emotional support if needed (Botma *et al.* 2010:212). All the participants were also reminded to make sure that they had signed informed voluntary consent forms before participation in the focus group interview. A summary of the answers received from the

questions that were asked in the narratives, Annexure K, were read to the participants and they were asked to verify the answers and given the opportunity to add any new information.

Questions asked in narratives:

1. My personal strengths that enable me to care for older persons are ...
2. This is how I manage to cope while caring for older persons ...
3. The following makes it worthwhile for me to care for older persons ...
4. This is how I manage to be resilient while caring for older persons ...

Two new questions asked during the focus group interviews:

5. Why do nurses caring for older persons need to be resilient?
6. What advice would you give these nurses to help them to be resilient?

All the focus group interviews were conducted consistently according to the interview schedule (Botma *et al.* 2010:212). Field notes were taken by the researcher during and after each focus group interview (Botma *et al.* 2010:212). The researcher was open and friendly and facilitated group discussion (Botma *et al.* 2010:212). The questions were asked in a conversational manner and communication techniques, such as exploring, clarifying, reflecting, focusing, validating and summarizing, as described by Kreigh and Perko (1983:250-254), were utilized.

The number of focus group interviews was determined by data saturation (Botma *et al.* 2010:211). Four focus group interviews were conducted and data saturation was experienced during focus group number four because the same themes started to emerge and the research question e.g. ‘What can be learned about the strengths and coping abilities of nurses caring for older persons?’ was answered.

Data analysis

Quantitative data analysis

The quantitative data consisted of the demographic information forms and the Resilience Scales that were completed by all the participants. The data were analysed by the statistical consultation service of the NWU Potchefstroom Campus using descriptive statistics. The Statistical Package for the Social Sciences (SPSS) statistical programme and the guidelines from the 'Resilience Scale User's Guide' were used (Wagnild 2011:72). Descriptive statistics were used to describe the results.

The level of resilience of each nurse was determined. According to Ahern *et al.* (2006:112), the scores of all the items are counted together in order to determine the resilience level. The scores that are possible range from 25 to 175, with higher scores indicating higher resilience (Wagnild & Young 1993:168; Ahern *et al.* 2006:112; Wagnild 2011:72).

Frequencies were calculated and associations were determined between the resilience of the participants and their employment status, marital status, gender, language, education, nursing title and years of service. The results of the quantitative data analysis will be reported and discussed in the results section of the article (see Section 2: Quantitative results and discussion). The researcher was able to calculate the level of resilience of the participants by hand as well and was able to compare the results with the results from the statistical consultation service as recommended in the Resilience Scale User's Guide (Wagnild 2011:73).

Qualitative data analysis

Content analysis was used to analyse the qualitative data because it produces an orderly and complete outline of all the data (Botma *et al.* 2010:213). The narratives were analysed using content analysis to learn from all the participants about their personal strengths, how they manage to cope, what makes it worthwhile and how they manage to be resilient while caring for older persons. The transcriptions of the focus group interviews were also analysed using content analysis in order to formulate recommendations to strengthen resilience in nurses caring for older persons. The group dynamics and the interaction between the participants in the group all formed part of the analysis and it was recorded in the field notes (Greeff cited by Botma *et al.*

2010:213). Themes and patterns materialized from the similarities and differences in the data (Greeff cited by Botma *et al.* 2010:213).

An experienced co-coder was asked to analyse all the qualitative data independently from the researcher. A protocol for data-analysis of the narratives and transcriptions of the focus group interviews was developed, Annexure P, and given to the co-coder. The basic steps, as explained by Creswell (2009:185-190) were followed during data analysis and the eight steps in the coding process according to Tesch (1990) (cited by Creswell 2009:186) were used as a guideline to code the data. The narratives were analysed first and then the transcriptions of the focus group interviews. The same steps were followed for both. An in-depth literature control, as part of the presentation of the results, revealed the model provided by Carr (2004:302-304) that spontaneously led to a further clustering and organisation of the themes and sub-themes. This final organisation of the themes and sub-themes is used to discuss the qualitative findings.

Model presented by Carr ‘Bringing strengths to bear on opportunities and challenges’ (2004:302-304).

The model presented by Carr served as an excellent vehicle to make sense of the data obtained, to organise the data and use it as a guide to formulate recommendations from the findings to strengthen resilience in nurses caring for older persons. The model presented by Carr (2004:302-304), (see Section 3: 2.1.3), provides a theoretical framework that supports the qualitative findings of the research.

Figure 2 outlines the process that was followed to analyse and cluster the themes and sub-themes that emerged from the analysis of the qualitative data.

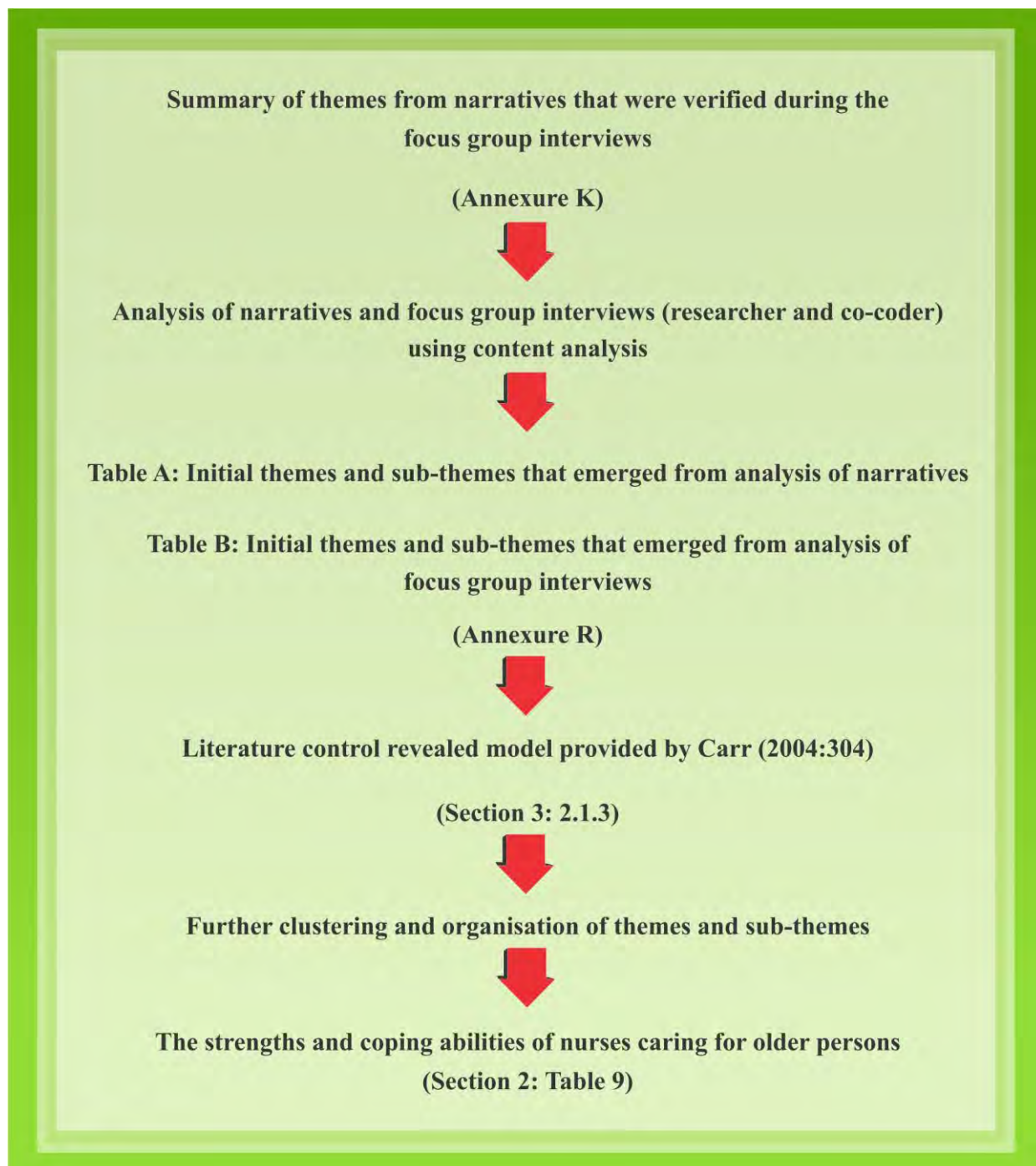


Figure 2: Process followed to analyse and cluster the themes and sub-themes that emerged from the analysis of the qualitative data.

RESULTS

Quantitative results and discussion

The research objective for collecting the quantitative data was to investigate the level of resilience in nurses caring for older persons.

Demographic profile

Table 2 outlines the demographic profile of the nurses caring for older persons in this sample, excluding the age. The age will be reported separately.

Table 2: Demographic profile of participants (n=43).

	Frequency	Per cent	Valid per cent
Employment status			
Full-time	36	83.7	83.7
Part-time	5	11.6	11.6
Per hour	2	4.7	4.7
Marital status			
Single	7	16.3	16.3
Married	20	46.5	46.5
Divorced	9	20.9	20.9
Widowed	7	16.3	16.3
Gender			
Male	0	0.0	0.0
Female	43	100.0	100.0
Home language			
Afrikaans	35	81.4	81.4
English	0	0.0	0.0
Setswana	6	14.0	14.0
Other	2	4.7	4.7
Highest level of education			
Grade 10	9	20.9	20.9
Grade 12	8	18.6	18.6
Certificate	14	32.6	32.6
Diploma	8	18.6	18.6
Bachelor's degree	1	2.3	2.3
Post-graduate	3	7.0	7.0
Nursing category			
Professional nurse	15	34.9	34.9
Enrolled nurse (staff nurse)	5	11.6	11.6
Auxiliary nurse	23	53.5	53.5
Number of years caring for older persons			
<6 months	5	11.6	11.6
6 months – 1 year	2	4.7	4.7
1 year < 5 years	5	11.6	11.6
5 years < 10 years	4	9.3	9.3
>10 years	27	62.8	62.8

Employment status

The results indicated that the majority of the participants in this sample 83.7% (n=36) were employed full-time. Regarding the rest of the participants, 11.6% (n=5) were employed part-time and 4.7% (n=2) of the participants were employed per hour.

Marital status

The highest percentage of the participants 46.5% (n=20) were married. The divorced participants accounted for 20.9% (n=9) of the sample. The single participants made up 16.3% (n=7) of the sample and the participants that were widows 16.3% (n=7) of the sample.

Gender

All the participants were female 100% (n=43).

Home language

According to the results, the mainstream of the participants used Afrikaans as home language 81.4% (n=35). Participants that spoke Setswana at home accounted for 14% (n=6) of the sample and the participants that spoke other languages at home accounted for 4.7% (n=2) of the sample. None of the participants spoke English at home.

The fact that the majority of the participants spoke Afrikaans at home may be attributed to the fact that this urban setting in the eastern portion of the North-West Province is predominantly Afrikaans-speaking, including the management and residents of the facilities that participated in the research.

Highest level of education

The results obtained from the highest level of education of the participants were initially unclear because some of them indicated both their highest school qualification as well as their highest professional qualification. It was decided to only take their highest level of education that was indicated on the demographic information form into account even if they did mark more than one option. Grade 10 was seen as the lowest qualification and a post-graduate qualification as the highest qualification.

The highest percentage of the participants in this sample 32.6% (n=14) indicated that a certificate is their highest level of education. Grade 10 was indicated by 20.9% (n=9) participants as their highest level of education whilst 18.6% (n=8) indicated that Grade 12 is their highest level of education. A diploma was also indicated by 18.6% (n=8) of the participants as their highest level of education. Having a bachelor's degree as highest level of education was indicated by only 2.3% (n=1) of the participants whilst having a post-graduate qualification was indicated by 7% (n=3) of the participants as their highest level of education.

Nursing category

The majority of the participants were auxiliary nurses 53.5% (n=23). Professional nurses accounted for 34.9% (n=15) of the sample and enrolled nurses (staff nurses) for 11.6% (n=5) of the sample.

The fact that the highest percentage of the participants were auxiliary nurses may be attributed to the fact that facilities caring for older persons often employ auxiliary nurses because their training prepares them well to provide in the special needs of the older person.

Number of years caring for older persons

The results indicated that 11.6 % (n=5) of the participants had less than six months' experience in caring for the older persons as an auxiliary nurse. The reason for including these nurses was that their training as an auxiliary nurse was one year and most of them also completed a caregiver course before they were accepted for training as an auxiliary nurse. The duration of the caregiver training course is between two and five months, depending on the institution providing the training. The researcher consulted with her supervisor and decided to include these nurses in the research because during their caregiver course as well as during their training as auxiliary nurses, they obtained at least six months' experience in caring for older persons. The participants that had been caring for older persons for between six months and one year was 4.7% (n=2) of the sample and the participants that had cared for older persons from one to less than five years was 11.6% (n=5) of the sample. The participants caring for older persons from five years to less than ten years constituted 9.3% (n=4) of the sample. The highest percentage of the participants in this sample 62.8% (n=27) had more than ten years' experience in caring for older persons.

The fact that 62.8 % of the participants had more than ten years' experience in caring for older persons, made the researcher realize that a lot can be learned from these nurses regarding their strengths and coping abilities while caring for older persons.

Age

The results indicated that the youngest participant was aged 24 and the oldest participant was 74 years old. The average age of the participants was 52 with standard deviation of twelve. It is interesting to note that there were two nurses in this sample that were 74 years old and they were still caring for older persons.

This finding is in accordance with (Oulton 2006:35S), who states that the reduced supply of nurses can amongst others be attributed to the fact that the nursing workforce is growing older. The SANC (2013a) statistics indicate that the age group with the highest number of registered nurses / midwives was between 50 and 54; the highest number of enrolled nurses / midwives between the ages of 30 and 34 and the highest number of enrolled nursing auxiliaries between the ages of 30 and 34 as well.

Reliability

According to Botma *et al.* (2010:177), the reliability of a measuring instrument is examined using a test called the Cronbach alpha that tests the internal consistency of the measuring instrument. Good internal consistency is indicated with a correlation of 0.8 to 0.9 (Botma *et al.* 2010:177-178).

Table 3 outlines the Cronbach alpha and the mean inter-item correlation for the Resilience Scale.

Table 3: Cronbach alpha and mean inter-item correlation for the Resilience Scale.

Cronbach alpha	Mean Inter-Item Correlation
.955	.497

Good internal consistency and reliability of the ‘Resilience Scale’ was indicated by the Cronbach alpha that was **.955** for this study.

Level of resilience

Table 4 outlines the minimum and maximum scores obtained by the participants in the Resilience Scale, the average score, as well as the standard deviation.

Table 4: Resilience Scale: minimum and maximum scores, mean and standard deviation.

	N	Minimum	Maximum	Mean	Standard Deviation
	43	31	172	152.6	22.3

The results indicated that the lowest score obtained by a participant was 31 and the highest score was 172. According to the results the average score of the participants was 152.6 with standard deviation of 22.3.

Table 5 outlines the scoring of the Resilience Scale indicating the different levels of resilience according to Wagnild (2011:72).

Table 5: Outline of the scoring of the Resilience Scale.

Very low	Low	On the low end	Moderate	Moderately high	High
25-100	101-115	116-130	131-145	146-160	161-175

(Wagnild 2011:72)

According to the results obtained from this sample of nurses caring for older persons, the participant with the lowest score of 31 had a very low level of resilience. The participant with the highest score of 172 had a high level of resilience. The average score of all the participants was 152.6 indicating that this sample of nurses caring for older persons had on average a moderately high level of resilience.

Table 6 summarises the level of resilience of the participants.

Table 6: Level of resilience of participants.

	Frequency	Per cent	Valid per cent
Very low	1	2.3	2.3
Low	0	0.0	0.0
On the low end	2	4.7	4.7
Moderate	8	18.6	18.6
Moderately high	16	37.2	37.2
High	16	37.2	37.2

Figure 3 provides a graphic presentation of the level of resilience of the participants.

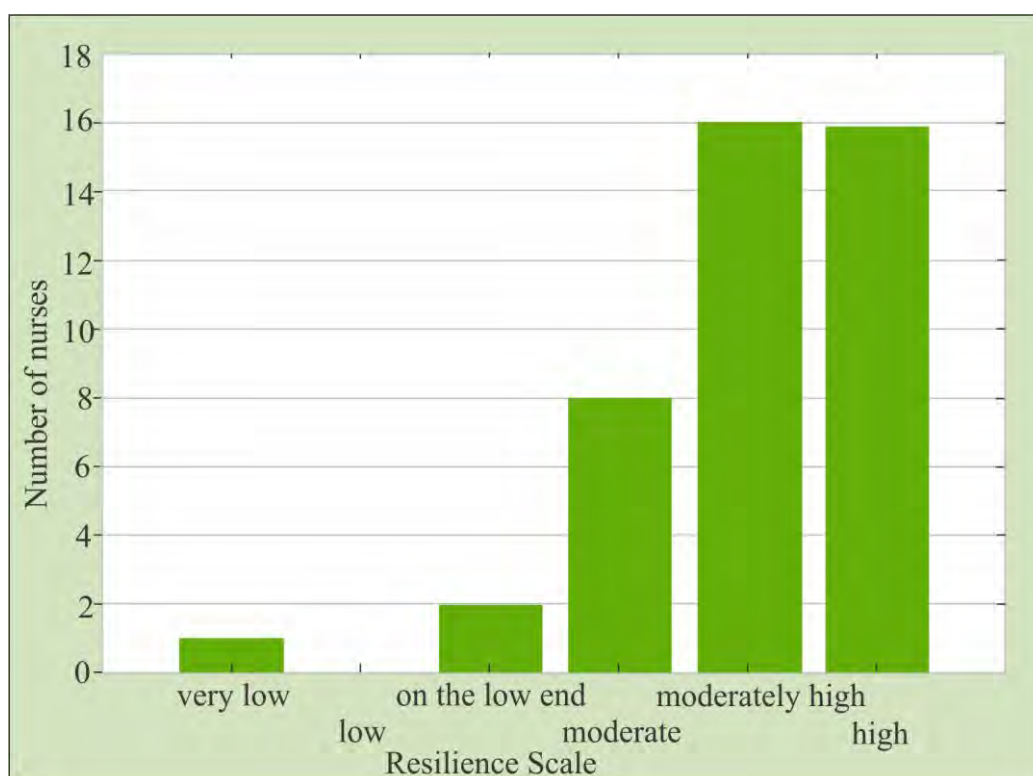


Figure 3: Level of resilience of participants.

The results indicated that 2.3% (n=1) of the participants had a **very low** level of resilience, no participant had a **low** level of resilience, 4.7% (n=2) of the participants had a level of resilience that was **on the low end**, 18.6% (n=8) had a **moderate** level of resilience, 37.2% (n=16) had a **moderately high** level of resilience and 37.2% (n=16) had a **high** level of resilience.

Table 7 outlines the interpretation of the scores for the Resilience Scale (Wagnild 2011: 76-78).

Table 7: Interpretation of the scores for the Resilience Scale.

Level of resilience	Meaning
Very low 25-100	Level of resilience is very low but not zero. All persons are resilient to some degree. Depression may be present and energy may be lacking. May not believe in own abilities. Do not see glass half full but rather half empty. May feel that everything is too much. May feel nobody understands situation, causing loneliness and feelings of desertion. May find it difficult to keep going. Resilience can be strengthened and will cause an important and positive change in life.
Low 101-115	Level of resilience is low but not zero. All people are resilient to some degree. May feel a little bit depressed and anxious about life. May feel life has no meaning. May not have a general sense of satisfaction and may feel that changes are needed. May be pessimistic. May not feel in control because too many things are going on in life. Can strengthen resilience and by doing so an important and positive change will occur in life.
On the low end 116-130	Level of resilience on low end but not zero. Resilience is present to some degree in all people. May feel somewhat depressed or anxious. May experience problems in life and try to resolve them. May experience difficulty to let go of things that they have no control over. May not feel appreciated. May feel that life is not fulfilling. May sometimes see that at the end of the tunnel, there is light again. Resilience can be strengthened and by doing so significant and positive change will occur.
Moderate 131-145	Level of resilience is moderate, not high or low. Have many characteristics of resilience that can be used to build on to strengthen resilience. Generally satisfied, some aspects of life not satisfied with. Aware that changes need to be made. Able to keep moving forward but lacking enthusiasm. May feel worn-out and emotionally exhausted at end of day. May be experiencing 'ups and downs'. Able to see positive things in life if they concentrate on it but tend to worry about things that are not going well. May still have a sense of humour but realise that need to laugh more and worry less. Resilience can be strengthened to make a considerable and positive change on life.
Moderately high 146-160	Level of resilience is moderately high. Doing well but believe can do better. Already have all the characteristics of resilience but would like to strengthen resilience further. Generally find life is meaningful and seldom feel depressed. Possibly dissatisfied with many aspects of life, for example work, relationships including personal and professional, the spending of leisure time and physical health. Aware of the fact that there is 'room for improvement'. Mostly have enough energy to handle the day. Possess a balanced viewpoint of life by realising that sometimes things go well while at other times they don't. Mostly own company is enjoyed. Dependable person. Will have advantages to recognise resilient strengths as well as areas where improvement is needed.
High 161-175	Level of resilience is high. Doing very well in approximately all aspects of resilience. Seldom feel depressed or anxious about life. Life is experienced as very purposeful. Excited to take on every new day. View life as an adventure. Seen by others as optimistic and buoyant. Own company as well as the company of others are enjoyed. Maintain a work-life balance. Experience the same difficult, painful situations like everybody else including illness, family or friends that die, being without a job and so forth. Despite these adverse events, still able to resume balance and stability and keep moving forward. Have handled a lot of adverse circumstances in the past and are convinced that will be able to handle it again. Dependable and resourceful. Role model to others because possesses a healthy outlook on life by looking at a situation from different viewpoints. Self-assured and in general satisfied with life.

Summarised and paraphrased from (Wagnild 2011:76-78)

Demographic profile versus level of resilience

The following explanation will clarify the interpretation of the results to determine if associations exist between the level of resilience of the participants and their demographic profile.

Statistical significance

If the results are not likely to be due to chance, it means that statistical significance exists (Burns & Grove 2009:559). According to Burns and Grove (2009:559), the difference indicated by statistical significance, is not always important in practice. Small p-values indicate significance in statistical significance tests (Ellis & Steyn 2003:51). No statistical significance was found in this study with regard to the demographic profile in relation to the level of resilience.

Practical significance

The importance of a study to the body of knowledge of nursing refers to the practical significance of the study (Burns & Grove 2009:559). Burns and Grove (2009:559) maintain that even if no statistical significance exists the results can have practical significance. Ellis and Steyn (2003:51) assert that if the difference is large enough to have an effect in practice, it can be seen as having practical significance. Practical significance was found in this study.

The effect size can be used to calculate practical significance (Ellis & Steyn 2003:51). The effect size does not depend on the size of the sample (Ellis & Steyn 2003:51). Regarding the effect size for the difference between means, Cohen (1988) (cited by Ellis & Steyn 2003:52), asserts that a small effect is indicated by $d=0.2$, a medium effect by $d=0.5$ and a large effect by $d=0.8$. Ellis and Steyn (2003:52) maintain that data with $d \geq 0.8$ is practically significant because the difference has a large effect.

Regarding the effect size for the relationship in a contingency table, Cohen (1988) (cited by Ellis & Steyn 2003:53), contends that a small effect is indicated by: $w=0.1$, medium effect by: $w=0.3$, and large effect by: $w=0.5$. Ellis and Steyn (2003:53) contend that a relationship with $w \geq 0.5$ is believed to be practically significant.

Descriptive statistics to indicate practical significance of the results

Associations between the level of resilience and demographic profile

Associations between the resilience of the participants and their demographic profile were determined to establish if any practical significance exists.

Table 8 outlines the associations between the demographic profile of the participants and their level of resilience.

Table 8: Associations between the demographic profile of the participants and their level of resilience.

	N	Mean	Standard Deviation	Minimum	Maximum	Effect size
Employment status						
Full-time	36	156.5	11.2			0.51
Part-time	7	132.6	46.8			
Marital status						
						Married
Single	7	153.4	16.3	130	172	0.25
Married	20	157.6	8.7	142	170	
Divorced	9	154.3	13.5	133	171	0.24
Widowed	7	135.3	47.9	31	166	0.46
Nursing category						
						Prof. Nurse
Professional nurse	15	153.7	8.8	133	167	
Staff nurse	5	163.6	4.5	158	170	1.12
Auxiliary nurse	23	149.4	29.3	31	172	0.15
						Enrolled (Staff) Nurse
						0.48

Employment status: Full-time versus part-time

An effect size of $d=0.51$ (medium effect), indicate that a practical significance exists between the resilience of participants employed full-time and the resilience of participants employed part-time. In this study participants that were employed full-time, had practically significant higher levels of resilience than participants employed part-time.

This finding differs from that of Ryan and Caltabiano (2009:44) when they studied the level of resilience in different groups of middle-aged people and found no significant difference between the resilience of unemployed, part-time / casual and full-time persons.

Marital status: Married versus single, divorced and widowed

An effect size of $d=0.25$ (small effect) indicates that there was not an important difference between the resilience of the married participants and that of the single participants. This finding was confirmed by Ryan and Caltabiano (2009:44), who found in their study that there was no significant difference between the level of resilience of single and the married groups of middle-aged people that participated in their study.

An effect size of $d=0.24$ (small effect) indicated that there was also not a meaningful difference between the resilience of the married participants and that of the divorced participants. This finding differs from what Ryan and Caltabiano (2009:44) found in their study, in which the separated / divorced group had higher levels of resilience than the married and single groups.

An effect size of $d=0.46$ (medium effect), indicating practical significance, indicated that the resilience of the married participants was higher than the resilience of the participants that were widows. No literature regarding this finding could be found yet.

Nursing category

An effect size of $d=0.48$ (medium effect) indicating a practical significance, means that the resilience of the enrolled nurses (staff nurses) was higher than the resilience of the auxiliary nurses who participated in this study. The resilience of the enrolled nurses was also higher than that of the professional nurses $d=1.12$ (large effect). However it is important to note that only five enrolled nurses participated in the study and it could have been a coincidence that their resilience was higher.

Although no literature regarding this finding could be found yet, the researcher worked as a manager of a private retirement village in this urban setting in the eastern portion of the North-West Province and can confirm from practical experience that the enrolled nurses often need to take charge of a ward in an Old Age Home and in general they are hard workers that can be relied upon. This might explain their higher levels of resilience.

Language, highest qualification, years of service and age

The language, highest qualification, years of service and age of the participants had no effect on their level of resilience.

Gillespie, Chaboyer, Wallis and Grimbeek (2007:427, 435) also found no statistical significance with regard to nursing experience, education and years of employment in their study of the resilience of operating room nurses. This was confirmed by Gillespie *et al.* (2009:968), whose study indicated that age, experience and education seem not to vary with resilience in operating room nurses. Ryan and Caltabiano (2009:44) also found no significant difference in the resilience of the following three age groups that participated in their study, 35-42 years of age, 43-50 years of age and 51-60 years of age.

Conclusion

The level of resilience in the participants was identified and interpreted. The results indicated that the majority of the participants had a moderately high to high level of resilience. On average the participants had a moderately high level of resilience.

These results lead to the conclusion that the strengths and coping abilities of these participants can be explored in order to formulate recommendations to strengthen resilience in nurses caring for older persons. It was also clear that some participants with lower levels of resilience currently care for older persons and that the former could benefit from recommendations to strengthen their resilience.

The associations between the level of resilience of the participants and their demographic profile were determined and interpreted. The results had practical significance that indicated that participants employed full-time had higher levels of resilience than participants employed part-time, the married participants had a higher level of resilience than the widows, and the enrolled nurses (staff nurses) had higher levels of resilience than the auxiliary nurses as well as higher

levels of resilience than the professional nurses. The language, highest qualification, years of service and age of the participants had no effect on their level of resilience.

The research objective for the quantitative data was thus reached.

Qualitative findings, discussion and literature control

The qualitative data was collected to reach objective two ‘to explore and describe the strengths and coping abilities of nurses caring for older persons’ as well as to contribute to the reaching of objective three ‘to formulate recommendations from the findings to strengthen resilience in nurses caring for older persons’.

Table 9 outlines the strengths and coping abilities of the participants. As mentioned earlier, these strengths and coping abilities emerged from the analysis of the qualitative findings obtained from the narratives and focus group interviews. These themes and sub-themes were further clustered and organised according to the model presented by Carr (2004:304).

In Table A and Table B, included as Annexure R, and in (Section 2: Table 9), the total number of times that a theme or sub-theme was mentioned by a participant in a narrative, is indicated by a ‘T’ and the total number of participants with a high level of resilience that mentioned a theme or sub-theme, is indicated by ‘HR’.

Example: Patience (T20) (7HR)

The following key can be used:

T = Total number of quotes that mentioned patience	HR= Number of quotes of participants with a high level of resilience that mentioned patience
T20	7HR

‘In total 20 participants mentioned patience as strength, seven of these participants had a high level of resilience’.

If the theme or sub-theme was mentioned in a focus group interview, it is indicated as ‘fg’ with the number of the focus group next to it. For example if the quote was from focus group interview 3, then it is indicated as fg 3. The participants in the focus group interviews had mixed

levels of resilience because all the participants were invited to participate in the focus group interviews irrespective of their level of resilience.

Following Table 9, the qualitative findings will be discussed and embedded in the literature in Table 10. Regarding the quotes used during the discussion of the qualitative findings, the words used by the participants were translated into English when they wrote or spoke in Afrikaans. As far as possible the exact English words were used when the participants wrote in English although the spelling mistakes were corrected. Each quote starts with a capital letter for uniformity. The researcher could only include a few of the quotes from the narratives and focus groups during the discussion of the findings in this article. A full set of quotes is attached as Annexure S. The organisation of Annexure S is according to the initial themes and sub-themes displayed in Table A and Table B (Annexure R).

In the discussion of the results the number of the narrative from which the quote was taken is provided in brackets at the end of each quote. The number of each narrative is colour-coded according to the level of resilience of the participant that wrote the words, for example '(6)'.

The different levels of resilience according to Wagnild (2011:72) are 'Very Low: 25-100', 'Low: 101-115', 'On the Low End: 116-130', 'Moderate: 131-145', 'Moderately high: 146-160' and 'High: 161-175'.

Table 9 outlines the strengths and coping abilities of nurses caring for older persons.

Table 9: The strengths and coping abilities of nurses caring for older persons.

Theme 1 Nurses need resilience in dealing with adverse working conditions while caring for older persons	Sub-theme 1.1 Nurses need to be resilient when caring for older persons due to the need for balance, the emotional nature of the work and work ethics. * The need for balance (fg 1, 2, 4) - ‘balance in life’ (fg 1, 2, 4) (T1) (0HR) - ‘batteries charged’ (fg 2) * The emotional nature of the work (fg 3, 4) - ‘sometimes discouraged’ (fg 3) - ‘emotional’ (fg 1, 3, 4) * Work ethics (fg 3) - ‘responsibility and sense of duty’ (fg 3)
	Sub-theme 1.2 The work environment including staff shortages, the physical nature of the work and the dependency of the older persons requires that nurses caring for them need to be resilient. * Staff shortages (fg 1, 2, 3, 4) - ‘few staff’ (fg 1, 2, 3, 4) - ‘accompaniment of students’ (fg 4) * Physical nature of the work (fg 1, 2, 3, 4) - ‘energy loaded working circumstances’ (fg 1, 2) - ‘hard work’ (fg 1, 2, 3, 4) * Dependency of the older persons (fg 1, 3, 4) - ‘Patients require a lot of help and attention’ (fg 1, 3) - ‘aggressiveness’ (fg 3, 4)

Theme 2

Personal strengths used or recommended by participants

Sub-theme 2.1

Nurses display a caring attitude towards older persons by being caring, patient, loving, friendly, respectful and by showing empathy and sympathy.

- * **Being caring** (T21) (8HR) (fg 1, 4)
- * **Being patient** (T40) (19HR) (fg 2, 3, 4)
- * **Being loving** (T50) (17HR) (fg 2, 3)
- * **Being friendly** (T22) (7HR)
- * **Being respectful** (T25) (14HR) (fg 1)
- * **Showing empathy and sympathy** (T13) (5HR) (fg 2)

Sub-theme 2.2

Nurses have a positive attitude towards caring for older persons by being positive, humorous, motivated and by persevering.

- * **Being positive** (T16) (7HR) (fg 2, 3)
- * **Being humorous** (T26) (7HR) (fg 1, 3, 4)
- * **Being motivated** (T3) (2HR)
- * **Persevering** (T8) (5HR)

Sub-theme 2.3

Nurses caring for older persons value good health, including physical, spiritual, emotional and social health as well as the use of medication.

- Good health** (T18) (8HR) (fg 1, 2, 3, 4)
- * **Physical health** (fg 1, 3, 4)
- * **Spiritual health** (fg 1, 2, 3, 4)
- * **Emotional health** (fg 3)
- * **Social health** (fg 4)
- * **Medication** (T1) (0HR) (fg 4)

Theme 3

Professional strengths used or recommended by participants

Sub-theme 3.1

Nurses caring for older persons communicate professionally by listening and providing feedback, and by keeping a professional distance.

- * **Communication** - Listening and providing feedback (T45) (**14HR**) (fg 3)
- * **Keeping a professional distance** (fg 2, 3)

Sub-theme 3.2

Nurses caring for older persons value education including previous experience, basic knowledge, to stay updated, specialized geriatric training and learning from older persons.

Education (T29) (**7HR**) (quotes included for education, previous experience and basic knowledge)

- * **Previous experience**
- * **Basic knowledge** (fg 1, 3, 4)
- * **To stay updated** (fg 2)
- * **Specialized geriatric training** (fg 3)
- * **Learning from older persons** (T13) (**5HR**)

Sub-theme 3.3

Nurses caring for older persons serve as role models by being passionate, by being trustworthy and responsible, by acknowledging the uniqueness and wholeness of older persons and by being organized.

Role models (T5) (**2HR**) (fg 1, 3)

- * **Being passionate** (T17) (**6HR**) (fg 3, 4)
- * **Being trustworthy** (T1) (**1HR**) (fg 3) **and responsible** (T12) (**4HR**) (fg 3)
- * **Acknowledging the uniqueness** (T1) (**1HR**) (fg 3) **and wholeness of the older persons** (fg 2)
- * **Being organized** (T4) (**2HR**)
- **prioritizing** (T2) (**0HR**) (fg 1, 4)
- **delegating** (T1) (**0HR**) (fg 3)

Theme 4

Contextual strengths used or recommended by participants

Sub-theme 4.1

The uniqueness of caring for older persons including the dependency, improvement and appreciation of older persons makes it worthwhile to care for them.

- * Dependency of older persons (T9) (2HR)
- * Improvement of older persons (T5) (2HR)
- * Appreciation from older persons and families (T19) (9HR)

Sub-theme 4.2

Nurses caring for older persons value the support from family, their colleagues in the multi-professional team and volunteers in the community.

- * Support from family and colleagues in the multi-professional team (T35) (13HR) (fg 1, 3, 4)
- * Volunteers in the community (fg 1)

Sub-theme 4.3

Nurses caring for older persons value a safe, homely environment as well as resources and equipment in the work environment.

- * A safe (T2) (1HR) (fg 2, 4) and homely environment (fg 1, 3, 4)
- * Resources and equipment (fg 1, 3)

Theme 5

Spiritual strengths used or recommended by participants

Sub-theme 5.1

Religion is valued by nurses caring for older persons. (T51) (13HR)

Sub-theme 5.2

Nurses caring for older persons believe that you need to treat others as you would like to be treated yourselves. (T15) (4HR)

Sub-theme 5.3

The provision of bereavement counselling to older persons and their families make it worthwhile to care for them. (T2) (0HR)

Table 10 provides a detailed discussion of the qualitative findings. The themes and sub-themes according to (Section 2: Table 9) are indicated clearly. A detailed discussion of each theme and sub-theme are provided. Relevant quotes from the narratives and focus group interviews are included to portray the views of the participants. An in depth literature control for each theme and sub-theme are given to ground the qualitative findings in the literature.

Table 10: Discussion, quotes and literature control of the strengths and coping abilities of nurses caring for older persons.

Theme 1: Nurses need resilience in dealing with adverse working conditions while caring for older persons		
Sub-theme 1.1: Nurses need to be resilient when caring for older persons due to the need for balance, the emotional nature of the work and work ethics.		
The need for balance (fg1,2,4)		
‘Balance in life’ (fg1, 2, 4) (T1) (OHR)	Nurses need to keep a balance in their own feelings because they often encounter conflicting situations and emotions in one day. By keeping a good balance between work and relaxation, nurses manage to be resilient while caring for older persons.	Participants say: <i>And to have balance in our lives</i> (fg 1:6); <i>You should be able to adjust...you need to keep a balance</i> (fg 2:12); <i>And to keep a balance on your own feelings</i> (fg 2:12-13); <i>You have to keep a balance</i> (fg 2:13); <i>One must have a very good balance</i> (fg 4:11). <i>Relax; relax when you are off duty. You need to keep a balance between work and leisure. If you do not keep a balance, one can get burned out (6).</i>
	According to Koen, Van Eeden, Wissing and Du Plessis (2011:109) resilient professional nurses state that a healthy and balanced way of life are important to remain healthy and enable them to give of their best. Wagnild (2011:16) supports this argument by asserting that equanimity refers to balance and harmony. Mealer, Jones, Newman, McFann, Rothbaum & Moss (2012:297-298) also confirm that highly resilient ICU nurses did not allow their work circumstances to interfere with their personal life. Ablett and Jones (2007:737) contend that palliative care nurses utilize strategies that include delegation to colleagues, humour, social support and work-life balance in order to cope. Sandmark, Hägglund, Nilsson & Hertting (2009:378) agree that nurses caring for older persons regarded a work-life balance as important and some of them worked part-time to accommodate their children and families. According to Cameron and Brownie (2010:70) a work-life balance can be encouraged by means of exercise, enough rest, social support and private interests that enhance happiness and resilience. This argument is supported by an integrative literature review done by Hart <i>et al.</i> (2012:9) who maintain that taking part in activities like exercise, doing volunteer work and social networking, help to reduce stress and focus on personal accomplishments and objectives. Glass (2009) (cited by Hart <i>et al.</i> 2012:5) concludes that reduced inner balance was experienced when nurses were not able to maintain a work-life balance. On the other hand it was found that nurses who were unable to maintain a work-life balance were more likely to experience ‘burnout’ (Hart <i>et al.</i> 2012:5).	

Theme 1: Nurses need resilience in dealing with adverse working conditions while caring for older persons		
‘Batteries charged’ (fg 2)	It is important for nurses caring for older persons to ensure that their ‘batteries are always charged’ to be able to keep on caring for these older persons.	Participants say: <i>..So you must make sure that your battery is always charged to be able to keep going and keep on (fg 2:11).</i>
	King (2012:65) confirms this statement by asserting that care workers constantly need to manage the older persons’ emotions as well as their own emotions and they need to ‘re-charge’ themselves emotionally to enable them to continue working in the forefront of the aged care sector. Care workers caring for older persons suffer from exhaustion and leave the aged care sector if they don’t develop the skills related to emotional resilience because of the constant challenges related to this emotional working situation (King 2012:65).	
The emotional nature of the work (fg3,4)		
‘Sometimes discouraged’ (fg 3)	Participants verbalized that they sometimes get discouraged while caring for older persons because of unpleasant incidents that occur.	Participants say: <i>If there are unpleasant incidents, that happen, it is human, and it will surely happen, then you get discouraged (fg 3:14);</i> <i>Yes, because the thing is I always say a lot of positive things hum, then there come one or two negative things, and unfortunately negative things work through so much quicker and denigrate the positive things a little bit, hum it's never good to get criticism, and especially not if it is negative criticism...(fg 3:14).</i>
	Hart <i>et al.</i> (2012:5) support this by stating that according to the integrative literature review they conducted, disappointments experienced at work often cause nurses to feel emotionally empty and exposed and incapable to reunite their values and their feelings. Nurses experience internal conflict when the goals of management are not compatible with their own professional or personal aspirations (Hart <i>et al.</i> 2012:5).	

Theme 1: Nurses need resilience in dealing with adverse working conditions while caring for older persons

'Emotional' (fg 1, 3, 4)

Participants agreed that caring for older persons is very emotional at times. When the older persons' belongings are lost, it causes a lot of stress for the nurses. The older persons die often and then the nurses are heartbroken and grieve for them. When the older persons are taken away by the family, the nurses feel bad because they feel that they were not good enough. The families of the older persons can also be very demanding and place a lot of pressure on the nurses.

Participants say:

...then you come the next day, and then you hear that's gone, that's gone, it makes you scared ... but it makes you scared when you hear that's gone...(fg 3:15);

You get emotionally involved, genuine you do. As when one of them dies, you grieve just as hard as them, and you really need to keep your cool, you cannot cry harder than the family, sometimes you feel that you want to cry harder than the family; you need to be strong all the time (fg 4:6);

Or sometimes the family take them away. It makes you feel „bad“ because it makes you feel like you were not good enough... Even if you did try your best (fg 4: 7);

But the worst in nursing is the family, I always say I'm not here to please the family, I'm here to do what is best for my patient. Yes; Yes see the family should be satisfied but if you do what is right for your patient the family will be satisfied. Yes there one should have quite a lot of patience (fg 4:13);

And I think the family, the family hum there are certain circumstances where the family can be demanding...Where they pressurize us. Yes, that you should give extra attention to the person, so yes, the family exert pressure, so be it (fg 1:7).

King (2012:66) confirms that caring for older persons is a type of work where the use of emotions forms a fundamental part of the work. Care workers caring for older persons work in an emotionally demanding work environment where the older persons often suffer from depression and dementia as well as from physical and emotional decline that may cause incontinence, aggression and even lead to death (King 2012:65). This argument is supported by Josefsson, Sonde, Winblad & Wahlin (2007:76) who contend that registered nurses caring for older persons with dementia, experience more inconsistent demands as well as higher levels of emotional demands than nurses working in general care of the older persons. Hart *et al.* (2012:12) add that great emotional reactions may be produced in nurses because they need to provide care to patients with an assortment of diagnoses and prognoses. Gattuso and Bevan (2000:897)

Theme 1: Nurses need resilience in dealing with adverse working conditions while caring for older persons		
	maintain that the nurses caring for older persons in their study experienced high stress levels that were caused by the conflicting emotions they experienced while they tried to balance caring and efficiency as well as their own emotions at the same time. Weman and Fagerberg (2006:281) support this by adding that nurses experience substantial emotional stress caused by the numerous changes and the shortage of time experienced while caring for older persons. According to King (2012:65) nurses need emotional resilience, referring to the ability to sidetrack or recuperate from emotional challenges experienced in order to continue working in the emotionally demanding working environment of caring for older persons.	
Work ethics (fg3)		
‘Responsibility and sense of duty’ (fg 3)	Nurses caring for older persons need to have a sense of duty and a sense of responsibility in order to be resilient when caring for older persons.	Participants say: <i>Sense of duty, sense of responsibility and of course you have work ethics, that work ethics is hum, if you do not feel so well the day, not just pick up the phone and say I do not come to work. Work ethics means you come to work because you have a responsibility not only to yourself but also to the elderly (fg 3:16).</i>
	According to the Concise Oxford English Dictionary (2011:1663) work ethics refers to the outlook that it is a person’s responsibility and duty to accomplish success by working hard and by being careful.	
Sub-theme 1.2: The work environment including staff shortages, the physical nature of the work and the dependency of the older persons requires that nurses caring for them need to be resilient.		
Staff shortages (fg1,2,3,4)		
‘Few staff’ (fg 1, 2, 3, 4)	During all four the focus group interviews it was confirmed that all the facilities caring for older persons that have participated in the focus group interviews, experience a shortage of staff most of the time although at other times there seem to be enough staff.	Participants say: <i>I think it's because we are a few staff and I think because we do not have enough hands to get to everyone as we would have liked to do it, and it causes guilt feelings and it is a vicious circle in the end (fg 1:6);</i> <i>...with the elderly we are only a few people (fg 2:11);</i>

Theme 1: Nurses need resilience in dealing with adverse working conditions while caring for older persons		
		<i>...some days are better than the others the other days the work will be heavier then you won't have time to do some things like talking to the patients or sitting down cutting nails but the other days you can take extra time and give them as much as you can (fg 3:15);</i> <i>You know in an old age home, it is a bit difficult because people come and go so today you have too few hands and tomorrow there are too many (fg 4:11).</i>
	According to Oulton (2006:34S) a shortage of nurses is experienced all over the world. The statistics of the South African Nursing Council (2013b) indicate that a nursing shortage is also experienced in South Africa. Jackson <i>et al.</i> (2003:42) add that all the disciplines in nursing experience a current nursing shortage including residential aged care facilities. Chenoweth, Merlyn, Jeon, Tait & Duffield (2013:8) contend that nurses caring for older persons with dementia mentioned that there is a shortage of qualified nurses and that the skill-mix is insufficient. Morgan, Semchuk, Steward & D'Arcy (2002:157) support this argument by adding that the staff caring for older persons in nursing homes, were concerned about the insufficient number of staff, which is not in accordance with the mounting intensity of the care that the older persons need. Dwyer, Andershed, Nordenfelt & Ternestedt (2009:185) conclude that staff working in nursing homes, experience moral discord between the care they would like to render and the care they are able to render.	
‘Accompaniment of students’ (fg 4)	Participants referred to the fact that if too many students are allocated to an old age home, then the nursing staff cannot teach them well.	Participants say: <i>Especialy if the students are here; Yes if the students are here then we have too many; From the ... and ...so if they all walk in here then it is too many; Totally too many; Two are just enough; And then you can learn them; Then you have time to show them better and to give everyone a turn to do a thing (fg 4:11).</i>
	According to Carlson, Kotzé & Van Rooyen (2003:30) one of the contributing factors why first-year nursing students feel uncertain and anxious, is the fact that nursing personnel are not available and accessible in the practical areas because of limited time. These student nurses experience the support and guidance of nursing staff in the practical learning environment as insufficient (Carlson <i>et al.</i> 2003:30).	

Theme 1: Nurses need resilience in dealing with adverse working conditions while caring for older persons

Physical nature of the work (fg1,2,3,4)

‘Energy loaded working circumstances’ (fg 1, 2)	Participants agree that caring for older persons is energy loaded and a big responsibility because you work with human lives.	Participants say: <i>I think it takes so incredibly hum it's such an energy loaded working environment, that we have, that we need to have resilience in our lives (fg 1:6);</i> <i>We work with people's lives not with machines (fg 2:11). If you do something wrong, or you're too tired, that person can die in your hands and it is quite important (fg 2:12).</i>
‘Hard work’ (fg 1, 2, 3, 4)	In all four focus group interviews it was agreed that caring for older persons is hard work. The fact that the work is physically and psychologically hard was confirmed. It seems that caring for bedridden older persons is less work than caring for those that are still mobile.	Participants say: <i>To care for the elderly is hard work (fg 1:7);</i> <i>They stay until the last at home and then you do not have all that equipment that can help you in the hospital, so then it requires a lot of physical activities (fg 2:13);</i> <i>Sometimes it is quite exhausting (fg 3:14);</i> <i>Physically and psychologically. Physically is basically the lifting and the bath and showers and the cleaning and psychologically is just the see-saw that their emotions ride, and yours with them (fg 4:9);</i> <i>And you have the struggle sometimes they get up and walk because they're late for church or they are late for work and to persuade them is not easy. Yes physically and psychologically. See the older people who are bedridden, are less work. Less work yes; It's less work; when they walk around it is let's go for a walk and you have to walk and</i>

Theme 1: Nurses need resilience in dealing with adverse working conditions while caring for older persons		
		<i>then it is going down here in the corridor and they do not want to, it's much more work there. Yes; they collect everyone's things and hide them, and then we need to look for it (fg 4:10).</i>
	According to Jackson <i>et al.</i> (2003:43), caring for older persons places physical demands on nurses. Josefsson <i>et al.</i> (2007:78) add to this by asserting that registered nurses caring for older persons with dementia indicated that they experienced their work as harder than those of nurses caring for older persons in general care with different diagnoses. Chenoweth <i>et al.</i> (2013:8) confirm that nurses caring for older persons suffering from dementia experience stress because of the extreme workloads, and they are dreading that it can lead to burnout.	
Dependency of the older persons (fg1,3,4)		
‘Patients require a lot of help and attention’ (fg 1, 3)	It was pointed out that older persons depend on the nurses and that they need a lot of help and attention.	Participants say: <i>Yes it's not actually a patient it's actually someone, someone who needs a lot of help and attention. Yes it's as if they are absolutely dependent, you need to walk a little, you know, with them. There are a lot that is dependent (fg 1:7);</i> <i>A lot is dependent (fg 1:8);</i> <i>They always say... if you were not here today, I do not know now, how can I say?</i> <i>They depend on you; Yes I depend on you (fg 3:15).</i>
	According to Gill, Gahbauer, Allore & Han (2006:418) the results of their research indicated that older persons move from a state of lesser frailty to a state of greater frailty more often than vice versa and that the movement between the states of frailty was dependent on their previous state of frailty.	

Theme 1: Nurses need resilience in dealing with adverse working conditions while caring for older persons

‘Aggressiveness’ (fg 3, 4)	The fact that older persons that suffer from Alzheimer’s disease wander around a lot, are emotionally demanding and can get aggressive, was confirmed by the discussions that took place.	Participants say: <i>Old people forget and they do not always know what they are saying, they bite you and pinch you sometimes underhand (fg 3:14);</i> <i>Alzheimer patients are very difficult. Yes they are. They are very difficult, there you need to work with this one and you should immediately turn around and work again with another one (fg 4:7);</i> <i>The nasty thing of them is when they wander and they want to walk away that's the biggest thing of them. Yes always they always want to walk away (fg 4:8);</i> <i>Sometimes they get aggressive. They get aggressive. Yes it's almost the most difficult part. And they assault us physically. Sometimes they do yes, they assault us physically (fg 4:8);</i> <i>Grab us; grandmother ... grabbed her the other day and pulled her over the cot (fg 4:9).</i>
	Hart <i>et al.</i> (2012:12) maintain that according to the integrative literature review they conducted, nurses working in healthcare facilities experience physical as well as psychological damage as a result of disturbing behaviour that includes harassment, horizontal violent behaviour as well as maltreatment. Koen, Van Eeden, Wissing and Du Plessis (2011:111-112) support this argument by asserting that less resilient professional nurses working in public and private hospitals as well as in primary healthcare clinics, reported that there is a great deal of violence in the workplace and added that nurses don’t experience safety and respect from patients or members of the multi-disciplinary healthcare team. According to Sharipova, Hogh & Borg (2010:338) most care workers caring for older persons experience work-related violence especially if they are young and have a low rank. Isaksson, Graneheim, Richter, Eisemann & Aström (2008:556) support this argument by adding that a large amount of caregivers caring for older persons in nursing homes were susceptible to violent behaviour. Two-thirds of the caregivers were susceptible to violence at some stage during the previous year, once a month every second caregiver was susceptible to violence and one-fifth of the caregivers were susceptible to violence a number of times a week (Isaksson <i>et al.</i> 2008:556).	

Theme 1: Nurses need resilience in dealing with adverse working conditions while caring for older persons

Schmidt *et al.* (2012:3135) cite different authors who maintain that the challenging behaviour older persons in nursing homes display includes: depression, passiveness, apathy, touchiness, aggression (especially when suffering from dementia), and behaviour that is verbally disruptive as well as wandering around. These authors agree that the challenging behaviour of older persons causes a lot of work-related stress to the nurses caring for them and that this influences the nurses' overall health status, their capacity to work and enhance their risk of burnout (Schmidt *et al.* 2012:3134). Morgan *et al.* (2002:158) confirm that nurses caring for older persons with dementia as well as those without dementia in one ward, experienced stress because they had to adjust their modus operandi all the time in order to avoid eliciting violent behaviour from the older persons. Nabb (2000) (cited by Jackson *et al.* 2003:43) asserts that the violence nurses caring for older persons experience is a major problem in elderly care and has been associated with nurses being absent from work and resigning.

Theme 2: Personal strengths used or recommended by participants

Sub-theme 2.1: Nurses display a caring attitude towards older persons by being caring, patient, loving, friendly, respectful and by showing empathy and sympathy.

Being caring (T21) (8HR) (fg 1, 4)	Caring was mentioned by participants in connection with personal strengths, coping, enabling them to be resilient and given as advice to be resilient. One participant mentioned that she was raised in a loving, caring family and another that she cared for her grandmother from a young age. It was also revealed that you get so close to the older persons as if they were your own grandparents. Nurses need to provide comfort to the older persons and make them feel safe. By leaving their own problems behind, nurses will be able to care for older persons. It was also given as advice that nurses caring for older persons must be caring and have compassion with the older persons.	Participants say: <i>Caring. Always you must have the soft heart for them (19);</i> <i>Compassion with their circumstances (32);</i> <i>And try to comfort them make them feel save while I am caring for them (21);</i> <i>When caring for the older patient is like when you are caring for your mother or grandmother or grandfather (33).</i> <i>....they need to care (fg 1:8);</i> <i>Do everything you do with compassion (fg 4:12).</i>
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Theme 2: Personal strengths used or recommended by participants

	Caring as a resilient strength is supported by Benard (1993:44) that asserts that children that are resilient show social competence and caring is one of the qualities of social competence. Brooks and Goldstein (2003:16) support this argument by maintaining that when people show compassion, they develop their own resilience by relating with other people and cherish the belief that they make a constructive difference in the world. Kalula, Khalil, Perold, Ross, De Villiers & Van Nieker (2011:41) contend that nursing is a caring profession and that all professionals in nursing must show compassion to older persons. This argument is also supported by Cruttenden (2006:351), who identified leadership as the fundamental strength of nurses that work in nursing homes and asserts that the three elements of leadership are an attitude of caring, willingness to learn and the ability to think critically. Hart <i>et al.</i> (2012:8) maintain that nurses experience psychological empowerment when they believe that they are successful in caring for patients and do not imagine themselves being unsuccessful (Hart <i>et al.</i> 2012:8). Perry (2009:14) adds that a patient-centred attitude where nurses pay attention to the small things that make patients feel valuable, in return causes nurses to experience their work as meaningful and professionally fulfilling.
Being patient (T40) (19HR) (fg 2, 3, 4)	Participants stated that patience as personal strength enables them to care for older persons. Patience also helps them to cope, makes it worthwhile to care for them and enable them to be resilient. Patience was given as advice to nurses to be resilient during the focus group interviews. They mentioned that nurses need to be patient and not get angry quickly if they want to cope while caring for older persons. If nurses spend time with the older persons and are patient, it will make it worthwhile to care for them. These participants agreed that a lot of patience is needed when caring for older persons. The importance of being patient when caring for older persons was confirmed during the focus group interviews. Participants say: <i>A person needs a lot of patience. To accentuate patience, patience, patience (9);</i> <i>Need to have patience with the older persons (13);</i> <i>My personal strengths to care for older persons is patience. To have the strength to take care with the older person you need to be patient and...(19);</i> <i>Be patient don't get angry very quickly (31);</i> <i>Patience is the mother of success (16)".</i> <i>Patience; yes (fg 2:13);</i> <i>That patience you cannot spell it out enough (fg 2:14);</i> <i>And handle very calmly (fg 2:14);</i> <i>Sister again its patience; yes; it is absolutely patience, you may not be in a hurry patience, love, positive attitude, responsibility (fg 3:17);</i> <i>Definitely again count to ten; patience; patience is your biggest thing (fg 4:12);</i> <i>It's basically that, patience that the main (fg 4:13).</i>

Theme 2: Personal strengths used or recommended by participants

	Patience as a strength used by resilient persons is supported by Grafton, Gillespie & Henderson (2010:699), who identified patience as one of the characteristics of resilience. Regarding caring for the older person, Kalula <i>et al.</i> (2011:40) assert that nurses must be patient and tolerant of the strange and unusual behaviours of the older persons that utilize the South African healthcare system. From a Judaeo-Christian viewpoint, patience is one of the fruits that the Holy Spirit produces in our lives (Galatians 5:22), we need to have patience with one another (Ephesians 4:2), patience can convince a prince (Proverbs 25:15), patience is superior to self-importance (Ecclesiastes 7:8) and according to (1 Corinthians 13:4), love is gentle and patient (Bible, 2010).
Being loving (T50) (17HR) (fg 2, 3)	Being loving towards older persons was mentioned by the nurses caring for them as a personal strength enabling them to care for these older persons. Being loving also helps them to cope, make it worthwhile and enables them to be resilient. Nurses caring for older persons also recommended that being loving will help nurses to be resilient. One of the nurses wrote that the love of God flows through her to the older persons. Another nurse mentioned that she realized that the older persons also have a lot of love for the nurses. It seems that older persons need a lot of love and they also show love towards the nurses caring for them. The giving and receiving of love make it worthwhile for nurses to care for older persons. Loving the older persons, the staff, their work and cultivating love for the older persons with caregivers and students help nurses to be resilient. Nurses caring for older persons agree that they need to be loving towards older persons. Participants say: <i>Through Him His love flows through me to people (5);</i> <i>Tons of love. My love for them gives me the strength to care for them every day (11);</i> <i>The elderly on the other side, give so much love and caring to you as a nurse, that it carries you through difficult times and help you to handle the crisis's one by one (33);</i> <i>The love that I have for my work it makes it worthwhile for me to care for my older persons (16);</i> <i>And likes to give love to them. Feel good when you can transfer your whole heart and soul to someone else (23);</i> <i>To cultivate a love for the elderly with the caregivers as well as the students that do their practical training here (18).</i> <i>Well firstly she needs to love the elderly; it's a very important point (fg 2:13);</i> <i>She must have a love for them (fg 2:14);</i> <i>In the end she was very fond of me but wow (fg 3:20).</i>
	Love as strength used by resilient persons is confirmed by Benard (1993:44) that asserts that resilient children work, play, love and expect well. Rollings (2008:55) argues that we demonstrate love in different parts of our personal and professional lives and that professional love is achievable and that the nursing

Theme 2: Personal strengths used or recommended by participants		
	profession must accept it enthusiastically. Fredrikson (2009) (as cited by Pipe, Buchda, Launder, Hudak, Hulvey, Karns & Pendergast 2012:12-13) identified ten forms of positivity and love is one of them. According to Richardson (2002:317) resilience theory contends that people have an inborn moral framework or that they naturally love one another. From a Judaeo-Christian viewpoint, Jesus Christ gave us a new commandment in (John 13:34-35), to love each other in the same way that He loves us, and that our love for each other will prove to the world that we are his disciples (Bible, 2010).	
Being friendly (T22) (7HR)	Being friendly was identified by the participants as a personal strength enabling them to care for these older persons. Being friendly also helps them to cope and enables them to be resilient. One participant mentioned that you need to be friendly towards the older persons in order for them to feel free and not be afraid of you. Another participant stated that if the nurses are friendly, the older persons are peaceful and calm. These participants highlighted the fact that friendliness helps them to be resilient while caring for older persons. Participants agreed that friendliness is an important personal strength needed by nurses caring for older persons.	Participants say: <i>Always be friendly with them show them the love (19);</i> <i>Be as friendly as you can cause these are older people they cannot be afraid of you, they must feel free around... (30);</i> <i>Friendly – be always like this because it makes the old persons peaceful and calm (26);</i> <i>Friendly, to be friendly with family (40).</i>
	Although friendliness is not mentioned specifically, Benard (1993:44) argues that resilient children show qualities of social competence that include bringing out positive responses from others that contribute to the establishment of positive relationships with grown-ups as well as their peers, that might indicate a friendly disposition. From a Judaeo-Christian viewpoint, kindness is one of the fruits that the Holy Spirit produces in our lives (Galatians 5:22), a joyful appearance brings happiness to your heart (Proverbs 15:30a), let everybody see that you are kind in everything you do (Philippians 4:5a), and according to (2 Corinthians 6:6), we provide evidence of ourselves by our wholesomeness, our thoughtfulness, our patience, our kindness, our genuine love and by the Holy Spirit within us (Bible, 2010).	

Theme 2: Personal strengths used or recommended by participants

Being respectful (T25) (14HR) (fg 1)	Respect was mentioned by participants with regard to personal strengths, coping, making it worthwhile, and enabling them to be resilient. Respect was also given as advice to be resilient. Participants mentioned that they need to have respect for themselves as well as for the older persons. They agreed that you should always treat older persons with respect and dignity and respect their decisions. Participants acknowledged that older persons need to be treated with respect because they had a full life and have made their mark in society. By displaying respect to older persons, they also respect you in return. Older persons must be treated as if they were our own family members. The privacy of the older persons also needs to be respected. Giving and receiving respect and the protection of the human dignity of the older persons make it worthwhile for nurses to care for them.	Participants say: <i>The biggest of all is to have respect for yourself in order to have respect for older persons (8);</i> <i>Treat them with respect (11);</i> <i>Someone who will treat them with respect and dignity (16);</i> <i>To see older persons as seniors that have made their mark in life and to display respect – generate mutual respect (5);</i> <i>The way I would like my parents to be treated, I treat older persons and respect their feelings and values (8);</i> <i>To respect older persons and others, for example their privacy (18);</i> <i>To retain their human dignity in all circumstances (18).</i> <i>They need to have respect for themselves to have respect for the older persons; respect, we must have respect (fg 1:8);</i> <i>Even though we sometimes think these people do not deserve it, it is okay to show respect for them because it always comes back to you at some stage then it comes back to you if you are expressing respect towards them (fg 1:9);</i> <i>Their privacy must also be respected; (fg 1:11).</i> As yet no literature could be found to support respect as a strength related to resilience. This may be a unique finding of this study. Regarding caring for older persons, Kalula <i>et al.</i> (2011:40) maintain that older persons made a contribution to the world and the nation and because of that they need to feel respected by the quality of the nursing care they receive. Byh and Mellerup (2006:5-8) (cited by Kalula <i>et al.</i> 2011:40) assert that nurses that come into contact or work with older persons as patients, must treat them with the respect that the African people command. From a Judaeo-Christian viewpoint, you need to respect your father and mother (Ephesians 6:2), you must never speak unkindly to an older man but treat him with respect in the same way that you would treat your own father (1 Timothy 5:1), and according to (1 Timothy 5:2) you must treat an older woman the same way you would treat your mother (Bible, 2010).
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Theme 2: Personal strengths used or recommended by participants

Showing empathy and sympathy (T13) (SHR) (fg 2)	Participants cited empathy and sympathy as personal strengths needed to care for older persons. Showing empathy and sympathy towards the older persons help them to cope and enable them to be resilient. They also advised other nurses to show empathy and sympathy towards older persons in order to be resilient. Participants agreed that nurses need to be able to put themselves in the shoes of the older persons and have empathy with them.	Participants say: <i>Have empathy and sympathy with the elderly (24);</i> <i>I understand what the older persons go through when they need to go from their familiar surroundings to a home for the aged (7);</i> <i>To put yourself in their place, if he or she should walk with difficulty, or wear a nappy, are to some a big embarrassment, to have empathy, and to show understanding for older men that need to be cared for by female nursing staff, to have the biggest patience (25);</i> <i>I place myself often in the shoes of the elderly – empathy and realize that they have so little to live for (20).</i> <i>And she needs to have empathy (fg 2:14).</i> Empathy as related to resilience was confirmed by Benard (1993:44) that contends that empathy is one of the qualities of the social competence that resilient children display. Brooks and Goldstein (2003:12) support this by asserting that resilient persons experience fulfilling relationships and that the foundation of these relationships is the ability to be empathetic and to figuratively walk in the shoes of other people. Cameron and Brownie (2010:70) state that nurses caring for older persons develop resilience by means of clinical knowledge, expertise and practice that makes them self-assured and accommodating while they prioritize their responsibilities and continue to be compassionate and empathetic towards the older persons and their families.
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Theme 2: Personal strengths used or recommended by participants

Sub-theme 2.2: Nurses have a positive attitude towards caring for older persons by being positive, humorous, motivated and by persevering.

Being positive (T16) (7HR) (fg 2, 3)	A positive attitude was mentioned by the participants as a personal strength that enables them to care for these older persons. A positive attitude also enables them to cope and be resilient while caring for older persons. These participants advised other nurses that a positive attitude will help them to be resilient while caring for older persons. One participant mentioned that the positive must be taken forward and the negative left behind. Participants agree that nurses need to be positive and motivated and not take everything the older persons say seriously if they want to cope while caring for them. They confirmed that by concentrating on the positive and by not looking at the negative, they managed to be resilient while caring for the older persons.	Participants say: <i>You must have a positive mindset regarding nursing to be able to work with the elderly (2);</i> <i>You need to get up with a positive attitude and look forward to come to work (3);</i> <i>Always try to look positive and stay positive. Try to take the positive forward and leave the negative behind. I know I have something good / positive to give back to those I work with (27);</i> <i>I always take the lead to keep my staff positive (20);</i> <i>As an Auxiliary nurse you must not take things that old people say to you very personally in that way I cope to my work and my old people (16);</i> <i>I do not see the negative, I look at the positive and try to let them concentrate on it. You can still walk even if it is with a cane etc (37).</i> <i>Positive; yes (fg 2:14);</i> <i>Positive attitude and yes (fg 3:18).</i>
	A positive attitude as strength displayed by resilient persons is confirmed by Wagnild (2011:16) who states that ‘equanimity’, is one of the core attributes of resilience and it means that someone is optimistic. Gillespie, Chaboyer, Wallis and Grimbeek (2007:427, 435) add that hope, self-efficacy and coping were the three variables that most strongly explained resilience and this is supported by Gillespie, Chaboyer and Wallis (2007:127-130) who contend that self-efficacy, hope and coping turned up as defining characteristics of resilience when they analysed the concept. Edward and Hercelinskyj (2007:241) maintain that hopefulness, intelligence and humour are characteristics of resilience. Fredrikson (2009) (as cited by Pipe <i>et al.</i> 2012:12-13), identified ten forms of positivity, including hope. Resilient persons are seen as being positive because when a situation looks uncertain, they are almost certainly watching out for opportunities (Wagnild 2011:16). This argument is supported by Cameron and Brownie (2010:68) who assert that a positive attitude, the belief that you	

Theme 2: Personal strengths used or recommended by participants

	make a difference, and a perception of faith, improve resilience in the workplace. Resilient professional nurses in a study conducted by Koen, Van Eeden, Wissing and Du Plessis (2011:109) reported that they have a positive state of mind regarding life and they try to make the best of each day. Mealer, Jones and Moss (2012:1447, 1449) assert that highly resilient nurses utilize optimism amongst other characteristics, to cope with stressful working circumstances in the ICU. Tugade and Fredrickson (2004:331), add by maintaining that persons with high resilience are inclined to experience positive feelings even when surrounded by stress. Hart <i>et al.</i> (2012:8) support this by reporting that nurses who were positive and hopeful could oppose or diminish the challenges in the industry to sustain their resilience. Fredrickson <i>et al.</i> (2003:365) assert that they agree with other theorists that positive emotions are important elements for better coping and flourishing regardless of difficulties experienced.	
Being humorous (T26) (7HR) (fg 1, 3, 4)	Humour was pointed out as a strength enabling nurses to care for older persons. Humour also helps them to cope, makes it worthwhile to care for them and enables them to be resilient while caring for them. Participants recommended humour to help nurses to be resilient while caring for older persons. According to these participants you need to have a good sense of humour, be able to laugh at yourselves, smile all the time, try to see the humour in a situation and laugh with the older persons and not at them. Participants cited that they cry and laugh with the older persons. They agree that the humour that is involved in caring for older persons as well as happy smiling older persons, make it worthwhile caring for them. These participants agree that by seeing the humour and by laughing with the older persons, they can manage to be resilient. .	Participants say: <i>Good sense of humour (38);</i> <i>To be able to laugh for myself (18);</i> <i>See humour in situations and laugh with an elderly and not at him (34);</i> <i>I also see the funny and the beautiful of a situation and an older person. I cry and laugh with them even if it is twice a day (7);</i> <i>Sometimes a lot of humour is involved with the care of elderly (20);</i> <i>You get the funny and tough some days, but if you make a picture and see the funny and can laugh about anything as long as you laugh with them and not at them (40) ”.</i> <i>They may not laugh at the older people; you can laugh with them not at them (fg 1:8);</i> <i>Did we write that she needs humour?; not to laugh at them, but to laugh with them and if you do not have humour, you are actually not going to make it (fg 3:22);</i> <i>And make jokes all day long; yes it's true; the old people laugh when I come in, if the old people see me, then they all laugh at me; you see with the humour, you get through everything; see the humour in everything; patience and humour, it is really so (fg 4:14)”.</i>

Theme 2: Personal strengths used or recommended by participants

Earvolino-Ramirez (2007:77) asserts that one of the defining attributes of resilience is having a sense of humour. Edward and Hercelinskyj (2007:241) support this by adding that humour is one of the characteristics of resilience. This is also supported by Grafton *et al.* (2010:699) who contend that a sense of humour was identified as one of the characteristics of resilience in their literature review. Wagnild (2011:16) adds to this argument by stating that equanimity is displayed by humour because people that are resilient have the ability to laugh at themselves and their situations. Holmes and Marra (2002) (cited by Koen, Van Eeden, Wissing & Du Plessis, 2011:110) also contend that humour is a component of resilience. Mealer, Jones and Moss (2012:1447), confirm that nurses that are highly resilient include humour and a positive attitude in the work situation leading to healthy emotional adjustment.

Different authors cited by Earvolino-Ramirez (2007:76-77, 81) agree that having a sense of humour about life and yourselves, are reported constantly in all resilience studies that have been conducted over time. These authors argue that having a sense of humour plays an important role to enable an individual to handle difficult situations, to strengthen their coping methods and to curb the force of emotional responses (Earvolino-Ramirez 2007:76-77, 81). Carr (2004:227) supports this by maintaining that humour helps us to cope because it enhances our happiness when we laugh and / or escalates the social support we receive from others because humour elicits social support from other people. Brooks and Goldstein (2003:123) add to this argument that it has frequently been established that humour helps people cope with hardship and that humour is an essential element of a resilient state of mind.

Jackson *et al.* (2007) (as cited by Hart *et al.* 2012:9) contend that nurses can build their resilience by using strategies such as having a positive mind-set, employing humour, laughing, positive thinking, visualization and positive confirmation. Cameron and Brownie (2010:68) maintain that individuals experience resilience when they recognize their ability to identify stressors and use tactics such as humour to diminish the effect of stress. Ablett and Jones (2007:736) contend that staff working in palliative care need to have a good sense of humour to enable them to care for persons that are dying and that humour protects them from the difficult aspects of death and religion. Tan (2009:407) supports this by adding that humour helps youthful adult-child caregivers to deal with the responsibilities of caring for a parent with Alzheimer's disease and that they do not need to be naturally humorous to be able to use humour to cope, it was also found that it is possible to learn how to use humour to cope. Gibson (2004:355) adds that smiling and laughing are infectious and that the advantages of laughing with others and encouraging a positive attitude, are endless and that patients will always remember a person that brought them happiness.

Theme 2: Personal strengths used or recommended by participants		
Being motivated (T3) (2HR)	Participants mentioned motivation as a personal strength that enables them to care for older persons. Motivation was also mentioned in connection with a positive attitude that helps them to cope while caring for older persons.	Participants say: <i>Good motivation (7);</i> <i>Motivated, liking what you do (26);</i> <i>Motivated and genuine (36).</i>
	Motivation as related to resilience is confirmed by Dwyer (2011:399) who asserts that nurses caring for older persons possess a resilience that verifies that they are tenaciously motivated to work within the aged care sector. Bernard (1993:44) maintains that resilient children have a sense of purpose and future, which may indicate motivation.	
Persevering (T8) (5HR)	Participants revealed that perseverance is a personal strength that enables them to care for older persons. They also acknowledge that perseverance helps them to cope. Participants agreed that perseverance is needed to be able to keep on and keep going while caring for older persons. They emphasized that nurses caring for older persons need to be able to persevere because sometimes the elderly don't want to help and it helps you to be able to go on.	Participants say: <i>Hang on and hold on (7);</i> <i>Perseverance – always finish what I undertake (26);</i> <i>My perseverance (43);</i> <i>Perseverance must always be because older people sometimes do not want to do anything (26);</i> <i>I am a person who persists in what I do because it has a purpose in life to make someone's life better who are unable to do it themself. One gets difficult cases but if you keep going on, you can win (35).</i>
	Literature that confirms the findings that perseverance is a strength related to resilience, is confirmed by Wagnild (2011:15) who states that perseverance is one of the five attributes that represent the resilience core. Perseverance is the willpower to keep going regardless of difficulties experienced, dissuasion, and disillusionment (Wagnild 2011:15). Wagnild (2011:15) maintains that resilience refers to the capability to rebound when knocked down, perseverance is needed to do this. Earvolino-Ramirez (2007:77) argues that self-determination is one of the characteristics of resilience and includes a strong inner belief that the person will persevere whatever happens in life. Dyer and McGuinness (1996:277) support this argument and assert that determination is one of the important characteristics of resilience. A resilient person has the attribute of 'stick-to-it-iveness', meaning that this person perseveres until the job is finished or the objective reached (Dyer & McGuinness 1996:277). Bernard (1993:44) concludes that resilient children have a sense of purpose that includes persistence.	

Theme 2: Personal strengths used or recommended by participants

Sub-theme 2.3 Nurses caring for older persons value good health, including physical, spiritual, emotional and social health as well as the use of medication.

Good health (T18) (8HR) (fg 1, 2, 3, 4)	Participants mentioned good health as a personal strength that enable them to care for older persons. Good health was also pointed out as support that helps them to cope, as making it worthwhile to care for them, enabling them to be resilient and given as advice to nurses to help them to be resilient. These participants agreed that good health can enable nurses to have the necessary strength and stamina to care for older persons. They highlighted the fact that good eating habits, enough rest, making time for themselves as well as for their friends and loved ones, can help them to be physically and mentally healthy and support them to cope while caring for older persons. One participant mentioned that her good health makes it worthwhile for her to care for older persons. Participants revealed that being healthy, following a healthy lifestyle and by getting enough rest, helped them to be resilient.	Participants say: <i>Firstly you need to experience good health (3);</i> <i>Stamina (7);</i> <i>Keep healthy course you're going to need more of your energy than you thought; eat healthy (30);</i> <i>When you are not at work, you need to relax and look after yourself. Get a hobby, visit your friends. Do not allow that there is nothing left for your loved ones, friends, and family and above all for yourself. You must make time for „me time“(6);</i> <i>Physically and mentally I always try to be healthy, in that way one can have the power to care for the elderly (34);</i> <i>Because I enjoy good health (3);</i> <i>To be healthy yourself, physically and psychologically (34).</i>
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Theme 2: Personal strengths used or recommended by participants

Physical health (fg 1, 3, 4)	During three focus group interviews participants gave advice that physical health is very important if nurses want to be resilient while caring for older persons. Nurses also need to eat healthy.	Participants say: <i>I believe they must be healthy first to do the job (fg 1:8);</i> <i>You have to keep yourself healthy; I can remember when you are sick yourselves, I was here in ...hospital and I was affected by the flu myself and the lady rang the bell just to pick up her handkerchief that she had dropped on the floor and I did not have that patience because I was sick myself so hum yeah you need to be friendly and stay friendly (fg 3:21);</i> <i>Healthy eating habits (fg 4:15).</i>
	Good health as a strength related to resilience is confirmed by Mealer, Jones and Moss (2012:1449) who assert that nurses with high resilience sustained good sleep practices and exercises for example jogging or going to the gymnasium. Caring for ourselves and balance are the physical, emotional and mental systems that are integrated into our everyday life to sustain a healthy and balanced way of life (Mealer, Jones & Moss, 2012:1449). Sleep patterns, exercise, amusement and diet are all included in physical health (Mealer, Jones & Moss, 2012:1449). Although not directly related to resilience, the assistant nurses caring for older persons in the study conducted by Sandmark <i>et al.</i> (2009:379) all participated in some kind of exercise that varied from cycling, using the stairs, swimming, walking, or going to the gym. Sandmark <i>et al.</i> (2009:382) contend that dealing with one's own health concerns and keeping a balance among work and relatives, must be promoted. Hägglund, Helsing & Sandmark (2011:329) assert that maintaining the ability to work in the age group over 50 years of age, was connected to rating your health as good, the ability to sleep well, convalescence and the feeling that you have control over your life.	

Theme 2: Personal strengths used or recommended by participants

Spiritual health (fg 1, 2, 3, 4)	In all four focus group interviews the importance of religion was highlighted to help nurses to be resilient. Their dependence on God, their willingness to serve and their faith and trust in the Lord was verbalized.	Participants say: <i>I think for myself it is primarily my dependence on God that makes me resilient; definitely; yes (fg 1:11);</i> <i>And as a human in this hum we must be willing to be servants not expecting anything in return in the process, we must be willing to serve, and not to be served. Not to be served; yes there are some of the old persons that cannot even read in a Bible at night, they cannot; if they ask you just pass on my Bible or read a bit to me. Pinch that little while off and read two or three verses, then they are happy because they cannot anymore (fg 1:12);</i> <i>One should be a believer also because most of the elderly people are religious people although I have found one that was an antichrist and it is very difficult to work with them (fg 2:14);</i> <i>No it's but faith and trust (fg 3:19);</i> <i>I thank God that I'm at my house (fg 4).</i>
	Spirituality was identified by highly resilient ICU nurses as the skill they use most frequently to cope in the stressful ICU milieu and they engaged in prayer and religious practices (Mealer, Jones & Moss 2012:1449). Koen, Van Eeden, Wissing and Du Plessis (2011:107) support this argument and state that most of the nurses with a high level of resilience in their study, mentioned that they rely on a strong belief system or religious viewpoint to guide them and make them strong. Mealer, Jones and Moss (2012:1449) add that emotional health includes religion, practices and coping methods that are used at home as well as at work.	

Theme 2: Personal strengths used or recommended by participants		
Emotional health (fg 3)	Participants referred to emotional health as advice to nurses to be resilient. In one focus group it was talked about that nurses caring for older persons must give recognition to themselves for a job well done.	Participants say: <i>I just want to, we must learn to give ourselves credit, give yourself time to if you did something know it is right; give yourself a star; just say to yourself, just I did it well. If someone does not say it to you won't feel it so learn to give yourself credit yeah</i> (fg 3:18).
	According to Mealer Jones and Moss (2012:1449) the following are included in emotional health: the ability to leave stress at work and to remember the positive incidents at work. Sandmark <i>et al.</i> (2009:379) maintain that women caring for older persons, who had their own families, made sure that they made time for themselves as well over the years because it was vital for their welfare and enabled them to recover from work.	
Social health (fg 4)	Nurses caring for older persons mentioned the importance of social health as advice to nurses to be resilient. These nurses agree that social health at work includes resting during their lunch hour and a comfortable work environment. At home social health can be enhanced by having silence, reading a book or watching television.	Participants say: <i>And then of course I sleep my hours, mealtimes</i> (fg 4:14); <i>Relax, relax completely</i> (fg 4:15); <i>To have a comfortable environment to work in</i> (fg 4:15); <i>You need that silence</i> (fg 4:17); <i>You take a book and you read it or you watch television; just relax</i> (fg 4:18).
	According to Mealer, Jones and Moss (2012:1449) highly resilient ICU nurses engaged in running, going to the gym, praying, spirituality, good sleeping habits and utilizing social support systems. Losada, Pérez-Peñaranda, Rodriguez-Sanchez, Gomez-Marcos, Ballesteros-Rios, Ramos-Carrera, Campo-de la Torre & García-Ortiz (2010:347) add that leisure time has an important influence on the psychological welfare of caregivers for older persons and can be utilized to cushion the distress they experience.	

Theme 2: Personal strengths used or recommended by participants		
Medication (T1) (0HR) (fg 4)	One participant referred to the fact that the use of medication can support nurses caring for older persons and help them to cope. During one of the focus group interviews, it was confirmed that medication helps nurses to cope while caring for older persons. The use of medication in the form of a tonic was also given as advice to nurses caring for older persons.	Participants say: <i>Sometimes it is necessary to drink a tranquilizer (Prozac) (not recommended) (6).</i> <i>A Valium (fg 4:4);</i> <i>Bioplus; yes bioplus yes, no we need something to drink (fg 4:14).</i>
	According to the Concise Oxford English Dictionary (2011:888) medication refers to medicine or drug or treatment that uses drugs. No literature could be found that confirmed that nurses caring for older persons use medication to cope while caring for them.	

Theme 3: Professional strengths used or recommended by participants		
Sub-theme 3.1: Nurses caring for older persons communicate professionally by listening and providing feedback, and by keeping a professional distance.		
Communication (listening and providing feedback) (T45) (14HR) (fg 3)	Participants revealed that communication is a strength enabling them to care for older persons. Communication helps them to cope, makes it worthwhile to care for older persons and enables them to be resilient while caring for them. Communication was also given as advice to nurses on how to be resilient while caring for older persons. According to these nurses caring for older persons, communication with the elderly entails making time to listen to them, to hear what they want to tell you, and to ensure you speak nicely and clearly to them. They recommended that nurses need to talk and listen, use the correct language, talk nicely to the older persons and to	Participants say: <i>I have an ear to listen to them because sometimes they want to share something with you. Give them a chance to speak because many people live alone and if someone comes, they are hungry to talk, be quiet and listen... (12);</i> <i>Like to listen to their complaints that need attention. Always talk nicely and clearly to the elderly (17);</i> <i>Have to remind myself sometimes / forced to listen again, to listen patiently. Do more listening than talking, and when I talk, with great love and care (27);</i> <i>Proper language use is also of utmost importance because one's approach tells if you are a team worker. So I speak properly to my co-worker as well as the older person I am caring first (14);</i>

Theme 3: Professional strengths used or recommended by participants		
	other staff members, explain what they are going to do, stay calm when the older persons are angry and speak softly and calmly. Communication with the older persons and their family makes it worthwhile for nurses to care for them, especially to listen to their stories, getting advice and encouragement from them, when they speak nicely to you and the trust and open communication the nurses have with the older persons. They agreed that listening, communication, being open to them, talking calmly, gently and softly to the older persons helps them to be resilient while caring for them. In one focus group interview it was highlighted that nurses must make sure that their tone of voice is right towards the older persons and the other staff.	<i>If they scold you, or throw something at you, just be calm and peaceful. Speak calmly. Walk out of the room and go back later when they are calm. Talk nicely again. They'll tell you what is wrong (9);</i> <i>To communicate with family and to make friends with the family (25);</i> <i>The trust and open communication. Getting to know them well (30);</i> <i>Art of listening, communication. Good interpersonal relationships. To put people first (7).</i> <i>Your tone of voice should be right towards the elderly and to your colleagues with whom you work with, because if your tone of voice is just a little different than what they are used to, then it is a big problem. You should work on your tone of voice (fg 3:16);</i> <i>I think personal relationships with your staff, and the residents (fg 3:20).</i>
	According to Brooks and Goldstein (2003:13) effective communication is an essential element of resilience and is strongly associated with empathy. The ability to listen actively and an awareness of how our verbal and nonverbal communication are experienced by others, all form part of communicating effectively (Brooks & Goldstein 2003:13). This argument is supported by Benard (1993:44) who asserts that resilient children show social competence that includes amongst others communication skills. Communication is a forceful instrument that healthcare personnel and nurses can take advantage of when working with patients to enhance their overall health and well-being (Williams, Kemper & Hummert 2004:7). Weman and Fagerberg (2006:285) maintain that most of the registered nurses in their study mentioned the fact that communication with the family members of the older persons was an important aspect of their work.	

Theme 3: Professional strengths used or recommended by participants		
Keeping a professional distance (fg 2, 3)	Participants recommended in two focus group interviews that nurses need to keep a professional distance while they care for older persons and they must not take everything the older persons say to them personally.	Participants say: <i>One should not take to heart everything they tell you (fg 2:14);</i> <i>You, I, will tell her you have to be involved in the elderly without completely... I have always been so involved in my patients and the families that I have some time and I could never succeed. I just could not get that emotional thing right that I almost not cry more than the family; I'm the same; She should and she must be able to have it without being sympathetic, yes to be too involved, yes so it's quite a thing (fg 3:17).</i>
	According to an integrative literature review regarding resilience in nurses that was conducted by Hart <i>et al.</i> (2012:8) emotional hardness and emotional aloofness were used as tactics by nurses when providing nursing care in situations that were demanding and traumatic. The nurses were able to carry out nursing care procedures that were uncomfortable and hurtful, but essential, in order for their patients to recover by being emotionally distant (Hart <i>et al.</i> 2012:8). Ablett and Jones (2007:737) support this argument by asserting that palliative care nurses were conscious of keeping professional borders and that it also had a protective purpose because it placed a distance between the nurses and the emotional anguish that is experienced when working with dying patients. Hertzberg and Ekman (2000:621) contend that staff caring for older persons with dementia, were more reserved in their manner of communicating regarding their experiences than the families of these older persons and they kept a definite distance between themselves and the families during group discussions.	

Theme 3: Professional strengths used or recommended by participants		
Sub-theme 3.2: Nurses caring for older persons value education including previous experience, basic knowledge, to stay updated, specialized geriatric training and learning from older persons.		
Education (T29) (7HR) (quotes included for education, previous experience and basic knowledge)	As an introduction to the findings regarding education, participants mentioned that previous experience and education are strengths that enable them to care for older persons. Education including basic knowledge and experience help them to cope; education makes it worthwhile caring for older persons and enable nurses to be resilient. Basic education, specialized geriatric training and to stay updated was also given as advice to nurses to be resilient.	
Previous experience	Participants use their previous experience in caring for older persons as well as their formal education in geriatrics while caring for older persons. Previous experience and the things they have learned also help these nurses to cope. These nurses agree that experience and continuing education help nurses to cope while caring for older persons.	Participants say: <i>I can portray and use my previous experience with the elderly and their children and families (27);</i> <i>I have completed the Geriatric course successfully (7);</i> <i>I have knowledge of Geriatrics. Have been working for 11 years with the elderly (24);</i> <i>Experience teaches you how to deal with it (17);</i> <i>To be willing to receive training. To provide in-service training to fellow-staff on how to work with the elderly. To know the Nursing Act and the Older Persons Act and how to apply it (18);</i> <i>Informed about new resources and possible medications to improve elderly people's situations (34).</i>

Theme 3: Professional strengths used or recommended by participants		
	According to Wagnild (2011:16) equanimity includes the aspect that resilient individuals discovered that they can use their own as well as other people's experiences and wisdom to direct their reactions. Cameron and Brownie (2010:70) support this argument and maintain that resilience in nurses caring for older persons is enhanced by clinical skills and knowledge as well as by experience.	
Basic knowledge (fig 1, 3, 4)	Participants mentioned that to know their patients and their needs helps them to cope while caring for them. They pointed out that it will help nurses to cope if they start to know the older persons and their needs, understand that their needs may differ, know their likes and dislikes and not hold their behaviour against them. They also stated that knowledge makes it worthwhile to care for older persons. Three focus group interviews confirmed the importance of basic knowledge regarding diseases, as well as knowledge regarding the needs and condition of older persons.	Participants say: <i>Every older person has different needs to look at (8);</i> <i>When working with old people you must firstly understand what their like and dislike are so that we can work together in everything we do (16);</i> <i>Seeing their needs and doing something about it (18);</i> <i>To apply expertise in the workplace (18);</i> <i>Learning to work through difficult times or situations (30).</i> <i>I think education is extremely important, they should have knowledge about, you know basic knowledge regarding diseases (fig 1:9);</i> <i>Knowledge, knowledge you need to know who are your diabetics and what special care and well everything that should be done (fig 3:19);</i> <i>We must understand each person's condition and physical restrictions; and his needs; and where it hurts and where it does not hurt and handled accordingly (fig 4:17).</i>
	According to Murphy (2007:873) one of the six factors that make the provision of high-quality care for older persons receiving long-term care possible, include the need to know the person. Personnel that are skilled and knowledgeable are one of the six factors that make the provision of high-quality care for older persons receiving long-term care possible (Murphy 2007:873). McAllister (2003:534) asserts that nurses need to receive a good education that teaches them skills to be life-long learners and equips them with the confidence in themselves to know how to think and search resourcefully for solutions.	

Theme 3: Professional strengths used or recommended by participants		
To stay updated (fig 2)	During one focus group interview it was stated that it is important to stay updated with regard to the Older Persons Act in order to be able to help and give advice to the older persons. Participants referred to the fact that education and training enable them to be resilient while caring for older persons. They all agree that continuing education helps them to be resilient while caring for older persons.	Participants say: <i>Gather knowledge about personalities, diseases etc. Do not fall into a rut (6);</i> <i>I ask if I don't understand. I'm always interested in situation that is new to me. I'm always open for discussion about the elderly. I want to know better about the elderly (30);</i> <i>Read a lot and keep up with new developments (35).</i> <i>And I do think that it is important when working with the elderly that you have to update yourself with the Older Person's Act in order for you to know what advice and help you can give them to protect themselves from society (fig 2:15).</i>
	Professional nurses with a high level of resilience wrote in their narratives about how important good training and continuous education are to empower them with the necessary knowledge and expertise to handle the difficulties and stress they experience in the nursing profession (Koen, Van Eeden, Wissing & Du Plessis 2011:108). Cheek, Ballantyne, Jones, Roder-Allen & Kitto (2003:108) argue that the key role players in aged care need to take hands with higher education and develop a prototype for the basic and further education of all nurses and care giving personnel that care for older persons where numerous points of entry and exit are provided in a profession that encourages lifelong learning and improvement of skills.	

Theme 3: Professional strengths used or recommended by participants

Specialized geriatric training (fg 3)	During one focus group interview, the importance of knowledge regarding specialized geriatric care was highlighted. It was pointed out that student nurses do not consider a career in geriatric nursing and that a specialized geriatric course should be offered.	Participants say: <i>And it's just interesting I usually ask the students especially the ...students whom of them is going to do geriatrics. I do not think we've got one so far; there is a gap in the training almost they must be more exposed to medical, medical and elderly care. Hum it seems to me that the elderly are somewhat forgotten because it's clinics and surgical and it's hum what do you call it like births, midwifery and psychiatry but not geriatrics not just and I think it forms a big part and in the future it is going to be an even larger portion / section of society; they have talked that they wish to make it a study field like obstetrics, geriatrics then you can specialize in geriatrics and I really think we should hum encourage it that a person can study in a specialty field (fg 3:18);</i> <i>...so knowledge in all those areas especially hum in your Parkinson's and Alzheimer's (fg 3:20).</i>
	According to Kovner, Mezey & Harrington (2002:78-79) there is a serious shortage of health care professionals that were adequately prepared to provide geriatric care and they argue that all personnel providing health care should be trained in geriatrics, and be able to gain access to geriatric specialists to make sure that older persons receive the correct treatment. Morgan <i>et al.</i> (2002:158) support this by asserting that the directors of nursing and the personnel working in rural nursing homes agreed that basic educational programmes need to include more information on how to care for persons with dementia and they all agreed that continuing education is needed more regularly. Lee, Coakley, Dahlin & Carleton (2009:541) argue that the RN residency programme is a successful programme to engage and develop nurses in practice and assert that the outcome of the programme was a group of nurses that were knowledgeable in palliative care for older persons, who will in turn improve the care provided to older persons and their families and create environments in their wards that are sensitive to older persons. Chang <i>et al.</i> (2002) (cited by Cruttenden 2006:359) support this argument by asserting that specialized gerontological education can be provided by means of mutual learning and practice, for example 'WebCT' and modules for learning that can be used for nursing homes in urban areas as well as those in rural areas.	

Theme 3: Professional strengths used or recommended by participants		
Learning from older persons (T13) (5HR)	Participants revealed that learning from older persons enable them to care for them. Participants also referred to the fact that learning from the life lessons from older persons makes it worthwhile for nurses to care for them. These nurses agree that the older persons have a lot of experience and wisdom and that the nurses can learn a lot from them.	Participants say: <i>Learn a lot from the elderly (23);</i> <i>They have so much to tell you. Life lessons that you can carry with you as long as you live (9);</i> <i>I see elderly persons as a source of knowledge – I learn daily more from life, to work with the elderly. All of them were „someone“ in life, a professional person or someone that did his part in society – the people all have experience and skills that cannot be bought. They are my tutor of life! What a privilege! (20);</i> <i>One can learn so much wisdom and life experience from them that is not written in books (6);</i> <i>You can learn a lot from the elderly, calmness, kindness, patience and wise words (17);</i> <i>It remains a privilege to work with elderly people. They are so full of life experience and knowledge that one learns something new every day. Despite their realization that this is the last stop – of the train – of life, all of them still try to feel positive about the things around them. One can learn a lot from it, in order for us not to feel negative about our own lives (20).</i>
	As mentioned under previous experience, Wagnild (2011:16) argues that resilient people discovered that they can utilize their own and other people's experiences and wisdom to give direction to their responses. Cameron and Brownie (2010:68) support this argument by asserting that resilience in nurses caring for older persons can be toughened if nurses believe that they make a difference, if they foster loving and warm relationships and share experiences with the older persons.	

Theme 3: Professional strengths used or recommended by participants

Sub-theme 3.3: Nurses caring for older persons serve as role models by being passionate, by being trustworthy and responsible, by acknowledging the uniqueness and wholeness of older persons and by being organized.

Role models (T5) (2HR) (fg 1, 3)	Participants acknowledged that to be a role model makes it worthwhile for nurses to care for older persons. Being a role model is also given as advice to nurses to be resilient. Participants also referred to the fact that making a difference in the life of an elderly person makes it worthwhile to care for them. When these nurses make a difference in the lives of the elderly, they experience job satisfaction and serve as role models to other nurses caring for older persons. Participants recommended that nurses caring for older persons should set an example to the other staff on how to care for older persons and be friendly.	Participants say: <i>To know every night that today I have made a difference in someone's life (27);</i> <i>I know I can make a difference in the last chapter of the older person's life (29);</i> <i>Job satisfaction – hard work for little recognition but knowing that you – even if only for one person, did something that made their day easier or better (42).</i> <i>The example you set for them to show how to deal with people, such as an Alzheimer person, the way you, those examples you give to our caregivers it it's important (fg 1:9);</i> <i>Show teeth all the way; you must put on your Colgate smile sister, you must put him on; a worker once told me that your face is a mirror so you have to remember what kind of image you send out (fg 3:21).</i>
	To have a resilient role model, spirituality, social support and hopefulness were identified by highly resilient nurses as characteristics that they use to cope with the stressful ICU work situation (Mealer, Jones & Moss 2012:1445). The importance of good role-models was confirmed by resilient professional nurses in a study conducted by Koen, Van Eeden, Wissing and Du Plessis (2011:107). This argument is confirmed by an integrative literature review done by Hart <i>et al.</i> (2012:9) where different authors agree that nurses can be supported to investigate career objectives, opportunities to network as well as resources by searching for mentors that can be trusted and who can serve as role models, give direction, inspiration and emotional encouragement. Ablett and Jones (2007:736) maintain that palliative care nurses were committed to make a difference in their role by giving their best to their patient as well as to their patients' relatives. Cameron and Brownie (2010:68) add that by making a difference, by having an optimistic outlook and faith, strengthens resilience at work.	

Theme 3: Professional strengths used or recommended by participants

Being passionate (T17) (6HR) (fg 3, 4)	Passion was mentioned by participants with regard to a strength that enable them to care for older persons and as helping them to cope. Passion makes it worthwhile caring for older persons and enable nurses to be resilient. Nurses were also advised to be passionate when caring for older persons in order to be resilient. Participants agreed that they need to have a passion to work with older persons and cope while caring for them. Participants highlighted the fact that nurses must want to care for the older person and be softhearted. Their passion for caring for the older persons makes it worthwhile for these nurses to care for them. Giving love and attention, doing their job to the best of their ability and by giving of themselves to the elderly, all make it worthwhile for them to care for the older persons. Their passion for their work and for the older persons also helps them to be resilient while caring for them. Two focus group interviews confirmed the passion nurses have to care for older persons.	Participants say: <i>I always say it is my passion to work with the elderly (17);</i> <i>That what I do here, I do not see it as my work but as my passion and my privilege (27);</i> <i>Passionate - Must do it because you want to do it (26);</i> <i>Passionate – to love my work and that what I do (26);</i> <i>My passion for old people keeps me positive and gives me reason to continue (29);</i> <i>It's my passion. It is a privilege. Thank you Lord! (20).</i> <i>Yes because you need to have a passion for old people to work with them (fg 4:19);</i> <i>I always think someone who works with the elderly really needs to be born like that (fg 3:18).</i>
	Passion as a strength related to resilience is supported by Brooks and Goldstein (2003:52) who maintain that when dedication is present, we have a feeling of purpose that informs us of the reason why we do what we do. They argue that we are directed by a mental picture that provides passion and significance to our existence and diminishes the force of stress and at the core we have a motive for getting up in the morning and meet the challenges of life (Brooks & Goldstein 2003:52). Ablett and Jones (2007:735-736) support this argument and assert that palliative care nurses made an active choice to work in palliative care, they show a high degree of dedication and consider it as an honour to care for people at the end of their lives.	

Theme 3: Professional strengths used or recommended by participants		
Being trustworthy (T1) (1HR) (fg 3)	Trust was mentioned by the participants with regard to making it worthwhile caring for them, with regard to advice on how to be resilient and with regard to the multidisciplinary team. One participant mentioned that trust makes it worthwhile to care for older persons while one focus group discussion pointed out that older persons need to be able to trust the nurses caring for them. The trust that the multidisciplinary team needs to have in one another will be discussed under contextual strengths.	Participants say: <i>Trust (34).</i> <i>That they can trust you; they must have great confidence in us to take those medications that we give them what they drink every day (fg 3:20).</i>
	According to Hart <i>et al.</i> (2012:12) nurses experience the work situation as more supportive in facilities where trust is very important. Pask (1995) (cited by Hertzberg & Ekman 2000:620) contends that trusting the nursing staff is vital for the welfare of relatives because trust is important in all relationships between people.	
Being responsible (T12) (4HR) (fg 3)	Being responsible was mentioned by participants as a strength enabling them to care for older persons, making it worthwhile to care for them, enabling them to be resilient and given as advice to nurses to be resilient. According to these participants they have a responsibility towards the older persons who have built the country and that caring for the older persons teaches the nurses to have responsibility in return. These nurses confirmed that by working hard and going the extra mile for the older persons helps them to be resilient while caring for them. Participants recommended that if nurses want to be resilient while caring for older persons, they need to be responsible.	Participants say: <i>I am a responsible person that strives to perfection (27);</i> <i>I am a responsible woman because of them (31);</i> <i>We have a responsibility towards our elderly people who have built the country. They planted the tree under which you and I sit today (6);</i> <i>It teaches me how to treat older persons to respect them to have some responsibility and to make my own decision (31);</i> <i>The responsibility that you have to follow. It has always been important to me that everyone should know I'm always available. Sometimes we do not feel good or walk lame, but it remains a privilege to work with the elderly. Do our best to do it with a spring in our step (38);</i>

Theme 3: Professional strengths used or recommended by participants		
	They agreed that nurses caring for older persons need to have a sense of responsibility.	<i>I try to do what they ask or just something extra. If I see needs attention what there is not every day time for, I do it with pleasure (40).</i> <i>There is big responsibility with our nurses you hear; there is big responsibility yes (fg 3:20).</i>
	Although not directly referring to resilience, Lundman, Al��x, Jons��n, Norberg, Nygren, Fischer & Strandberg (2010:251) assert that inner strength is to accept responsibility for oneself and for others and to tolerate and handle problems and hardship. Hart <i>et al.</i> (2012:11) maintain that nurses are empowered to be more responsible and take ownership of their profession when their organization encourages them to make decisions at ground level.	
Acknowledging the uniqueness (T1) (1HR) (fg 3) and wholeness of the older persons (fg 2)	One participant wrote that she sees every older person as a unique human being. The uniqueness of each older person is confirmed by this participant. It was mentioned in one focus group interview that the older persons must be seen as holistic beings and treated as such. During the focus group interviews, it was recommended that nurses must treat all the older persons the same and not have ‘favourites’.	Participants say: <i>Every older person is unique to me with his own manners (5).</i> <i>That she see the person as a whole, not just as a physical, not only as a problem, she must see and approach the person holistically (fg 2:14);</i> <i>You must not distinguish, don’t distinguish between the residents, it is difficult but you may not do it; treat everyone fairly; the same; don’t have favourites, if you have, you say it at your house (fg 3:10).</i>

Theme 3: Professional strengths used or recommended by participants		
	Although not in relation to resilience, Murphy (2007:873) asserts that one of the six factors that makes the provision of high-quality care for older persons receiving long-term care possible, include the provision of holistic care that is centred on the person. According to Tuck, Alleyne, and Thunganjana (2006:246) (cited by Grafton <i>et al.</i> 2010:701) ‘holistic care’ entails the relationship between the biological, psychological, social and spiritual dimensions of persons. Nurses providing holistic care need to offer their knowledge and skills as well as a part of themselves personally and spiritually within professional interactions (Grafton <i>et al.</i> 2010:701). Cameron and Brownie (2010:68) contend that nurses caring for older persons cultivate their own resilience according to the level of contentment attained when supplying holistic, specialized care.	
Being organized (T4) (2HR)	Participants mentioned that planning, time-management, working systematically, organization and routine help them to cope while caring for older persons.	Participants say: <i>Plan – work must be planned in advance (26);</i> <i>I can manage my time at home and at work; make time for everyone (31);</i> <i>To tackle tasks systematically and successfully. To be organized, not to grab here and let go there (7);</i> <i>I like a routine and as far as possible to work in a routine, also good for the elderly (27).</i>
	According to the Concise Oxford English Dictionary (2011:1009) ‘organize’ refers to order and arranging systematically. Testad, Mikkelsen, Ballard & Aarsland (2010:789) assert that leadership and organizational aspects in nursing homes need to receive more attention in order to promote the health and welfare and reduce turnover of staff caring for patients with dementia.	

Theme 3: Professional strengths used or recommended by participants		
-Prioritising (T2) (OHR) (fg 1, 4)	Participants mentioned that the ability to prioritise helps them to cope while caring for older persons. The fact that nurses caring for older persons need to be able to prioritise was also given as advice in two focus group interviews. These nurses need to distinguish what is important first and what can be done later on.	Participants say: <i>Prioritize things and do important things first (38);</i> <i>I treat every old person's situation according to urgency. I determine what is important and what is less important and act accordingly. Each situation on its merits and to handle each case on its merits. (7)</i> <i>Yes and that you have to prioritise what is important and what is not important now (fg 1:9);</i> <i>You just start immediately, it is as if you kick in, you go into a routine, you first do this, and this is important and then you do this and then that (fg 4:15).</i>
	According to the Concise Oxford English Dictionary (2011:1141) 'prioritise' refers to determining the relative importance of a task. Cameron and Brownie (2010:70) assert that nurses caring for older persons cultivate resilience by means of their practical knowledge, their skills and their experience that allow them to be self-assured and adaptable in their attitude to prioritise tasks while at the same time upholding kindness and empathy to the older persons and their families.	
Delegating (T1) (OHR) (fg 3)	The fact that nurses should be able to delegate was mentioned in one narrative as well as in one focus group interview.	Participants say: <i>I delegate some of my non-professional duties to my caregivers and cooks that I know have the ability to perform these tasks (7).</i> <i>And you have to, you have to be able to delegate, (fg 3:20).</i>
	According to Case (2004:17) (cited by Clark, 2008:288) delegation is handing over the power to carry out chosen responsibilities, to a capable person, in special circumstances.	

Theme 4: Contextual strengths used or recommended by participants

Sub-theme 4.1: The uniqueness of caring for older persons including the dependency, improvement and appreciation of older persons makes it worthwhile to care for them.

Dependency of older persons (T9) (2HR)	Participants revealed that the dependency of the older persons on the nurses makes it worthwhile to care for them. These participants agreed that the fact that the older persons are dependent on them makes it nice to work with them and provide in their needs.	Participants say: <i>Deep compassion for older persons that have lost their independence (5);</i> <i>I like to help to relief their need even if it is only a hug or a nice friendly smile or to rub their back or body with „deep heat“ (7);</i> <i>Because I know the elderly is dependent on someone, is it nice to work with them (39);</i> <i>Help and safety of my older persons (16).</i>
	Although not related to making it worthwhile but related to dependency, Agüero-Torres, Fratiglioni, Guo, Viitanen, Von Strauss, & Winblad, (1998:1452) assert that dementia and cognitive impairment contribute strongly to an increase in functional dependence and a deterioration of function.	
Improvement of older persons (T5) (2HR)	Participants stated that when the condition of the older person improves, it makes it worthwhile caring for them. They highlighted the fact that it makes it worthwhile for them when a wound heals, an older person starts to walk again, see them well cared for, when their condition improves and seeing them happy and satisfied.	Participants say: <i>If a wound heals after a long treatment. If someone starts to walk again after a sickbed (15);</i> <i>To see that their needs are met. To see them well cared for and comfortable (18);</i> <i>Solution or improvement of the elderly's situation – illnesses or physical problem. A well-cared-for, happy elderly (34).</i>
	No literature could as yet be found to support the fact that the improvement of the older persons makes it worthwhile to care for them. This may be a unique finding of this study.	

Theme 4: Contextual strengths used or recommended by participants

Appreciation from older persons and families (T19) (9HR)	Participants agreed that the appreciation of the patient and family makes it worthwhile for them to care for these older persons. This appreciation seems to be an important aspect that makes it worthwhile for nurses to care for older persons.	Participants say: <i>You do not always expect a thank you, just a smile of satisfaction (32);</i> <i>Gratitude. That words thanks and please. Sometimes it's just the crooked smile that makes the difference (17);</i> <i>To see an old wrinkled face beam with gratitude. The hugs of older persons and their family / children when you have done something for them – that can improve their quality of life (29);</i> <i>„Thank you my child, I appreciate it“, says she softly. It is and feels good to know I get up and go do my „work“ and it is appreciated by a person who has walked a long way (43).</i>
	Literature confirms that the appreciation of the older persons and their families is important to nurses. The literature also highlights the importance of the appreciation of the colleagues. According to King (2012:66), the fact that older persons recognized the role of the caregivers, assisted the workers to discuss the strain that is caused between caring and working for payment and diminished the frustration they experienced. Chenoweth <i>et al.</i> (2013:10) support this argument by asserting that nurses caring for older persons and persons with dementia, mainly obtained satisfaction when patients and colleagues provided recognition for their work. Häggström (2005:36) adds that caregivers that worked with older persons within a municipal setting valued the closeness they experienced towards the older persons and the recognition they received from them as well as the support and recognition between the colleagues at work, and this prevented them from leaving their jobs. Sandmark <i>et al.</i> (2009:376) confirm this, stating that the older person's reactions were important to the nurses caring for them because caring for older persons was demanding and not well paid. Weman and Fagerberg (2006:281, 287) conclude that registered nurses caring for older persons acknowledge that the appreciation they receive from management, colleagues and / or family members of the older persons, as important aspects of their work in the community that makes their work worthwhile.	

Theme 4: Contextual strengths used or recommended by participants

Sub-theme 4.2: Nurses caring for older persons value the support from family, their colleagues in the multi-professional team and volunteers in the community.

Support from family and colleagues in the multi-professional team (T35) (13HR) (fig 1, 3, 4)	Participants mentioned that the support of family and their colleagues in the multi-professional team enables them to cope and be resilient while caring for older persons. Support was also mentioned as advice to nurses in order to be resilient. According to these participants, they get support from their families, the elderly and their team members. They give support to the older persons and try to find solutions to their problems. They also highlight the importance of support obtained from an objective person to talk to. Providing support to the family of the older persons also enables them to be resilient. They agree that they need to work together with the patient, his family and the multi-professional team. The importance of teamwork, sharing the workload and the support the team members give one another were highlighted. They also mentioned that being part of a team makes it worthwhile and enables them to be resilient while caring for older persons. It was mentioned that a doctor must be available and that the team members must be able to trust one another. The team must enjoy working together and they must also provide emotional support to each other as needed.	Participants say: <i>I gained that strength from home to my parents and grandparents (33);</i> <i>My family's continued support. Someone to talk to who is not in the same environment I work in, the support / love / care of my fellow workers. The fact that I work in an environment that provides me with security / safety... (27);</i> <i>Sometimes the elderly are rejected by their families. Then they depend on you. Some go through difficult times. You are their right-hand and eyes in life to help (9);</i> <i>I can be there for the family to reassure that we are here to take care of the elderly or to support them with the loss of a parent – even if only to be there – to give a hug or a warm cup of tea (38);</i> <i>Knowing that you can feel free to share your stress and worry with your senior. At our institution – open door policy. It helps a lot. Sometimes you experience many conflicting emotions in one day, it takes a lot of your energy – what helps then is that I can defuse with my colleague. Our institution's professional staff is very supportive! (29);</i> <i>I know and experience that I have a proper support system in my seniors and the management of the unit (27);</i> <i>Teamwork comes a long way for it enables me to cope under stress because if we share the workload the stress levels decrease as we help each other (14);</i> <i>Teamwork (42);</i> <i>Furthermore is the team that handles the care not only a nursing team. We are like a family that support each other and help to carry each other's burdens, even if it is just</i>
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Theme 4: Contextual strengths used or recommended by participants

		to listen (38); <i>Knowing that you work in a multidisciplinary team – make stress and pressure easier to handle. Weekly professional meeting where feedback and information are exchanged (29);</i> <i>To have a good working relationship with my co-workers. To guide and motivate my colleagues (18);</i> <i>Co-operation at all times by older person and staff (26).</i> <i>Then we go on to the office sister, and then we give sister ... a hug and says “ag” sister smile a little bit, then the tears run down and then we smile again; one should pay attention to your colleagues, for example, I work with sister we are a team and sister ... is our mother here so I keep an eye on her because she is the hand over us and if I see sister does not feel well, then we make something that is nice, you may be feeling down, you do not always have your sparkling days, you have your down days too (fg 3:22).</i> <i>There must be a doctor available in a facility you should hum be able to refer your people (fg 1:9);</i> <i>What is also very important is when for example I ask someone go do this for me, that I can trust that person to do it; yes (fg 1:9);</i> <i>I feel if the staff enjoy working together, then it is for the nurses better or nicer to go back as when they feel they go into this fight and they fight it alone; if everyone works together, it is much easier (fg 1:11);</i> <i>You just need to work in a nice crowd that works together because if one goes a different way, it is not going to work (fg 4:14).</i>
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Theme 4: Contextual strengths used or recommended by participants

Resilient professional nurses in a study conducted by (Koen, Van Eeden, Wissing & Du Plessis 2011:107) mentioned that the correction and support that their friends provided, gave them direction and enabled them to organize their lives. Hart *et al.* (2012:8) add that nurses use foundational associations with their friends, family members and colleagues to cope at work. Sandmark *et al.* (2009:378) highlighted the fact that assistant nurses caring for older persons sometimes obtained support from children, family and relatives, and the nurses acknowledged the importance of the social support provided by their friends or family. According to Weman and Fagerberg (2006:288) registered nurses and members of the family need each other when caring for older persons and it is expected from family members to assume more responsibility for their relatives and provide assistance and support when needed.

Earvolino-Ramirez (2007:76-77, 81) identified social support / positive relationships as one of the defining characteristics of resilience and cite other authors that confirm that if adults have social support and a meaningful relationship with at least one friend or family member, resilient outcomes can be expected. Herrman *et al.* (2011:263) support this and assert that although stress is essential to develop in a healthy way, resilience is more prone to be obtained if children or adults can avoid severe, recurrent or long-standing stress or when the effects of stress are cushioned by relationships that are supportive. Carr (2004:126) adds that children experiencing harsh conditions, grow stronger from these difficult experiences and demonstrate noticeable resilience if they are offered continuous social support. Rutter (2007:206) contends that positive interpersonal relationships are connected with resilience. Pooley and Cohen (2010:34) support this, asserting that external resources, for example the use of social support, is important to the process of resilience. According to Mealer, Jones and Moss (2012:1445-1449) nurses that are highly resilient, acknowledged positive social support that includes an assortment of relationships inside and outside the work environment, for example with friends, family and colleagues, as one of the attributes they use to cope in the stressful ICU work environment. Grafton *et al.* (2010: 698) support this argument by asserting that an environment that is supportive was identified as one of the factors that can enhance resilience in oncology nurses.

According to Cameron and Brownie (2010:66) the support of colleagues that presented opportunities to debrief and authenticate their experiences, as well as the use of humour, enhanced their well-being and enabled nurses caring for older persons to develop resilience. This was supported by Hart *et al.* (2012:9) who identified the support of colleagues as an important factor and assert that the supportive relationships provided by interaction and connection with other people are important in the enhancement of personal resilience in nurses. Josefsson *et al.* (2007:72) add to the discussion and contend that the support that registered nurses caring for older persons in municipal elderly care experienced from management and colleagues was in

Theme 4: Contextual strengths used or recommended by participants

general high and those working with patients with dementia experienced even higher support. Ablett and Jones (2007:737) contend that nurses providing palliative care signified delegating to colleagues, using humour, keeping a balance between work and private life and networks that provide social support as ways of coping with their work. King (2012:51) concludes that employers can enhance job satisfaction and keep personnel in aged care if they provide positive work environments that allow their staff autonomy, opportunities to become professional caregivers, support to manage emotions and enhance emotional resilience and the appreciation of clients for the role of the caregivers.

According to Cameron and Brownie (2010:68) resilience is enhanced when support is received from colleagues and mentors and when team companionship is experienced. Koen, Van Eeden, Wissing and Du Plessis (2011:109) add that resilient professional nurses mentioned that the support of friends and fellow-workers enabled them to debrief and ventilate. Dackert (2010:302) asserts that an improved team climate that provides support for nurses to be innovative, might increase the welfare of the nursing staff and decrease their response to stress. Spear, Wood, Chawla, Devis & Nelson (2004:58) support this, contending that job satisfaction is enhanced when nurses are clear about their roles, when they receive social support and when they experience teamwork. Chenoweth *et al.* (2013:9) add that peer support including efficient teamwork contributed to nurses' decision to remain in their present job. Sandmark *et al.* (2009:377) contend that the support of a strong work team meant a lot to the staff over the years and that the work team had a bigger influence on a positive work environment than management. Chou, Boldy & Lee (2002:54) add that the satisfaction of staff caring for older persons in residential aged care was based on the personal satisfaction they experience, their workload, the team spirit, their training and the professional support they receive. The highest level of satisfaction was experienced in connection with team spirit (Chou *et al.* 2002:54). Murphy (2007:880) confirms that one of the six factors that assist in the provision of high quality nursing care to older persons in long-term care facilities is sufficient multidisciplinary resources.

Theme 4: Contextual strengths used or recommended by participants

Volunteers in the community (fg 1)	Participants pointed out the use of volunteers as advice to other nurses to help them be resilient while caring for older persons. During the focus group interviews it was mentioned that the community must get involved with the older persons and support them by providing a safe environment to move around in and by realizing that the population is growing older. It was also mentioned that the older persons need to give something back to the community. The importance of volunteers from the community to get involved in the care of older persons was highlighted.	Participants say: <i>Hum, and that's what I mean by community involvement, we need to be able to make the community aware of here is an old age home, it should be a safe environment for our elderly, we must be able to feel confident to move about in the community.... we should show the world and others that we are going to be an older generation, we are becoming the older people, the elderly are no longer from 60 to 70, it is now from 60 to 100 and that we must realize. That we have to realize in our society that we are getting older and how do we go about with our people (fg 1:13);</i> <i>Yes we must use our elderly themselves in projects to reach out to the community again.....To also give them interest as something they can still do (fg 1:13);</i> <i>Hum community service. Volunteers (fg 1:9);</i> <i>I mean if and this is how the community is fed it sounds so funny because you feed the community, you start as a baby and we learn in the community to raise your child well so that one day he can look after himself, one day be able to care for his children, but not to care for his parents one day (fg 1:10);</i> <i>And then come the circle and then the children become the caregivers and then they can no longer care then the community become the caregivers and therefore I think it is so very important to involve the community in order for the cycle to be completed.</i> <i>We do not want to burden to the community, but that they can help us, (fg 1:10).</i>
	According to Caplan and Harper (2007:95-96) volunteers in their study provided interventions to older persons that were patients in a geriatric ward, which included: visits on a daily basis, activities that were therapeutic, assistance with feeding and hydration and protocols regarding vision and hearing. Results indicated that these older persons showed a lower incidence of delirium and a reduction in the severity and duration of the delirium (Caplan &	

Theme 4: Contextual strengths used or recommended by participants

	Harper, 2007:97). The incidence of falls and nursing home placements was also reduced (Caplan & Harper 2007:97-98). Cognitive and physical functioning improved and length of hospital stay was reduced although unplanned readmission after one month was increased (Caplan & Harper 2007:97-98). The programme was also cost-effective (Caplan & Harper 2007:95). The benefits of volunteer work provided by the older persons themselves, was confirmed by a study conducted by Lum and Lightfoot (2005:31) supporting earlier research that older persons that work as volunteers, reported better health themselves, were less depressed, experienced a reduced decline in functioning and had lower mortality rates than older persons that did no volunteer work, regardless of their suffering from the same medical conditions. However, the volunteering had no influence on the amount of health conditions that were diagnosed by doctors or on the rate of admission to nursing homes (Lum & Lightfoot 2005:51-52). It seems that the volunteer work increases the older persons' social and psychological resources that enable them to handle the medical conditions (Lum & Lightfoot 2005:51-52).	
Sub-theme 4.3: Nurses caring for older persons value a safe, homely environment as well as resources and equipment in the work environment.		
A safe environment (T2) (IHR) (fg 2, 4)	Safety, including a safe environment, was mentioned by participants as enabling them to care for older persons. These participants highlighted the fact that the safety of the older persons as well as the safety of the staff providing the care, needs to be taken into account. A safe environment for the older persons was also discussed in the focus group interviews. In one focus group interview it was stated that nurses caring for older persons need to protect the older person and in another the importance of environmental safety was highlighted.	Participants say: <i>With my protective feeling I ensure their safety (4);</i> <i>Safety for those who care (23).</i> <i>And to protect them (fg 2:15);</i> <i>One's environment must be right, meaning yes all that concerns security, loose carpets, loose wires that should not be lying around and all those things because otherwise you are going to be picking up people the whole day (fg 4:17).</i>
	Oulton (2006:39S) contends that the creation of a safe and secure work environment that is non-discriminatory and attractive for old and new nurses, although not related to resilience, as one of the possible solutions for the global shortage of nurses.	

Theme 4: Contextual strengths used or recommended by participants

Homely environment (fig 1, 3, 4)	Participants mentioned the creation of a homely environment as advice to nurses to be resilient. The importance of creating a homely environment for the older persons in the old age homes and retirement villages was discussed in the focus group interviews.	Participants say: <i>I think what would make it very enjoyable in my opinion, is the Eden concept, I think this is one of the most wonderful ways to handle the elderly. Give a little independence back to them, so if a resident don't feel like eating breakfast early in the morning but first to lie a little later and you give him his breakfast in the room, it's a small difference, but you it makes a big difference to them. It is that little bit of dignity of I can also still decide that you know, this is not a hostel, those routines, hum I know we must keep to routines, it always make our work easier, but that think outside the box, to give them time to sit in, to let them participate in a trail in the neighbourhood, for example, in that way we can make it nice for ourselves also, to be able to move out, not only to sit between four walls of a room (fig 1:12-13);</i> <i>Create a homely environment; yes; homely atmosphere that's why I always say let's come away from this clinical white hospitals we are not hospitals; we are a home for the elderly; a house with the emphasis on home (fig 3:24);</i> <i>One actually has more of a homely environment in a place for the elderly, you it's not really, you should have a part of a hospital as well, but more homely, and it's really nice to me (fig 4:19).</i> The 'Eden Alternative' is a model that strives to change the culture in residential aged care facilities by enriching the lives of the older persons and the staff by using children, animals and plants to cheer up the environment and create a homely atmosphere (Brownie 2011:63). Human growth is promoted and the older persons are empowered to build and follow meaningful lives (Brownie 2011:63). According to Brownie (2011:67) the 'Eden Alternative' integrates camaraderie, meaningfulness, diversity and impulsiveness into the daily events of the older persons where the older persons make the decisions and are able to engage in opportunities to reach their full potential. Hudson (2012:66) asserts that residential aged care is cheered up, vitalized
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Theme 4: Contextual strengths used or recommended by participants

	and renovated when mutually dependant interactions are fundamental and wherever creativeness is prized over regulations, laughter and joyfulness exist together with sadness and sorrow, and quality is the mutual aim for all caring. Dwyer (2011:399) contends that a holistic milieu and enhanced efficiency of all the workers in residential aged care facilities can be obtained by optimistic, healthy workplace atmospheres that focus on the development of skills in practical leadership and authority. Murphy (2007:878) concludes that one of the six factors that assist in the provision of nursing care of high quality for older persons in long-term facilities, include amongst others the provision of a social milieu that feels like home.	
Resources and equipment (fg 1, 3)	The importance of resources for example hearing aids, glasses, false teeth, wheelchairs and other aids to help the older persons to maintain their human dignity was discussed in one focus group interview. In another focus group interview, the importance of the correct equipment to care for older persons including a 'hoist' and equipment to bath the older persons that prefer bathing instead of showering was discussed.	Participants say: <i>They have hearing problems, their glasses break, their teeth break, it is part of their human dignity to hum to keep going on, it should be available for our elderly, that's so terribly important that it should be available, wheelchairs, aids, hum community service. We need to use, excuse you all, use our resources in the community; resources, hmm (fg 1:9);</i> <i>Your equipment; equipment to work with the elderly because it is different from other situations, in South Africa, they do not look at the equipment that should be there for the elderly, I mean we decide now actually all elderly should shower but how many of them might desire to sit in a nice lovely bath, but because someone has decided everyone should shower, now they take out all the baths, I have to say, if one day I need to go to an old age home or retirement village, I would love to bath, so give me a lift or something where I can relax in a bubble bath; bubble bath I say; yes you are still alive, you know, and equipment such as a hoist, but it is expensive equipment and stuff, equipment to help the nurses; we have had heavy elderly; yes and where the nurses got injured, yes; very heavy elderly; so equipment is very important (fg 3:23).</i>

Theme 4: Contextual strengths used or recommended by participants

According to Oosthuizen and Ehlers (2007:14) one of the factors that was recommended in order to convince nurses to stay in South Africa and not immigrate, was the provision of enough resources and equipment.

Theme 5: Spiritual strengths used or recommended by participants

Sub-theme 5.1: Religion is valued by nurses caring for older persons. (T51) (13HR)

Participants declared that religion is a strength that enables them to care for older persons. These participants highlighted the fact that their faith in Jesus Christ gave them the power to care for these older persons. They also revealed that their religion helps them to cope while caring for older persons. These participants testify that they are able to cope because God makes it possible for them. They pray and ask God to help them to cope and He answers by helping them to cope while they care for older persons. The participants also referred to the fact that their spiritual beliefs and practices make it worthwhile for them to care for older persons. According to these nurses their Christian beliefs and the opportunity to tell the older persons about the Lord makes it worthwhile to care for them. The religious beliefs of the participants enabled them to be resilient while caring for older persons. These participants acknowledge the fact that the only reason they are able to be resilient while caring for older persons is because God helps them to be resilient.

Participants say:

You must know the Lord (2);

I feel they are the gold of the world and Jesus put us all on the earth with a purpose and mission. Mine to be there for those who need me (11);

Pray is also one of my strongest points for it enables me to face anything in life because Christianity has taught me that I don't have to fight anything alone when my Redeemer lives (14);

Faith – without it you cannot do your work (26);

With the Lord above. The Lord gives your strength to do it. You should ask God every day to give you strength to be able to do it (28);

In the morning before I come into contact with an older person, I get still and talk to „Our Father“. I ask for guidance and patience and I ask that He opens the way for me to approach the older person so he / she can be at ease when I work with them (12);

I let the „Holy Spirit“ lead me to work with each elderly person (4);

The most important is that Jesus is walking the road with me and He is my greatest pillar (7);

Theme 5: Spiritual strengths used or recommended by participants

To have peace when I see the person is far away from the Lord and I tell them about the Lord, and I see the progress (2);

All I ask from God is that he must give me power to be more resilient while caring for older patient (33);

Through the power from above. To constantly acknowledge your dependence on God in prayer (7);

Power from Above – my Creator – without it I would never have made it; Grace, Peace, Holy Spirit who is my companion every day, making it possible for me (27).

According to Cameron and Brownie (2010:68) resilience in the work situation can be strengthened by being optimistic, by creating a difference or by being conscious of a religious belief system. Ablett and Jones (2007:736) assert that palliative care nurses mentioned that being aware of their own spirituality, enabled them to handle the needs of their patients and the families of their patients.

Richardson (2002:314) asserts that resilience is concerned with finding the motivational core in people and most people believe that they derive their strength from their God or an inspired force. Reich *et al.* (2010:199) argue that religious commands to develop optimistic emotions and override pessimistic emotions are abundant, referring to the counselling of the apostle Paul to early Christians in (Philippians 4:6) ‘Don’t worry about anything’ and (Philippians 4:4) ‘Always be full of joy in the Lord’ (Bible, 2010). According to Reich *et al.* (2010:199) for a long time psychological theories endorsed the idea that religion assists in stabilizing the emotions of people. Reich *et al.* (2010:199) cited other authors that agree that many studies endorse the belief that religion is connected to desired emotional outcomes and they imply that religion might play an important role in the promotion of emotional resilience.

Dick (2012:174-175) argues that not much consideration has been given to the religious concerns of staff caring for older persons and the findings of her study revealed that these staff did not use spiritual practices from outside for spiritual support but they utilized other religious resources, for example meaningfulness, relationships and hopefulness for both older persons and staff. Spiritual care for staff caring for older persons may include training to strengthen feelings of hope, meaningfulness, connectedness, ‘making a difference’ and by strengthening relationships with good communication techniques (Dick 2012:174-175).

Theme 5: Spiritual strengths used or recommended by participants

According to Monareng (2013:18) a lot of nurses experience difficulty in providing spiritual nursing care to their patients. Monareng argues that spiritual care is usually based on the religious upbringing of the nurse and not inevitably as part of the professional training of the nurse. Although prayer and the singing of religious songs for patients were frequently used during spiritual care, Monareng (2013:1, 8) maintains that praying, reading of the Bible and religious music are not the only spiritual interventions nurses can provide, they should also provide information to patients and do appropriate referrals because patients must be acknowledged as spiritual beings that deserve respect. MacKinlay (2008:157) adds that both basic and continuing nursing education need to address ageing and spirituality and should include spiritual assessment and consciousness of spirituality in older persons.

Sub-theme 5.2: Nurses caring for older persons believe that you need to treat others as you would like to be treated yourselves. (T15) (4HR)

Based on their spirituality, the participants mentioned that to treat others as you would like to be treated yourselves, is a strength that enables them to care for older persons. These participants highlighted the fact that they should treat the older persons the way that they would like to be treated when they are old themselves. By treating others the way they would like to be treated, helps them to cope while caring for older persons. They realized that it could be their own family that is being cared for and that they would only like the best treatment for their parents or grandparents. The participants declared that to treat others the way they would like to be treated, enables them to be resilient while caring for older persons.

Participants say:

My own policy = Do to others as you would like them to do to you!! (5);
Put myself in the place of the elderly with all his illnesses and disabilities (34);
You always have to realize it could be your mom or dad that you care for. Also remember you will also get older and then you would want other people to handle you and treat you the way you would want to be treated (3);
Every day to look after them and their needs as you want to be done to yourself. To love everyone as yourself!! (4);
Always live the statement: Do unto others as you want done to yourself. Always think that perhaps it may be my mother / father or grandmother / grandfather who needs to be looked at. Then I will only want the best (29);
I'm also going to grow old, be a grandmother, and then I want my children and grandchildren to care as I did (3);
You must treat them the way you would like the others to treat you if you are old take yourself and put yourself as if you are old and how would you like to be treated when you are old (21).

Theme 5: Spiritual strengths used or recommended by participants		
	Although not directly related to resilience but with regard to caring for the older person, Kalula <i>et al.</i> (2011:40) remind nurses that they will also grow older and they must keep this in mind when they come into contact with older persons. One of the categories identified in a study with palliative care personnel, referred to care giving as providing the care you would like for yourself (Ablett & Jones 2007:739). From a Judaeo-Christian viewpoint, this is confirmed by (Luke 6:31) who asserts that we need to do to other people what we would like them to do to us (Bible, 2010).	
Sub-theme 5.3: The provision of bereavement counselling to older persons and their families make it worthwhile to care for them. (T2) (0HR)		
	Participants pointed out that providing bereavement counselling to the older patients and their families makes it worthwhile caring for them.	Participants say: <i>And then sometimes too often: bereavement counselling, when the death angel intercedes, the support to those left behind, and the last service to the deceased, the caring, the assistance with the undertaking of the funeral, to the hearse, the last farewell of a beloved granny / grandpa, a life which ended forever, one granted to him / her as a complete person, now just body without the spirit! (4);</i> <i>To assist them and their families at the time of death, bereavement counselling (18).</i>
	Although not related to resilience, Kalula <i>et al.</i> (2011:247) assert that every nurse who cares for older persons, will sometimes need to care for a dying patient and will come across death, dying, grief and loss. Nurses need to be empathetic and support the family with compassion by listening carefully and answering questions as honestly as possible (Kalula <i>et al.</i> 2011:247). Clarke and Seymour (2010:857) contend that the following three themes emerged regarding end-of-life concerns as experienced by older persons: talking about it, aspects that influence the apprehension they have regarding death and dying, and planning in advance.	

The qualitative findings, discussion and literature control contributed to the reaching of objective two, namely ‘to explore and describe the strengths and coping abilities of nurses caring for older persons’ and contributed to reaching objective three, ‘to formulate recommendations from the findings to strengthen resilience in nurses caring for older persons’. The recommendations to strengthen resilience in nurses caring for older persons are discussed after the ethical considerations, rigour and limitations.

ETHICAL CONSIDERATIONS

The research was conducted under the ethical approval of the RISE project (Annexures A and B), and submitted to the Research Ethics Committee of the NWU. The researcher took ‘the right to self-determination, the right to privacy, the right to anonymity and confidentiality, the right to fair treatment, and the right to protection from discomfort and harm’ into account during all three phases of the research (Burns & Grove 2009:189).

Right to self-determination

The nurses were treated autonomously by acknowledging their right to make their own decisions regarding participation in the research. Respect for people was demonstrated by conducting the research under the ethical approval of the RISE project (Annexures A and B), by obtaining permission from the managers of the facilities caring for older persons (Annexure D) and by informing the nurses of the proposed research and by allowing them to choose to participate voluntarily in the research (Botma *et al.* 2010: 277).

Right to privacy

The right to privacy was respected by conducting the data collection at each facility in a private venue and by closing the door during data collection. The researcher explained to the nurses that the results of the research may be published but that their names and the names of the facilities will be held confidential.

Right to anonymity and confidentiality

The research data obtained during phase one was anonymous. No form of identification was provided on the demographic information form, the Resilience Scale, or the narrative. The data

was also reported anonymously. Confidentiality was maintained by keeping the names used by the nurses in the narratives and focus group interviews confidential. All the data was protected by storing it safely for data analysis. The confidentiality of the research data was further ensured by requesting the person that transcribed the focus group interviews (Annexure N) and the person that acted as co-coder for the narratives and focus group interviews (Annexure Q), to sign a confidentiality declaration.

Right to fair treatment

Fair selection and treatment were ensured by an all-inclusive voluntary sample and by treating the nurses fairly and respectfully during the research. The researcher adhered to the conditions and data collection procedures that the nurses agreed on and gave written consent to.

Right to protection from discomfort and harm

No risk to the nurses or the facilities was foreseen (Botma *et al.* 2010: 277). Benefits might be gained when the researcher provides feedback concerning the results of the research on how to strengthen the resilience of nurses caring for older persons. This could empower the nurses to be more resilient and even flourish while providing care to the older person. It could also benefit the facility if the nurses were more resilient and better able to cope with their valuable work.

RIGOUR

The rigour of the quantitative data was guaranteed by using a validated and reliable self-report instrument namely the Resilience Scale. The authors of the Resilience Scale, Wagnild and Young (1993:165), conducted a psychometric assessment of the Resilience Scale and the findings of their study maintained the ‘internal consistency reliability and concurrent validity of the Resilience Scale as an instrument to measure resilience’. Wagnild (2009:105) reviewed twelve particular studies conducted since 1999, that have used the Resilience Scale, and reported that the ‘Cronbach alpha coefficients ranged from .72 to .94 supporting the internal consistency reliability of the Resilience Scale’. The construct validity of the Resilience Scale was also confirmed by these studies (Wagnild 2009:105).

The Resilience Scale was originally tested with adults but later on a number of studies have validated that the scale has performed well when used on participants of all ages and from

different racial groups (Ahern *et al.* 2006:121). The Resilience Scale was used in numerous studies (Ahern *et al.* 2006:116-118). Wagnild (2009:105) confirmed that the Resilience Scale has proved to be a dependable and legitimate instrument to measure resilience and has been used with a wide variety of studied populations. The Resilience Scale was also used in South Africa by Koen, Van Eeden and Wissing (2011:4) with 312 professional nurses employed in public and private hospitals and primary healthcare clinics and a Cronbach alpha coefficient of 0.95 was obtained confirming the reliability and internal consistency of the Resilience Scale.

The trustworthiness of the qualitative data (narratives and focus-group interviews), was guaranteed by subjecting the research to four criteria (truth value, applicability, consistency and neutrality) as established by Lincoln and Guba (cited by Botma *et al.* 2010:292).

Truth value was ensured by the researcher by reporting the nurse's viewpoints portrayed in the narratives and focus-group interviews as clearly and honestly as possible (Morse and Field, cited by Botma *et al.* 2010:292). Data triangulation (Creswell 2009:191; Klopper [cited by Botma *et al.* 2010:292]), was used by asking the nurses to write narratives as well as by conducting focus group interviews to further explore their strengths and coping abilities. During the focus group interviews member-checking (Creswell 2009:191; Klopper [cited by Botma *et al.* 2010:292]), was done by asking the nurses to verify the results obtained from the narratives. During the focus group interviews the advice given to nurses caring for older persons to be resilient, further confirmed the results obtained from the narratives.

Applicability was ensured by providing a rich in-depth description of the narratives written by the nurses and the focus-group interviews conducted with them as well as by describing the all-inclusive sample and the explorative descriptive design with multiple phases that was used as recommended by (Moule and Goodman [cited by Botma *et al.* 2010:292]).

The consistency of the qualitative data was improved by using a co-coder and by the triangulation of data as advised by (Polit & Beck [cited by Botma *et al.* 2010:292]).

Neutrality was ensured when the researcher used bracketing, the researcher wrote a narrative during the trial run of the research as well as before data collection and an independent person was used as the co-coder, who confirmed the truth, significance and importance of the data as described by (Botma *et al.* 2010:292).

LIMITATIONS OF THE STUDY

Although an all-inclusive sample was used, the sample size was relatively small (n=43) for phase one and (n=17) for phase two. Taking this into account the results of the research could only be generalised with caution to similar contexts.

The Resilience Scale questionnaire was only available in English although the participants were mostly Afrikaans. Although most of the participants could read English well, the researcher had to explain the questionnaire in Afrikaans to some of them. The limitation was handled successfully in this way but it is recommended that the questionnaires should be translated into the official languages used by the participants for future research.

CONCLUSIONS AND RECOMMENDATIONS

During the formulation of the recommendations the quantitative results, including the results from the demographic information forms and Resilience Scales; the qualitative results, including the themes identified from the narratives and focus group interviews; as well as relevant literature were brought into relation with one another, and were integrated, leading to the following conclusions.

It was clear that there is a need to strengthen the resilience of nurses caring for older persons. The research gap, namely a need for recommendations to strengthen the resilience of nurses caring for older persons, could also be confirmed. It could further be concluded that nurses caring for older persons need resilience because they experience adverse working conditions while caring for older persons. It was seen further that these nurses use their personal, professional, contextual and spiritual strengths to handle these adverse working conditions. Recommendations to strengthen the resilience of nurses caring for older persons should take the adverse working conditions into consideration as opportunities and challenges to strengthen their resilience. These recommendations should further encourage nurses to use each one of their strengths to cope with the adverse working conditions they experience while caring for older persons. By using these strengths to cope with these adverse workplace conditions, these nurses enhance their personal, professional, contextual and spiritual strengths, leading to the positive outcome that their resilience is strengthened, and ultimately better care is provided to older persons.

These conclusions form the basis for the recommendations for community nursing practice, nursing education and further research.

Recommendations for community nursing practice

The formulation of recommendations to strengthen resilience in nurses caring for older persons are the positive outcome and unique contribution of this research.

The recommendations to strengthen the resilience in nurses caring for older persons are intended for both such nurses and for management in the care of older persons, as indicated in Table 11.

Table 11: Recommendations to strengthen resilience in nurses caring for older persons.

Recommendations to address the need for resilience in nurses caring for older persons
- Nurses caring for older persons should acknowledge their need for resilience. They can strengthen their resilience by following these recommendations and by attending in-service training or workshops to strengthen their resilience in order to handle the adverse working conditions they experience while caring for older persons, because resilience may empower them to cope, survive and flourish in these adverse working conditions. - Management should acknowledge the need for resilience and they can strengthen the resilience of nurses caring for older persons by providing opportunities to all categories of nurses to strengthen their resilience by providing opportunities for in-service training sessions or attending workshops.
Recommendations to address adverse working conditions
The resilience of nurses caring for older persons should be strengthened by empowering them to use their strengths to handle the following adverse working conditions they experience while caring for older persons: the need for balance, the emotional nature of the work, work ethics, staff shortages, the physical nature of the work and the dependency of the older persons.
Recommendations to strengthen resilience by encouraging nurses to use their strengths
Nurses can strengthen their resilience by using their personal, professional, contextual and spiritual strengths to handle the adverse working conditions they experience while caring for older persons.
Nurses can strengthen their resilience by using their personal strengths, including a caring attitude, a positive attitude and good health to enable them to handle the adverse working conditions they experience while caring for older persons.
Nurses can strengthen their resilience by using communication, education and being a role model as professional strengths while caring for older persons in order to handle the adverse working conditions they experience while caring for these older persons.
Nurses can use their contextual strengths, including the uniqueness of caring for older persons, support and the work environment to enable them to handle the adverse workplace conditions they experience while caring for older persons and to strengthen their resilience.
Nurses can strengthen their own resilience by being aware that the uniqueness of caring for older persons, including the dependency, improvement and appreciation of the older persons make it worthwhile for nurses to care for them.
Nurses can strengthen their resilience and handle the adverse working conditions they experience while caring for older persons by using their spiritual strengths, including the use of religion, treating others the way they would like to be treated and by providing bereavement counselling.

Recommendations for nursing education

Although the word nurses will be used, all recommendations include student nurses as well as qualified nurses.

- Nursing education institutions should give attention to the reality that the population is ageing in South Africa and globally. The basic education of nurses should contain a sufficient amount of theoretical and practical education and training regarding geriatric care to prepare nurses adequately to care for older persons in the community as well as in hospital. Continuing education and training should also be available to nurses that would like to specialize in geriatric care and improve their theoretical knowledge and practical skills while caring for older persons.
- Nursing education institutions should give attention to including resilience training in undergraduate as well as in post-graduate nursing curricula to empower nurses to learn and internalize all aspects of resilience to equip them to handle the adverse working conditions they experience in the nursing profession as well as when caring for older persons. Evidence-based literature regarding resilience and the strengthening of resilience in nurses could be included in these nursing curriculums.
- Nursing education should include explanations of the importance of resilience and nurses should be encouraged to use the recommendations to strengthen their resilience when working with older persons.
- Nurses should be educated regarding their potential to use their personal, professional, contextual and spiritual strengths to handle the adverse working conditions they face while caring for older persons.

Recommendations for nursing research

- Research could be conducted to formulate a definition of resilience applicable to nurses caring for older persons.
- Research could be conducted to develop a new model and / or theory on how nurses caring for older persons could strengthen their resilience.

- Nursing research could be conducted to establish what course content needs to be included in an undergraduate curriculum, continuing education courses as well as in specialization geriatric courses.
- Research could be conducted to further explore the factors that make it worthwhile for nurses to care for older persons.
- Further research could be conducted regarding the adverse working conditions nurses experience while caring for older persons using a bigger sample of nurses.
- It should be investigated whether there is an association between the resilience of nurses caring for older persons and the quality of care they provide by investigating whether the strengthening of their level of resilience will improve the quality of care they provide to the older persons. Evidence-based guidelines can be used to strengthen their resilience.

FINAL CONCLUSION

As final conclusion it can be declared that the purpose and objectives of the study were reached because the level of resilience in nurses caring for older persons was investigated, their strengths and coping abilities were explored and described and recommendations were formulated to strengthen resilience in nurses caring for older persons. The valuable practical implication of this research is the expectation that the implementation of these recommendations will produce the positive outcome of strengthening the resilience of nurses caring for older persons and enable them to survive, cope and even flourish, in the adverse working environment of caring for older persons.

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Competing interests

‘The authors declare that they have no financial or personal relationship(s) which may have inappropriately influenced them in writing this article.’

Authors' contributions

P. conducted the research and wrote the manuscript based on a dissertation for a master's degree in community nursing science. E. acted as supervisor and M.P. as co-supervisor.

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