

Fostering a caring presence and resilience among professional nurses working in primary health care

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DECLARATION

I, Jennifer Villaflores, student number 21074682, declare the following:

The research study, “Fostering a caring presence and resilience among professional nurses working in primary health care” is my own work, although I respect and acknowledge the professional contribution given by my supervisor in this research study.

I thoroughly read and understood the North-West University’s “Policy on Plagiarism and other forms of Academic Dishonesty and Misconduct, (2011)” and have applied and implemented this policy as well as the computer program recognised in the North-West University (NWU), namely “Turnitin” in my research study to avoid any forms of plagiarism. (see Annexure D).

I have used the Harvard method for citation and referencing whereby each significant contribution and quotation of other people has been attributed by citing and referencing the acquired information in my research study.

I have also submitted my dissertation to an accredited member of the South African’s Translators’ Institute for language editing (see Annexure J).

My research study has been approved by the Scientific Committee of the research focus area, INSINQ, the Health Research Ethics Committee of the Faculty of Health Sciences, NWU, Potchefstroom Campus, the Department of Health: North West Province, the Ethical Committee of the district, the Operational managers of the different clinics and lastly the participants (primary health care professional nurses) and patients who were involved in the study.

The research study conforms to the research ethical standards of the NWU (Potchefstroom Campus).

Miss J. Villaflores

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“I can do all things, through Christ who strengthens me.”

Philippians 4:13

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ABSTRACT

Background: Professional nurses are given multiple roles and responsibilities and due to today's pressured work environment of endless multi-tasking and multiple priorities, nurses run the risk that their caring presence and resilience may not come across effectively to patients and their families. Practicing caring presence improves the mental wellbeing of nurses, in which resilience is embedded, with a positive outcome of experiencing decreased stress and an enhanced capacity to cope.

Purpose: The purpose of the research was to explore and describe the caring presence and resilience of professional nurses in primary health care (PHC) and how caring presence and resilience can be fostered among these nurses within the primary health care clinics around a semi-urban area in a district of the North West Province.

Method: The research design selected was a qualitative, ethnographic study whereby two ethnographic methods were used namely: participant observation and semi-structured interviews, supported by field notes. Data was collected from an 'emic' perspective and purposive sampling was done. The target population were all professional nurses working in different government clinics and stable patients who were willing to participate. The sample size was determined by data saturation. Data collection was divided into two (2) processes whereby Hyme's acronym "SPEAKING" (which stands for the setting, participants, ends, acts, keys, instrumentality, norms and genre) was used to provide structure to the video recordings conducting a reflective practice. Semi-structured interviews were conducted, transcribed word-for-word and analysed. The researcher also generated field notes to strengthen the research findings.

Results: The video recordings showed that participants had the knowledge and skill to provide effective care to patients, however, due to certain factors, their caring presence was not well reflected to their patients. In the semi-structured interviews, participants were able to describe the concept of caring presence effectively, but did not seem to know the concept of resilience. Once resilience was explained, participants were able to share certain traits of resilience through their personal encounters in the workplace. Participants provided a description of challenges with recommendations on how to foster caring presence and resilience.

Conclusion: PHC professional nurses have adapted to the culture in PHC, displaying unintentional non-caring behaviours in rendering care to cope under difficult working conditions. These behaviours formed a pattern among PHC professional nurses, posing a risk to displaying a caring presence. Suggested recommendations to foster caring presence and resilience include addressing stressful and poor working conditions under which PHC professional nurses work. Recommendations were also based on findings of relevant literature and the conclusions which included informing PHC professional nurses of the risks that prevent a caring presence and to apply cultural transformation to positively foster a caring presence, which would then foster resilience. Recommendations are made for nursing education as well as limitations and areas for future research.

Key words: *Caring presence, resilience, professional nurse, primary health care, preserve, foster*

OPSOMMING

Agtergrond: Veelvoudige rolle en verantwoordelikhede word aan professionele verpleegkundiges gegee, en as gevolg van vandag se werksdrukomgewing met eindelose veelvoudige betaking en veelvoudige prioriteite, loop verpleegkundiges die risiko dat hulle deernisvolle teenwoordigheid en veerkragtigheid nie doeltreffend aan pasiënte en hul families oorgedra kan word nie. Die uitoefening van deernisvolle teenwoordigheid verbeter die emosionele welsyn van verpleegkundiges, waarby veerkragtigheid ingesluit is, en lei tot positiewe uitkomste, soos die ervaring van afnemende stres en 'n verhoogde kapasiteit om tred te hou.

Doel: Die doel van die navorsing was om die deernisvolle teenwoordigheid en veerkragtigheid van professionele verpleegkundiges in primêre gesondheidsorg (PGS professionele verpleegkundiges) te verken en te beskryf, asook hoe deernisvolle teenwoordigheid en veerkragtigheid onder hierdie verpleegkundiges bevorder kan word binne die primêre gesondheidsorgklinieke in 'n buitestedelike gebied in 'n distrik van die Noordwes-Provinsie.

Metode: Die gekose navorsingsontwerp was 'n kwalitatiewe, etnografiese studie waarin twee etnografiese metodes gebruik is vir die insameling van data, naamlik waarneming van deelnemers en semi-gestruktureerde onderhoude, ondersteun deur veldnotas. Data is ingesamel vanuit 'n emiese perspektief en doelgerigte monsterneming is gedoen. Die teikenpopulasie was almal professionele verpleegkundiges wat in verskillende regeringsklinieke werk en stabiele pasiënte wat bereid was om deel te neem. Die steekproefgrootte is bepaal deur dataversadiging. Data-insameling is in twee prosesse verdeel waarin Hyme se akroniem "SPEAKING" (wat staan vir *setting, participants, ends, acts, keys, instrumentality, norms* en *genre*) gebruik is om struktuur aan die video-opnames te gee. Semi-gestruktureerde onderhoude is gevoer, wat woord vir woord getranskribeer en geanaliseer is. Die navorser het ook veldnotas gegenereer om die bevindinge van die navorsing te versterk.

Resultate: Die video-opnames het getoon dat deelnemers die kennis en vaardighede het om effektiewe sorgsaamheid aan pasiënte te bied, maar agv sekere faktore is hulle sorgsame teenwoordigheid nie goed aan die pasiënte oorgedra nie. In die semi-gestruktureerde onderhoude was die deelnemers in staat om die konsep 'deernisvolle

teenwoordigheid' effektief te beskryf, maar het blykbaar nie die konsep 'veerkragtigheid' geken nie. Sodra veerkragtigheid verduidelik is, was deelnemers in staat om sekere kenmerke van veerkragtigheid te deel deur middel van hul persoonlike ervarings in die werkplek. Deelnemers het 'n beskrywing van uitdagings met aanbevelings gegee oor hoe om deernisvolle teenwoordigheid en veerkragtigheid te bevorder.

Gevolgtrekkings: PGS professionele verpleegkundiges het aangepas by die kultuur in PGS en vertoon onbedoelde nie-deernisvolle gedrag in die lewering van sorg om moeilike werksomstandighede die hoof te bied. Hierdie gedrag vorm 'n patroon onder PGS professionele verpleegkundiges, wat 'n risiko is vir die vertoning van 'n deernisvolle teenwoordigheid. Die aanbevelings voorgestel om deernisvolle teenwoordigheid en veerkragtigheid te bevorder, sluit in die aanspreek van stresvolle en swak werksomstandighede waaronder PGS professionele verpleegkundiges werk. Aanbevelings is ook gebaseer op bevindinge in relevante literatuur en die gevolgtrekkings, wat insluit die inlig van PGS professionele verpleegkundiges oor die risiko's wat 'n deernisvolle teenwoordigheid voorkom, en om 'n kulturele transformasie van 'n deernisvolle teenwoordigheid te kweek, wat dan veerkragtigheid sal bevorder. Aanbevelings word gemaak oor verpleegonderwys sowel as beperkings en gebiede vir toekomstige navorsing.

Sleutelwoorde: Deernisvolle, veerkragtigheid, professionele verpleegkundige, primêre gesondheidsorg, bewaar, bevorder

LIST OF ABBREVIATIONS

- ANA - American Nursing Association
- ANC - Antenatal care
- APHA - American Primary Health Association
- HREC - Health Research Ethics Committee
- NWU - North West University
- PHC - Primary health care
- PN - Professional nurse
- SANC - South African Nursing Association

TABLE OF CONTENTS

DECLARATION.....	(i)
ACKNOWLEDGEMENTS.....	(ii)
ABSTRACT	(v)
OPSOMMING.....	(vii)
LIST OF ABBREVIATIONS.....	(ix)
TABLE OF CONTENTS	(x)

CHAPTER 1

OVERVIEW OF RESEARCH STUDY

1.1 INTRODUCTION	1
1.2 BACKGROUND	1
1.2.1 Caring Presence	3
1.2.2 Resilience	5
1.2.3 Caring Presence and resilience in the nursing context	6
1.3 PROBLEM STATEMENT	7
1.4 RESEARCH QUESTIONS	9
1.5 PURPOSE	9
1.6 PARADIGMATIC PERSPECTIVE	9
1.6.1 Meta-theoretical assumptions	10
1.6.1.1 Man	10
1.6.1.2 Health / Illness	11
1.6.1.3 Environment	11
1.6.1.4 Nursing	12
1.6.2 Theoretical assumptions	12
1.6.2.1 Central theoretical argument	12

1.6.2.2 Conceptual definitions	13
1.6.2.2.1 Caring presence	13
1.6.2.2.2 Resilience	14
1.6.2.2.3 Professional nurses in primary health care	14
1.6.2.2.4 Primary Health Care	14
1.6.2.2.5 Foster	15
1.6.3 Methodological assumptions	15
1.7 RESEARCH METHODOLOGY	16
1.7.1 Research Design	16
1.7.2 Research Method	17
1.7.2.1 Population and sampling	19
1.7.2.2 Data collection plan	19
1.7.2.2.1 Participant observation	20
1.7.2.2.2 Semi-structured interviews	21
1.7.2.2.3 Documentation and field notes	21
1.7.2.3 Data analysis	22
1.8 METHODS TO ENSURE RIGOUR	23
1.9 ETHICAL CONSIDERATIONS	24

1.10 DISERTATION OUTLINE	26
---------------------------------	-----------

1.11 CHAPTER SUMMARY	26
-----------------------------	-----------

Figure 1.1	The four interlinked approaches of caring presence	5
-------------------	---	----------

Figure 1.2	Visual presentation of the central theoretical argument	13
-------------------	--	-----------

Figure 1.3	Graphical representation of Creswell's steps of data analysis	22
-------------------	--	-----------

Figure 1.4	Lincoln and Guba's framework for trustworthiness	24
-------------------	---	-----------

Figure 1.5	Graphic representation of the three basic principles relevant to the ethics of research	25
-------------------	--	-----------

Table 1.1	Overview of the research method and procedures	18
------------------	---	-----------

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION 26

2.2 RESEARCH DESIGN 26

2.2.1 Qualitative research design 28

2.2.2 Ethnographic research 28

2.3 RESEARCH METHOD 29

2.3.1 Population 29

2.3.2 Sampling 29

2.3.3 Sample 31

2.3.4 Role play and trial run 32

2.3.5 Data Collection 32

2.3.5.1 Participant observation 33

2.3.5.2 Semi-structured interviews 34

2.3.5.3 Documentation and field notes 35

2.3.6 Data analysis 35

2.3.7 Integration of data with literature findings 38

2.4 MEASURES TO ENSURE RIGOUR 38

2.4.1 Truth Value 38

2.4.2 Applicability 39

2.4.3 Consistency	39
2.4.4 Neutrality/ confirmability	40
2.5 ETHICAL CONSIDERATIONS	40
2.5.1 Respect for all persons	41
2.5.2 Beneficence	42
2.5.3 Justice	43
2.6 CHAPTER SUMMARY	44
Diagram 2.1 Framework of research methodology	27

CHAPTER 3

FINDINGS OF THE STUDY

3.1 INTRODUCTION	45
3.2 THE APPLICATION OF DATA COLLECTION AND DATA ANALYSIS	45
3.2.1 Data collection	45
3.2.2 Data analysis	49
3.3 RESEARCH RESULTS AND LITERATURE INTEGRATION OF THREE SETS OF RESEARCH FINDINGS	51
3.3.1 Research findings on how participants enacted caring presence	52
3.3.1.1 Theme 1: The setting seemed to be clinical	53
3.3.1.1.1 The consultation rooms seemed to be moderately conducive to enact caring presence	54
3.3.1.1.2 The appearance of professional nurse was clinical and authoritative	55
3.3.1.2 Theme 2: The manner in which participants enacted caring presence	56
3.3.1.2.1 The participants enacted caring presence	56
3.3.1.3 Theme 3: Participants met the ends (goals) of the consultation	60
3.3.1.3.1 Participants were able to provide care to meet the needs of the patients	60

3.3.1.4 Theme 4: Participants made contact with patients through nursing interventions	61
3.3.1.4.1 The nature of contact participants makes with patient	61
3.3.1.5 Theme 5: Participants reflected the ‘keys’ of caring presence through the use of their tone, manner and spirit of enacting caring presence	63
3.3.1.5.1 Attitude of professional nurses	63
3.3.1.6 Theme 6: Participants utilised effective instrumentality through the use of verbal and non-verbal communication techniques	65
3.3.1.6.1 Communication (verbal and non-verbal) between the participant and patient indicated understanding	65
3.3.1.7 Theme 7: The focus of the patient-nurse consultations was influenced by the nature of the consultations	67
3.3.1.7.1 Consultations were mainly nurse-focused	67
3.3.1.8 Theme 8: Genres: The consultation is clinical in nature and challenges that limit caring presence	69
3.3.1.8.1 The overall consultation between the participants and patients seem to be clinical in nature	69
3.3.1.8.2 Challenges experienced that may prevent caring presence between the professional nurse and patient	70
3.3.2 RESEARCH FINDINGS ON THE PARTICIPANTS’PERCEPTION ON CARING PRESENCE AND RESILIENCE	72

3.3.2.1 Theme 1: Caring presence and resilience from primary health care professional nurses' perspective	74
3.3.2.1.1 Research findings on the meaning of caring presence	74
3.3.2.1.2 Research findings on the meaning of resilience	76
3.3.2.2 Theme 2: Challenges primary health care professional nurses experience regarding caring presence and resilience	78
3.3.2.2.1 Sub-theme 1: Communication challenges	78
3.3.2.2.2 Sub-theme 2: Staff shortages in general	85
3.3.2.2.3 Sub-theme 3: Lack of Resources and equipment in the workplace	88
3.3.2.2.4 Sub-theme 4: Services professional nurse provide	90
3.3.2.2.1 Sub-theme 5: Unsatisfactory remuneration that PHC professional nurses are receiving on a monthly basis	91
3.3.2.3 Theme 3: Recommendations from PHC professional nurses to foster caring presence and strengthen resilience	92
3.3.2.3.1 Sub-theme 1: Providing effective communication among staff members and patients and staff members and managers at health care facilities	92
3.3.2.3.2 Sub-theme 2: Addressing staff shortages at health care facilities	96

3.3.2.3.3 Addressing lack of resources and equipment at the workplace	97
3.3.2.3.4 Addressing of services professional nurses provide	98
3.3.2.3.5 Addressing feelings of remuneration primary health care professional nurses are experiencing	99
3.3.3 FIELD NOTES OF RESEARCH STUDY	100
3.3.3.1 Methodological notes	100
3.3.3.2 Theoretical notes	102
3.3.3.3 Subjective notes	103
3.4 CHAPTER SUMMARY	105
Diagram 3.1 Process of collecting data	49
Diagram 3.2 Process of analysing data	50
Diagram 3.3 Brief layout of process of discussing research findings	51
Diagram 3.4 Brief summary of observing caring presence of primary health care professional nurses using the acronym “SPEAKING”	54
Table 3.1 Overall demographic data of participants	44
Table 3.2 Brief summary of the research findings on the participant’s perceptions of caring presence and resilience	73

CHAPTER 4

CONCLUSIONS, EVALUATION, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

4.1 INTRODUCTION	106
4.2 THE CONCLUSION OF THE STUDY	106
4.3 EVALUATION OF THE STUDY	108
4.4 LIMITATIONS OF THE STUDY	109
4.5 RECOMMENDATIONS	110
4.5.1 Recommendations for nursing practice	110
4.5.1.1 Recommendations to the North West Department of Health and to the two (2) district managers and operational managers of the clinics	111
4.5.1.1.1 Recommendations on providing effective communication at health care facilities	111
4.5.1.1.2 Recommendations on improving staff shortages and the workload at health care facilities	114
4.5.1.1.3 Recommendations on addressing the lack of resources and equipment at health care facilities	115
4.5.1.1.4 Recommendations on addressing the services professional nurses provide	115
4.5.1.1.5 Recommendations on addressing remuneration of primary health care professional nurses	116

4.5.1.2 Recommendations to primary health care professional nurses	116
4.5.1.2.1 Recommendations on fostering a caring presence in the workplace environment	116
4.5.1.2.2 Recommendations on fostering a caring presence through the manner in which participants enacts and reflects caring presence during nurse-patient consultations	117
4.5.1.2.3 Recommendations on fostering and implementing resilient behaviours and attitudes among primary health care professional nurses	118
4.5.2 Recommendations for nursing education	118
4.5.3 Recommendations for future research	119
4.6 CHAPTER SUMMARY	120
REFERENCES	121

ANNEXURES

Annexure A: North-West University Ethics Committee approval letter	130
Annexure B: North-West Department of Health approval letter	131
Annexure C: An example of a transcription from the semi-structured interviews	132
Annexure D: Turnitin Originality Report	133
Annexure E: Consent form for participants	134
Annexure F: Consent form of managers	135
Annexure G: Consent form of patients	136
Annexure H: Letter to the Primary Health Care Managers	137
Annexure I: PowerPoint presentation on fostering a caring presence and resilience among primary health care professional nurses	138
Annexure J: Certificate on the certifying of language edited in this dissertation	139
Annexure K: Interview guide for semi-structured interviews	140

CHAPTER 1

OVERVIEW OF THE RESEARCH STUDY

1.1 INTRODUCTION

This chapter consists of a background discussion that highlights the aspects that initiated the study and a problem statement which states the main focus of the study. The research questions were formulated from integrating the background and problem statement, followed by the purpose of the study. The paradigmatic perspective, research design and method and the ethical considerations applicable to this study are also discussed. Lastly, the dissertation is outlined and the summary concludes Chapter 1.

1.2 BACKGROUND

Caring is inevitable in nursing as nursing is defined by the American Nurses Association (2015:online) as a process that defends, promotes and optimizes health as well as the ability to prevent illness and injury, reduce suffering through diagnosing and treating and caring for individuals, families and communities. Nurses take on this profession as many have a deep desire and calling to compassionately care for the sick, wounded, traumatised and weak, thus making excellent caregivers (Knobloch, 2007:10). In the community, nurses are seen as leaders; health care providers, educators, counsellors, referral resources, role models and advocates, also serving as initiators and primary influencers in creating a positive, safe and healthy work environment (Brown & Bar, 2013:E1; Clark, 2008:20).

Multiple roles are thus given to nurses and they not only take on these roles expected of them in their workplace, they also take on the roles and responsibilities outside the workplace, for example be mothers (or fathers), parents, wives (or husbands) and/or active community members. Many nurses unknowingly develop positive coping skills such as resilience, to manage with the pressures and stress experienced every day (Koen & Du Plessis, 2011:4). However, due to today's pressured work environment of endless multi-tasking and multiple priorities, nurses run the risk that their caring

presence and resilience may not come across effectively to patients and their families (Leebov, 2009:online).

Looking at caring presence specifically, Osterman *et al.* (2010:198) define this concept as a way of being there in the context of another. People can be in the same room with one another and be so self-absorbed in their own thoughts or interests that interaction takes place only superficially. Within a healthcare context, the nurse may be physically (in body) there with a patient while at the same time focusing on other matters. In such cases the nurse's caring presence is inhibited due to their focus not being on the nurse-patient interaction or relationship (Osterman *et al.*, 2010:198). This can therefore lead to miscommunications between the patient and professional nurse (PN) which has a negative impact on patient care as communication, trust, support, safety and advocacy will be compromised and needs of patients will not fully be met (Finfgeld-Connett, 2008a:116; Tavernier, 2006:153). In addition, nurses that do not practice caring presence are likely to cause medical errors due to miscommunication between patient and nurse, increased stress and poor coping skills (Finfgeld-Connett, 2008a:116; Thorsteinsson, 2002:40).

Nurses' caring presence may cause challenges in improving patient care in the South African health care system. Over the years, the South African health care system has been evolving to better patient care; shifting from a hospital care treatment to an integrated primary health care community based service as the intention was to promote and implement the phrase "Prevention is better than cure" (Dennill *et al.*, 1999:35). As the South African health care system shifted from a hospital based service to an integrated primary health care (PHC) community based service, the workload of PHC nurses increased leading to quality care being compromised as these nurses provide care to hundreds of community members on a daily basis (Buchan, 2006:16). Therefore the nursing profession is seen as a busy profession as health care is continuous; nurses provide around the clock care at hospitals and at some clinic facilities, working about 40 or more hours per week (Horwitz & Pundit, 2008:37). The aim of PHC services, as the point of entry to health care, is to improve accessibility to health care, to promote health and to prevent disease (Van Rensburg, 2004:162). A comprehensive approach is followed, and it is expected from professional nurses in PHC to assess, diagnose and treat a wide range of ailments

and conditions, and to promote health across the lifespan from before birth to the elderly (Van Rensburg, 2004:162).

One of the most common challenges experienced by professional nurses within a South African PHC setting is thus providing quality care to a large number of patients each day (Walker & Gilson, 2004:1252; Sabo, 2006:138). Coping with this high workload can cause burnout leading to stress, fatigue and decreased motivation (Sabo, 2006:138; Koen, 2010:10; Knobloch, 2007:4-6). Furthermore, Taylor and Barling (as cited by Edward & Hercelinskyj, 2007:240) add to the statement above by mentioning that nursing is a profession that is associated with the terms such as “stress” and “burnout.” However, despite the burnout and stress experienced by PHC professional nurses, many still remain in the profession of nursing coping with every day challenges and adversities in the workplace (Koen & Du Plessis 2011:4). Professional nurses that still manage to positively cope with these challenges and adversities providing caring presence in the workplace are seen as resilient in their workplace.

In order to provide further background, caring presence and resilience are explored further.

1.2.1 Caring presence

‘Caring presence is the mutual act of intentionally focusing on the patient through attentiveness to their needs by offering of one’s whole self to be with the patient for the purpose of healing’

(Tavernier, 2006:154)

Caring presence has evolved from its roots in theology and philosophy appearing only in nursing literature in the 1960s where Vaillot (as cited by Du Mont, 2006) described caring presence as an existential concept in the practice of nursing. Osterman *et al.* (2010:198) simply defines the term presence as being there in the context of one another and also mentions that there are three ways of “being there” namely: 1. Partial presence 2. Full presence and 3. Transcendent presence. Partial presence within a nursing context is based on a way of being there in which the nurse is physically there focusing his or her energy on a task that is relevant to the patient, but is without acknowledging the patient entirely. Full presence is when the nurse is fully focused on

the patient providing empathy, care and the use of self in face-to-face interaction. Lastly, transcendent presence is spiritual in nature and a broader, more abstract and elusive way of being there for a patient. Through a nurse's presence, an environment of peace, comfort and harmony is created and felt by the patient (Osterman *et. al.*, 2010:198).

'Caring presence' is also defined by Finfgeld-Connett (2008b:528) as two separate concepts to better understand the meaning of caring presence. 'Caring' is defined as an interpersonal process characterised by skilled and professional nursing, interpersonal sensitivity and intimate relationships and the term 'presence' is also defined as an interpersonal process that is characterised by compassion, holism, closeness, vulnerability and adaptation to unique circumstances (Finfgeld-Connett, 2008:528b). Therefore, Finfgeld-Connett (2008b:111) argues that the phrase 'caring presence' when used together is synonymous in nature making the phrase seem redundant. However, Amendolair (2007:58) counter argues and states that caring requires presence in order for nurses to exhibit caring behaviours. Brown and Gaut (as cited by Amendolair, 2007:58) also elaborate that through the action of 'caring presence', patients experience quality of care.

Furthermore, the concept of caring presence is defined by Covington (2003:304-306) as consisting of four interlinked approaches namely: a way of being, a way of relating, a way of being-with and being there, and lastly as means for nursing interventions (see figure 1.1). Caring presence, as a way of being, is an approach for the nurses to assess and identify the patient's needs and from there be an advocate for patients; intervening therapeutically on their behalf. Caring presence, as a way of relating is illustrated as a way to assist patients with their needs by promoting comfort to provide opportunities for growth and healing. Caring presence defined as being-with and/or being there are both means for the nurse to illustrate caring behaviours to patients such as comfort, listening, attentiveness and providing physical, psychological, and spiritual support. Caring presence, as a nursing intervention, is a critical approach to the patient's well-being, because the presence of the nurse with the patient provides the nurse with opportunities to improve patient outcomes and prevent complications.

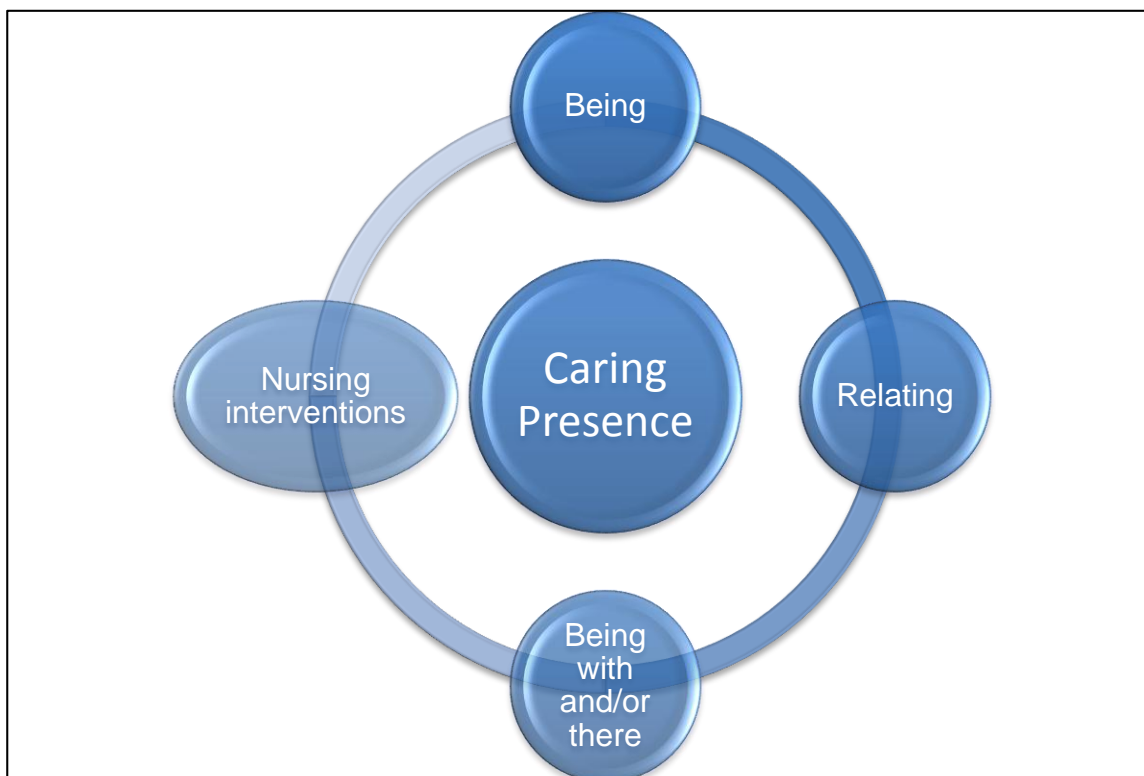


Figure 1.1: The four interlinked approaches of caring presence

(Adapted from Covington, 2003:304-306)

1.2.2 Resilience

“When we learn to become resilient, we learn how to embrace the beautifully broad spectrum of the human experience”

(De Walt, 2012:online)

Resilience has various definitions, however in this context, the most appropriate definition for resilience is the ability for people to ‘rebound’ or recover in the face of difficult times (Jacelon, 1997:123). Life is not easy; there are everyday difficulties and struggles, however, resilience has important characteristics for nurses in their everyday work as Taylor and Barling (as cited by Edward & Hercelinskyj, 2007:240) mention that nursing is a profession that has been associated with stress and burnout. People with high resilience have specific traits or attributes known as ‘protective factors’ assisting individuals to overcome adversity and these traits include the following, namely: hardiness, coping, self-efficacy, optimism, tolerance, adaptability, self-esteem and a sense of humour (Grafton *et al.*, 2010:699; Koen, 2010:22-24). A study was done by Richardson (2002:312) to understand the origin of resilience and

resilience was conceptualised as an innate energy or motivating life force within an individual. Linking to the origin of resilience, Gillespie *et al.* (as cited by Grafton *et al.*, 2010:699) add that resilience is a dynamic process where, even though there is continuous adversity, positive reintegration occurs enabling the innate resource (spirit, energy life force) to learn from every adverse experience and build a greater resilience.

1.2.3 Caring presence and resilience in the nursing context

“Presence is not a question of judging or evaluating a client or a client’s situation. Presence is to see the client’s situation in a positive and creative light with a vision for how the present situation of the client relates to his further spiritual development. It is to accept a person as he is. It is to understand that the person is exactly where he needs to be in order to take the next step in his spiritual development. It is not about fighting with problems, darkness, drama and defences on the personality level, it is about becoming aware. It is about lighting the light in the inner being of another person.”

(Giten, 2013:online)

Koen and Du Plessis (2011:4) mention that resilience enables professional nurses to find satisfaction and meaning in their work and be successful caregivers. A study was conducted on the resilience of professional nurses and from the findings from Koen (2010:10) the following characteristics were identified as resilience namely: hope, optimism, coping self-efficiency, sense of coherence, mental health and wellbeing, joyfulness, appreciation of life, self-respect, perseverance, overcoming of obstacles, self-reflection, self-control, vigilance, constructiveness, self-discipline, efficiency, being committed, taking responsibility, passionate, flexible, able to adapt, open minded, handling of emotions, striving for improvement, confidence and mature with inner strength and proudly professional. These resilient characteristics correlate with McMahon and Christopher’s (2011:75) four main characteristics essential to enhance caring presence, namely: professional, moral, relational and personal maturity. A professionally mature nurse is coherent and constructive using empirical, esthetical, personal and ethical knowledge to deliberately provide caring presence, rather than being task orientated and providing only routine care to patients (Koen & Du Plessis 2011:4; McMahon & Christopher, 2011:75). A morally mature nurse is described by Valliot (as cited by McMahon & Christopher, 2011:75) as a “committed nurse”

choosing to engage with patients despite all obstacles rather than being detached during care. Relational maturity is the ability to communicate effectively with the patient through therapeutic use of self as an instrument (McMahon & Christopher, 2011:75). Lastly, a personally mature nurse is self-aware and self-knowing, able to overcome obstacles through balancing personal and professional obligations, thus remaining free from burnout, compassion fatigue, or preoccupation (Bright, 2012:54; Knobloch, 2007:16; Koen & Du Plessis, 2011:4; Machon & Christopher, 2011:75-76). It is thus clear that caring presence and resilience are interlinked with one another as the two terms have similar, mutually enhancing characteristics. In addition, Finfgelgeld-Connett (2008b:116) states that practicing caring presence in itself improves the mental wellbeing of nurses, in which resilience is embedded, as they experience decreased stress and an enhanced capacity to cope.

1.3 PROBLEM STATEMENT

Nursing is a diverse profession where multiple roles are given to nurses and they not only take on these roles expected of them in their workplace such as being health caregivers, educators and advocates for patients, they also have to take on other roles and responsibilities outside the workplace for example be mothers (or fathers), wives (or husbands), parents and/or active community members within their community. The multiple roles and priorities that nurses' experience at the workplace increases the risk that their caring presence may not come across effectively to patients and families they serve (Leebov, 2009:online). In addition, one of the most common challenges experienced by professional nurses within a South African PHC setting is providing quality care to a large number of patients each day which can cause burnout leading to stress, fatigue and decreased motivation (Kautzky & Tollman, 2008:24).

There is currently (and has been) a great deal of research being done on resilience within the nursing profession (Edward & Hercelinskyj, 2007:240-241; Koen, 2010:10; Koen & Du Plessis, 2011:8). This research is essential, as resilience in the workplace is proven to overcome 'stress' and 'burnout' embedded within nursing (Koen, 2010:10; Koen & Du Plessis, 2011:8). In addition, a great deal of research literature also elaborates how caring presence is important to improve the quality of patient care (Baart, 2002:1-2; Bright, 2012:12-15; Brown *et al.*, 2013:E1-E6; Finfgelgeld-Connett,

2008a:116). However, a research gap could be identified, namely that no scientific literature could be found on fostering caring presence and resilience of professional nurses in PHC.

From experience working as a student in PHC and as a registered PN in two different public clinics around a semi-urban area in a district of the North-West Province for two consecutive years, caring presence is being practiced among PHC professional nurses as many do portray certain characteristics that enhance caring presence. These PHC professional nurses are also seen as resilient in the workplace despite the alarming rate of staff shortages, high workload, lack of resources and negative patient behaviours that they are faced with on a daily basis. On the other hand, many PHC professional nurses may be unaware of their caring presence and resilience in the workplace leading to absenteeism from burnout and staff shortage, poor level of patient satisfaction from miscommunication and burnout, work overload leading to poor work satisfaction and conflict among staff members. The question arises that if caring presence and resilience are not effectively established and applied within a professional nurse's life, how can a caring presence and resilience then be fostered to limit burnout, stress, compassion fatigue and preoccupation with a high workload to ultimately promote quality patient care? On the other hand, the question can also be asked on what can be learned from PHC nurses who do seem to enact caring presence and who do seem to be resilient in their workplace. Currently, no adequate academic based literature to answer these questions has been found.

Therefore the focus of this research will be on fostering a caring presence and resilience among professional nurses within PHC. This research formed part of an overarching study called the RISE project, aiming at 'Strengthening the resilience of health caregivers and risk groups' (Koen & Du Plessis, 2011:4).

1.4 RESEARCH QUESTIONS

The research questions applicable for the study include the following:

- How is caring presence enacted among PHC professional nurses?
- What are the perceptions of PHC professional nurses on caring presence and resilience?
- How can caring presence and resilience be fostered among primary health care professional nurses at public clinics around a semi-urban area in a district of the North West Province?

1.5 PURPOSE

The purpose of the research is to explore and describe the caring presence and resilience of professional nurses at public clinics around a semi-urban area in a district of the North West Province and how caring presence and resilience can be fostered among these nurses. The information of the study may contribute to the development of recommendations to foster the caring presence and resilience of PHC professional nurses.

The objectives of the study will thus include the following:

- To explore and describe how caring presence is enacted among PHC professional nurses.
- To explore and describe the perceptions of PHC professional nurses on caring presence and resilience.
- To explore how caring presence and resilience can be fostered among PHC professional nurses at public clinics around a semi-urban area in a district of the North West Province.

1.6 PARADIGMATIC PERSPECTIVE

Polit and Beck (2012:622) state that a paradigm is defined as a world view and is compared as observing the world through lenses; assisting in improving one's focus and broadening one's mind on a phenomenon.

The paradigmatic perspective is therefore defined as assumptions or beliefs that form a framework for observations and reasoning, necessary for interpreting and

internalising the research process (Botma *et al.*, 2010:187; Burns & Grove, 2005:645). In this research study, the researcher discusses the paradigmatic perspective through discussing the meta-theoretical, theoretical and methodological assumptions.

1.6.1 Meta-theoretical assumptions

Meta-theoretical assumptions are not scientifically proven yet these beliefs are still considered to be true and factual by the person adhering to the assumptions (Polit & Beck, 2012:622). The following components are discussed and are based on an academic, personal, cultural, and Christian-religious worldview namely: man (as a living being), health/illness (which includes the state of man), environment (referring to the community) and nursing (which includes the discipline and purpose).

1.6.1.1 Man

The researcher believes that every man is a unique living being, created by God, the Father in His own image. Man is a multidimensional being, because every man is created with a soul, which is defined by the Catechism of the Catholic Church (1996-2015) as human consciousness and freedom. God, from His unconditional love for man, gave man the ability to choose his own destiny and created man for a significant purpose, which is included and revealed in God's Will and plans. In the Holy Bible, God shares His messages through his son Jesus Christ, spreading the Word of loving one another as God loves us and treating people as you would like to be treated. Furthermore, in the Holy Bible, many stories revealed how man overcame toils and tribulations through calling on God for His help and guidance. God promised man that He will not give man anything man cannot handle (1 Corinthians 10:13) (Bible, 1993:1164).

In this study, man is referred to as the participants, which are the registered professional nurses and the patients. The meanings mentioned in the Holy Bible is about unconditional love, the manner in treating people and overcoming challenges that are all relevant in the research study as the expectation of a professional nurse is to render optimal care to patients through unanticipated and difficult circumstances or challenges experienced at the workplace and the patients also go through challenges regarding maintaining their health and wellbeing. Professional nurses should treat patients with love and care in order for patients to receive optimal care.

1.6.1.2 Health/ Illness

Health is defined by the World Health Organisation (2013:online) as a “state of complete physical, mental, social well-being and not merely the absence of disease or infirmity”. Furthermore, the World Health Organisation (2013:online) includes that health is a harmonious, dynamic and balanced unity between the internal (which includes the mind, body spirit) and external (which includes the physical, social and spiritual) existence of a person. Illness is therefore viewed oppositely, where there is a disharmony and imbalance between the internal and external existence of a person (World Health Organisation, 2013:online).

In this study, health is viewed as professional nurses providing and fostering a caring presence and resilience to provide optimal care and wellbeing for their patients and also for themselves. Illness, in this study refers to the risk factors observed by the researcher that inhibits a caring presence, as well as negative feelings and challenges experienced by professional nurses that inhibit a caring presence and resilience. Therefore, recommendations should be considered and implemented to foster a caring presence and resilience which will then enable professional nurses to provide optimal health care for patients and themselves.

1.6.1.3 Environment

The researcher views an environment as part of the world which God has created and should therefore be respected. In addition, the meaning of the term ‘environment’ has various definitions, however, the definitions relevant for this research study is defined by the Macmillan Dictionary (2009-2015:online) as an external condition in which a person works, as well as the social and cultural forces that shape the life of a person or community.

In this study, the term environment refers to the workplace as well as the social and cultural practices of professional nurses working at public clinics around a semi-urban area in a district of the North West Province.

1.6.1.4 Nursing

The American Nurses Association (2015:online) defines nursing as a process that defends, promotes and optimizes health as well as the ability to prevent illness and injury, reduce suffering through diagnosing, treating and caring for individuals, families, communities. In addition, Henderson's theory (as cited by Letsie, 2015:109) also adds to the concept of nursing, viewing nursing as a profession with a unique function to assist individuals, (sick or well), in the performance of attaining health or its recovery. Furthermore, this is done through empowering individuals by providing evidence based knowledge that if applied, will aid in helping gain independence to maintain and sustain optimal health and wellbeing (Henderson as cited by Letsie, 2015:110).

In this study, nursing is viewed as a caring profession that requires nurses to effectively portray nurse-patient interaction through being resilient which will then provide optimal patient care and improve the wellbeing of nurses. Therefore, fostering a caring presence and resilience among PHC professional nurses is essential in providing optimal care for patients.

1.6.2 Theoretical assumptions

Theoretical assumptions are theoretical descriptions derived from scientific knowledge within the nursing field and other fields. The key concepts relevant in this research study include the concepts of caring presence, resilience, professional nurses in primary health care, primary health care and foster (Polit & Beck, 2012:665).

The focus of the study was derived from a functional approach and therefore the researcher's theoretical assumptions were based on a central theoretical argument and conceptual definitions. The following central theoretical argument is central in this study, followed by conceptual definitions (Polit & Beck, 2012:665).

1.6.2.1 Central theoretical argument

Creating a deeper understanding of how a caring presence is enacted among professional nurses and exploring and describing their perceptions of caring presence and resilience will enable the researcher to formulate recommendations on how a

caring presence and resilience can be fostered to thus improve quality patient care and their own well-being.

Figure 1.2 provides a visual presentation of the central theoretical argument of this study.

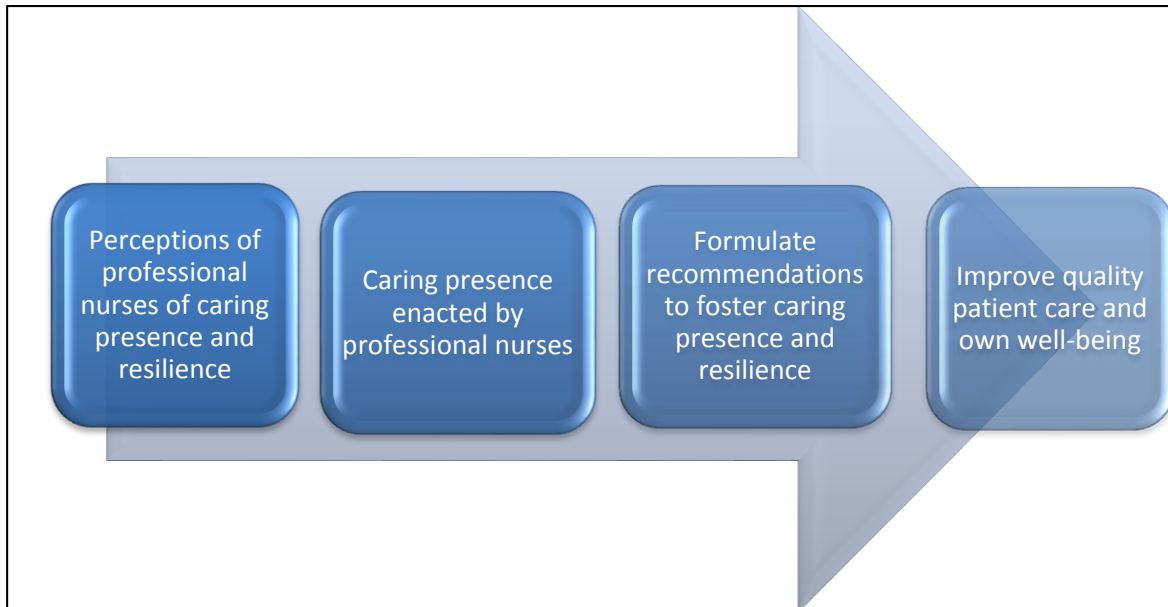


Figure 1.2: Visual presentation of the central theoretical argument

1.6.2.2 Conceptual definitions

1.6.2.2.1 Caring presence

The term refers to caring for patients by fully and transcendentally being there for the patient (Osterman *et al.*, 2010:198). Full presence is the epitome of empathy, caring and the therapeutic use of self in face-to-face interaction focusing on the patient's problems, issues and needs (Osterman *et al.*, 2010:198). Transcendent presence is a broader, more abstract and elusive way of being there for a patient (Osterman *et al.*, 2010:198). Through a nurse's presence, an environment of peace, comfort and harmony is created and felt by the patient (Osterman *et. al.*, 2010:198).

In this study, caring presence refers to the PHC professional nurse purposely focusing on the patient by being attentive to their needs, offering of one's whole self to be with the patient to promote healing (Tavernier, 2006:154).

1.6.2.2.2 Resilience

Resilience is defined in the Oxford dictionary of English (2005:online) as the activity of rebounding or springing back; rebound; to recoil and to return to the original position. Within the context of the study, resilience is defined as the ability for people to 'spring back' or 'rebound' in the face of difficult times (Jacelon, 1997:123). Koen and Du Plessis (2011:4) indicate the following as characteristics of resilience namely: hope, optimism, coping self-efficiency, sense of coherence, joyfulness, appreciation of life, self-respect, perseverance, overcoming of obstacles, self-reflection, self-control, vigilance, being constructive, self-discipline, efficiency, commitment, taking responsibility, passionate, flexibly, able to adapt, open minded, handling of emotions, striving to improve, confidence and maturity and professionalism. In this research, resilience refers to the ability of professional nurses in PHC to overcome stress and burnout through overcoming difficulties in the workplace by adapting; to become stronger and more committed to a profession that they value (Koen, 2010:22).

1.6.2.2.3 Professional nurses in primary health care

In this research the term professional nurse refers to all individuals that are registered at the South African Nursing Council (SANC) as such, and who practice in line with the definition provided by the American Public Health Association (APHA), namely as professional nurses that practice in PHC settings to promote and protect the health of individuals, families and communities using and implementing knowledge from nursing, social and public health sciences (Clark, 2008:4-5).

1.6.2.2.4 Primary Health Care

In this study, PHC is defined as health care provided by professional nurses at a clinic. A clinic is an establishment devoted to the treatment of particular diseases or medical care of out-patients (Oxford, 2007:online). Furthermore, the American Nurses Association (ANA) defines that the PHC practice as population focused, with the goal of promoting health and preventing disease and disability for all people through the creation of conditions in which people can be healthy (Clark, 2008:4-5).

1.6.2.2.5 Foster

The term 'foster,' according to the Oxford Dictionary (2014), is defined as encouraging the development of something (especially something desirable), to cherish or to nourish.

In this research, the focus is on exploring and describing how caring presence and resilience is fostered among PHC professional nurses. From the background discussion, it is clear that some professional nurses are aware and might enact caring presence and might demonstrate resilience, whilst others might not. Both caring presence and resilience can be a natural strength, and/or it can be fostered through interventions such as education and training, reflection, introspection and personal and professional growth (McMahon & Christopher's, 2011:75). Currently there is a need for empirical investigations on how to foster caring presence and resilience in professional nurses in primary health care.

1.6.3 Methodological assumptions

"The ethnographer goes into the field with the aim of discovery and becomes a human instrument that perceptively gathers information from people and events and then makes sense of what is seen by identifying patterns and formulating scientific explanations."

(Roper & Shapira 2000:65)

The methodological assumptions are defined as assumptions made by the researcher regarding the methods used in the research process, in this case in the process of ethnographic qualitative research (Creswell, 2014:455). The planned process and execution of the plan for collecting and analysing data proved to be good scientific practice and ensured that the research findings of the study were trustworthy, had a structured framework and was therefore consistent with the research questions, purpose, objectives and ethical considerations of the study (Botma *et. al.*, 2010:283). Data collection is explained as part of the research process that describes how the researcher gathered relevant information for the research objectives and to answer the research questions of the study (Brink, 2010:141; Klopper, 2008:69). Data was collected using an inductive strategy, because the researcher used a central

conceptual approach instead of an obvious conceptual framework (Botma *et al.*, 2010:190).

Data was also collected from an 'emic' perspective by collecting data through participant observations and individual semi-structured interviews as the informants' behaviour, perceptions and opinions were needed for the study (Botma *et al.*, 2010:195). An 'emic' perspective means that the researcher makes field notes and the information is thus constructed in categories that she builds up inductively from what was learned from the participant, which also enables participants to voice their opinions (Henning, 2013:83). The researcher, from a reflexive viewpoint, interpreted what was seen and heard from participants during data collection; as the researcher was part of the nursing culture being studied and was influenced by the experiences and relationships encountered on caring presence and resilience (Roper & Shapira, 2000:4). The researcher was in uniform when conducting the study to not only be professional, but also enable professional nurses to feel they can relate to the researcher who is also a PHC PN.

1.7 RESEARCH METHODOLOGY

The research methodology consists of the research design and method. The research design and method are discussed briefly to provide an overview. A more comprehensive discussion follows in Chapter 2.

1.7.1 Research Design

The research design selected is a qualitative, ethnographic study. Ethnography is defined by Roper and Shapira (2000:1) as a research process of learning about people by learning from them. Brink (2010:114) also defines ethnography more scientifically as an in-depth study of naturally occurring behaviour within a culture or social group concerned with behaviour, beliefs, values and attitudes of a specific group of people within a specific culture. In this study, the researcher selected an ethnographic approach allowing the researcher to experience and observe the perceptions, opinions and behaviours with regards to caring presence and resilience of professional nurses working in PHC while maintaining the professional distance necessary to conduct the research (Brink, 2010:115; Roper & Shapira, 2000:2). The researcher used two

ethnographic methods to collect data namely: participant observation and semi-structured interviews, supported by field notes. Professional nurses in PHC (which are the participants of this study) were encouraged to participate and give their perceptions on fostering a caring presence and resilience. This design is applicable as the researcher aims to learn from participants within their 'nursing' culture; gaining more insight on the awareness of caring presence and resilience among professional nurses through each individual experience and thus establishing how caring presence and resilience can be fostered in their workplace (Roper & Shapira, 2000:13).

The researcher is also a PN working in primary health care and is therefore part of the nursing culture understanding the culture and is motivated to conduct this study to contribute in the quality of patient care and the wellbeing of nurses.

1.7.2 Research Method

The research method and procedure is briefly summarized in Table 1: Overview of the research method and procedures, followed by a discussion.

Table 1.1: Overview of the research method and procedures

Objective	Population & Sampling	Data collection	Data analysis	Rigour
<p>1. To explore and describe the perceptions of PHC professional nurses on caring presence and resilience</p> <p>2. To explore and describe how caring presence is enacted among PHC professional nurses</p> <p>3. To explore how caring presence and resilience can be fostered among PHC professional nurses at public clinics around a semi-urban area in a district of the North West Province</p>	<p><u>Population</u></p> <p>Target population included:</p> <ul style="list-style-type: none"> • Registered professional nurses working in PHC clinics. • The total number of professional nurses working in PHC is 64 at the ten clinics. • Patients that are in stable condition attending the clinic for their chronic medication or follow up visit. <p><u>Sampling</u></p> <ul style="list-style-type: none"> • Purposive sampling for both registered professional nurses and patients. • Therefore the sample size was determined by data saturation. 	<p>The researcher observed how the professional nurse enacts caring presence during a consultation with a patient at the PHC.</p> <p>Semi-structured interviews were conducted with registered professional nurses where the researcher used a voice recorder during the interview.</p> <p>Field notes were taken throughout the research study.</p>	<p>Coding field notes and interviews, sorting to establish patterns, generalising ideas and noting down personal reflections and insights.</p> <p>The video recorded consultation were analysed with the professional nurse during the semi-structured interview where the professional nurse reflected on how the professional nurse enacted caring presence using the acronym “SPEAKING” as a framework.</p>	<p>Applying Lincoln and Guba’s framework of trustworthiness (see Chapter 2 for more detail)</p>

1.7.2.1 Population and sampling

The setting was the ten (10) public PHC clinics around a semi-urban area in a district of the North West Province. The target population were all PHC professional nurses working in different public clinics. The researcher also chose patients that were in a stable condition who were willing to participate during their consultation with the PN.

Purposive sampling was used to select an appropriate number of participants who were willing to participate from the total number of professional nurses (Brink, 2010:123; Botma *et al.*, 2010:200-201). The selection criteria included all professional nurses working at a public PHC clinic who were willing to participate; of any age, race, gender and years of experience, a PN that obtained either a nursing degree or diploma, and who are registered with the SANC as a registered professional nurse. The exclusion criteria included professional nurses that did not wish to participate, student nurses or other categories of nurses.

The selection criteria for the patients that professional nurses consulted for the study were stable patients above the age of eighteen years that were not unwell or in an emergency situation, and not requiring urgent attention from their health care provider.

The exclusion criteria for patients were patients that did not wish to participate in the study, unwell patients or patients that needed urgent attention from their health care provider and/or any patient below the age of eighteen years.

During the data collection, when the researcher achieved data saturation through generating high quality and sufficient data, where no new themes emerged from data collection, the sample size was then determined reaching a total number of twelve PN participants.

1.7.2.2 Data collection plan

The researcher collected data using two ethnographic methods namely: participant observation and semi-structured interviews. Data collection was also supported through the researcher taking field notes. For the preparation for data collection and to ensure that the researcher was competent in collecting data, the researcher

conducted role plays with non-participants, and received feedback from the researcher's supervisor before commencing with actual data collection.

The effectiveness of the data collection was tested through firstly conducting role play whereby the researcher used non-participants to test the data collection methods, followed a trial run where the researcher observed and interviewed professional nurses at the researcher's workplace to establish if participants were comfortable, that they understood the procedure and questions and if there were any changes needed to be made. The following three data collection techniques were used:

1.7.2.2.1 Participant observation

The researcher observed how the professional nurse enacted caring presence during a consultation with a patient at the PHC clinic. Before the participant observation was commenced, the researcher obtained informed consent from both the participant and the patient, as explained under in the consent forms found in Annexure E and G. The participants (which were the PHC professional nurses) were observed according to Hyme's acronym (as cited by Roper & Shapira 2000:71): "SPEAKING" (which stands for Setting, Participants, Ends, Act, Key, Instrumentality, Norms, and Genre).

The **setting** was consultation roomss at the PHC. The primary health care professional nurses were the **participants** selected for the study and were observed on their **enactment** of a caring presence during the nurse-patient consultation. The **ends** and **key** of the event were the manner in which a caring presence was enacted by the PHC professional nurse during the nurse-patient consultation. The **instrumentality** in the study was verbal and non-verbal communication. **Norms** were observed by observing if a routine was followed and lastly the **genre** was observed by observing the overall nurse-patient consultation.

Verbal and written consent was given by both the patient and professional nurse to video record the nurse-patient consultations capturing verbal and non-verbal interactions thoroughly, giving a better, more holistic picture on the enactment of a caring presence by professional nurses. Another aim of the video recording the nurse-patient consultation was to enable a more accurate data analysis and cross checking for the research study (Creswell, 2014:203; DiCicco-Bloom *et al.*, 2006:315-316; Klopper, 2008:69).

1.7.2.2.2 Semi-structured interviewing

The researcher used a reflective practice, reflecting with the participants about the nurse-patient consultation, highlighting how caring presence was portrayed during the consultation. The video recording of the nurse-patient consultation was watched by the researcher and the participant. The purpose was for participants to examine their personal thoughts and actions.

From the video recording, further questions were asked by the researcher:

- How do you think you enacted a caring presence during this consultation?
- What made it easy/difficult for you to enact caring presence in this consultation?
- What were the difficulties that challenged your resilience?

Follow-up questions were asked to further explore the perceptions of the participants on the concepts of caring presence and resilience:

- What are your views on caring presence and resilience?
- Tell me of a time when you enacted a caring presence and resilience at work.
- In your opinion, what do you recommend on fostering a caring presence and resilience in the workplace?

1.7.2.2.3 Documentation and field notes

The researcher documented all observations, conversations, feelings and interpretations in the field notes (Roper & Shapira, 2000:84-85). Demographic data of each participant was also collected such as the participant's gender, age, race, years of service and qualification, for the purpose of illustrating multiple perspectives from the participants (Creswell, 2014:199-200).

1.7.2.3 Data analysis

The data analysis process was done by coding field notes and interviews, sorting to establish patterns, generalising ideas and theories and noting down personal reflections and insights (Roper & Shapira 2000:93). The data obtained during the interviews were word-for-word transcribed after participant observations and interviews were completed at the clinics. The researcher transcribed and analysed the interviews conducted on a consistent pace for the avoidance of an overload of

information and to also establish data saturation from the interviews conducted, before moving to another clinic (Creswell, 2014:194-195). ‘Winnowing’ of data was implemented, through focusing only on data relevant for the research topic; namely fostering a caring presence and resilience in the workplace among PHC professional nurses (Creswell, 2014:195).

The researcher analysed data according to Creswell’s steps of data analysis (see Figure 1.3):

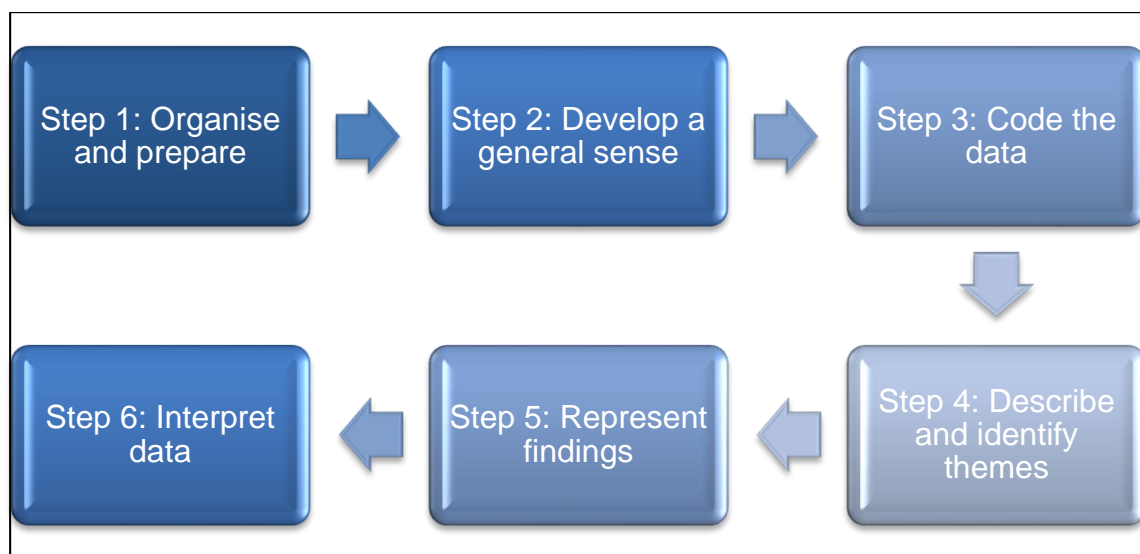


Figure 1.3: Graphical representation of Creswell’s steps of data analysis as applied

(Adapted from Creswell as cited by Botma *et. al.*, 2010:223-224)

The data collected was coded using descriptive labels which summarised the content of the observations and interviews answering the research questions in the study (Roper & Shapira, 2000:94). Ethnographic research is broad; therefore the researcher started with the coding process by creating a preliminary description of categories with the participant observation and semi-structured interviews for analysis (Creswell, 2014:199), namely the setting, demographic data, general perspectives, specific perspectives and strategies (Creswell, 2014:199-200; Roper & Shapira, 2000:94-96), which are discussed in detail in Chapter 2.

After the data was descriptively grouped, patterns of reoccurrence were established and these patterns were refined to create themes, subthemes and categories. This enabled the researcher to determine appropriate and re-occurring data and classify the data into themes for data saturation (Creswell, 2014:200). The researcher furthermore made use of reflective practice which according to Somerville and Keeling (2004:42) is a process of examining personal thoughts and actions to better understand one's self in building on existing strengths and take appropriate future action. Furthermore, the aim of reflective practice was to develop professional actions that were aligned with personal beliefs and values which was established later when integrating the research findings from the video recordings with the semi-structured interviews.

An independent co-coder was involved in the study that analysed the data separately from the researcher. Consensus was reached therefore identifying themes as accurate and relevant to the study (Jooste, 2010:322). After the consensus established, the research findings were then linked to academic literature to understand, compare, establish and differentiate the rich and complex data collected.

1.8 METHODS TO ENSURE RIGOUR

Rigour was applied by the researcher through the constant application of self-reflection and self-honesty in the research study (Botma *et al.*, 2010:231). The researcher was seen as an 'insider' to the 'culture' of nursing, where the data collected and analysed were consciously and objectively described and analysed from the researcher's observations and also the participant's point of view to avoid any means of bias.

Rigour was furthermore applied in every aspect of the study by using the four (4) criteria of trustworthiness from Lincoln and Guba (as cited by Botma *et al.*, 2010:292; Klopper, 2008:69-70) namely: Truth value, applicability or transferability, consistency and neutrality or conformability (see Figure 1.4) (see more detailed discussion in Chapter 2).

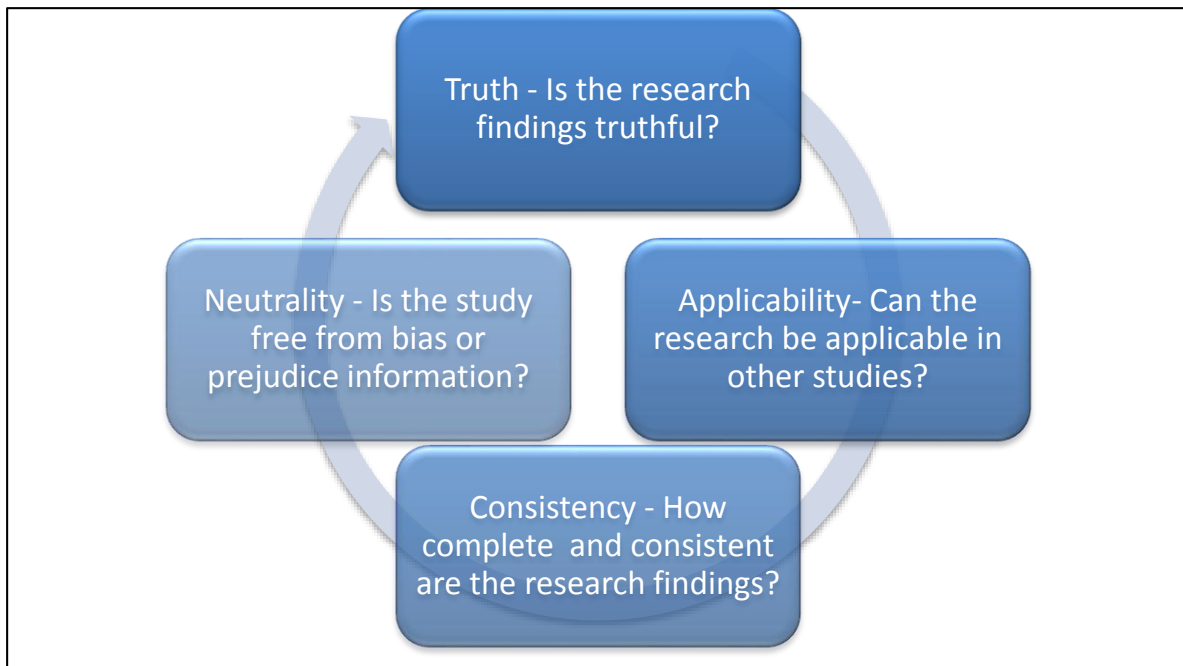


Figure 1.4: Lincoln and Guba's framework for trustworthiness

(Adapted from Botma *et. al.*, 2010:292)

1.9 ETHICAL CONSIDERATIONS

Ethical considerations were constantly applied throughout the research study to prevent any kinds of harm towards the participants and patients. Ethical considerations were applied by promoting justice, respect and beneficence to all participants and patients (see Figure 1.5) (see more detailed discussion in Chapter 2).

The study continued when ethical approval and permission had been granted by the following:

- The Health Research Ethics Committee of the North-West University of the Faculty of Health Sciences, Potchefstroom Campus (see Annexure A)
- The Department of Health: North-West Province (see Annexure B)
- The district managers and operational managers of the ten government clinics around the area where the research took place (see Annexure H and F)
- Voluntary informed consent of participants: Professional nurses and stable patients (see Annexure E and G)

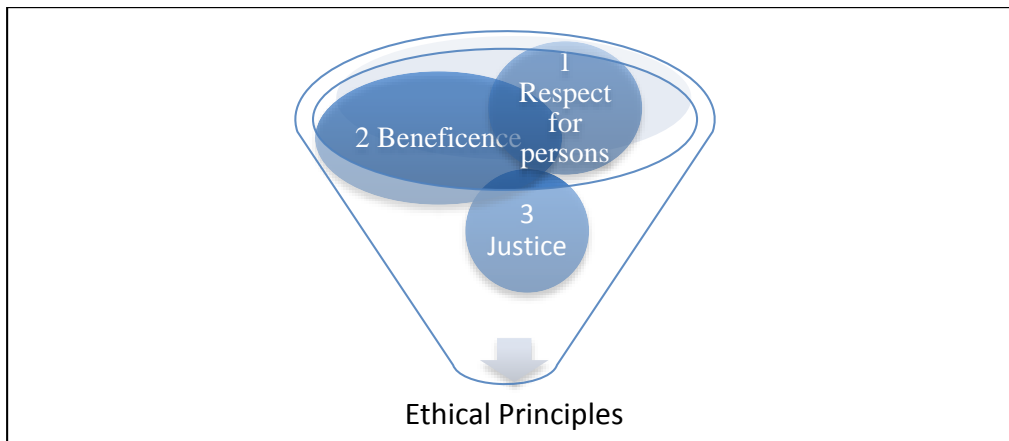


Figure 1.5: Graphic representation of the three basic principles relevant to the ethics of research

(Adapted from Botma *et al.*, 2010:345 -348)

1.10 DISSERTATION OUTLINE

The dissertation outline includes the following chapters:

Chapter 1: Overview of the research study

Chapter 2: Research methodology

Chapter 3: Findings of the study

Chapter 4: Conclusions, evaluation, limitations and recommendations of the study

1.11 CHAPTER SUMMARY

The introduction and background thoroughly explains the motive behind the research topic, 'Fostering a caring presence and resilience among professional nurses working at primary health care.' Furthermore the problem statement with the research questions clarified the need for this research. The purpose of the study was therefore stated correlating with the research questions. The research design and method were identified and will furthermore be elaborated in Chapter 2. Procedures to ensure rigour throughout the study were indicated. Ethical considerations were also indicated and lastly, and an outline of the dissertation was compiled.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

Chapter 1 was an overview of this research study. In Chapter 2 a more detailed description was given, focusing on the research methodology which included the research design and research method. The research method covered the population, sample, sampling method and size, pilot study, data collection, data analysis and lastly the literature integration. Methods to ensure rigour and ethical considerations to ensure true and substantial research findings was also thoroughly discussed.

2.2 RESEARCH DESIGN

De Vos, Strydom, Fouché and Delpont (2011:143) and Brink (2010:92) define a research design as a technique dictated by the research question where the researcher carries out the project focusing on the end product, and all the steps in the process to achieve the outcome expected. To answer the research questions, the researcher selected a qualitative, ethnographic design as described by Roper and Shapira (2000:1) and Brink (2010:114). An ethnographic approach was chosen to allow perceptions, opinions and behaviours to be observed with regard to the caring presence and resilience of professional nurses working in PHC, while maintaining the professional distance necessary to conduct the research (Brink, 2010:115; Roper & Shapira, 2000:2).

Two ethnographic methods to collect data, namely participant observation and semi-structured interviews, supported by field notes. Data analysis commenced after data collection through coding the interviews to establish patterns, generalise ideas and theories and note down personal reflections and insights (Roper & Shapira 2000:93). Diagram 2.1 is a brief summary of the research design and its application in the research method, followed by a discussion of the design.

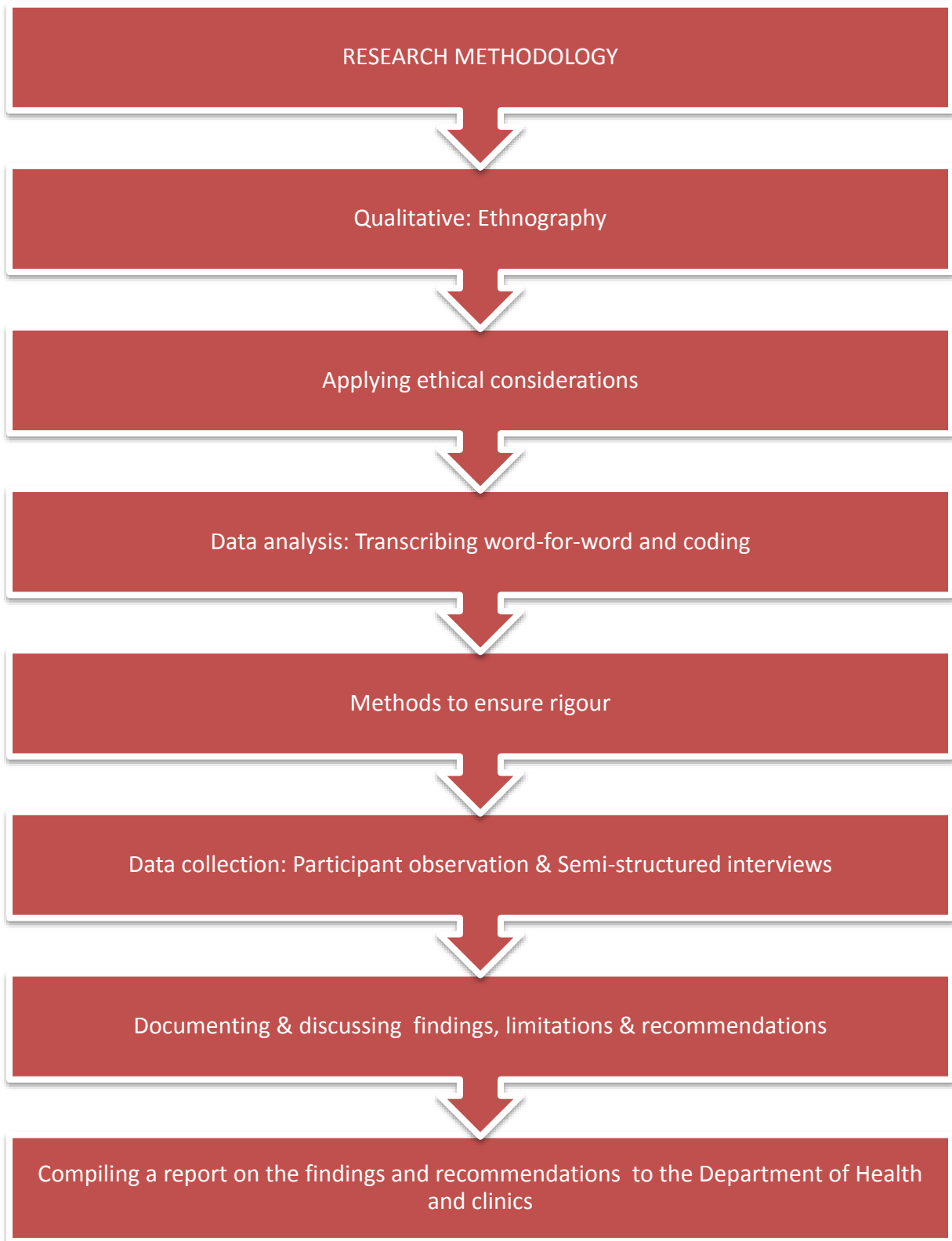


Diagram 2.1: Framework of research methodology

2.2.1 Qualitative research design

Klopper (2008:62-63) states that qualitative research begins by accepting that there are many truths in the world valid to specific contexts. This means that in qualitative research, the researcher's aim is to find meaning in the views of those being researched, as little is known about a topic.

A qualitative research approach was used to explore, observe and describe professional nurses' caring presence and resilience in PHC clinics. Data was collected through participant observation and semi-structured interviews, followed by analysing data thematically by first transcribing data that had been collected and coding (Brink 2010:11). The researcher had constant interaction with participants, studying them at their workplace environment and was also subjective through applying inductive and dialectic reasoning in the study (Brink 2010:11).

2.2.2 Ethnographic research

Ethnography is defined by Roper and Shapira (2000:1) as a qualitative approach of learning about people by learning from them. Brink (2010:114) also defines ethnography more scientifically as an in-depth study of naturally occurring behaviour within a culture or social group concerned with behaviour, beliefs, values and attitudes of a specific group of people within a specific culture. In this study, the researcher selected an ethnographic approach allowing the researcher to experience and observe the perceptions, opinions and behaviours with regard to a caring presence and resilience of professional nurses working in PHC clinics, while maintaining the professional distance necessary to conduct the research (Brink, 2010:115; Roper & Shapira, 2000:2).

Being a PN working in PHC clinics created an understanding to the nursing culture in PHC which enabled a trust relationship to be formed among participants. This also made the researcher more motivated to conduct the study at the public clinics around a semi-urban area in a district of the North West Province, because of the personal involvement at the clinic (Henning *et. al.* 2013:41-42). The researcher selected an emic perspective, experiencing the culture of the participants from an 'insider's point of view,' meaning the researcher being a professional nurse working in PHC (Brink 2010:114-115).

2.3 RESEARCH METHOD

Research method is a process that arranges and analyses the study in an organised manner (Klopper, 2008:69). The research method included the following steps that are discussed below, namely the population, sampling, sample and sample size, pilot study, data collection, data analysis, ethical considerations and research rigour (Brink, 2010:53; Klopper, 2008:69).

2.3.1 Population

The term population is defined by Brink (2010:206), Botma *et al.*, (2010:290) and Klopper, (2008:69) as an entire group of people that meet a certain criterion for inclusion and is of interest to the research. In this study, the target population was professional nurses working in PHC at public clinics around a semi-urban area in a district of the North West Province. Patients that were in a stable condition were also included in the study during their consultation with the professional nurse. They did not participate as research participants; however, the patients were included in order to enable observations of nurse-patient consultations. The total number of the target population in all ten clinics were sixty four PHC professional nurses (N=64) and the total number of participants that participated in the study were twelve as data saturation was obtained through the observations and interviews of the twelve participants.

2.3.2 Sampling

Purposive sampling was used for this study for participants (professional nurses) to represent the study phenomenon and for gaining knowledge and experience to provide essential input and meaning to this study (Brink 2010:133).

Recruitment and sampling were conducted in the following order:

1. The sample was recruited and selected by notifying and inviting all public clinics in the semi-urban area in a district of the North West Province to invite professional nurses to willingly participate in the study.
2. Approval was firstly obtained from the North West Department of Health and district managers to start the study. An operational manager's meeting was held

whereby the study was explained using a power point presentation (see Annexure I) and two consent forms were given to each operational manager; one form for asking their permission to conduct a study in their clinic and the other consent form was for the PHC professional nurses at the clinic (see Annexure F and E).

3. The study was explained thoroughly to the operational managers of each clinic and asked the managers to explain the study and to kindly give each PN a consent form and if there were any further enquiries, the contact numbers of the researcher were available on each consent form.
4. A period of one week was given to manager and professional nurses and a follow up was done, giving the operational managers time to freely decide if they would like their clinic to participate or not.
5. Once permission had been granted from the operational managers and the number of professional nurses were made known, the intended plan was to invite patients collecting their chronic treatment or at the clinic for antenatal visits via the clerks (as this was the plan mentioned in the research proposal; however, the rectifications are discussed in detailed in Chapter 3). The patients who were stable and willing to participate were chosen for the observation by the professional nurse during a nurse-patient consultation.

(Botma *et al.*, 2010:200-201; Brink, 2010:123)

The eligibility (or inclusion) criteria for participating in this study were the following:

- Professional nurses working at a government PHC who were willing to participate in the study.
- Professional nurses working in PHC of the age of above 18 years, race, gender and years of experience.
- Professional nurses who had obtained either a nursing degree or diploma, and who were registered with SANC as registered professional nurses.

The exclusion criteria included:

- Professional nurses that did not wish to participate.
- Student nurses or other categories of nurses.

The selection criteria for the patients that professional nurses consulted for the study were:

- Stable patients that 18 years of age or above and of any race, gender and social background
- Stable patients that were not unwell or in any emergency situation, and
- Stable patients not requiring urgent attention from their health care provider.

The exclusion criteria for patients were:

- Patients that did not wish to participate in the study,
- Unwell patients or patients that needed urgent attention from their health care provider, and/or
- Any patient below the age of eighteen (18) years

The selection inclusion and exclusion criteria of both participants and patients were strictly followed and met in the study to protect and promote safety and yield to accurate findings (Sofaer, 2002:334).

2.3.3 Sample

The study was chosen to be qualitative so therefore the sample size was determined by the saturation of data obtained through a repetition of themes and subthemes from data collection and during data analysis (Botma *et. al.*, 2010:200). Purposive sampling was done; selecting a total amount of twelve professional nurses who were willing to participate. The process of sampling followed an 'acquiring informants' approach (Burns & Grove, 2005:534), where potential participants were seen as colleagues in research.

As a PN working at a PHC clinic within a semi-urban area in the North West Province, entry to this population was therefore already obtained. A professional relationship with the participants was built and maintained to prevent confounding bias and also

obtained their cooperation in sharing their perceptions and behaviour with regard to caring presence and resilience.

Census of the setting was taken by inquiring how many professional nurses were employed at that particular clinic to gain an accurate population size for the study (Roper & Shapira, 2000:70).

2.3.4 Role play and trial run

A trial run is defined as a small-scaled run of the actual research study to assess the viability of the proposed study and to establish possible flaws in the data collection methods (Brink, 2010:166). Before the trial run, and in order for the preparation of collecting data and ensuring the researcher's competence, the researcher firstly conducted a role play with non-participants, compiled a report by collecting data from a fictional consultation (of which the non-participants were fourth year nursing students), analysed the data and submitted the compiled report to the supervisor. Feedback was received that was necessary before commencing with actual data collection.

After the role play report had been proved to be precise, a trial was done to test the effectiveness of the data collection method. This trial run was conducted whereby a few participants were observed and interviewed where the researcher works to establish if the participants were comfortable, understood the procedure and questions and if any changes were required. To limit bias, both the role play and trial run were excluded from the research findings.

2.3.5 Data collection

Data collection is explained as part of the research process that describes how the researcher gathered relevant information for the research objectives and to answer the research questions of the study (Brink, 2010:141 & Klopper, 2008:69).

Data was also collected from an 'emic' perspective by collecting data through participant observations and asking questions in individual semi-structured interviews as the informants' behaviour, perceptions and opinions were needed for the study (Botma *et al.*, 2010:195). An interview guide was used during the semi-structured interviews providing an informed structure to the interviews. (See Annexure K)

The researcher used the following three techniques to collect data: participant observation, semi-structured interviews and field notes.

2.3.5.1 Participant observation

Experience was gained through working as a student nurse and community service nurse and due to currently working at one of the PHC clinics as a professional nurse, automatic entry is gained into this population. During the conduction of research, the closeness was built and maintained with participants to obtain their trust and co-operation in openly sharing their perceptions and behaviours with regard to fostering caring presence and resilience (Burns & Grove, 2005:534).

Professional nurse were observed on how they enacted a caring presence during a consultation with a patient at the PHC clinic. In the research proposal, what was initially stated was that participants would be observed during two different nurse-patient consultations; however, due to the shortage of time and staff and to ensure that participants were not inconvenienced, the researcher decided to only observe one nurse-patient consultation to reflect on during the semi-structured interviews (the changes are further discussed in the limitations of the study in Chapter 3).

Before the participant observation commenced, informed consent was firstly obtained from both the participant and the patient, as explained under 'Ethical considerations'. The participant was observed according to Hyme's acronym (as cited by Roper & Shapira 2000:71): 'SPEAKING', which is distinguished as the Setting, Participants, Ends, Act, Key, Instrumentality, Norms and Genre.

The **setting** was observed by how the professional nurse was presented and how the environment worked appeared, namely the consultation room at the PHC. The PHC professional nurses (which were the **participants**) were observed on how they **enacted** a caring presence; for example how the PN spoke to the patient on first contact (for example, did the professional nurse greet the patient and/or introduce herself/himself), how the patient was treated during the consultation (did the PN ask the patient what the problem was, was effective communication skills applied; listened and answered the patient appropriately, provided the patient with suitable health education according to the patient's condition, assessed the patient according to the

nursing process), how the PN portrayed their tone of voice, facial expression and gestures around the patient. The **ends** and **key** of the event were established on how a caring presence was enacted during nurse-patient consultation. The **instrumentality** in the study was observed by the language (verbal and non-verbal), the manner in which the PN spoke to the patient. **Norms** were observed by observing if a routine was followed, if the PN provided individual care according to the needs of the patient. The **genre** was observed by observing the overall nurse-patient consultation.

2.3.5.2 Semi-structured interviews

After observing the PN during the nurse-patient consultations, a semi-structured interview was conducted in a safe, comfortable and private room at the PHC clinic, at a time convenient for the participants. The aims of the semi-structured interviews were to explore and describe the perceptions of PHC professional nurses on the concepts of caring presence and resilience and also to explore how a caring presence and resilience can be fostered among PHC professional nurses.

The video recording recorded during the nurse-patient consultation was watched by the participant to provide an opportunity to reflect and elaborate on their own behaviour and self-evaluate on how they practiced caring presence.

From the video recording further questions were asked (which is also referred to in Annexure K):

- How do you think you enacted caring presence during this consultation?
- What made it easy/difficult for you to enact caring presence in this consultation?
- What were the difficulties that challenged your resilience?

Follow-up questions were also asked to further explore the perceptions of the professional nurse on caring presence and resilience, such as:

- What are your views on caring presence and resilience?
- Tell me of another time when you enacted caring presence and resilience at work.

- In your opinion, what do you recommend on fostering a caring presence and resilience in the workplace?

Communication techniques, such as trust building, summarising and paraphrasing, probing, clarifying, reflecting and active listening were all applied during the interview. The above-mentioned interview schedule (Annexure K) was developed, based on the objectives of the research, in consultation with the supervisor, and reviewed by the School of Nursing Science Research committee. Probing and para-phrasing was also techniques used during the interview to not only facilitate the conversation enabling participants to feel listened to and comfortable, but to also gain a better insight from participants. The duration of the interview varied from fifteen to sixty minutes. Audio-recording and field note taking were used when doing the semi-structured interviews; making short notes as the professional nurse spoke as well as after the interview, and then the data was transcribed word-for-word for data analysis (Roper & Shapira 2000:84-85).

2.3.5.3 Documentation and field notes

All observations, conversations, feelings and interpretations were documented in the field notes (Roper & Shapira, 2000:84-85). Demographic data of the participants were also collected such as the participant's gender, age, race, years of service and qualification for the purpose of illustrating multiple perspectives from individuals (Creswell, 2014:199-200). Throughout the data collection and data analysis of the study, the researcher made memos, as they were seen as reflective remarks often used to make connections between pieces of information and interpret data (Roper & Shapira, 2000:101). A general summary of field notes was compiled focusing on the methodology (which consisted of the data collection and analysis), theoretical aspects (which focused on the integration of research findings and literature) and subjective observations (which provided personal reflections of the researcher).

2.3.6 Data analysis

Tech's five steps (as cited by Creswell, 2014:194-195) of data analysis is a process involving procedures of coding, identifying patterns, generalising, making reflective memos and formulating concepts. Data analysis process was done by coding the

interviews. Furthermore, the data was sorted to establish patterns, generalise ideas and reflecting on personal reflections and insights (Roper & Shapira 2000:93).

Data analysis proceeded subsequently after data collection. As mentioned in the data collection method, the participants were firstly observed during consultation sessions with a patient. The consultations were video-recorded and used when interviewing the participant on how each individual enacted a caring presence. The data obtained during the interview was word-for-word transcribed once participant observations and interviews had been completed at a clinic. The interviews conducted were transcribed and analysed to avoid overload of information and to establish data saturation from the group of participants, before moving to another clinic (Creswell, 2014:194-195). 'Winnowing' of data occurred by focusing only on data appropriate for the topic, namely caring presence and resilience in the workplace (Creswell, 2014:195).

Data was analysed according to Tech's method of qualitative data analysis:

Step 1: Organise and prepare

Organising and preparing data were done during the collection of data through transcribing the nurse-patient consultations and semi-structured interviews (Botma *et al.*, 2010:224).

Step 2: Develop a general sense

A general sense of data was developed through reflection on the data collected and by the field notes made during data collection (Botma *et al.*, 2010:224).

Step 3: Code the data

The data collected was coded using descriptive labels which summarised the content of the observations and interviews answering the research questions in the study (Roper & Shapira, 2000:94). Ethnographic research is broad; therefore the coding process was started by creating a preliminary description of categories with the participant observation and semi-structured interviews for analysis (Creswell, 2014:199). The description included the following categories (Creswell, 2014:199-200; Roper & Shapira, 2000:94-96):

- **Setting:** The environment where the study was conducted which was at the clinic, the consultation room for the observations and a private room for the semi-structured interview.
- **Demographic data** of the participant, such as gender, age, race, years of service and qualification
- **General perspectives** of the understanding on how participants enacted caring presence
- **Specific perspectives** which included the participant's understanding about caring presence and resilience
- **Strategies** on how caring presence and resilience could improve among professional nurses

Step 4: Describe and identify themes

After the data had been descriptively grouped, patterns of re-occurrence were established and these patterns were then refined to create themes, subthemes and categories. This enabled to determine appropriate and re-occurring data and classify the data into themes (Creswell, 2014:200).

Step 5: Represent findings and Step 6: Interpret data

After data had been analysed the findings were summarised as themes and subthemes and are discussed in Chapter 3. A co-coder was involved in the study to analyse the data, to establish additional themes, and to reach consensus on the themes and the accuracy and relevance to the study of the identified themes (Jooste, 2010:322).

After the co-coder had evaluated the data, themes had been formulated and all the data had been judged as adequate, the findings were linked to the academic literature to understand the rich and complex data collected. Throughout the data collection and data analysis of the study, the memos were made, as they were seen as reflective remarks often used to make connections between pieces of information and interpret data (Roper & Shapira, 2000:101). A general summary of field notes were compiled focusing on the methodology (which consisted of the data collection and analysis),

theoretical (which focused on the integration of research findings and literature) and subjective observations (which provided personal reflections of the researcher).

2.3.7 Integration of data with literature findings

Brink (2010:68) states that one of the purposes of searching for literature is to inform or support a qualitative study, especially in combination with data collection and data analysis. Therefore, after data had been collected and analysed into themes and subthemes, significant literature was searched and integrated that literature with the research findings in order to add a meaningful explanation to the data obtained (Shezi, 2013:34).

2.4 MEASURES TO ENSURE RIGOUR

Rigour was applied in every aspect of the study by using the four criteria of trustworthiness from Lincoln and Guba (as cited by Botma *et al.*, 2010:292; Klopper, 2008:69-70), namely:

2.4.1 Truth value

In this research truth value was obtained by the following (Knobloch & Siedine as cited by Jooste, 2010:319-320):

- The participant was observed during the nurse-patient consultations to ensure adequate time for data collection to not only learn about caring presence from participants, but also build trust and rapport. Working at all PHC clinics in a semi urban area of the North West Province as a student and a community service nurse and currently working at one of the PHC clinics as a PN, therefore automatically has gained entry to this population. Therefore, when conducting research, social closeness was built and maintained with participants to obtain their trust and co-operation in openly sharing their perceptions and behaviours with regard to caring presence and resilience (Burns & Grove, 2005:534).
- Constant interpreting of relevant behaviour of the participants was done to gain a more in-depth understanding of the views and perceptions of the participants.

- Using two different data collection methods (participant observation and semi-structured interviews) and in-depth data analysis methods (such as Tesch's five steps and involving a co-coder) to ensure triangulation.
- Seeking academic references by regularly reviewing electronic academic journals, articles and books, as well as constantly seeking advice from the researcher's study supervisor and other professionals experienced in the field of research was done to ensure all information provided in the study was academically accurate.
- Possible researcher and video-recording effects was minimized by means of
 - obtaining voluntary informed consent from both the participant and the patient;
 - reflecting on the video-recording together with the PN, which gave an opportunity to vent emotions, ask questions, and reflect on perceptions on caring presence and resilience.

2.4.2 Applicability/ transferability

Applicability was obtained using the strategy of transferability, applying the criteria of selecting sources, data saturation and thick description (Klopper, 2008:69-70).

In this research applicability was obtained by the following (Klopper, 2008:69-70):

- Purposeful sampling was done in the study, selecting professional nurses who voluntarily wanted to participate. In addition, enough time was given for professional nurses to read and understand the consent form and to choose if they wanted to be participants of this study.
- In-depth descriptions was obtained from the participant observations and semi-structured interviews to ensure that sufficient data was collected.

2.4.3 Consistency

Consistency was obtained using the strategy of dependability. Applying the criteria will include auditing and triangulation (Klopper, 2008:69-70).

In this research consistency was obtained by the following (Knobloch & Siedine as cited by Jooste, 2010:319-320):

- After data collection and data analysis, the study was submitted to be evaluated by external examiners who came with conclusions about the dependability of the data.
- Continuous peer examination and triangulation also contributed to the dependability of the research.

2.4.4 Neutrality/ confirmability

Neutrality was obtained using the strategy of confirmability; applying the criteria of audits and triangulation (Klopper, 2008:69-70).

In this research neutrality was obtained by the following (Knobloch & Siedine as cited by Jooste, 2010:319-320):

- Applying auditing and triangulation during data collection and data analysis ensured that the research had introduced no bias and was focused on achieving the purpose of the research
- In addition, the researcher involved a co-coder as well as triangulation to implement neutrality.

Measures to ensure rigour was thoroughly applied in the study for the purpose of ensuring that the study is valid and reliable as well as based on academically sound research (Shenton, 2004:73).

2.5 ETHICAL CONSIDERATIONS

Ethical considerations were constantly applied within the study to prevent any kind of harm to the participants and patients by promoting justice, respect and beneficence for all participants and patients. Ethical considerations were linked into every phrase and aspect of research to ensure the research study is accurate, bias is reduced and that participants are protected from any harm. Before the study could commence, the participants were thoroughly informed of the study via mediators (managers of primary

health clinics) and a consent form was signed by the participant, agreeing to participate in the study and also being made aware that they may withdraw from the study without having to provide a reason and at any time (See annexure E).

Basic ethical principles were applied within the research study according to the North-West University's Ethics Policy where the research proposal for the study was submitted to the Research Committee of the School of Nursing Science for quality control. Ethical clearance was obtained from the Health Research Ethics Committee (HREC), Faculty of Health Sciences, North-West University, Potchefstroom Campus (see Annexure A) and approval was also presented and granted to and reviewed by the North West Department of Health Research committee (see Annexure B). Information was distributed to the district health services and to each clinic explaining what the research study entailed, and that confidentiality and anonymity were applied throughout the study. Operational managers of clinics were requested to act as mediators and to recruit participants and provide assistance in obtaining informed consent from participants (see Annexure E). Informed, voluntary consent was obtained from participants (professional nurses) and from stable patients (see Annexure E and Annexure G).

2.5.1 Respect for all persons

Respect for all participants and patients was applied within the study by approaching participants with respect and dignity to gain their trust and support and also, participants and patients were given a choice to voluntarily agree to participate and verbal and written consent was obtained to ensure the participant and patient were well aware of what the research study entailed. The letters of consent were explained and written according to their level of understanding.

The following rights of the participants and patients were protected within the research study (Jooste, 2010:277–280):

- The right to privacy, confidentiality and anonymity
- The right to justice and equality
- The right to protection and truthfulness
- The right to freedom of choice and withdrawal

If the participants observed felt emotionally uncomfortable, this type of situation was prepared whereby continuous signs of emotional discomfort would be observed and these signs would be reflected with the participants whether they were comfortable to continue. In addition, an advanced psychiatric nurse was asked to be on standby for emotional support of the participants if needed.

Patients who were consulted by professional nurses at PHC clinics were not directly involved as participants. However, in order to gain an in-depth understanding of the research findings, the researcher felt that the involvement of patients as necessary in the study as patients are the PHC users and recipients of 'caring presence'. These patients were seen as a vulnerable population due to them possibly being illiterate and living in poverty. Measures were implemented to ensure patients were not exposed to unfair and disrespectful conduct by means of the following: Mediators informed patients visiting the PHC clinic about the research and what was expected of them, namely to allow a video recording of the professional nurse's behaviour during the consultation. As far as possible, the patient's face was not recorded during the video recording, to protect the identity and dignity of the patient. No physical examinations where the patients' body was exposed in any way were video recorded. Patients were free to withdraw from the research at any time, without penalty.

2.5.2 Beneficence

The direct benefits for participants were established firstly by creating a deep understanding of how an individual enacted caring presence and resilience. Recommendations were able to be made on how a caring presence and resilience could be fostered to thus improve quality patient care and also self-wellbeing.

The indirect benefit was established as individual nurses enacted and fostered a caring presence and resilience in their workplace. They can inspire other nurses which will improve the quality care at the clinics which will then benefit the patients of the community.

There were no direct benefits for patients, as this research focused solely on fostering a caring presence and resilience among PHC professional nurses. However, the indirect benefit will be established once individual nurses enact and foster a caring

presence and resilience in their workplace to inspire other nurses, which will improve the quality care at the clinics benefiting the patients of the community.

2.5.3 Justice

Justice was implemented by treating all participants fairly and respecting their choice to participate or not. A fair selection of participants was used within the study to ensure the study contains justice. In addition, scientific honesty, accuracy and ethical principles were also thoroughly applied within the study to ensure that the study conducted was based on the ethical principal of justice (Jooste, 2010:227-228).

In addition, experts in conducting qualitative, ethnographic research, specifically participant observation, semi-structured interviewing and documentation (field notes) were consulted. Expertise was developed in data collection, as mentioned above through guidance from the researcher's supervisor and academic journals and books. Video and audio-recorded role plays were conducted of the participant observation and semi-structured interviews, with examples of field notes, followed by a feedback discussion with the supervisor regarding competence and ethical conduct, before commencement of data collection. Role play and a trial run were conducted to test the data collection (observation, semi-structured interview and field notes) in order to refine these methods. The data of the role play and trial run were excluded in the data collection and data analysis. There were no costs involved for participants and patients partaking in the study as the researcher conducted the study at the clinic.

Copies of raw data are being kept electronically (password protected) and in hard copy in a safe place in a locked cabinet for a period of seven years. Consent forms signed by participants and patients are being treated with utmost confidentiality by researcher and study leader thus keeping consent forms safe by storing all of them, video footage, recordings and notes in a lockable cabinet during the study and also storing these documents after the study in a lockable cupboard. The data will then be destroyed after seven years.

The findings of the study will be shared through written as well as verbal feedback to each manager of the clinics.

2.6 CHAPTER SUMMARY

In Chapter 2 of the research study, the research methodology was discussed thoroughly, explaining the research design, research method and methods to ensure rigour; and ethical considerations applied throughout the study. The research findings of the research study are presented in Chapter 3.

CHAPTER 3

FINDINGS OF THE STUDY

3.1 INTRODUCTION

Chapter 2 described the research design and methods, ethical considerations and rigour. In this chapter, the researcher discussed the application of the data collection and data analysis, as well as the findings of the research. The research findings of the video recordings, semi-structured interviews and field notes were separately discussed and concluded with an integration of these findings. The findings were furthermore compared with literature establishing if the research results and findings corresponded with previous literature or were regarded to be novel research.

3.2 THE APPLICATION OF DATA COLLECTION AND DATA ANALYSIS

The following sections describe how data was collected through video recordings, semi-structured interviews and field notes followed by a discussion of the analysis of the transcribed data.

3.2.1 Data collection

The sample size of the data collected consisted of a total of twelve participants from six clinics in a semi-urban area in a district of the North West Province. The following table represents the demographical data of the twelve participants:

Table 3.1: Demographical data of participants

Gender	Age	Race	Years of service	Qualification
4 Males 8 Females	Ages varied and ranged between 25 years to 54 years	African (9) White (1) Coloured (1) Indian (1)	Years of service 1 year to 26 years in the service	Degrees (7) Diplomas (5) Specialised in PHC (2)

Demographic data of participants varied in gender, age, race, years of service and qualifications. This is an indication that opinions from diverse participants were obtained.

Role play and the trial run were used to practise effective video recording and establish precision of conducting and applying communication techniques during the video recordings and semi-structured interviews. The role play and trial run were excluded from the data analysis and research results, as both the trial run and role play were inventive situations used to ensure the researcher was competent to collect factual and accurate data (Brink, 2010:166).

Data collection was conducted over a period of three months on scheduled dates that suited each participant. After obtaining the necessary ethical clearance and permission to conduct the research, the study was firstly presented to the two district managers at the district who approved of the study and created an appointment to present the study during an operational manager meeting whereby all operational managers were informed about the study and all managers consented, signing the consent form.

The operational managers were invited to act as mediators, informing PHC professional nurses at their clinics of the study and inviting them to participate. Once the various consents were obtained, the researcher visited a total of six out of the ten clinics, excluding the following clinics:

- Excluded Clinic 1 – Clinic 1 is where the researcher worked and to prevent any bias, from colleagues, this clinic was excluded
- Excluded Clinic 2 – Clinic 2 had only one professional nurse on duty running the whole clinic, thus to prevent any inconvenience to the professional nurse this clinic was excluded
- Excluded Clinic 3 – Clinic 3 is situated at a hospital directly next to another clinic, so the researcher purposefully selected the other clinic within the same area
- Excluded Clinic 4– Clinic 4 was excluded as the data collected from six clinics showed satisfactory data saturation.

There were two (2) participants per clinic that were willing to participate in the study. However, due to the challenge of shortage of staff, participants would constantly postpone the appointment dates to another day that suited them.

Participants that freely agreed to participate in the study were warmly welcomed and a trustful and professional relationship was initially created by ensuring the participant felt comfortable, knowing what the study was about, that confidentiality would be maintained at all times, and lastly that the participant may withdraw participation in the study at any time of the research without any coercion or penalty.

Once voluntary and verbal consent was granted by participants, written consent had to be given by the patient to video record the patient–nurse consultation. The mediators of patient selections were not the clerks (as initially planned in data collection, see Chapter 2) due to the clerks' uncertainty or lack of knowledge concerning the health status of the patient. In addition, one of the inclusion criteria for patients (as mentioned in the consent form and Chapter 2 of the research methodology) was that the patient should not be clinically ill or in any emergency situation. Therefore the participants (professional nurses) were involved to act as mediators and to clinically screen the patient and then ask the patient in a language the patient understood if they were willing to participate in a research study that focused on the care professional nurses gave patients. Patients were given opportunity to ask questions, and they were given time to consider the request. All patients co-operated freely and willingly, signing the consent form and each participant was video-recorded during a nurse-patient consultation. The angle of the video recording only showed the participant as the patients' backs faced the camera to ensure privacy was maintained.

After the video recordings of the nurse-patient consultation, semi-structured interviews were conducted with participants in an available, unoccupied room at the clinic. Before the interviews commenced, once again participants were made aware that they understood the terms of the consent and that written and verbal consent was obtained from each participant. The researcher communicated with participants using the acronym 'SOLER' (which is to sit squarely, open body posture, to listen, make eye contact and relax) to make the participant feel comfortable study (Botma *et al.*

2010:207). In addition, communication techniques such as probing, clarifying and explaining were used by the researcher to gain insight and meaning for the research study (Botma *et al.* 2010:207). The interviews in general, were focused on the research study as participants did not deviate from the research topic and provided rich data which then reached data saturation (as many participants from different clinics were discussing similar matters).

Each participant was given an opportunity to reflect and self-evaluate on the manner on how they consulted and enacted caring presence with patients through watching themselves in a video recording taken during their consultation with a patient. An ethnographic, emic perspective was used to enable participants to feel that they were being understood by a PHC PN and therefore also gained the knowledge and experiences from the participants (Brink, 2010: 114-115). The raw data obtained by all twelve participants were transcribed by the researcher, word-for-word, and the names of participants, clinics and also other names mentioned in the interviews were removed (see Annexure C for an example of a transcription). The belief is that self-collecting and transcribing the data would enable more involvement in this research and would therefore be beneficial in the gaining of more knowledge and insight when analysing the data.

After the semi-structured interviews had been transcribed, the documents, audio recordings and video-recordings were all kept in a safe computer folder, using a password-protected pin code. When the data was sent to the co-coder, a password-protected code was inserted and the anonymised transcriptions were sent to the co-coder.

Diagram 3.1 briefly explains how data was collected for the research study. Data was collected in three phases by firstly collecting observational data from the video recordings using the acronym "SPEAKING" as a form of structure, followed by transcribing data from semi-structured interviews and lastly, accumulating field notes while conducting the process of data collection and analysis.

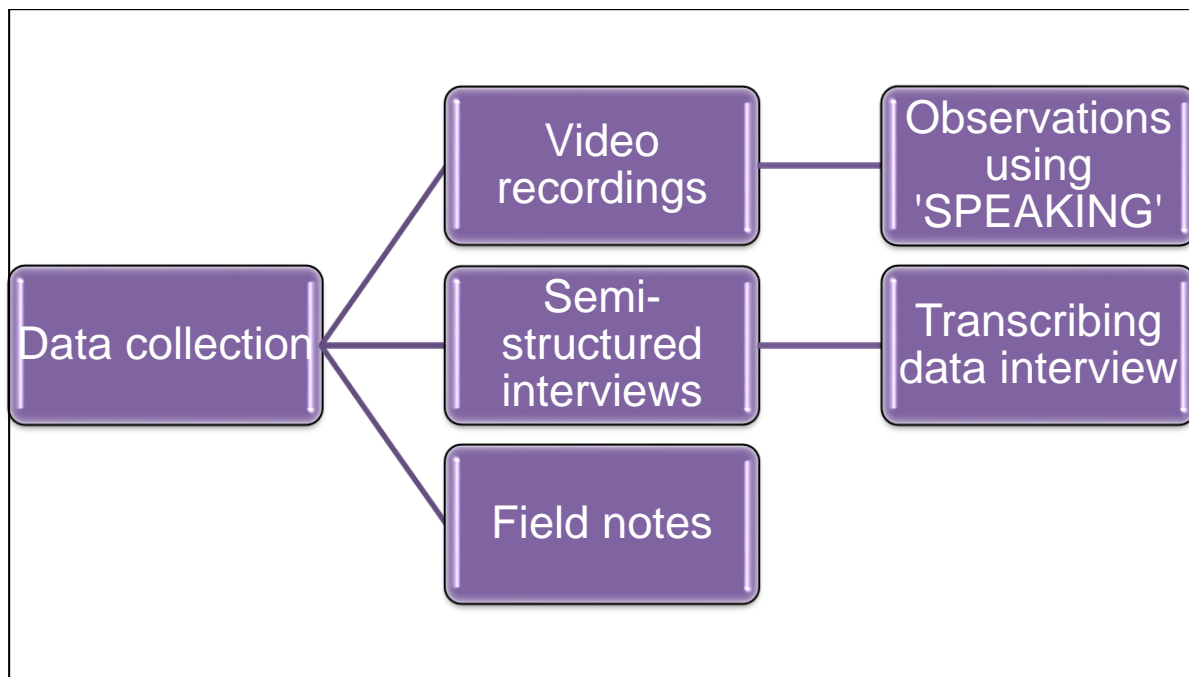


Diagram 3.1: Process of collecting data

3.2.2 Data analysis

After the data collected had been transcribed, each transcript was read thoroughly searching for specific words or phrases that were relevant to the study. These specific words or phrases were grouped as preliminary codes used to identify codes and categories. From the codes and categories, main themes and subthemes were established and academic literature was then combined to support the research findings. The video recordings were analysed according to Hyme’s acronym ‘SPEAKING’ observing each participant during a nurse-patient consultation. A detailed description of the data analysis approach and the techniques was explained in Chapter 2, section 2.3.6. Consensus was established among the researcher, supervisor of the study and the independent co-coder with regard to the main themes and sub-themes that were composed from the transcriptions of audio-recording and field notes of the semi-structured interviews as well as the observations and field notes from the video recording consultations. Furthermore, the research findings collected from both research methods were discussed separately followed by a concurrent discussion and integration with literature to enrich the findings.

Diagram 3.2 outlines the data analysis process. As mentioned already, the data collection was divided into three phases and also analysed the data in three phases.

Firstly video recordings were analysed using the acronym “SPEAKING” as main themes and creating further subthemes, secondly, the semi-structured interviews analysed through coding each transcribed data set to establish data saturation and to create subthemes and main themes. During the beginning of the interviews, the researcher used reflective practice through sharing the video recording of the nurse-patient consultation with the participant where participants had the opportunity to reflect and examine personal thoughts and actions better to understand themselves and how they enacted caring presence. Lastly, a general summary of field notes was compiled, focusing on the methodology (which consists of the data collection and analysis), theoretical (which focuses on the integration of research findings and literature) and subjective observations (which provides personal reflections of the researcher).

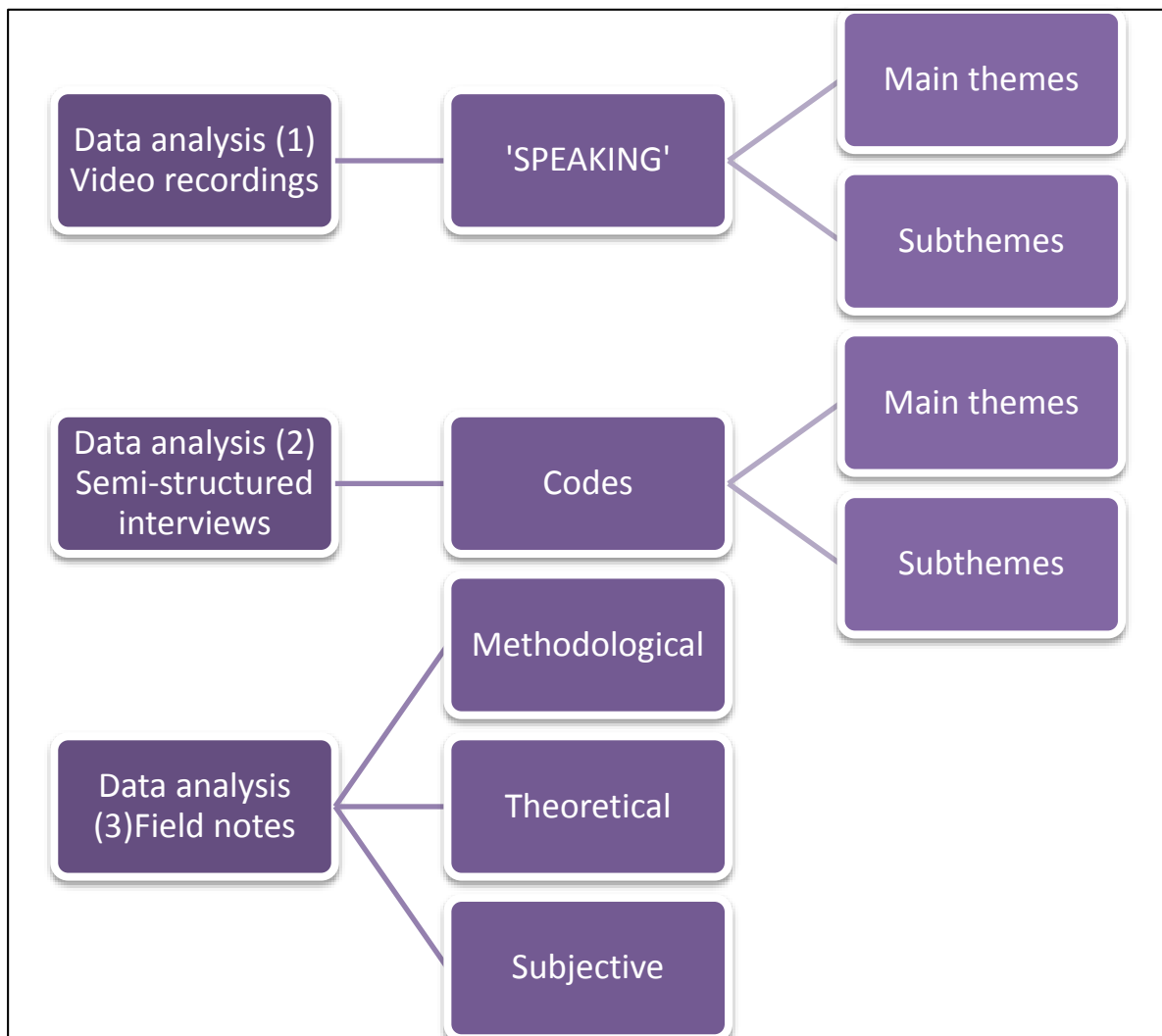


Diagram 3.2: Process of analysing data

3.3 RESEARCH FINDINGS AND LITERATURE INTEGRATION OF THREE SETS OF RESEARCH FINDINGS

Three sets of findings (namely findings from the video recordings, semi-structured interviews and field notes), are separately discussed with references to examples from the video recordings and semi-structured interviews as evidence of the findings. Academic literature was then integrated to each set of findings to establish correlations and differences between what was found and what was in the literature. After the sets of findings were integrated with literature, all three sets of findings were interpreted with their literature to furthermore establish a correlation between what participants said in the interviews to what was observed during the consultations and in the field notes. The three sets of findings that were integrated conclude the discussion on the research findings.

Diagram 3.3 provides a brief layout on the discussion of the research findings.

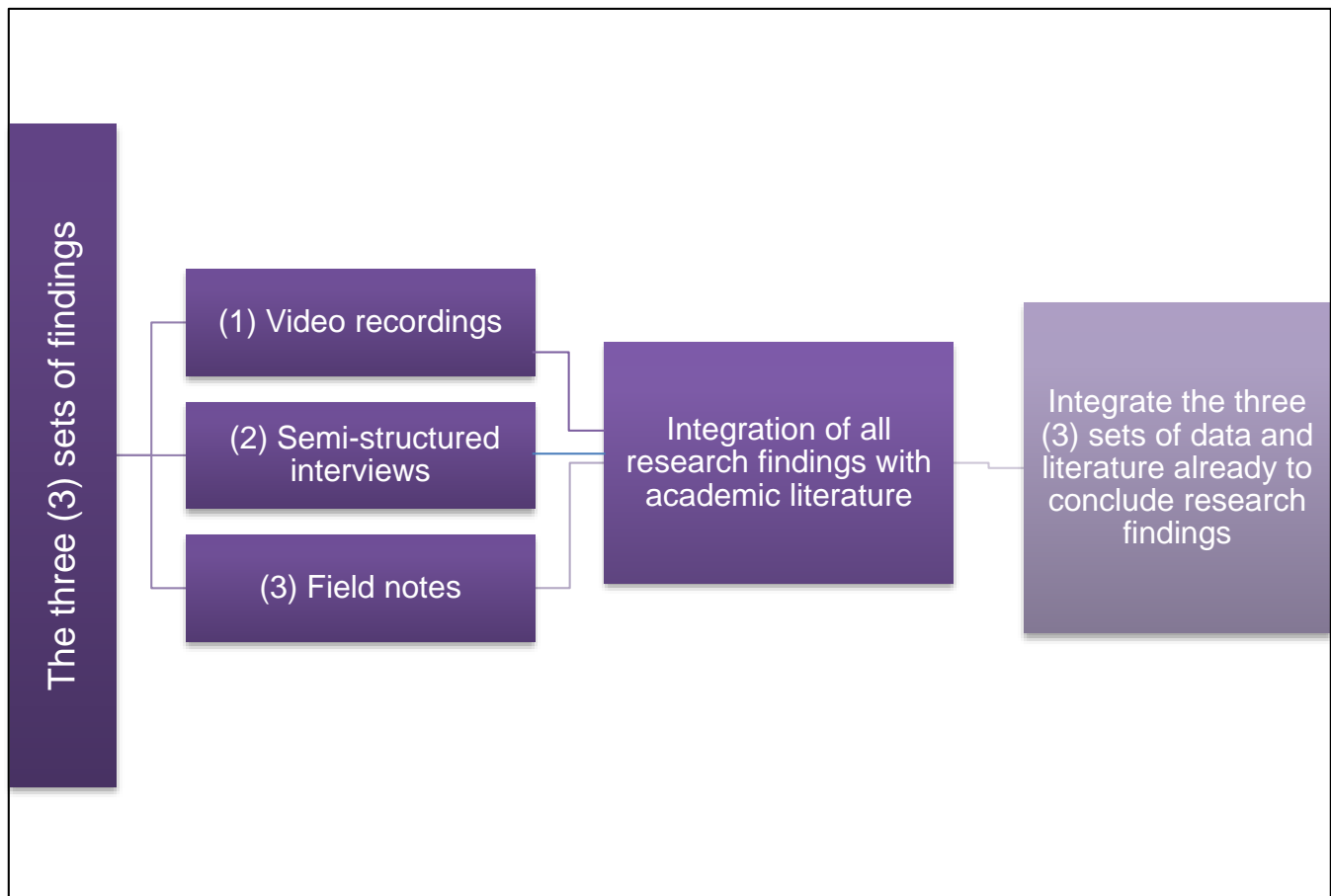


Diagram 3.3: Brief layout of process of discussing research findings

3.3.1 Research findings on how participants enacted caring presence

Eight main themes could be identified from the video recordings, and are discussed in the following section.

Hyme's acronym, "SPEAKING" was utilised as a method of structuring observations during the video recording sessions with twelve participants (as cited by Roper & Shapira, 2000:71). The acronym "SPEAKING" is composed of the following words, and a brief indication of how these terms are applicable in the research study are provided, followed by a discussion (see Diagram 3.4).

3.3.1.1 Theme 1: The setting seemed to be clinical

- 3.3.1.1.1 The consultation rooms seemed to be moderately conducive to enact caring presence
- 3.3.1.1.2 The appearance of professional nurse was clinical and authoritative
- Literature integration

3.3.1.2 Theme 2: The manner in which participants enacted caring presence

- 3.3.1.2.1 The participants enacted caring presence
- Literature integration

3.3.1.3 Theme 3: Participants met the ends (goals) of the consultation

- 3.3.1.3.1 Participants were able to provide care to meet the needs of the patients
- Literature integration

3.3.1.4 Theme 4: Participants made contact with patients through nursing interventions

- 3.3.1.4.1 The nature of contact participants make with patient
- Literature integration

3.3.1.5 Theme 5: Participants reflected the 'keys' of caring presence through the use of their tone, manner and spirit of enacting caring presence

- 3.3.1.5.1 Attitude of professional nurses
- Literature integration

3.3.1.6 Theme 6: Participants utilised effective instrumentality through the use of verbal and non-verbal communication techniques

- 3.3.1.6.1 Communication (verbal and non-verbal) between the participant and patient indicated understanding
- Literature integration

3.3.1.7 Theme 7: The focus of the nurse-patient consultations was influenced by the nature of the consultations

- 3.3.1.7.1 Consultations were mainly nurse-focused
- Literature integration

3.3.1.8 Theme 8: Genres: The consultation is clinical in nature and challenges that limit caring presence

- 3.3.1.8.1 The overall consultation between the participants and patients seem to be clinical in nature
- 3.3.1.8.2 Challenges experienced that may prevent caring presence between the professional nurse and patient
- Literature integration

Diagram 3.4: Brief summary of observing caring presence of primary health care professional nurses using the acronym "SPEAKING"

3.3.1.1 Theme 1: The setting seemed to be clinical

It was clear that the setting where the consultations took place was clinical. This theme focused on two specific aspects regarding caring presence, firstly the appearance of the consultation room and secondly that of the PN.

3.3.1.1.1 The consultation rooms seemed to be moderately conducive to enact caring presence

The consultations rooms seemed to be moderately conducive to enact caring presence, as evident from the following findings.

- **The general state of the consultation rooms were neat and clinical**

From the twelve participants, all nurse-patient consultations took place in a consultation room with a door that could close to ensure privacy and windows that were opened at some clinics and closed at other clinics. The state of the consultation room in general seemed neat and tidy where the consultation room appeared to be in an organised state, however in some consultation rooms, guideline manuals, books and protocol posters were seen on the beds and not stored in the drawers or posted up on the walls and patient medications were placed on top of the bed. Certain consultation rooms lacked essential equipment such as a basin to wash hands, red bins to throw medical waste in and also equipment needed to conduct certain medical examinations for example an ENT (Ear, nose and throat) scope which is one of the examining equipment.

At all clinics, it was observed that there seemed to be no indication that the consultation room was the participant's consultation room (such as the name of the participant on the front door, pictures on the desk or belongings of the participant in the consultation room), which made participants seem detached from the consultations room they were working in.

- **The structure of the consultation rooms is similar in all clinics**

The structure of the consultation rooms were similar in all clinics consisting of one table and two chairs, one or two bed(s) and one or two cupboards. In most consultation rooms of all the clinics, the participant was facing the patient with a table in-between

the patient and the participant, where participants were writing clinical notes while the patient was speaking to them which minimised the participant's eye contact made with the patient. However, in two observations, one participant was standing facing the patient using a movable table to write on and in the other, the table was in front of the wall and the patient and participant were talking to one another without a table between them, clinical notes were completed after the conversation and examination had been conducted with the patient.

3.3.1.1.2 The appearance of professional nurse was clinical and authoritative

The participants were all neatly dressed, some wearing uniform and others wearing clothing with designated colours according to the clinic's policy, showing self-awareness in how they presented themselves. The presence or state of professional nurses was that they seemed to present with a leadership/authoritative feature towards patients and their colleagues by the way they made certain matters their responsibility, their role as a PHC professional nurse, the use of knowledge and advice they gave to patients and colleagues and nursing interventions that they implemented to ensure quality nursing care.

Literature integration

Literature echoes that the setting can play a role in the enactment of caring presence. Meehan (2015:online) states that a therapeutic milieu is a natural part of nursing and is formed by the presence of a nurse, how they are in themselves and how they practise nursing. Creating a therapeutic milieu is about generating a healing culture, rich in therapeutic interpersonal relationships and co-operative attentiveness (Meehan 2015:online). This is done to foster optimal patient healing through providing a practice setting for nurses which is conducive to optimal health and provide the best possible practice for patients (Meehan, 2015:online). Furthermore, in order to generate a therapeutic milieu, nurses should care for themselves before they could truly care for other people (Meehan, 2015:online). This is done by accepting that each person comes to practise as an autonomous human being with their own sense of personal and professional identity, integrity and self-respect, with their personal histories and anticipated futures (Meehan, 2015:online).

3.3.1.2 Theme 2: The manner in which participants enacted caring presence

The manner in which participant's enacted caring presence was evident in the following ways: assessing and identifying the patient's needs, by relating with the patient, by being with the patient/being there for the patient and lastly by providing nursing care for patients.

3.3.1.2.1 The participants enacted caring presence

The participants enacted caring presence in the following ways:

- **Through assessing and identifying the patient's needs**

During the video recordings most participants were able to assess and identify the needs of the patients by asking direct questions in the language the patient could understand. Some participants would speak in only English and/or Afrikaans and the patients were still able to communicate their reasons for coming to the clinic and understand what the participant was saying. A few participants would assess the patients' emotional wellbeing if they seemed unsure of the patients' emotional wellbeing.

An example was when one participant spoke to a patient, asking the patient if she was only there for chronic medication and the patient then verbalised that she also had painful breasts. The participant furthermore asked whether she was on any family planning method, to obtain a history from the patient, and a pregnancy test was also done. The patient tested positive for pregnancy. The participant seemed unsure as the patient was quiet and the participant's face or gestures did not indicate any emotion. The participant then probed the patient on the feelings she was experiencing and the patient then said she was happy to be pregnant.

Full physical examinations and screening were only conducted on selected patients. Physical examinations were conducted during all antenatal care (ANC) and video-record of the physical examinations were excluded to ensure privacy. In the video recordings, patients were consulted for routine chronic medication, antenatal check-ups and for minor ailments.

- **Through relating with the patient**

During the video recordings, some participants were able to promote comfort and to provide opportunities for growth and healing by speaking in the language the patients understood, listening to the patient and providing patients with alternative methods through health education to meet the needs of the patients. By observation it was found that, there were other participants who would just give the treatment to the patients without giving the patient health education or asking how the patient was doing.

In an example of some consultations observed, both the participant and patient seemed to be in a hurry to finish the consultation so that the patient could leave. The 'rush' experienced by both participant and patient made relating to the patient a challenge as not enough time was given for the participant to provide optimal care to the patient and the patient did not have time to receive this optimal care.

- **Through being with the patient / there for the patient**

In the video recordings, participants displayed caring behaviours to patients, such as comfort, listening, attentiveness and providing physical and psychological support. Some participants would smile and have a relaxed, but meaningful conversation, displaying care through asking the patients relevant questions, such as asking how the patient was doing, if the vital signs were in any way abnormal, or the participants would ask about stresses. The smiling, listening and open body language that some participants portrayed, enabled patients to feel more relaxed to talk. Other participants seemed professional when consulting the patient; however, there were some challenges observed that could negatively impact on caring presence, such as the following:

- Use of eye contact was minimised due to most participants writing clinical notes while listening to the patients. At times the participant would stop and look at the patient and then continue writing.
- Some participants, while talking to the patients, would get up and collect the patient's medications from the cupboard.
- There were also some interruptions while participants consulted with patients. Other people would enter the consultation room to fetch something, or ask assistance or advice from the participant.

- Another observation made was that participants focused on the physical, and in some cases the emotional needs of patients, but none of the participants provided any spiritual support to patients in the consultation rooms. However, in the mornings on weekdays, some professional nurses with all staff members would sing gospel songs and pray with the patients, as observed in most clinics.
- One participant, as observed, seemed angry and also concerned about a young patient, when the participant asked the patient in a stern voice why the patient had defaulted on treatment for three months. The participant still maintained a professional behaviour by not shouting or passing rude remarks to the patient. However, the patient was quiet, only speaking when asked questions by the participant.

- **Through providing nursing care**

It was clear from the observations that the participants followed clinic procedures and protocols and referred patients accordingly. Patients were given treatment and if it was not in stock, participants would give alternative medication (according to clinic protocols) or provide health education to patients on dietary changes they should make to ensure they were receiving adequate nutrients.

For example, a patient came for her routine ANC check-up, the participant took history, did a physical examination and provided the patient with treatment. However, calcium gluconate was out of stock at the main hospital pharmacy from where all clinics receive medicines. The participant explained the problem and gave an alternative, emphasising on the importance of calcium gluconate for the foetus, the side effects and also that the patient should include dairy products in her diet.

As observed, there were a few nursing interventions that could affect nursing interventions of caring presence, such as:

- Becoming angry towards the patient who defaulted on treatment;
- Postponing the drawing of blood to another date as blood is difficult to be drawn, because the patient does not have visible veins; and
- Not providing the patient with health education as the patient regularly comes to the clinic to receive medication and “knows it all.”

Literature integration

Sahlsten *et al.* (2008:2) confirms that the manner in which professional nurses behave towards a patient can either promote or restrict effective patient participation. In Chapter 1 the concept of caring presence was defined and described by various authors as the way of being there for a patient holistically (Osterman *et al.*, 2010:198; Finfgeld-Connett, 2008:111; Covington, 2003:307). Specifically focusing on Osterman *et al.* (2010:198) three divisions of the term presence were discerned, namely partial presence, full presence and transcendent presence.

The manner in which participants in the research enacted caring presence, seemed to correlate with having partial presence, which is defined within a nursing context as a way of being there in which the nurse is physically there focusing his/her energy on a task that is relevant to the patient, but without acknowledging the patient entirely (Osterman *et al.*, 2010:198).

Sahlsten *et al.* (2008:2) further state that patient participation is an essential basis for nursing care and medical treatment and therefore knowledge of what influences patient participation is important when addressing patient expectations and demands. Relevant to the research findings, Wellard, *et al.* (2003:255) state that two factors restricting patient participation are: limited communication between nurses and patients and task-orientation nursing labour which is referred to as routine tasks and delegations of nurses. Sahlsten, *et al.* (2008:3) mention that when nurses, who are expected to provide support to patients, seem to view patients in an unreflective and non-understanding manner, due to their multi-tasking labours, patients tend to feel ignored and disappointed with the health service they are receiving. In addition, professional nurses who portray a bossy or condescending attitude towards patients reflect a belief that the nurses know better and can at times exclude the patient's interests. Nurses need to empower patients through listening to their problems and working out solutions together to avoid a patient from defaulting on treatment (Sahlsten, *et al.*, 2008:2).

3.3.1.3 Theme 3: Participants met their ends (goals) of the consultation

The manner in which participants met their ends (goals) of the consultation was observed through the manner in which they provided care and how the needs of the patients were met in the nurse-patient consultation.

3.3.1.3.1 Participants were able to provide care to meet the needs of the patients

Through observations of the video recordings, the participants were all able to provide care according to the needs of the patients. In the video recordings, participants were consulted for routine chronic medication, antenatal check-ups and for minor ailments only. Participants asked direct questions to obtain the main reason for the consultations and treated patients according to their needs by using their experiences, knowledge and instincts. Patients would be given information on when to return, if they were not better, when to return to the clinic within a period of days, and follow-up dates were also given if necessary.

An example of the purpose, goal and outcomes met was when an ANC patient consulted a participant. Although the consultation took about thirty minutes, the participant initially started by casually talking to the patient in a language the patient understood. The participant made the patient laugh and took the history of the patient. The participant also wanted to understand the patient's condition more and asked the patient questions regarding her history noted in the file. From the history, the participant was able to establish that certain tests have not yet been done. The participant conducted those tests, constantly explaining what she was about to do, asking the patient's permission first and also clarifying any uncertainties the patient might have concerning her pregnancy. All findings of the physical examinations were explained to the patient and essential health education was given to the patient regarding her pregnancy condition. The patient was asked what meaningful advice she learned and the patient was given the opportunity to tell the participant what she had learned and what she should do to maintain optimal health for herself and her unborn baby. As the patient left, she thanked the participant for helping her and for the good service.

Literature integration

Sahlsten, *et al.* (2008:2) confirm that independence is part of human nature and that patients desiring to do as much as they can by themselves, are therefore normal. Therefore, as professional nurses, patients should be evaluated on their knowledge as this shows that professional nurses are interested in their patients and are encouraging patients to take responsibility for their own wellbeing and health. Furthermore, Covington (2003:307) adds that when developing and applying nursing interventions, caring presence should be included, as this is a critical approach to the patient's wellbeing, because the presence of the nurse with the patient provides the nurse with opportunities to improve patient outcomes and prevent complications.

3.3.1.4 Theme 4: Participants made contact with patients through nursing interventions

3.3.1.4.1 The nature of contact participants makes with patient

Nursing interventions are important for providing care to patients and therefore the nature of contact participants made with patients was discussed through the following observations, namely the general routine of care participants utilised at the clinic, the focus on utilising protocols at clinics and lastly, the methods of presenting health education.

- **The general routine of care participants utilise at the clinic**

The participants observed in the video recordings, had various methods of providing care. Some would search for answers using prescribed protocol manuals and books, others would ask a colleague or another health care member of higher rank, such as the doctor, for advice and in addition, there was the build-up and development of experience through the years of counselling patients that participants also utilised to provide care to patients. Providing care can be seen in various ways as each participant is seen by the researcher as an individual. However, there were certain similarities in what participants did when providing care to patients, such as the way most participants would write and collect the patients' medication from the cupboards while the patient was speaking. The general care that participants provided at the clinics became a routine-like culture at the clinics and due to the nurse-patient ratio

imbalance; “quantity” care is seen to be given more, rather than quality care. Participants had to see a large number of patients in a short time to accommodate other patients waiting. Therefore, certain aspects of care, such as physical examinations and diagnostic tests, were unintentionally omitted or postponed due to shortage of staff and limited time.

- **Focusing on the utilisation of protocols at clinic**

As observed, at every clinic there were different protocol posters pasted on the walls of the consultation rooms and on top of the participant’s tables. Books on clinic protocols and procedures were accessible and visible. Some participants utilised these protocols by reading while the patient was present and showing pictures to the patient while explaining the condition to the patient. Others were able to utilise the clinic protocols from their developed experiences. In general, all participants showed evidence-based knowledge when providing care to their patients.

- **Health education was presented in various ways**

As observed three participants did not give patients health education as patients just came for treatment collection, and another case involved the patient defaulting on treatment and the participant appeared angry at the patient. Health education is a powerful tool used to empower peoples’ knowledge to prevent further complications and improve one’s ’health. The one participant gave much health education on the topic of pregnancy in a language the patient did not understand so clearly, and therefore the message on health education did not come across effectively. Another participant gave health education according to the needs of a patient, giving the patient sufficient time to answer questions the participant might have had concerning her pregnancy. To establish if the patient understood what was said, the participant used the strategy of asking the patient what she had learned and the patient repeated in her own words what she had been told by the participant. The other six participants gave health education according to topics relevant to the patients’ conditions in a language that the patient could understand.

An example of effective health education was obtained during one video recording, when a patient complained of upper and lower backache. The participant took the history of the patient and established that it was highly likely that the pain was caused from the incorrect lifting of heavy objects at his workplace. Before providing treatment to the patient, the participant explained by demonstrating to the patient on how he should lift a heavy object using a box at the clinic and then asked the patient to imitate what he just saw so that the participant could help him if he needed further assistance in correct lifting of heavy objects. The participant was able to speak the language of the patient and he clearly understood what the participant was saying.

Through basic health education of the lifting of heavy objects correctly, the patient now has the knowledge to prevent future injuries, which thus improves wellbeing.

Literature integration

When mentioning that examinations and procedures are omitted or postponed, patients are of the view that professional nurses do not seem to care enough to actually spend genuine time caring for them and therefore have a negative perception towards professional nurses, labelling nurses as cold hearted (Mashego & Peltzer, 2005:17). In addition, professional nurses who implement quality assurance standards ensure consistency; however, quality assurance programmes run the risk that health personnel become dependent on checklists and other documentation rather than delivering a dynamic and creative performance (Bamford, et al., 1999:12). Routine care can therefore inhibit caring presence, as part of the definition of caring presence, according to Tavernier (2006:154), is the ability to fully focus on the patient as a whole being to address that patient's needs.

3.3.1.5 Theme 5: Participants reflected the 'keys' of caring presence through the use of their tone, manner and spirit of enacting caring presence

3.3.1.5.1 Attitude of professional nurses

The attitudes of professional nurses could be divided in two sections, namely the general behaviour professional nurses have towards the patient and the general behaviours the patients have towards professional nurses.

- **The general behaviours professional nurses have towards the patient**

Participants reflected the 'keys' of caring presence through the use of their tone, manner and spirit when enacting caring presence. The behaviours of participants observed towards patients during the video recordings seemed professional and many participants displayed caring presence by listening to the patient, obtaining a history from the patient, providing health education and treatment to the patient and even showing concern for the patient's physical and emotional wellbeing. All participants seemed to take a leadership position towards patients and some participants showed care by speaking in a friendly and polite tone of voice, by eye contact and by smiling to their patients, the opportunity participants would give to patients to ask questions and the open body language which made patients feel more relaxed. As observed in the video recordings, a few participants would also use their own senses (look, listen and feel) to establish problems that patients might be experiencing by not only asking direct questions (such as how can I help you or why are you at the clinic today), but by looking deeper into a matter and clarifying with the patient the participant's observations.

For example a patient consulted with a participant explaining to the participant that he was here to collect his chronic medication. The patient was older than the participant and the participant looked at the patient's file and also observed that the patient appeared hygienically clean; however, there was a strong odour of urine that the patient was smelling of. The participant asked the patient respectfully and acted professionally asking in a sensitive manner if he was experiencing any difficulties with urination. The patient then told the participant that he did have urination problems (where his urine would feel hot) and at times he would have lower backache problems. A physical examination was then conducted through a closed curtain and video recording was not conducted during the examination to ensure and maintain privacy. The participant was able to diagnose and treat urinary tract infection of the patient and provide health education on preventing further complications and recurrent infections.

- **The general behaviours patients have toward the professional nurses**

During the video recording observations, the patients all seemed respectful and friendly toward the participants. The general observation is that patients appeared to look up to the participants as leaders, listening to what the participants told them,

acknowledging that the information and treatment provided would benefit their health. A few patients also came across as appreciative, thanking the participant for the good service.

Literature integration

Pope (2011:33) suggests that a positive attitude towards patients involves applying principles of patient-centred care which includes applying listening skills, treating patients as individuals, understanding the patient's rights and values, treating the patient with respect, dignity and confidentiality, empowering and encouraging patient autonomy and lastly building mutual trust and understanding. The outcomes of patient centred care will therefore allow patients to feel satisfied with patient care and also improve their own health through making collaborated decisions with professional nurses regarding their health and wellbeing (Pope, 2011:33).

Pope (2011:34) further states that the feeling of anger towards a patient shows that the participant is concerned and does care; however, anger blocks patient centred care which can lead to reduced patient ability to maintain autonomy over health care choices and undignified health care delivery.

3.3.1.6 Theme 6: Participants utilised effective instrumentality through the use of verbal and non-verbal communication techniques

3.3.1.6.1 Communication (verbal and non-verbal) between the participant and patient indicated understanding

The manner in which participants utilised instrumentality was through providing effective communication to patients using non-verbal and verbal communication techniques. In addition, the manner in how the patient understood the participant was also observed.

- **Verbal communication participants presented towards the patient seemed to be clear and understandable**

As observed in the video recordings participants were able to utilise effective instrumentality through the use of verbal communication techniques. There were only two participants who experienced language barriers as both participants could not understand the language that the patient was speaking and they tried to accommodate the patient by speaking in different languages in a layman's form of language for the patient to understand. The other ten participants were able to speak in a language that the patient understood which created a good communication interaction between patient and participant.

- **Non-verbal communication professional nurses presented towards the patients was generally used effectively to show interest in the patient**

In general, the participants seemed to be relaxed when communicating with the patients, smiling and showing listening skills such as slightly tilting their head to one side, responding to the patient, which then also made the patient feel relaxed. The table between the patient and participant made it difficult for patients to see open body language; however, there were other non-verbal features that showed that the participant was relaxed. Furthermore, eye contact was also minimised as many participants tended to write while consulting with patients, which could hinder caring presence as part of caring presence requires professional nurses to be there fully for the patient. There was one participant who appeared angry and concerned through the tone of her voice being stern and her crossed arms, because the patient defaulted on treatment, which made the patient seem uneasy and also guilty of defaulting on treatment.

- **Participants attempted to communicate in a way the patient could understand**

During the video recordings, participants communicated verbally to the patient in a language that the patient could understand, avoiding the use of medical terms and jargon, using simple terms to explain the patient's condition and/or when giving health education. Generally observed, most participants communicated by accommodating

different patients from different backgrounds, accepting these differences by trying their best in providing health education that would benefit the patient.

Literature integration

According to Andrus (2015:online), caring presence entails creating an environment where patients truly feel cared for and listened to in their care plan. Andrus (2015:online) views on caring presence can be linked to what was observed in the video recordings by the researcher, whereby participants showed interest in their patients by listening and responding to them, the use of eye contact, smiling, wanting to know more from the patients by asking questions, explaining to the patient about the patient's condition and providing suitable health education.

There are, however, certain factors that can negatively influence caring presence with regard to certain communication factors, such as multi-tasking behaviours while talking to the patient (as mentioned in theme 2), anger shown towards patients who default on treatment (as mentioned in theme 6) and the language barriers where some participants and patients do not speak the same language. Negative communication factors can inhibit the enactment of caring presence as caring presence entails holistically caring for the patient, facilitating comfort to promote growth and healing (& Covington, 2003:307; Finfgeld-Connett, 2008:528). Furthermore, caring presence is seen as an interpersonal process characterised by compassion, holism, closeness, vulnerability and adaptation to unique circumstances (Finfgeld-Connett, 2008:528).

3.3.1.7 Theme 7: The focus of the nurse-patient consultations was influenced by the nature of the consultations

It was clear that the focus of the nurse-patient consultations was influenced by the nature of the consultations. The observations pointed towards the research finding of consultations mainly being nurse-focused.

3.3.1.7.1 Consultations were mainly nurse-focused

According to the video recordings, all participants provided nurse-focused care. In the nurse-patient consultations, the participant would lead by taking control of the

consultation, through the use of various verbal communication techniques to entice the patient to tell the participant the main reason for being at the clinic on that day. The participant would focus mainly on the present condition and link the previous history of the patient that was in the patient's file to provide structure for the consultation. Some participants would ask direct questions to obtain a brief history and current condition from the patient. Mostly, all of the participants would not wait for the patient to ask for advice or health education, as the participant would immediately provide health education that was seen as relevant for the patient's condition.

- **The general focus of the nurse-patient consultation**

The general focus of the nurse-patient consultation as evident from all video recording footage was to provide patients with treatment and care, in order for patients to receive optimal care and prevent further complications and future problems concerning their health. As observed, there were two main priorities among participants namely, to ensure patients receive treatment and to ensure that clinical notes were completed. These priorities are essential in caring for the patient, however, the main focus was not the patient as a whole being, as it was noticed by the researcher that participants would partially focus on the patient, but focus mostly on the factors of patient care.

For example, as observed, a patient came to the clinic to collect his chronic medication. As the patient entered the participant immediately mumbled a hello, not looking at the patient, because the participant was completing the notes of the file of previous patient. The participant requested the patient to have a seat, taking the patient's file and clinic book from the patient. During most of the consultation there was silence, the participant asked closed ended questions that needed a yes or no answer; however, the participant seemed professional towards the patient, the participant followed procedures such as doing the pill count, writing clinical notes and giving the patient a follow up date for returning for his medication. The participant asked the patient only after the patient had received his treatment if there were any other problems and the patient responded by saying no. The patient left the consultation rooms still thanking the participant who was still writing in the file and did not look at the patient, but kept on writing.

Literature integration

Firstly, according to Brown, (2013:E1) and Clark, (2008:20), in PHC nurses are seen as leaders in the community whereby, as observed by the researcher, care is reflected through their leadership quality; professional nurses are taught in their profession to lead and are responsible for their own actions. Professional nurses assume an authoritative style of consulting which can inhibit patient centred care resulting in a negative influence in caring presence. Patient centred care according to Pelzang (2010:914) is defined as treating the patient as a unique individual through considering the patient's point of view and circumstances in a decision making process, setting goals with the patient. Furthermore, Pelzang (2010:914) includes that the patient should lead the consultation which will enable the nurse to provide more effective quality care as the patient will be able to take control of his/her health and be more open towards them.

The second norm that was observed is the divided focus of participants in PHC due to professional nurses having multiple roles within the clinic that also need attention. Executing these multiple roles by multi-tasking while also consulting a patient can therefore lead to misunderstandings and miscommunications whereby the participants come across as professional, but very busy and distant or detached from patients (Leevbov, 2009:online).

3.3.1.8 Theme 8: Genres: The consultation is clinical in nature and challenges that limit caring presence

Through the theme of genre, the observations were divided and discussed into two (2) sections which include the clinical nature of the overall consultation and the challenges found that limit the enactment of a caring presence.

3.3.1.8.1 The overall consultation between the participants and patients seem to be clinical in nature

The overall consultation between the participant and patient, as observed by the researcher in the video recordings is that the participants portray an image of leadership with multiple roles and responsibilities. During the consultations of the patients, participants, through their knowledge and skills were able to provide physical

and emotional support, assess and refer patients to members of the multidisciplinary team to ensure patients received optimal care. They were able to provide evidence-based knowledge in a form of health education to empower patients to take responsibility for their own wellbeing. Participants aimed to provide treatment and care for the patient and ensured that when the patient left, the needs of the patients were met. Patients seemed appreciative, thanked the participant for good service and left the clinic after receiving treatment and also having more knowledge to be applied at home to ensure the patient was empowered. Overall, the patient care provided by participants was optimistic and satisfactory. However, it seemed that caring presence was only enacted in a limited manner.

3.3.1.8.2 Challenges experienced that may prevent caring presence between the professional nurse and patient

Through the twelve video recordings and the eight (8) themes discussed, it was evident that the following challenges and factors (as also mentioned in the previous themes) can negatively influence caring presence:

- A consultation room that seems detached to the participant can affect the caring presence, as participants who do not seem to pay attention or take responsibility for their environment, are more likely to reflect that care towards patients in that manner.
- The consultation rooms do not have treatment and equipment needed to provide care for the patient. This can be inconvenient to both the participants and patients as participants have to look for treatment in other consultation rooms, which delays the consultation.
- The structure of the consultation rooms where there is a table in between the patient and participant. This prevents participants from showing their open body language toward the patient and may come across as distant toward the patient.
- Use of eye contact was minimised due to most participants writing clinical notes while listening to the patients. At times the participant would stop and look at the patient and then continue writing.
- Some participants, while talking to the patients, would get up and collect the patient's medications from the cupboard.

- There would also be some interruptions while participants consult with patients where other people would enter the room to fetch something at that consultation rooms, or ask assistance or advice from the participant.
- Another observation made was that none of the participants provided any spiritual support to patients in the consultation rooms; however, in the mornings on weekdays, some professional nurses with all staff members would sing gospel songs and pray with the patients, as observed in most clinics
- Negative emotions of anger shown towards a patient that defaults on treatment can inhibit caring presence as the patient will withdraw from what the participant is saying.
- Postponing the drawing of blood to another date as taking of blood is difficult because the patient does not have visible veins, can delay care provided to the patient
- Not providing the patient with health education as the patient regularly comes to the clinic to receive medication and “knows it all” can prevent the patient from being empowered and taking control of his or her health.
- Imbalance of the nurse-patient ratio negatively impacts on the care provided by participants who also have multiple roles and tasks to complete on a daily basis and consult many patients daily. To save time, nurse focused care is provided to patients, which can come across as quantity care rather than quality care.

Literature integration

Oosthuizen (2012:49) states that in the current media, there is much information on the images of nursing, referring to the profession of nursing to be a caring, compassionate and knowledgeable profession. This positive image is, however, dominated by negative reporting, where patients state that nurses are uncaring and that their behaviour reflects laziness, ruthlessness and incompetence (Oosthuizen, 2012:49). Caring presence behaviours are poorly reflected, because nurses are used to providing care in a manner that assists with coping strategies associated with high levels of burnout and limited time (Oosthuizen, 2012:49). According to Van der Colff and Rothmann (as cited in Viljoen, 2012:9) the coping methods include withdrawal or avoidance that are seen as passive coping strategies with three associated traits that

include depersonalisation, emotional exhaustion and lack of personal accomplishment.

To help more patients in a short time frame, participants would unintentionally depersonalise themselves through portraying negative attitudes or detached responses towards patients. Feelings of personal emotional exhaustion would surface and to avoid those feelings, professional nurses would emotionally and cognitively distance themselves from their work for apparently coping with work overload. Lastly, professional nurses are not regularly given the opportunity to practise self-reflection and self-evaluation which may therefore lead to feelings of insufficiency, incompetence, lack of achievement and unproductiveness (Viljoen, 2012:9).

3.3.2 RESEARCH FINDINGS ON THE PARTICIPANTS'

PERCEPTIONS ON CARING PRESENCE AND RESILIENCE

Three main themes followed by categories and subthemes were identified from the semi-structured interviews illustrating the research topic of 'Fostering a caring presence and resilience among professional nurses working in primary health care'. Certain applicable direct quotations from participants as well as relevant academic literature are used in the discussion of the themes, to validate the themes, categories and subthemes of the research study.

Table 3.2 provides a brief summary of the research findings on the participants' perceptions of caring presence and resilience.

Table 3.2: Brief summary of the research findings on the participants' perceptions of caring presence and resilience

3.3.2.1 Theme 1 Caring presence and resilience from PHC professional nurses' perspective	3.3.2.2 Theme 2 Challenges PHC professional nurses experience regarding their work in relation to caring presence and resilience	3.3.2.3 Theme 3 Recommendations from PHC professional nurses to foster caring presence and strengthen resilience
<p>3.3.2.1.1 Research findings on the meaning of caring presence:</p> <ul style="list-style-type: none"> • Communication (Interaction between professional nurse and the patient) • Qualities (certain traits that reflects caring presence) • Conduct (acting a certain way that reflects) caring presence • Literature integration 	<p>3.3.2.1.2 Research findings on the meaning of resilience:</p> <ul style="list-style-type: none"> • Type of qualities and skills of an individual • Attitude of an individual • Literature integration <p>3.3.2.2.1 Communication challenges</p> <ul style="list-style-type: none"> • Language barriers • Literature integration • Attending to rude and ill patients • Literature integration • Various amounts of paperwork • Literature integration • Appraisal of positive performance • Literature integration • Poor teamwork and communication • Literature integration • Attending to ethical dilemmas and decision making • Literature integration • Lack of training and feedback on amended protocols and guidelines • Literature integration <p>3.3.2.2.2 Staff shortages in general</p> <ul style="list-style-type: none"> • Multiple roles and duties • Literature integration • Quality versus quantity care • Literature integration <p>3.3.2.2.3 Lack of resources and equipment at the workplace</p> <ul style="list-style-type: none"> • Shortage of medication • Literature integration • Lack of equipment or broken equipment • Literature integration <p>3.3.2.2.4 Services Professional Nurses provide</p> <ul style="list-style-type: none"> • Unfair practices in inequality • Literature integration <p>3.3.2.2.5 Unsatisfactory remuneration</p> <ul style="list-style-type: none"> • Feelings of demoralisation and resignation • Literature integration 	<p>3.3.2.3.1 Providing effective communication</p> <ul style="list-style-type: none"> • Effective communication among staff members and patients • Literature integration • Effective communication among staff members • Literature integration • Effective communication among staff members and management • Literature integration <p>3.3.2.3.2 Addressing staff shortages at health care facilities</p> <ul style="list-style-type: none"> • Literature integration <p>3.3.2.3.3 Addressing lack of resources and equipment at the workplace</p> <ul style="list-style-type: none"> • Literature integration <p>3.3.2.3.4 Addressing services professional nurses provide</p> <ul style="list-style-type: none"> • Literature integration <p>3.3.2.3.5 Addressing remuneration of PHC professional nurses are experiencing.</p> <ul style="list-style-type: none"> • Literature integration

3.3.2.1 Theme 1: Caring presence and resilience from primary health care professional nurses' perspective

The first main theme identified is how participants interpret the meaning of fostering caring presence and resilience.

3.3.2.1.1 Research findings on the meaning of caring presence

During the conduction of the methodology, all twelve participants gave their own views on how they showed caring presence towards the patient during the video recording, as well as their perception of the meaning of caring presence. According to the research findings, caring presence can be grouped into three subcategories namely:

- **Subcategory 1: Communication (interaction between professional nurse and the patient)**

The participants defined caring presence as being there for the patient, by understanding what the patient was saying and listening to the patient. Furthermore participants stated that caring presence was about providing sufficient time and attention for the patient to express concerns freely. Participants were of the opinion that a patient-centred approach should be implemented to meet the needs of the patient, allowing the patients to lead the consultation. Most participants mentioned that knowledge and experience were important to provide the patient with treatment, advice, assistance and health education and to refer the patient for further necessary treatment to ensure optimal wellbeing of the patient would be achieved. In addition, protocols and procedures should also be followed to protect the patient from any harm. Words of encouragement and reassurance should be provided to instil hope for the patient on living healthily. Furthermore, patients should be counselled with a smile and positive attitude to make them feel comfortable and at ease.

“I think its nurses being more there for the patients, listening”

“Caring presence is you showing that you care for the patient, by actually listening...”

“I think I did my caring presence, by means of uhm, introducing myself to the patient,

uhm by means of making a patient feel at ease, speaking in the language the patient understands, uhm explaining everything that I was doing to the patient and allowing the patient to ask questions and answer them...”

“... I think it is in a way the way where you interact with the patient. Firstly, to get what they came for, give them enough time to verbalise their problems and then from then, you give them information, maybe if necessary about the illness, or whatever problem they came with and then explain the treatment or the management and possibly explain the prognosis if maybe if it is an incurable illness...”

...”The patient must get enough information to make the right decision...”

- **Subcategory 2: Qualities (certain traits that reflects caring presence)**

Participants stated that to have caring presence was to be resilient, facing daily challenges experienced each day. PHC professional nurses should maintain a non-prejudice and non-judgemental attitude towards every patient; treating them the way you (as an individual) would want to be treated and also treating patients as if they were family. Caring presence means placing yourself in the “patients’ shoes” by understanding that they are from different backgrounds and therefore empathising with the patient.

“...I think I see it as a nurse more or less putting herself in patients’ shoes...”

“Generally, I think caring presence is like during an interaction with the patient whereby you will be caring for her you “empa-gateng” you empathise with her that, like what she is going through, you should be able to experience that as well, though we have like different patients coming from different backgrounds, but ya, at the end of the day you need to care for that patient.”

“For me it’s like treating the patient totally like body, mind, soul you must treat the patient holistically and you must be opened to the patient’s views as well, because you can’t enforce anything on them, so whatever decisions you are supposed to make, you are supposed to make it with the patient.

- **Subcategory 3 Conduct (acting in a certain way to reflect caring presence)**

Caring presence is showing patient care by a smile, making eye contact, the use of touch and openness. Caring presence is the act of generously choosing to give more than is expected as a professional nurse. Caring presence further entails setting an example as a leader within the community and the youth by acting professionally mature towards every patient and lastly doing the “right thing” at work even if no one is watching.

“It’s like listening to the person and then eh, feeling what the person is saying and ya and just comforting the patient with your smile...”

“...Following protocols and ensuring that everything is being done the correct way...”

“...Even if there is no one actually with the video camera or, you do the right thing...”

Literature integration

Caring presence is defined by Finfgeld-Connett (2008a:528) in a similar way as described by participants, namely that it is an interpersonal process characterised by certain skills of professional nursing, interpersonal sensitivity and intimate relationships. In addition, caring presence is also characterised by qualities one should have which include compassion, holism, closeness, vulnerability and adaptation to unique circumstances (Finfgeld-Connett, 2008b:528).

3.3.2.1.2 Research findings on the meaning of resilience

Interestingly, some participants shared that they did not know the definition of resilience. However, once this concept was explained briefly by the researcher, namely that it is the ability to ‘bounce back’ in adversity, all participants were able to find the meaning of this concept in the values of their own personal experiences.

According to these research findings, resilience could be grouped into two subcategories namely:

- **Subcategory 1: Type of qualities and skills of an individual**

According to the participants, resilience is defined as managing pressured circumstances and allowing professional development in order to manage a situation in a mature manner. Furthermore, resilience is about addressing ethical dilemmas on a daily basis through prioritising and acting in the best interest of the patient (Koen, 2011:65). Resilience at the workplace is seen by participants as coping with staff shortages, lack of resources and equipment though finding alternatives using innovative thinking and improvisation to solve challenges (Koen, 2011:65).

“Resilience in my view is to be able to manage in every situation. To be able to bounce back uhm, from whatever that’s happening.”

“The way I see resilience is the ability for me as an individual to cope and be able to continue despite the problems, despite the fact that you overburden with problems, despite if you are short staffed or short of medication, it’s all about coming up with the best plan on how to care of the patient at that moment...”

- **Subcategory 2: Attitude of an individual**

Participants are of the view that resilience entails staying positive and realistic regardless of difficult circumstances and to constantly be updating one’s knowledge. Increasing one’s knowledge will increase one’s resilience as one will have the necessary tools to solve challenges effectively. In addition resilience is also learning from previous mistakes and past experiences of other professional nurses and setting an example of behaving in a positive and professional manner towards patients and colleagues.

“For me, resilience and caring presence go hand-in-hand, because showing that you care and are there for a patient, means you putting yourself in the patients’ shoes, treating patients the way you want to be treated as a person by being positive, helpful, encouraging and respectful. I like to treat people as them being a family member which encourages me to do the right thing at all times.”

“To be resilient is to have the knowledge to back up what you practice and to be confident in what you do as a professional nurse. Resilience also entails, asking for a second opinion if unsure and constantly building your knowledge by reading books and attending courses.”

Literature Integration

Jacelon (1997:123) and Richardson (2002:312) similarly define resilience as having an intrinsic motivating force to recover, manage and cope in difficult situations, learning from these situations to build a greater resistance.

3.3.2.2 Theme 2: Challenges primary health care professional nurses experience regarding caring presence and resilience

The second main theme identified is how participants working in PHC experience challenges regarding their work which negatively influence caring presence and resilience. The second main theme that will further be discussed is divided into five sub-themes, namely communication challenges, staff shortages, lack of resources and equipment in the workplace, services that professional nurses provide and unsatisfactory remuneration that PHC professional nurses are receiving on a monthly basis.

3.3.2.2.1 Sub-theme 1: Communication challenges

Communication challenges derived from the research findings were divided into seven sections which include the following:

- **Language barriers between the patient and nurse**

According to some participants, there is miscommunication between patients and participants due to the different languages the participant and patient are speaking. Participants feel that if patients do not understand the participants, patients will just agree, which could have a negative influence when making a diagnosis. In addition, participants also feel that effective care cannot be given as the patient may not feel open to ask questions regarding their health.

“Like I was asking the patient the language of the patient, cause I saw her saying yes to everything so it was difficult for me to, to, to, to write down the pain, how on which diagnose to give her so that why I asked her what language is she speaking, cause sometimes it is difficult somebody saying yes, yes not saying no to every question, ya so it was difficult for me the language barrier.”

“I feel that I do enact caring and presence, but due to language barriers as well the patients might feel that I do not care enough basically...”

“It’s just because I feel that we are not on the same level when language is concern. So I think the patients don’t open up as much...”

Regarding communication challenges, some participants according to their culture, have a great respect towards their elderly patients. Participants are therefore of the view that certain issues are sensitive to talk about, because according to culture, certain issues are seen as a taboo.

“...in our culture you respect the elders.” So some of the things we need to be sensitive when we ask, when we ask, when we talk we need to be sensitive.”

“Like for example, maybe eh, maybe you will be asking maybe sexual issues. Then you have to be sensitive, meaning that you have to eh to put some respect there...”

Literature integration

In the nursing field, communication is essential and crucial as it is required in correctly diagnosing the patient to provide patients with effective care. According to Kaur *et al.* (2014:20) language barriers can cause miscommunications and misunderstandings between the patient and nurse, which can be a disadvantage for the patient as this can lead to a misdiagnosis and medical errors. In addition communication challenges can also prevent a trust relationship between the patient and nurse as patients cannot understand what nurses are saying and therefore cannot have an open relationship with them (Kaur *et al.*, 2014:20).

- **Primary health care professional nurses attending to rude and ill patients.**

Participants feel that some patients are rude, impatient and have negative attitudes towards the professional nurses with the perception that they have to wait in long queues when they only came to the clinic to collect their treatment. Patients are also of the view that health education is unnecessary and irrelevant. Therefore with the negative behaviours of patients, participants find it difficult and not motivating to care for patients that are rude towards them, because they do not feel appreciated. Some

participants feel taken for granted by patients as some patients expect professional nurses to work without having tea or lunch in between.

Another viewpoint that some participants have is that when dealing with sick people, participants tend to feel overburdened with emotions as they too can relate towards what the patient is feeling as some participants also have personal problems outside the workplace.

“Sometimes, you find that uhm some patients, sometimes when you are sick, some people tend to be impatient and (participant sighs) with this attitude... for example you might give them health education that they are supposed to use condoms for them, because the medication alone won't be helping and then you find a patient that comes and feels that you are wasting their time, they just want their medication to go home.”

“...negative because they don't they don't want us to take lunch or tea and they want us to help them and help them and they don't want us to even appreciate.”

“...we deal with who are sick, who are having problems, it becomes heavy on your heart...”

Literature integration

Hawken (2005:266) states that some patients are “difficult”, which makes the management of these patients frustrating and challenging for health care professionals. Hawken (2005:266) further adds that there are different types of difficult patients; however, in the research findings participants speak of rude, ill and unappreciative patients. Effective communication requires professional nurses to understand their patients and their experiences they express by conveying a verbal and nonverbal message that the patient is understood and is accepted (Kourjouta & Papahanaslou, 2014:65). Miscommunication between professional nurses and patients is common in PHC as professional nurses often feel overburdened with work, while patients feel unimportant, because they wait in long queues for treatment and feel that there is poor communication from professional nurses (Nesengani, 2014:82).

- **Various amounts of paperwork needed to be completed by every primary health care professional nurse for every patient**

Many participants feel that the administrative work, which entails writing repetitive clinical notes in the patient's clinic file, patient's clinic book and in various registers, is strenuous, time consuming and redundant. Participants feel that they do not spend enough time with patients as their focus is mostly directed to completing the administrative work thoroughly and effectively.

"I think the writing, sometimes it's just too much for us, because of you want to listen to the patient again we have to write everything down..."

"...sometimes the patient thinks that you don't listen to them, you are just writing everything down and not eh looking at them..."

Literature integration

Nursing documentation and record keeping are essential parts of nursing practice with clinical and legal implications. In addition, nursing documentation is a dynamic and complex process whereas this process has been evolving to adapt to the immense amounts of medical related knowledge that is being generated to create enhanced health care to patients (Nursing Informatics, 2007:online). In South Africa, health care systems are under pressure to implement quality assurance programs and medical technologies with the need to ensure their effectiveness and efficiency (Bamford, 1999:12). All these implementations are included in the nursing documentation whereby nurses are more focused on completing the documentation, rather than spend quality time with the patient, which can then lead to medical errors and patients not being effectively cared for (Health Information and Management Systems Society Nursing Informatics, 2007).

- **Appraisal of the primary health care professional nurses 'positive' performance**

Participants feel that they are unappreciated, unmotivated and at times prejudicially treated by both patients and management. In addition, participants feel that they are constantly being criticised for any mistakes they make, as both patients and

management would rather condemn mistakes than give recognition for positive performances and provide valuable rectifications where needed.

“...if you do the right things, nobody says anything, when you do one wrong thing, a lot of people come and say a lot of things...”

“It’s just that I feel that nurses are under appreciated...”

Literature integration

Stapleton *et al.* (2008:6) are of the view that as human beings, we believe and are motivated either towards pleasurable outcomes, for example receiving an appraisal or complement after helping patients or receiving more money and gifts for a job well done. In addition, people are also motivated through an aversion of painful or unpleasant outcomes (Stapleton *et al.*, 2008:6). For example, managers reprimanding professional nurses to perform better otherwise they will face negative consequences such as receiving warnings (Stapleton *et al.*, 2008:6). Stapleton *et al.* (2008:6) suggest that while it is preferable to motivate staff towards something pleasurable, the reality is that in PHC, employees are motivated more in the opposite way where staff members feel more demotivated in their work.

- **Poor teamwork and communication among staff members as well as among staff members and management**

Participants feel that there is poor teamwork and communication at the workplace among staff members and also between staff members and management. At some clinics, there are no regular staff meetings and staff members treat one another as strangers and for these reasons, the workplace seems unpleasant. In addition participants also stated that the poor teamwork among staff members caused an overload of work which led to burnout and stress.

“...we are understaffed, our staff is on leave, so to tell you the honest truth, I can’t tell you when last did we have a staff meeting...”

“...we are living past each other...”

“There isn’t real communication at this clinic now.”

Literature integration

Communication skills are often disregarded and undervalued as effective tools associated to job satisfaction and contentment (Stapleton, *et al.*, 2008:9). Kalisch and Begeny (2005:550) further add that poor teamwork and one way communication in the workplace negatively affect health care delivery, which can lead to negative consequences. The negative consequences include an instability in the workplace that causes elevated stress levels among staff members which then leads to feelings of inability to cope as the workload is imbalanced; one person will work harder than the other to provide care for patients (Kalisch & Begeny, 2005:550). Another negative consequence of poor/no teamwork leads to an absence or neglected common purpose and destiny where staff members do not have a goal to work towards as they do not assume responsibility for the actions of their colleagues (Kalisch & Begeny, 2005:550). The last negative consequence is an inhibiting physical environment whereby not assuming responsibility as a team for the environment can cause physical harm towards patients and staff members (Kalisch & Begeny, 2005:550).

- **Primary health care professional nurses attend to ethical dilemmas and decision making everyday**

Some participants indicated that, due to a shortage of resources, ethical dilemmas occur and certain crucial decisions are made regularly at the workplace, which makes a participant question their beliefs and actions. Participants feel that they have to improvise by going against certain protocols and procedures to care for a patient.

For example:

“...we created in the facility (participant whispers: it’s not legal), but uhm, we created something where, if there is defaulters, we like take it out and like keep it for a month. If there is someone that comes in a urgently needs medication, we would issue to them and then we would make sure that the doctor writes a new script and so when they come for the next visit, there will definitely be treatment for them. For me it’s like I can’t let a patient leave this facility without the service that we provide, because this is a service we provide for them and now they are leaving without the service and it’s against the Batho Pele principles as well...”

“It’s just that uhm, ethical, your ethics is put on the line, because other people don’t do their job properly by the script going missing. Whose fault is that, uhm... and then it eventually becomes your problem and then it gets quite frustrating I can imagine if the script is not there and the patient is waiting for medication and then you don’t let the person just go home, you give the medication of somebody else...”

Literature integration

Ethical dilemmas and daily decision making are part of the nursing profession and nurses are taught to do what is best for the patient, treating patients as human beings. Professional nurses who contemplate their decisions frequently, lack a “reflection-on-action” approach, which is defined by Schon (as cited by Stapleton, *et al.*, 2008:6) as a process of development whereby, when faced with a difficult challenge, health care professionals work through it instinctively by recalling similar previous experiences of their own or of other health care professionals, until the matter is resolved. Stapleton, *et al.* (2008:6) further argue that there needs to be shared experiences among health care professionals to practise a “reflection-on-action” approach to decrease feelings of insecurity and doubt in the workplace.

- **Lack of training and feedback on amended protocols and guidelines**

Many participants feel that there is insufficient training and feedbacks on trainings regarding amended protocols and guidelines. Protocols and guidelines are constantly changing and are not explained, which makes participants feel uncertain and uneasy in the workplace. In addition, participants feel unskilled due to certain procedures they have not received through training.

For example: “Like workshops, like in service workshops on implants like all the new procedures. We received new STI guidelines, but nobody ever went for in-service training, Pharmacy is saying that Erythromycin is being phased out, but no one is being trained on, what I do now.”

Literature integration

Kautzky and Tollman (2008:24) state that there is a critical shortage of trained health personnel, while Delobelle *et al.*, (2011:1) add that nursing graduates continue to feel ill-prepared and unsure for practice. Many professional nurses in primary health care

are faced with challenges each day and due to factors such as staff shortage and a high workload, and professional nurses' lack of training in knowledge needed to provide effective care to patients. Furthermore, Stapleton, *et al.*, (2008:6) add that organisations do not readily encourage new learning as organisations thrive on routine and status quo. Nevertheless, nursing is classified as both an academic and practical discipline and is a dynamic profession blending evidence-based practice with intuition, caring and compassionate traits to provide the best quality care to patients (American Nurses Association, 2004:online). Therefore, constant training and education is needed within health care settings and among professional nurses in order for nurses to feel confident in the workplace and to develop personally and professionally (Stapleton, *et al.*, 2008:11).

3.3.2.2.2 Sub-theme 2: Staff shortages in general

Shortage of staff was discussed and grouped into two sections which include the following:

- **Primary health care professional nurses have multiple roles and duties that needs to be attended to on a daily basis at work.**

A shortage of staff according to most participants, has become an immense challenge to provide caring presence and be resilient. Most participants stated that they have a negative attitude, because they feel overburdened and stressed from work, due to a shortage of staff and the multiple roles and duties they have to attend to on a daily basis. Participants do not get enough time to take lunch or tea breaks and moreover, outside the workplace, after work they feel physically drained and feel guilty for not spending time with their loved ones. Participants also feel that too many patients attend at one clinic, when patients actually have accessible care nearby where they stay. Patients constantly complain about the long queues at the clinics, but do not understand that there is a shortage of staff. One participant will see about fifty patients a day and will also have to attend to emergency situations. Regarding annual leave and absenteeism, participants are of the view that some staff members take leave simultaneously, while other staff members will frequently be on sick leave and/or stay away from work, causing a shortage of staff.

“...we are severely, severely short staffed... I have realised that you know we are severely overworked...”

“I mean how do you smile, how do you lift up the patient and show caring when outside there are about one hundred patients waiting outside for you to be seen, you know and this side we are short staffed...”

“...when I get home, I don't want to lie, I'm drained, I am drained and I have a small little boy which I even don't get time to spend time with my son so I'm drained. So when I get home, sometimes I would just get in the bed, get into bed and just sleep...”

“...we are understaffed and with us being understaffed, your resilience is really pushed to a maximum. You are tired, because of not actually what you do, but the load that you have to cope with. So right now in the clinic situations, I think the resilience is very low.”

Literature integration

Primary health care professional nurses are given multiple roles and responsibilities that they are expected to fulfil to provide patients with optimal care. According to the World Health Organisation (2011:online) primary health care professional nurses occupation includes the following namely: health promotion, illness prevention, midwifery, antenatal and postnatal care, treatment and care of the sick people, rehabilitation and palliation, community development, population and public health, education and research and lastly policy development and advocacy. Professional nurses not only take on these roles expected of them in their workplace, they also take on the roles and responsibilities outside the workplace, for example be mothers (or fathers), parents, wives (or husbands) and/or active community members. According to the American Nurses Association (2015:online) the negative effects of staff shortages is that nurses need to often work long hours under stressful conditions (due to multiple roles they must assume) which can result in fatigue, injury, illness and job dissatisfaction causing mistakes and medical errors that may be harmful to patients.

- **Quality versus “quantity” care primary health care professional nurses provide**

Participants are of the view that if there is a staff shortage, they cannot perform their duties optimally, because they feel rushed and pressured at the workplace and therefore provide quantity instead of quality care to patients. The quantity care provided to patients creates frustration among participants as they would like to provide thorough care. However, due to factors such as limited time and staff shortages, participants do not have the time and energy to talk to patients in depth, and certain examinations and procedures are also either postponed to the patient’s next appointment date or are omitted.

Participants state that some implementation of programs and intervention programs designed to make the workload better, appear effective in theory, but are ineffective in the practice setting due to staff shortage.

“Mostly neh, the challenges is when there is shortage of staff, because I believe that every client needs the Sister to be there and to listen and not just to give treatment and go, others just need to talk, more than getting treatment, but we are short-staffed, you are not going to get enough time to talk to the patients, you see. So you just work, work, work to get finished.”

“...shortage, it prevents you from going to full extent, to do everything on that client, because now you push other things aside saying you will do them next time that you come, instead of doing everything, treating the patient holistically at that moment.”

“...when there are a lot of patients for one nurse, the ratio is so big that you can’t even manage to manage the patients...” You sometimes omit other things that are necessary for the patients, thinking that you want to reach those patients; you do not want other patients to go home, you want to reach them, so sometimes you omit certain things like examination of the eyes, physical examinations you end up by not doing it and by not doing it, you expose the patients to other illnesses that you could have prevented for, that you could have seen.”

“ICDM is working in theory, but then in practice (participant frowns and shakes his

head)... I think that ICDM would work for a hand full of patients, if you had a hand full of patients and enough staff, you won't have a problem, but every day is thousands and thousands of patients and if we have thousands of thousands of patient it won't work, it would not work at all, because it is currently not working..."

Literature integration

According to Essays UK (2013:online), nurses are globally seen as front-line caregivers of a larger professional group, spending most of the time with the patient, and nursing is therefore recognised by patients and also the community as a trusted profession. Essays UK (2013:online), further argues that in order to facilitate quality assurance in health care facilities, an adequate number of nurses is needed. A shortage of nursing staff has proven (through various studies) to negatively impact the quality of patient care causing unintentional physical harm and neglect towards patients and also poor job satisfaction among staff members which can create a high turnover and poor work performance (Essays UK, 2013:online).

3.3.2.2.3 Sub-theme 3: Lack of resources and equipment in the workplace

Lack of resources and equipment was discussed separately which included the following:

- **Shortage of medication at the health care facility that is needed to improve the patient's health**

Participants have a sense of despair and hopelessness when addressing the challenge of shortage of medication at the health care facility, as shortage of medication prevents the patient from receiving optimal care. Participants are of the view that patients come to the clinic to receive treatment for various conditions and if there is no medication in stock, participants send patients home and some participants even try to provide health education which at times seems insufficient.

"I mean some things we don't have control over like shortage of medication, you wonder, (participant's phone rings) I want to give this person Panado, but it's not here so somehow it feels like I don't care enough, because this person came to me, he's in pain, but I'm doing nothing, like giving health education is nothing..."

“...the difficulty that I experienced was shortage of medicine in the clinic. Sometimes, even today, I had to prescribe INH for the patient and now we don't have vitamin B6 which is supposed to counteract the side effects of INH so I would say that it is a very big challenge to us, so I tell you how it is. Most of the times it's medication that is necessary for the patient to get, not just uh luxury, so that is always a factor...”

Literature integration

According to SPP Stock Outs National Survey (2013:1) in recent years, clinics and hospitals in South Africa are facing nationwide challenges with medication shortages which have a direct negative impact on patient care. Health care workers provide medication to patients (who cannot afford to buy over the counter medication and treatment) for sustaining optimal health and preventing treatment resistance among patients that are chronically ill (SPP Stock Outs National Survey, 2013:1). On a larger view point, medicine stock outs also weakens South Africa's struggle against HIV, TB and other serious diseases and therefore medication in health care facilities should be regarded an important necessity and shortages should be treated as a national emergency (SPP Stock Outs National Survey, 2013:1).

- **Lack of equipment in the workplace**

Participants feel that lack of equipment or broken equipment prevents the participant from providing care as certain equipment is necessary to ensure the treatment and care provided is effective for the patient.

“And the other thing, its support of equipment. I would say that one falls under maybe logistics. If equipment's are not readily available, then we have a problem, simple things like Hb meter. When we don't have an Hb meter and the Hb meter is faulty, we end up diagnosing patients and we treat them wrong. So we exposing them to other uhm, complications.”

Literature integration

According to Politics Web (2013:online) one of the fundamental system failures that has been identified by health care workers relates to the purchasing and maintenance of equipment. Health care workers view medical devices and equipment as important for diagnosing and providing treatment to a wide range of medical conditions (Politics

Web, 2013:online). Failure to provide adequate and functional equipment prevents health care workers to effectively treat patients and therefore patient care is compromised (Politics Web, 2013:online).

3.3.2.2.4 Sub-theme 4: Services professional nurses provide

The services that professional nurses provide are discussed by establishing the themes as:

- **Unfair practices in inequality where some patients are treated better than other patients**

At the clinics, some participants have negative perceptions of certain patients who address professional nurses indifferently due to their networks of connections with higher ranks of health care professionals at the health care facility. Patients have an expectation to be helped faster and to be treated more special due to these connections and complain that their expectations are not met. Participants feel that all patients should be treated fairly and equally and not be judged nor treated differently on appearance and/or status.

“I treat every single patient that comes into my consultation rooms as if they are my first and last patient.”

“We are having problems with people that know people from higher places...the way you treat the one patient, just because she is family or friends with somebody, you treat the other, because that is what we did, we took an oath to treat people the same way”

Literature integration

According to the SANC (2013:1), ethics in nursing is seen as a fundamental part of the nursing profession and provides guidance to nurses in making moral decisions at the workplace. Part of the ethical principles that is appropriate to the research findings under the heading “Code of Ethics for nursing practitioners in South Africa” include practising justice for all. Justice is defined according to SANC (2013:4) as nurses acting fairly and equitably towards all patients in situations that include prioritising care or any situation that may be perceived or experienced as unequal. Therefore, not

providing equal services towards patients goes against the 'South African Code of Ethics for nursing practitioners.'

3.3.2.2.5 Sub-theme 5: Unsatisfactory remuneration that PHC professional nurses are receiving on a monthly basis

The unsatisfactory remuneration that PHC professional nurses are receiving on a monthly basis was discussed by establishing the themes as:

- **Feelings of demoralisation and resignation towards the profession of nursing due to poor working conditions and job dissatisfaction**

Some participants feel that they are not being recognised extrinsically and feel discouraged towards their profession as they are not being paid sufficiently for what they are doing. Participants also feel that their remuneration does not equate to the continuous rise of the cost of living. Some participants are therefore of the view that it would be more beneficial for them to resign and seek alternative employment.

“I am also thinking that maybe if government can also look at uhm, the workload that we have and the stress that we go through. I’m thinking maybe if financially they can look into it, because you become demoralised if you wake up every morning and you are not being recognised with any other job... at the end of the day, I still need the money, so I’m thinking that we have families to take care of at the end of the day. Then it will motivate us more to do our job.”

“...I think that, I feel that there is nothing that hinders with apart from the money issue... because I want to leave...”

Literature integration

According to Stapleton *et al.* (2007:816), the turnover for professional nurses is initiated by “on-the-job” factors which cause job dissatisfaction. The most common factors include staff shortage with a combination of an elevated workload and unsatisfactory remuneration (Stapleton *et al.*, 2007:816). All these factors combined stimulate feelings to resign with a belief that an alternative job will include better working conditions as people are of the view that “the grass is greener on the other side” (Emanuel & Pryce Miller, 2013:17).

3.3.2.3 Theme 3: Recommendations from primary health care professional nurses to foster caring presence and strengthen resilience

In theme three, participants have made recommendations to overcome the challenges mentioned under main theme two (2) to foster caring presence and strengthen resilience.

3.3.2.3.1 Subtheme 1: Providing effective communication among staff members and patients and staff members and managers at health care facilities

- **Effective communication among staff members and patients**

Participants suggested that devising one simpler and realistic writing tool for documentation purposes would enable PHC professional nurses to spend more time and have more focus on caring for patients. Concerning communication barriers, where both the patient and professional nurse speak and understand two different languages, participants also propose training more interpreters at health care facilities. Participants advised other professional nurses to have culture congruency by respecting people and speaking in an acceptable manner. Furthermore, staff members should develop a sense of professional maturity to understand and accept people, regardless whether they are rude and/or ill.

“I think the paperwork it is a lot of work for the staff, if it is only one recording per patient, I think it will be easier.”

“...we need to be respectful with all patients... in a mature way, like it in a professional setting by the way so you help them to reach that place where they understand that at the end of the day, seriously that person is here to help me....”

Literature integration

Patients view nurses as leaders and role models in the community, therefore nurses have a responsibility to ensure that patients receive effective health care delivery and optimal care (Brown, 2013:E1; Clark, 2008:20). In the research findings, the

recommendations that professional nurses made, included devising a simpler documentation tool to spend more time verbally communicating with the patient and less time writing. According to Roper (1999:1), medical records are seen as an important communication method for the multi-disciplinary team and therefore need to be kept safe and be accessible. There is a great need for professional nurses to be trained in nursing documentation and to be educated on the importance of good medical records.

Part of providing caring presence requires applying certain communication techniques which include listening attentively and understanding the patient to meet the needs of the patient to thus prevent any harm towards patients. Trained interpreters were also suggested by participants and Taylor, *et al.* (2013:43) confirms that new and innovative approaches are necessary to meet the needs of people, which include utilising interpreters, using pictures to represent meaning and/or promoting the learning of English.

Hawken (2005:266) states that when dealing with difficult patients that are rude, ill and/or unappreciative, health care professionals should behave in a professional manner by applying general strategies for dealing with difficult patients. These strategies include showing empathy, being tolerant and relating to the patient in a non-judgemental manner (Hawken, 2005:266). Health care professionals should not negatively react towards difficult patients, as this will not solve the matter effectively; however health care professionals should try to understand and relate to the patient, providing sincere communication with the patient by, for example, apologising for the long wait in the queue, because it is a busy morning (Hawken, 2005:266).

- **Effective communication among staff members**

Participants feel that there is insufficient communication among staff members, causing an imbalance of workload and also ineffective implementation of programs that are supposed to aid in reducing the workload among health care professionals. Participants also suggest that team building be implemented by creating opportunities where staff members have the chance to bond with one another and where team building can be practised.

“Teamwork is of the utmost importance, because that is the only way can move forward with the shortage of staff and influx of patients and I think that is the main thing. And communication with each other continuously, like having meetings at least once a week.”

“I think team building, uhm... I don't know how to put it, like maybe once in every quarter, we take out professional nurses and there is no need to even spend they can bring the team builders...”

Literature integration

In the research findings, participants are of the view that there need to be more communication and teamwork among staff members to provide an effective health care service, to divide the workload, and to lessen work related stress, which will thus promote job satisfaction. Meehan (2015:online) is of the view that effective teamwork among staff members creates a therapeutic milieu, thus stimulating positive work performance at health care facilities.

Furthermore, Meehan (2015:online) states that effective teamwork is achieved by nurses showing care towards one another. These traits of care include being respectful, attentive and appreciative towards one another, as well as being sensitive towards the needs of a colleague who is seen to need additional encouragement and help (Meehan, 2015:online). Student nurses should also be cared for by nurses in charge by acting as supportive role models, as they are the future of nursing (Stapleton *et al.*, 2007:811).

- **Effective communication among staff members and management**

Participants suggest that management should be more involved in encouraging teamwork among staff members through building projects and activities, implementing delegation of daily duties and responsibilities and provide regular staff meetings to strengthen the communication and teamwork among staff members. Most participants request establishing support services where staff members can have the opportunity to be debriefed formally (individually) or informally (within a group) for continuous emotional wellbeing and support.

Together with debriefing sessions, some participants are also of the view that spirituality should be practised more and incorporated into the health care facility to further strengthen emotional and also spiritual wellbeing and support. Furthermore, participants feel that they should have debriefing sessions on ethical dilemmas for reflective purposes thus learning and establishing preventative measures where possible, to ensure professional development. Participants also suggest that staff members should be given equal opportunities to attend educational trainings and enough time should be provided to ensure feedback to the rest of the health care facility is given.

“I would say support from the management’s side. If the management’s side is able to support the staff, then I think it would improve in turn.”

“I think also uhm what can management do is to actually make attitudes of nurses more positive, you know, maybe come here once in a month and just give us a debriefing session where you feel fresh after it and feel energised again so that you can carry on.

“You know sometimes even if you can have a long week, but if you can go to church and get people talking about good things that people do, so then when you come Monday you are fresh again and you want to continue doing good to others.

So maybe once in a while, have a debriefing session and where we can have a reflect on what we have been doing and then where can we improve and things like that, just so that you are consistent, you care throughout.”

“...continuous training would bring back the resilience as well, because if you are informed, communication once again, you will know what to do and you won’t feel frustrated or tired and be negative towards the patient as well.”

“...I would say that the trainings to go to refreshing trainings to go and inform people of the guidelines, to know how to treat the patients...”

Literature integration

Stapleton *et al.* (2008:10) suggests that in the field of nursing, management should motivate the development of emotional self-awareness in staff, self-control, adaptability and initiatives in management and organisational teamwork and collaboration in social networks, to enhance the morale and improve the nursing performance within health care facilities. In the research findings, emotional self-awareness is mentioned by participants whereby they suggested that debriefing and counselling sessions be conducted for reflective and learning purposes.

Furthermore, Stapleton *et al.* (2008:4) add that ‘coaching’ of staff should be utilised as a leadership tool to promote collaboration, innovation, development and employee motivation in the workplace. This will allow staff members to plan and achieve short and long term goals within the workplace (Stapleton *et al.*, 2008:4). In addition, studies have shown that managers who show more warmth and affection towards staff members, are mentors to staff members, guide them to develop their strengths and capabilities and also improve and rectify faults, achieve a high level of positive performance among staff members (Stapleton *et al.*, 2008:4).

3.3.2.3.2 Sub-theme 2: Addressing staff shortages at health care facilities

Participants suggest that government members in charge of recruiting new staff should take the incentive of firstly assessing the imbalanced patient–nurse ratio within the community and further create more posts for PHC professional nurses. Participants are optimistic that if more PHC professional nurses are recruited, experienced PHC professional nurses will refrain from wanting to resign as more staff members will improve the work conditions, thus decreasing job dissatisfaction and improve patient care.

This was confirmed by the following quotations:

“I think if maybe the government, maybe the government can employ at least a lot of nurses, then it will become better for us to treat patients holistically.”

“I think that if we can have enough staff, the care to patients, I won’t lie, the care would be nice.”

Literature integration

Buchan and Aiken (2010:3262) state that one of the immense challenges of achieving an effective health care system is the scarcity of qualified health personnel, which includes nurses, and also the shortage of nursing professionals. Therefore, as suggested by participants in the research findings, in the policy agenda for addressing nursing shortages, the government should recruit more qualified professional nurses. Recruiting more professional nurses will lead to a chain of solving negative factors caused by staff shortage, which will then promote an effective health care system (Buchan & Aiken 2010:3262).

3.3.2.3.3 Sub-theme 3: Addressing lack of resources and equipment at the workplace

Participants suggest that there should be available resources and functional equipment at the workplace as this will enable participants to provide optimal care to patients. Equipment specifically used at the clinic is used to assist health professionals to determine the patient's health by making a diagnosis.

Available resources such as medication, and will enable health professionals to provide patients with the necessary care as confirmed by the following experts:

“There is a big need for equipment as most of the time, equipment is either broken or we don't have it at the clinic. So if there can be a budget allocated for the clinic to repair or buy equipment this will help us nurses to help the patients more effectively and not always be a frustrated.”

“Shortage of medication is a big problem at the clinic facilities and I feel like if we can solve the shortage of medication, patients will actually think that we are helping them instead of sending them home without medication and just health education. Medication needs to be given so that health education can work.”

Literature integration

The SPP Stock Outs (2013:1) suggests that medication stock outs need to be addressed and treated as a national emergency, whereby patients should have access to medication that is essential to sustain the patient's health and wellbeing. In addition, shortages of medical devices and equipment should also be addressed, as they are

essential tools used to diagnose patients and provide treatment for patients correctly (Politics Web, 2013:online).

3.3.2.3.4 Sub-theme 4: Addressing of services professional nurses provide

Participants are of the view that there is a great deal of information in the medical world of nursing that is constantly evolving and therefore in order for professional development to be established among individuals, constant in-service training, refresher course trainings, workshops and debriefing sessions should be implemented regularly within all the clinics. Most participants have a strong will to do right for patients and would like to provide patients with care that is in the best interest of the patient and therefore feel that they need the knowledge to do so.

In addition, participants are of the view that patients should be treated equally, regardless of their culture, race, age, economic background or appearance. Professional nurses need to accept people for who they are in order to provide effective care as experienced in the following responses:

“I would say that the trainings, to go to refreshing trainings, to go and inform people of the guidelines, to know how to treat the patients, because if the people are not informed, they are always doing the wrong thing, not knowing what are the correct things.”

“...continuous training for the staff which is in place as well... Like workshops, like in service workshops on implants like all the new procedures.

“I think professional nurses neh, should continuously be refreshed. There should be refresher courses, ya especially on how to run a PHC clinic, how to see people at a primary health care level, because here it’s not always that you have someone to ask for a second opinion, so you must be knowing your story, so people should be like, people should be in serviced that to guidelines.”

Literature integration

According to the SANC (2013:online), the code of ethics in nursing is essential in providing professional conduct and interaction between patients and nurses and also supports nurses to make moral decisions. Therefore, according to the research findings on the challenges of services professional nurses provide, participants need to be given training and or refresher courses on the code of ethics of nursing to provide effective care to patients.

3.3.2.3.5 Subtheme 5: Addressing remuneration of primary health care professional nurses

Participants are of the view that they should receive an increment in their salary. The two main reasons why participants suggest a salary increase are to support their families in a country where the cost of living is high and they are constantly working hard to provide optimal care for patients. An increment is believed by some participants to motivate staff members to do better as a salary increase would illustrate recognition and appraisal for staff members working at the clinic facilities.

“At the end of the day, you need to be recognised and you can say sometimes you get paid by some, I get payment, sometimes when a person says to me thank you very much, you have helped me, today I’m, but at the end of the day, I still need the money, so I’m thinking that because we have families to take care of at the end of the day. Then it will motivate us more to do our job.”

Literature integration

Literature supports that employees may feel demoralised about their salaries if the remuneration they receive is not sufficient to cover the cost of living (Larrabee *et. al.*, 2003:272). A poor remuneration also contributes to job dissatisfaction (Larrabee *et. al.*, 2003:272). The government needs to address the remuneration of professional nurses and communication between human resources and the employees should also be improved by regular induction meetings, feedback concerning remuneration and reasons for increment delays (Larrabee *et. al.*, 2003:272). Professional nurses should be counselled and advised on financial aid and budgeting to empower them to take control of their finances.

3.3.3 FIELD NOTES OF RESEARCH STUDY

The researcher took field notes throughout the research study focusing on methodological, theoretical and subjective notes. The reasons for taking field notes in the research study was to firstly support the collection and analysis of research findings, secondly to reflect on the theoretical aspect of the research study and lastly, to personally reflect on the research study as a whole entity.

3.3.3.1 Methodological notes

Methodological notes initially started after all permissions from the necessary committees were collected (the lists are mentioned in Chapters 2 and 3). The district managers were firstly addressed and were both were impressed and happy with the proposal and suggested that the same proposal be presented to all managers from the various clinics during one of the operational managers' meeting. The research was presented to all the managers using a PowerPoint presentation, also giving them opportunities to ask questions (see Annexure I). Conveniently, all the managers were interested in the research study and gave informed and written consent. The managers were invited to act as mediators, by informing professional nurses of the research study and establishing whether professional nurses would willingly participate. A list was compiled together with the managers and a date was requested on suitable date to come to the clinic to determine if professional nurses were interested and would like to be participants in the study.

According to the dates, each clinic was visited on the list, obtained informed and written consent from two participants per clinic, as well as dates when these participants would be available. There were no difficulties with participant selection as participants had already been informed by their managers. However, when coming on that arranged date to the clinic, the participant would postpone the meeting to another day due to staff shortages. Despite the postponements efforts were always made to be considerate towards the participants, adapting to their time schedules.

Initially, stated in Chapter 2 was that a clerk of the clinic would be the mediator for the selection of patients according to the inclusion and exclusion criteria (as described in the various consent forms). However, it was felt that the clerks would not be able to

establish certain inclusive and exclusive criteria due to their lack of medical knowledge and therefore the participants were selected to be the mediators during the video recording consultations, and there were no difficulties. The participants would randomly ask patients if they would like to participate and would inform the patient about the research study and all patients agreed and consented. The video recordings took place in a consultation room. The video recordings were taken by standing in the furthest corner of the consultation room while focusing on the participant's front and the back of the patient. Before every video recording, the participant and patient would be briefed by informing them that the researcher will not participate in the consultation and the participant should behave as though it were a normal nurse-patient consultation.

Generally, participants seemed to naturally ignore the video recording. However, there was one participant who seemed nervous when the video recording occurred and during the interview another participant mentioned that if a person was being observed, that person tended to be more aware of his/her actions and would act and perform better. The video recordings generally highlighted the reality of a nurse-patient consultation, showing how the participant enacted caring presence. All participants were knowledgeable in providing care for the patient; however, most participants could still improve in enacting a caring presence. The setting of most consultations, the various interruptions experienced and certain repeated actions and behaviours that are a part of the nursing culture made it difficult for participants to create a therapeutic environment.

Semi-structured interviews were conducted in a private consultation room whereby both the participant and researcher were nervous, but as the interviews progressed both they became more relaxed and participants seemed to open up. The participants in general seemed comfortable as the researcher wore her uniform when visiting the clinics and was known to a few professional nurses, because of working as a nursing student at all the clinics.

A comfortable environment was provided, accepting what the participant chose to share or not share. There were, however, a few encounters that disturbed the interview, where the participant's phone would ring or someone would come into the

room to talk to the participant or collect something, even when a “Do Not Disturb” sign was inserted on the front of the door. Regardless of the interruptions, both the participant and the researcher maintained focus on the research topic and discussion.

Data saturation was obtained repetitive topics could be established and the practicality was maintained during the interviews as professional nurses felt comfortable in sharing matters related to the research topic. There were various challenges mentioned by the participants where their facial expression and tone of voice would change negatively. Negative feelings were allowed to surface, in order for the participant to create suggestions on how to improve or overcome these challenges and to realise that many people would feel the same way.

The interviews were aimed at allowing the participant to self-reflect on how he/she enacted caring presence, to debrief on the various challenges experienced by participants on a daily basis, to support the participant and together with the participant, establish positive traits that each participant has and to voice the opinions of participants on how to foster caring presence and strengthen resilience.

Data analysis was initially organised and prepared by using the ATLAS TI program, however due to the researcher focusing more on how the program functioned and less time analysing the data, the supervisor, co-coder and researcher all decided that analysis should be done manually, still using Creswell’s steps of data analysis. Data analysis started by the researcher firstly analysing the observation video recordings, followed by the transcriptions from the semi-structured interviews, and integrating the academic literature with the research findings.

3.3.3.2 Theoretical notes

The researcher was prepared, determined and focused in obtaining data and came to the conclusion that the professional nurses did not fully understand the term ‘resilience’ and seemed to not fully practise resilience in the workplace. Participants highlighted valuable traits of caring presence in the interviews; however, in the consultations, due to certain behaviours and actions that have become a norm in the PHC professional nurses’ culture, participants could not fully enact caring presence. Participants from different clinics provided the researcher with similar and relevant

information about the challenges that prevented them from fostering caring presence and resilience that they experienced, specifically related to a clinic setting.

Furthermore, participants commented that there was a great need of modifications that needed to be made for better working conditions. In addition, they were able to reflect on how they enacted caring presence and voiced their opinions on how to further foster caring presence and strengthen resilience. In conclusion the research findings were established and discussed whereby consensus was reached among the researcher, supervisor and the independent co-coder.

3.3.3.3 Subjective notes

Personally, the overall experience of preparing and conducting the study was intriguing, yet also quite challenging, as the researcher was a novice in conducting a research study. Caring presence and resilience were concepts regarded in literature to be complex topics, so therefore, to simplify the concepts, the researcher initially compared caring presence to driving a car in cruise control, whereby the driver is physically in the car. However, because of being deep in thought, the person is considered not to be in control of the car. This can lead to an accident, causing serious harm to the driver, passengers and also other road users.

This example is relevant as nursing is seen as a busy profession, whereas professional nurses' minds are at times elsewhere and due to experiences, some professional nurses perform their duties routinely ("in cruise control"). This can cause medical errors that can cause harm to patients and create perceptions that nurses are uncaring and too busy to care for patients. Caring presence is about being there for the patient, treating the patient holistically and taking control of one's thoughts to thoroughly focus on providing optimal care for patients. Furthermore, the researcher concluded that if nurses were to enact caring presence behaviours, they would experience more self-worth, confidence and motivation, which would strengthen and create improved coping skills.

The researcher based her study on principles of honesty and justice and also focused on the main goal of understanding how caring presence and resilience could be fostered among PHC professional nurses.

Throughout the research study, the guidance was sought from the supervisor, the independent co-coder and read academic literature to formulate skills and techniques essential for obtaining data and analysing the data obtained from the video recordings and semi-structured interviews. The researcher acknowledges that during the first interview, certain communication techniques and skills came across as rigid, as the researcher felt very nervous; however, as the interviews progressed, the researcher felt more competent to conduct interviews, building a trust relationship with the participants.

Throughout the study, refinements were constantly made and these refinements were viewed by the researcher as opportunities for personal development. Therefore, as the researcher continued to apply the plans in the research study, some aspects that were initially planned and written in the proposal, had to be altered, and amended when implemented to adapt to certain situations. Reflecting back on Chapters 1 and Chapter 2, instead of conducting two patient – nurse video recordings with one participant using two different patients, the researcher decided to only video record one nurse-patient consultation per participant. The reason for one consultation per participant was to save time for both the participant and researcher as participants would have to watch two consultations to establish how they had enacted caring presence, and the researcher would have redundant data as one consultation seemed sufficient to obtain observational data.

The journey of creating a study has enabled the researcher to personally and professionally mature, gaining more insight and knowledge on fostering caring presence and strengthening resilience. Through the different inspiring stories that each participant told during the interviews, the researcher learned that all the participants were passionate and knowledgeable about being professional nurses and portrayed certain leadership qualities that patients highly depended on. Participants also shared certain personal challenges that prevented them from enacting caring presence and made resilience seem difficult to attain to which the researcher felt she could relate as she is also a PN working in PHC. The researcher discovered that, what started off as just an interview to obtain and analyse data, turned out to be an opportunity for participants to reflect, to be debriefed and also to find a means of bettering their situation in the workplace. The researcher is of the view that if the

knowledge obtained from the research findings were to be applied to professional nurses, they would be able to develop professionally and personally, reaching their full potential, which could also inspire other staff members to be better people.

3.4 CHAPTER SUMMARY

In Chapter 3 the understanding of actual data collection and data analysis was truthfully described. Research findings and results from the data collection and analysis were each discussed separately and then integrated with literature to ensure that the research study is authentic. Chapter 4 will be about the concluding reports, evaluation, limitations and recommendations of the research study, followed by all the references used in the research study.

CHAPTER 4

CONCLUSIONS, EVALUATION, LIMITATIONS AND RECOMMENDATIONS OF THE STUDY

4.1 INTRODUCTION

In the previous chapters the overview and the research methodology was discussed. The research findings were also addressed whereby caring presence behaviours were observed. Participants were also given an opportunity to provide their opinions and perceptions on caring presence and resilience, the challenges that they experienced in the workplace, as well as recommendations on how to foster a caring presence and resilience among PHC professional nurses. Literature was also added to the research findings to validate, compare, differentiate and establish if the research findings were unique.

In Chapter 4 the conclusions from the research findings were discussed and drawn from the findings and integrated literature. Thereafter, the evaluation, limitations and recommendations of the research study was thoroughly discussed.

4.2 CONCLUSIONS OF THE STUDY

It can be concluded that to an extent, professional nurses in PHC do enact caring presence, specifically through assessment and identification of patient needs, relating with the patient, being with/there and through providing nursing care and making contact with the patient through verbal and non-verbal communication. In addition professional nurses also show a positive, interested and have respectful attitude towards patients.

Participants reflected on their own conduct and shared their views on caring presence, and generally stated that caring presence was about being there for the patient holistically, providing them with vital information and health education to promote optimal health for them. Participants further concluded that professional nurses should attend to patients with a smile, making them feel at ease and cared for, by also listening to them attentively. They shared that to have caring presence is to be resilient

as these concepts are complimentary to each other and these interlinked concepts entail having a non-judgmental attitude and includes a generous practice of giving. Interestingly, what was defined as caring presence by participants during the interviews was not fully portrayed in the consultations. Professional nurses in PHC thus seem to portray physical and partial caring presence, and are aware of and can share their view on a fuller and deeper level of caring presence, but tend not to display transcendental presence.

Furthermore, as observed, PHC professional nurses have adapted to their environment as best as they could to manage the high workload and challenging work conditions mentioned in the challenges of the research findings, and meeting the needs of patients. However, it is also clear that there were certain behaviours that posed a risk in inhibiting caring presence. These risks are practised unintentionally by professional nurses and these behaviours seem to be a part of the nursing culture within primary health care, for example being highly dependent on strictly following nursing intervention protocols.

Further factors that pose a risk by inhibiting caring presence, also related to the culture within primary health care nursing, included breaking eye contact to complete notes and focussing more on getting medication from the cupboard, interruptions during the consultation, scolding the patient, not providing health education and not assessing or attending to the spiritual needs of patients.

In addition, participants' caring presence may be inhibited by having to deal with communication challenges, staff shortages in general, lack of resources and equipment at the workplace, lack of communication and teamwork, high administrative workloads, feeling unappreciated, inner conflict, not being updated on amended protocols, unfair treatment of patients and unsatisfactory remuneration. Some of these challenges were observed and confirmed during the consultations. It thus seems that there is a need that these challenges should be addressed in order to improve the working conditions to foster a caring presence among PHC professional nurses.

Focusing on resilience, it was clear that, although participants found it difficult to define the concept of resilience, once explained by the researcher, participants were able to

provide personal cases where they experienced being resilient in a particular situation or case. They viewed resilience as staying positive and coping with challenges. Many participants were unaware that they have resilience, as many participants developed individual abilities of coping to handle challenges in the workplace. Some participants confirmed directly in the interviews that they were resilient, coping with a shortage of staff, assuming their multiple roles and responsibilities on a daily basis and still provided quality care. It therefore can be concluded that being resilient may assist PHC professional nurses to stay positive and cope with challenges in PHC, enabling them to enact caring presence in spite of the difficult work circumstances.

The recommendations expressed by participants are aimed to provide professional nurses working at PHC clinics with a voice of unity, stating that if some of the recommendations they proposed were to be implemented, their resilience and caring presence could be facilitated and fostered. The recommendations strongly correlate with the challenges they experienced, and include providing effective communication as well as addressing staff shortages, the lack of resources and equipment, services provided by nurses and remuneration.

4.3 EVALUATION OF THE STUDY

The researcher's sincere evaluation of the research study reflects the reason why the study was started. The researcher has seen from being a student nurse, to being a team leader as a PHC professional nurse, the need to foster a caring presence and resilience among PHC professional nurses. The researcher is of the view that the study truly reflects the risk factors of the PHC nursing culture and the need for a cultural transformation in order to foster a caring presence and strengthen resilience.

Briefly summarising the research study, Chapter 1 and Chapter 2 of the study were based on an overview plan to provide structure and guidance on achieving the three research objectives and procedures when conducting and implementing the data collection and data analysis plan. Ethical considerations were also strictly adhered to and principles of trustworthiness were constantly applied during the conduction of the study.

In Chapter 3, the research findings proved to be significant and relevant to the research purpose as the researcher firstly established how caring presence is enacted by observing PHC professional nurses during the video recordings, followed by establishing PHC professional nurses' perceptions of the two concepts of caring presence and resilience and recommendations of how caring presence and resilience could be fostered among PHC professional nurses. Primary health care professional nurses were also provided an opportunity in the interviews to self-reflect on how they personally enacted a caring presence during their consultations with patients. In addition they were also given an opportunity to express what the challenges were that they experienced and which prevented a caring presence and resilience.

The research outcomes and results were integrated with academic literature to support and confirm the research findings. Therefore, the research purpose was achieved by the research findings. The qualitative, ethnographic research design was agreed upon by both the researcher and supervisor proving to be effective, because the researcher is a PHC professional nurse and therefore has an automatic admission to the PHC nursing culture and was accepted by PHC professional nurses as many recognised the researcher as a previous student nurse, therefore feeling comfortable to communicate with the researcher.

4.4 LIMITATIONS OF THE STUDY

Through the research study, the following limitations will be identified and discussed as follows:

- The research design chosen was a qualitative, ethnographic research design restricting the research study to only clinics around a semi-urban area of the North West Province.
- The original plan that the researcher created in her proposal and described in Chapter 1 and 2 had to be amended to suit the needs of the participants as there were limited staff and time. Therefore, instead of video recording two consultations, the researcher adapted to only observing one video recording.

- The plan that the researcher created and stated in the proposal and Chapters 1 and 2 stated that the clerks would be mediators for the patients, selecting patients who satisfied the inclusion criteria. However, when the actual conducting of the research commenced, the researcher sought what was best for the research study and decided that the participants would be mediators as they were more experienced in selecting random patients within the inclusion criteria who were willing to participate in the study.
- The target group was only PHC professional nurses and therefore the researcher sought the opinions and perceptions of registered PHC professional nurses only and not of other nursing categories (such as enrolled nurses and assistant nurses).
- One of the research data collection methods included video recordings and the researcher is of the view that some participants did not truly portray their true behaviour when consulting with the patient, due to possible insecurities of being video-recorded and observed by the researcher and thus establishing the Hawthorn effect. A participant also mentioned in the interview, that one tended to act best while being observed by someone. To counter this effect, semi-structured interviews were also conducted, and field notes were taken. The researcher was able to identify aspects that were contradicting and confirmational in the findings, as mentioned in Chapter 3 and in the conclusions of the research.

4.5 RECOMMENDATIONS

Recommendations are formulated for nursing practice, nursing education and for further research.

4.5.1 Recommendations for nursing practice

Recommendations have a vital role in improving and fostering a caring presence and resilience among PHC professional nurses. The following suggestions are directed to the North West Department of Health Directorate Policy, planning, monitoring and

evaluation, the two district managers and operational managers of the clinics and PHC professional nurses. The recommendations are as follows:

4.5.1.1 Recommendations to the North West Department of Health and to the two (2) district managers and operational managers of the clinics

The researcher used the participants' views and suggestions obtained during the interviews and added more suggestions from the appropriate literature, on strategies to foster a caring presence and resilience among PHC professional nurses by addressing the following:

- Improving effective communication at health care facilities
- Improving staff shortages and the workload at health care facilities
- Improving the shortage of medication and equipment at health care facilities
- Improving services that professional nurses provide
- Improving the remuneration of professional nurses

4.5.1.1.1 Recommendations on providing effective communication at health care facilities

In order to provide effective communication at health care facilities among staff members and patients, among staff members and staff members and management, the following needs to be improved:

- **Effective communication among staff members and patients can be established by implementation of the following suggestions:**
 - The Department of Health should devise a simpler documenting tool such as creating a checklist that will be less time consuming for PHC professional nurses when writing medical notes. Training courses or in-service training for PHC professional nurses should then be provided on the importance of nursing documentation and how to complete amended documents to ensure that the nursing documentation is still maintained for quality assurance provision.

- PHC professional nurses should be trained and counselled on how to deal with all patients in a professional manner by focusing on practising communication techniques and having professional conduct. These training and counselling sessions will be aimed at encouraging and motivating professional growth and development as individuals.
- The Department of Health should set and implement a precedent policy for all government clinics that will assist with interventions for improving the workplace environment to reflect a caring presence and create resilient behaviours.
- The Department of Health should train and avail people as interpreters to assist health care professionals who do not understand the languages of the patients. The use of pictures to represent meanings, such as for example symptoms, should also be utilised in order for PHC professional nurses to be aware of the patients' feelings.
- **Effective communication among staff members can be established by the implementation of the following suggestions:**
 - PHC professional nurses should be counselled on the importance of communication and teamwork among staff members.
 - Management should encourage and motivate communication and teamwork among staff members by creating activities that will strengthen the bond and teamwork among staff members, holding regular staff meetings and also solving grievances and conflict among staff members appropriately. In this case the culture of opening the day with prayer and hymns can play a significant role in strengthening the bond among staff members.
 - Daily delegation should be implemented at health care facilities to enable a manageable workload among PHC professional nurses.

- **Effective communication among staff members and management can be established by implementing the following suggestions:**
 - Management should take a leading, coaching and supportive role towards staff members.
 - Management should create and implement a policy on guiding primary health care operational managers and professional nurses on strategies to foster a caring presence and resilience at government clinics.
 - Recommended policies that management consider should be on confronting the challenges experienced by PHC professional nurses regarding the following: improving effective communication at health care facilities, improving staff shortages and the workload at health care facilities, improving the shortage of medication and equipment at health care facilities, improving services that professional nurses provide and lastly, improving the negative feelings about remuneration that professional nurses are experiencing. Policies should also include interventions of overcoming these challenges to foster a caring presence and resilience.
 - Management should be able to meet the current needs of staff members, including PHC professional nurses, namely:
 - The need for emotional self-awareness where PHC professional nurses have the opportunity to be counselled and debriefed on discrete matters that are affecting them emotionally, financially, mentally and/or spiritually.
 - The need for spiritual upliftment and guidance, whereby PHC professional nurses have the opportunity to go to church or for church leaders to be more involved, coming to the health care facilities to provide spiritual healing to both PHC professional nurses and patients.
 - The need for more knowledge through in-service training, workshops or refresher courses whereby PHC professional nurses feel up to date regarding their knowledge and whereby sufficient feedback is given on the trainings attended. Policies and procedures that are constantly changing to effectively provide optimal care to patients need to be discussed with PHC

professional nurses so that the policies and procedures can be followed effectively.

- The need for more auditing and feedback on auditing of patient files. PHC professional nurses feel that more auditing of medical records should be done on a regular basis and feedback and training should be given in order to facilitate professional development.
- Managers should be role models to staff members and also mentors by coaching PHC professional nurses to be leaders at the health care facilities by creating an open communication between staff members and the manager. Managers should allow PHC professional nurses to be innovative to develop employee motivation in the workplace.

4.5.1.1.2 Recommendations on improving staff shortages and the workload at health care facilities

In order to improve staff shortages and the workload at health care facilities the following need to be addressed:

- A strategic plan needs to be developed by the government for recruiting more qualified PHC professional nurses, as a shortage of PHC professional nurses is causing poor working conditions and poor work performance.
- Strategies should be implemented whereby clinics among the communities can target certain sections within the community and be responsible for the health care of those people, advising them to collect their treatment at their nearby clinic and adhere to clinic appointment dates as this can also solve high workloads caused by many patients gathering at one clinic, and the expected quality service can then be given to the anticipated number of patients for that specific day.

4.5.1.1.3 Recommendations on addressing the lack of resources and equipment at health care facilities

In order to address the lack of resources and equipment at health care facilities appropriately the following suggestions should be taken into account:

- Budgeting and planning need to be reviewed annually, by creating a report on the relevant medications and equipment needed at health care facilities.
- Amended policies and procedures should be provided and explained to health care professionals on the use of alternative medications and tests to ensure the patient is still provided with optimal care.
- A network of communication should be implemented among clinics and the hospital, creating a “borrow and return” process whereby if medication is out of stock at a specific clinic, medication can be “borrowed” at other health care facilities to ensure the common goal of the patient receiving optimal care is achieved.

4.5.1.1.4 Recommendations on addressing the services professional nurses provide

In order to improve on the services PHC professional nurses provide, the following recommendations should be implemented:

- Refresher courses should be provided to PHC professional nurses on the code of nursing ethics which entails treating all patients with justice, fairly and equally.
- Policies should be implemented and practised at clinics on the code of ethics and the consequences of insubordination.
- In-service training and counselling should be given about patients’ culture in order to improve cultural congruency and cultural competence.

4.5.1.1.5 Recommendations on addressing remuneration of primary health care professional nurses

In order to change the negative feelings with regard to remuneration that PHC professional nurses are experiencing, the following recommendations should be implemented:

- The government needs to be aware of the imbalance of the increasing cost of living and insufficient remuneration that professional nurses are receiving, in order to adjust the remuneration scale.
- Communication between human resources and the employees should be improved through regular induction meetings, feedback concerning remuneration and reasons for increment delays.
- Services should be made available for staff members to receive confidential financial counselling on budgeting and advice on debt counselling as this can assist PHC professional nurses to be financially mature and alleviate their financial burdens.

4.5.1.2 Recommendations to PHC professional nurses

The researcher formulated three sets of recommendations to foster a caring presence and resilience among PHC professional nurses by addressing the following:

- Fostering a caring presence in the workplace environment
- Fostering a caring presence through the manner in which participants enact and reflect caring presence during nurse-patient consultations
- Strengthening and implementing resilient behaviours and attitudes among PHC professional nurses

4.5.1.2.1 Recommendations on fostering a caring presence in the workplace environment

In order to foster a caring presence, the environment should be able to reflect the caring presence provided by PHC professional nurses. The structure of the consultation rooms should be conducive to PHC professional nurses by constructing

and maintaining a **therapeutic milieu** that will benefit both the patient and professional nurse. A therapeutic milieu will provide a sense of professional identity; taking responsibility for their environment bearing in mind to create an environment that would positively benefit both the participant and the patient. PHC professional nurses should be inspired to reflect their professional identity in their consultation rooms, making their consultation rooms their own.

4.5.1.2.2 Recommendations on fostering a caring presence through the manner in which participants enacts and reflects caring presence during nurse-patient consultations

In order to foster a caring presence, PHC professional nurses should encourage and facilitate **patient participation** and **patient-centred care**. This is done by firstly acknowledging risk factors of one's behaviour that inhibit one's ability to provide a caring presence and from there, facilitating change to these risk factors. PHC professional nurses should practise intentionally being there for and being with patients. So, instead of multi-tasking, one task should be managed at a time. PHC professional nurses should provide caring presence by the way in which they explain the concept of caring presence during the interviews, namely full presence, and strive to enact transcendent presence. Communication should be effectively shown by listening attentively to the patient and interacting with the patient, allowing the patient to express his/her problems freely. Certain qualities include treating the patient as though he/she were family members, or how you as an individual want to be treated and lastly, portraying a conduct such as choosing to generously give to patients and to do the right thing. Regarding the 'right thing,' PHC professional nurses should be encouraged to provide patients with optimal care through their nursing interventions which include attending to patients' needs and not omit or postpone physical examinations and diagnostic tests due to limited time. PHC professional nurses also need to believe in themselves and their knowledge to reflect this belief through providing vital health education that will benefit patients. Methods on improving health education skills should be implemented among PHC professional nurses to sensitise them to the importance of providing health education to patients.

4.5.1.2.3 Recommendations on fostering and implementing resilient behaviours and attitudes among primary health care professional nurses

In order to foster and implement resilience among PHC professional nurses a **transformational culture** is needed within PHC facilities. PHC professional nurses need to individually implement **self-care** and **self-reflection**, because in order to care for others, one must first care for one self. Self-care and self-reflection among PHC professional nurses will spontaneously foster and implement resilient behaviours and attitudes as engaging in caring presence requires nurses not suffering from exhaustion, compassion fatigue or burnout. For that reason, living a healthy balanced life such as, for example, taking breaks and eating a healthy meal during work, will provide the necessary renewal to be therapeutically present throughout the course of a shift. Self-reflection is also essential for enhancing mental and emotional development.

PHC professional nurses have certain behaviours which are seen as norms within the PHC nursing culture due to repetitive and patterned observations made in the video recordings. These unintentional behaviours can cause a risk in inhibiting a caring presence among patients, conveying a message to the patient of busyness, unimportance and also coldness. PHC professional nurses need to acknowledge these risk behaviours to facilitate change, which will as well foster a caring presence and also foster and improve resilient behaviours.

4.5.2 Recommendations for nursing education

Nursing educators should provide student nurses with constant training on fostering a caring presence and resilience within the nursing health practice facilities through initially being roles models and also establishing role models within health care facilities who practise caring presence and resilience by whom student nurses can internally socialize and learn from. In addition, nursing educators should provide formal training and encourage student nurses to practise principles of patient-centred care. Practising and implementing behaviours of caring presence will strengthen the resilience of the student nurse which will, in future, lead to knowledgeable, competent and caring professional nurses at health care facilities.

Furthermore, nursing education should also be extended by providing qualified and experienced professional nurses with refresher courses, training and activity workshops on techniques on fostering a caring presence and resilience among health care professionals at health care facilities. Professional nurses should have the opportunity to learn how to self-reflect, create a therapeutic environment, facilitate patient participation and effective communication and provide patient-centred care, as these are all important aspects of providing a caring presence within the workplace. Providing a caring presence will thus strengthen the resilience of the professional nurse. Change in a culture is difficult. Therefore, to implement a transformational culture, professional nurses need to be educated on enhanced practices that will improve their patients' health and wellbeing as well as their own wellbeing.

4.5.3 Recommendations for future research

The following research problems are presented for further research:

- Further research can be done in elaborating on more of the research challenges, which include ineffective communication, staff shortages, lack of resources and equipment, unequal services professional nurses provide and unsatisfactory remuneration not only at government primary health care clinics, but other health care facilities such as hospitals, old age homes and health centres, and also at private health care facilities.
- Further research can be done by elaborating on the recommendations presented to improve and foster a caring presence and resilience at primary health care clinics and assessing the effectiveness of the recommendations when applied in practice.
- Involvement of all other nursing categories to explore and describe their perceptions on caring presence and resilience and how to foster a caring presence and resilience within health care facilities.
- Further research can be conducted on implementing a caring presence and resilience among health care professionals, which include members from the multidisciplinary team.

- A quantitative, qualitative or mixed method research approach can be conducted on approaches that will strengthen a caring presence and resilience, such as spiritual healing, reflective practice, creating a therapeutic milieu, involving patient participation and/or focusing on providing care for nurses within primary health care clinics.

4.6 CHAPTER SUMMARY

In this chapter, the research findings and results were summarised and concluded, followed by discussing the evaluation and limitations of the research study. Furthermore, through the research findings, recommendations addressed to the North West Department of Health Directorate policy, planning monitoring and evaluation, the two district managers and operational managers of the clinics were made for PHC professional nurses. Recommendations were also made for nursing education and for future research.

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Annexure A:

North-West University Ethics
Committee approval letter

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: (018) 299-4900
Faks: (018) 299-4910
Web: <http://www.nwu.ac.za>

Ethics Committee

Tel +27 18 299 4852
Email Ethics@nwu.ac.za

ETHICS APPROVAL OF PROJECT

The North-West University Ethics Committee (NWU-EC) hereby approves your project as indicated below. This implies that the NWU-EC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: FOSTERING A CARING PRESENCE AND RESILIENCE AMONG PROFESSIONAL NURSES WORKING IN PRIMARY HEALTH CARE																														
Project Leader: Dr E du Plessis																														
Ethics number:	<table border="1"> <tr> <td>N</td><td>W</td><td>U</td><td>-</td><td>0</td><td>0</td><td>1</td><td>5</td><td>2</td><td>-</td><td>1</td><td>4</td><td>-</td><td>A</td><td>1</td> </tr> <tr> <td colspan="3">Institution</td> <td></td> <td colspan="5">Project Number</td> <td></td> <td colspan="2">Year</td> <td colspan="2">Status</td> </tr> </table> <p><small>Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation</small></p>	N	W	U	-	0	0	1	5	2	-	1	4	-	A	1	Institution				Project Number						Year		Status	
N	W	U	-	0	0	1	5	2	-	1	4	-	A	1																
Institution				Project Number						Year		Status																		
Approval date: 2014-11-20	Expiry date: 2015-11-30																													

Special conditions of the approval (if any): None

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principle investigator) must report in the prescribed format to the NWU-EC:
 - annually (or as otherwise requested) on the progress of the project,
 - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-EC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-EC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-EC retains the right to:
 - request access to any information or data at any time during the course or after completion of the project;
 - withdraw or postpone approval if:
 - any unethical principles or practices of the project are revealed or suspected,
 - it becomes apparent that any relevant information was withheld from the NWU-EC or that information has been false or misrepresented,
 - the required annual report and reporting of adverse events was not done timely and accurately,
 - new institutional rules, national legislation or international conventions deem it necessary.

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

Yours sincerely

Linda du Plessis
Digitally signed by Linda du Plessis
 DN: cn=Linda du Plessis, o=NWU,
 Vaal Triangle Campus, ou=Vice-
 Rector: Academic,
 email=linda.duplessis@nwu.ac.za,
 c=US
 Date: 2014.12.02 18:51:18 +02'00'

Prof Linda du Plessis
(chair NWU Research Ethics Regulatory Committee (RERC))

Annexure B:

North-West Department of Health
approval letter



health

Department of Health
North West Province
REPUBLIC OF SOUTH AFRICA

3801 First Street
New Office Park
MAHIKENG, 2735

Eng: Keitumetse Shogwe
Tel: 018 391 4504
kshogwe@nwpg.gov.za
www.nwhealth.gov.za



POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

Name of researcher : Ms J Villaflores
North West University

Physical Address DAISY STREET
(Work/ Institution) PROMOSA CHC
POTCHEFSTROOM 2531

Subject : Research Approval Letter- Fostering a caring presence
and resilience among professional nurses working in
Primary Health Care.

This letter serves to inform the Researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The Researcher is expected to arrange in advance with the chosen facilities, and issue this letter as proof that permission has been granted by the Provincial office.

This letter of permission should be signed and a copy returned to the department. By signing, the Researcher agrees, binds him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively, the Researcher can also provide the Department with an electronic summary highlighting recommendation that will assist the department in its planning to improve some of its services where possible. Through this the Researcher will not only contribute to the academic body of knowledge but also contributes towards the bettering of health care services and thus the overall health of citizens in the North West Province.

Kindest regards

Dr. FRM Reichel
Director: PPRM&E

DEPARTMENT OF HEALTH
PRIVATE BAG #2068
MAHIKENG 2735
2015 FEB 26
SUPERINTENDENT GENERAL

26/02/2015
Date

Researcher

27/02/2015
Date



Healthy Living for All

Annexure C:

An example of a transcription from
the semi-structured interviews

TRANSCIBING DATA PARTICIPANT 9

Researcher: Good afternoon (Participant's name), my name is Sr. Jennifer (Participant: hmm) and I am here to conduct my research on fostering a caring presence and resilience among Primary Health Care professional nurses

Participant: Okay.

Researcher: So you have watched how you consulted with the patient in the video recording, uhm, during the consultation with the patient.

Participant: Yes

Researcher: Uhm what I would like to ask you is, how do you think you enacted a caring presence during the video consultation with the patient?

Participant: Er, can you please rephrase the question again?

Researcher: Okay, how do you think, you showed a caring presence in the consultation?

Participant: Okay... I think it was uh... can I say well done...

Researcher: Okay

Participant: Ya, because the patient was, and the way we were interacting, it made the patient to feel free.

Researcher: Okay

Participant: The patient was able to say all the problems, even though she only came for collection of treatment, I still checked the other areas and if she had other complaints needed to be attend to and I also feel that I was kind and encouraging the patient to, to say everything, she came to clinic to say.

Researcher: Alright, also, the eye contact that you made with the patient as I also observed and you listening to the patient and you making the patient feel comfortable like you said, yes that is a very good way of enacting caring presence.

Participant: Thanks. (Participant shyly smiles)

Researcher: Okay. So, uhm the next question that I would like to ask you is what is your view on caring presence? How do you think or what do you think caring presence is?

Participant: Caring Presence?

Researcher: uh-huh. (Researcher nods her head)

Participant: Hmmmm.... I'm not sure if I understand the question well.

Researcher: How do you define caring presence? I would like your personal view, your definition of caring presence.

Participant: Okay, now I understand.

Researcher: Yes.

Participant: Uh... I think it is in a way, the way where you interact with the patient or a client. Firstly, to get what they came for, to give them enough time to verbalise their problems and then from then you give them information, maybe if necessary about the illness, or whatever problem they came with and then explain the treatment or the management and possibly you explain the prognosis if maybe if it is an incurable illness, but if it's an illness that needs treatment like hypertension, yes just inform the patient on how to take care of the condition especially at home.

Researcher: Yes.

Participant: So I think it's about information. The patient must get enough information to make the right decision and also giving your full attention to the patient.

Researcher: Ya. To the patient, it's true.

Researcher: And then, your views on resilience?

Participant: Resilience...

Researcher: What, how do you define resilience?

Participant: Uh... (Participant nervously laughs) I still don't, you know that word, I might interpret it in a certain way which you don't mean it. So I want to get it clear and right...

Researcher: Okay, uhm, resilience is a way of coping in challenging situations. Many nurses are aware, I mean unaware that they have resilience, but a lot of nurses have

that resilience in the workplace. An example that a person told me is the fact that she as a Primary health care professional nurse comes every day to work, there's certain circumstances, she deals with emergency cases, she deals with difficult patients, patients that have problems, yet she still comes the next day and overcomes new problems. You said earlier when we met, yet you still make it work in the clinic, so that is part of a definition of resilience.

Participant: Resilience, yes okay.

Participant: What I make of it is, when you, when you are with the patients, who needs help and they are relying on you, you need to in a way put yourself in their shoes and then sometimes I, I just assume that they are my family, maybe it's my mother who came, like the elderly patients, so how would they be treated in another facility if it wasn't me helping them. So I respect them to think that they have families and in a way it encourages me to do the right thing

Researcher: yes.

Participants: Especially if the patients appreciate, because some of the people, they will meet us on the street and they will tell their families that we are taking care of them, so that is something that is mostly pushing me to do what I do, irrespective of the situation.

Researcher: So the resilience, in a way is like being a strength in a community and to people can, because people are relying on you and you treating people like family motivates you to care for people.

Participant: Yes that is exactly what I mean, because uh, if you uh, everybody has problems and you come to work and you bring your problems, it will affect your work, so (Participant coughs), sorry.

Researcher: No its okay.

Participant: So, in a way I've been exposed to many patients that have a lot of problems. Now to me it makes me see my problems as little and it makes me want to do better for them to give them that information, to give them that, you know something that will change their life, so that they can at least open up to me.

Researcher: That is a very good way of showing resilience. Resilience also signifies strength and that is why caring presence and resilience are so linked together, because you must be able to be there for a person, yet put your problems aside and then also, in order to give care to give care to the person, so that is a way very good way of showing resilience.

Researcher: The next question I would like to ask...

Participant: yes

Researcher: Is to tell me of a time when you enacted caring presence and demonstrated resilience, like a case you experienced.

Participant: Uhm... specifically should I mention a particular incidence?

Researcher: Like a case, yes please

Participant: Okay, I have many...

Researcher: Well any, one that stands out for you specifically.

Participant: Uh, I have been so attached to HIV, because many of our young people come here when they are already at the fourth, stage four of HIV, because they don't want to test possibly of they are scared. So, I can just mention one care where there was a patient that came and then she came with a sexually transmitted infection, she didn't know her status, but she was clinically ill and then she was kind of denying the issue that she might be HIV infected so I gave counselling to the lady and the I called the counsellor and the HIV testing came out reactive. (The researcher did not hear the word reactive)

Researcher: Negative?

Participant: Reactive

Researcher: reactive, ya oh positive, sorry didn't hear clearly.

Participant: So with the patient, we took bloods to stage the patient and prepare the patient for ARV initiative medication, because clinically, according to what I was seeing she was stage three (3) or four (4), so she was deserving to be initiated on ARVs (Researcher: ya). So from there we got the bloods, the CD4 count was low, it was less than three fifty (350), we started on ARVs and today the patient is coming to the clinic

and she is well. I meet her most of the time in the community and then she is always appreciative on what I did for her and now she is able to go now and is able to work for her family and her children and support them. So those are, can say those are one of the cases. But I had so many it's just that others I can't recall. You know even in cases of hypertension and diabetes, you know managing patients even when we are off work. They always come and ask for advice, maybe if they have forgotten something, we are also available for patients to answer.

Researcher: But the fact that you reassure patients that people can live a long life with HIV, being strong for the patient, so the patient is now complying with the treatment and the patient is living with HIV (Participant: yes), but is "living" not just I have HIV and I'm going to die, but has that positive, that positive..... Uhm, how must I say?

Participant: Influence...

Researcher: Yes the positive influence you had came across to the patient.

Researcher: Okay, then. So are there any problems at the clinic, regarding the video now and in practice in general that you experienced that prevents you from enacting a caring presence and resilience?

Participant: Uhm the difficulty that I experienced was shortage of medicine in the clinic. Ya. Sometimes, even today, I had to prescribe INH for the patient and now we don't have vitamin B6 which is supposed to counteract the side effects of INH so I would say that it is a very big challenge to us so I tell you how it is. Most of the times it's medication that is necessary for the patient to get, not just uh luxury, so that is always a factor affecting the....

Researcher: The shortage of treatment?

Participant: Ya. The treatment of medicine.

Researcher: Yes that can be a big problem, as we as nurses are doing our best, but if there is no medication to give to patients, because it is out of stock, that becomes a problem in giving patients proper care.

Participant: Ya.

Researcher: Okay. The last question that I would like to ask, is what can be done to foster caring presence and strengthen resilience among primary health care nurses?

Participant: Okay....

Researcher: Or within the primary health care sector

Participant: Okay, I think, I think that, that there are many, many issues involved, but I will try to mention some.

Researcher: Yes please.

Participant: Firstly, the shortage of staff as we already spoke about it. When there are a lot of patients for one nurse, the ratio is so big that you can't even manage to manage the patients. Honestly, you sometimes omit other things that are necessary for the patients, thinking that you want to reach those other patients; you do not want other patients to go home, you want to reach them, so sometimes you omit certain things like examination of the eyes, physical examinations you end up by not doing it and by doing it, you expose the patients to other illnesses that you could have prevented for, that you could have seen.

Researcher: So your focus is on quality and not quantity care?

Participant: Ya, because of the time factor and the shortage of staff and it is not on purpose. We just don't have enough hands and time.

Participant: And the other thing, its support of equipment. I would say that one falls under maybe logistics. If equipment's are not readily available, then we have a problem, simple things like Hb meter. When we don't have an Hb meter or the Hb meter here is faulty, we end up diagnosing patients wrong and then we treat them wrong. So exposing them to other uhm, complications, because we won't know if the patient is anaemic.

Researcher: Yes, that is true...

Participant: And the other thing is uh, I wanted to say, I don't know how to put it in classes, but I would say that the trainings, to go to refreshing trainings, to go and inform people of the guidelines, to know how to treat the patients, because if the people are not informed, they are always doing the wrong thing, not knowing what are the correct things.

Researcher: And also guidelines are changing now and then you get one guideline that was maybe two (2) years back, it's not the same on what was discovered, on what is researched based so yes.

Participant: And uh, then lastly I would say support from the management's side. If the management's side is able to support the staff, then I think it would improve in turn.

Researcher: Yes, so support, as in how Charge?

Participant: Uhm including issues, such as personal issues, maybe those people that come to work and are having constraints at home issues, then they can be supported to deal with those issues and things

Researcher: Such as?

Participant: Like I was thinking most of the health care professionals, specifically nurses, they are not having any sessions of debriefing or anything, when they experience stress it's like nobody's going to...

Researcher: Help them or support them yes

Participant: Help them, ya. So when they get to work, they get demoralise, they do the wrong thing, sometimes not intentionally, because they are disrupted from work. So...

Researcher: Debriefing is a very important part.

Participant: Ya. And appreciation, appreciation

Researcher: Yes, like if a person is doing good, then the patient must be recognised and appreciated to motivate people

Researcher: Ya.

Researcher: Appreciated? Like just saying plain thank you to the nurses for just working hard?

Participant: Yes. I was thinking about it's not about PMDS, where people say we want PMDS, where we want money, it's about being recognised that this is being done well.

Researcher: Yes.

Participant: Yes just to say, thank you. Because, if you do the right things, nobody says anything, when you do one (1) wrong thing, a lot of people come and say a lot of things so that is why I say and appraisal is of the importance. Ya.

Researcher: Is there anything else that you would like to mention?

Participant: Uhm I think uhm, no let's just stick to those four.

Researcher: Alright, thank you so much for your inputs.

Participant: Okay, no thanks a lot.

Annexure D:

Turnitin Originality Report

Turnitin Originality Report

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PLESSIS

by EMMERENTIA DU



From Jennifer Villaflores (a3136599-36a9-4723-a417-6cdfaf8f14ce)

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- 3 < 1% match (publications)
PETA STAPLETON. "Boosting morale and improving performance in the nursing setting", Journal of Nursing Management, 9/18/2007

- 4 < 1% match (publications)
Cross-Cultural Advancements in Positive Psychology, 2013.

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- 7 < 1% match (student papers from 07-May-2014)
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Paper ID: 424894213

- 8 < 1% match (Internet from 17-Mar-2013)
<http://www.apna.asn.au/lib/pdf/definitionofprimaryhealthcarenursing.pdf>

- 9 < 1% match (publications)
Eileen Grafton. "Resilience: The Power Within", Oncology Nursing Forum, 11/01/2010

Annexure E:

Consent form for participants

TO THE PROFESSIONAL NURSES OF THE CLINIC
PARTICIPANT INFORMATION LEAFLET AND CONSENT

TITLE OF THE RESEARCH PROJECT:

FOSTERING A CARING PRESENCE AND RESILIENCE AMONG PROFESSIONAL NURSES WORKING IN PRIMARY HEALTH CARE

REFERENCE NUMBER: NWU-00152-14-S1

PRINCIPAL INVESTIGATOR:

JENNIFER VILLAFLORES

ADDRESS:

North West University
Faculty of Health Sciences
Private Bag X6001
Potchefstroom
2522

CONTACT NUMBER:

074 074 5480

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

You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University **NWU-00152-14-S1** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records.

What is this research study all about?

- *This study will be conducted in clinics around the area of Potchefstroom and will involve video recording and semi-structured interviews with experienced health researchers trained in caring for patients. Three to four participants will be included in this study from every clinic within the Potchefstroom area.*
- *The objectives of this research are:*
 - To explore and describe the perceptions on caring presence and resilience of professional nurses in PHC in Potchefstroom on caring presence and resilience.*
 - To explore and describe how caring presence is enacted among professional nurses in PHC in Potchefstroom*

Why have you been invited to participate?

- *You have been invited to participate, because you're nursing knowledge, experiences and opinions are highly essential for the study.*
- *You have also complied with the following inclusion criteria:*
 - A primary health care registered professional nurse working in a clinic within the Potchefstroom area of any age, race, culture, gender and years of nursing experience.*
- *You will be excluded if you do not wish to participate in the study.*

What will your responsibilities be?

- *You will be expected to be observed during two separate consultations with two stable patients by video recording the consultation.*
- *A semi-structured interview will then be done which will not last for longer than one hour to gain knowledge and opinions from your experience as a professional nurse working in a primary health care setting. The semi-structured interviews will be audio recorded.*

Will you benefit from taking part in this research?

- *The direct benefits for you as a participant will be established firstly by creating a deep understanding of how you, as an individual enact caring presence and resilience. The researcher will be able to make recommendations on how caring presence and resilience can be fostered to thus improve quality patient care and also you're own well-being.*
- *The indirect benefit will be established once individual nurses enact and foster caring presence and resilience in their workplace to inspire other nurses which will then improve the quality care at the clinics which will then benefit the patients of the community*
- *Are there risks involved in your taking part in this research?*

The risks in this study are

1. Fear that confidentiality will be breached

The researcher will ensure that confidentiality is kept at all times and names of members will not be mentioned in the study, the semi-structured interview and video recordings will be done in a room with the door closed to constantly maintain confidentiality. When feedback is given to management on recommendations on how to foster caring presence and resilience in the workplace, the names of the participants will be withheld from the recommendations.

2. Fear that the study will interfere with patient consultations and will be time consuming

Once consent is granted by the professional nurses that they would like to participate in the study, the researcher will ask the assistance of the clerks to

inform the patients at the reception area in a group that a study for professional nurses is going to be done and at least eight patients will be needed that are at the clinic for antenatal visits, receiving chronic medications where nurses will be assessed during their consultation. Once patients are established, consent forms will be read and signed before they are consulted to save time. The video recording will be done facing the professional nurse and not the patient and the researcher will not interfere with the patient-nurse consultation but will only sit in an isolated corner and observe.

The benefits outweighs the risks

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

- *Should you have the need for further discussions after the or example feeling uncomfortable with video recordings or disclosing personal and emotional information during the semi-structured interviews, an opportunity will be arranged for you to voluntarily consult with the clinic psychologist available on a Tuesday every week.*

Who will have access to the data?

- *Confidentiality and Anonymity will be ensured by researcher at all times and names of members will not be mentioned in the study, the semi-structured interview and video recordings will be done in a room with the door closed to constantly maintain confidentiality. When feedback is given to management on recommendations on how to foster caring presence and resilience in the workplace, the names of the participants will be withheld from the recommendations.*
- *Only the researchers J. Villaflores and supervisor Dr. E. du Plessis will have access to the data. Data will be kept safe and secure by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. As soon as data has been transcribed it will be deleted from the recorder. Data will be stored two years.*

Will you be paid to take part in this study and are there any costs involved

No, you will not be paid to take part in the study, but refreshments will be served during the semi-structured interviews. The study will be conducted at the clinic depending on what time and date will the participant will be available. There will thus be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

- You can contact J Villaflares at 074 074 5450 if you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 2094; carolien.vanzyl@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.
- You will receive a copy of this information and consent form for your own records.

How will you know about the findings?

- The findings of the research will be shared with you through a written as well as a verbal feedback to each manager of the clinic and will advise the managers to facilitate these recommendations to improve the quality care of not only patient's, but professional nurses as well.

Declaration by participant

By signing below, I agree to take part in a research study Fostering a Caring Presence and Resilience among professional nurses working in primary health care.

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) On (*date*)
20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I (*name*) declare that:

- I explained the information in this document to
.....
- I encouraged him/her to ask questions and took adequate time to answer them.

- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter.

Signed at (*place*) On (*date*)
20....

.....
Signature of person obtaining consent
Declaration by researcher

.....
Signature of witness

I (*name*) declare that:

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

Signed at (*place*) On (*date*)
20....

.....
Signature of researcher

.....
Signature of witness

Annexure F:

Consent form of managers

TO THE MANAGER OF THE CLINIC

PARTICIPANT INFORMATION LEAFLET AND CONSENT

TITLE OF THE RESEARCH PROJECT:

FOSTERING A CARING PRESENCE AND RESILIENCE AMONG PROFESSIONAL NURSES WORKING IN PRIMARY HEALTH CARE

REFERENCE NUMBER: NWU-00152-14-S1

PRINCIPAL INVESTIGATOR:

JENNIFER VILLAFLORES

ADDRESS:

North West University
Faculty of Health Sciences
Private Bag X6001
Potchefstroom
2522

CONTACT NUMBER:

074 074 5480

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

You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University **NWU-00152-14-S1** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records.

What is this research study all about?

- *This study will be conducted in clinics around the area of Potchefstroom and will involve video recording and semi-structured interviews with experienced health researchers trained in caring for patients. Three to four participants will be included in this study from every clinic within the Potchefstroom area.*
- *The objectives of this research are:*
 - To explore and describe the perceptions on caring presence and resilience of professional nurses in PHC in Potchefstroom on caring presence and resilience.*
 - To explore and describe how caring presence is enacted among professional nurses in PHC in Potchefstroom*

Why have you been invited to participate?

- *Your clinic has been invited to participate, because the experiences, nursing knowledge and opinions of primary health care professional nurses at your clinic are highly essential for the study.*
- *You have also complied with the following inclusion criteria:*
 - A primary health care facility within the area of Potchefstroom with qualified and registered professional nurse working in a clinic of any age, race, culture, gender and years of nursing experience.*
- *You will be excluded if you do not wish to participate in the study as this study is not compulsory.*

What will your responsibilities be?

- *You as manager will be expected to inform the professional nurses of the study and to also inform the researcher when the best time will suite the staff who agreed to participate.*
- *The professional nurses will be observed during two separate consultations with two stable patients by video recording the consultation.*
- *A semi-structured interview will then be done which will not last for longer than one hour to gain knowledge from the experiences and opinions from the professional nurses observed during their two consultations with the patients. The semi-structured interviews will be audio recorded.*

Will you benefit from taking part in this research?

- *The indirect benefit will be established once individual nurses enact and foster caring presence and resilience in their workplace to inspire other nurses which will then improve the quality care at the clinic which will then also benefit the patients of the community*
- *Are there risks involved in your taking part in this research?*

The risks in this study are

1. Fear that confidentiality will be breeched

The researcher will ensure that confidentiality is kept at all times and names of members will not be mentioned in the study, the semi-structured interview and video recordings will be done in a room with the door closed to constantly maintain confidentiality. When feedback is given to management on recommendations on how to foster caring presence and resilience in the workplace, the names of the participants will be withheld from the recommendations.

2. Fear that the study will interfere with patient consultations and will be time consuming

Once consent is granted by the professional nurses that they would like to participate in the study, the researcher will ask the assistance of the clerks to inform the patients at the reception area in a group that a study for professional nurses is going to be done and at least eight patients will be needed that are at the

clinic for antenatal visits, receiving chronic medications where nurses will be assessed during their consultation. Once patients are established, consent forms will be read and signed before they are consulted to save time. The video recording will be done facing the professional nurse and not the patient and the researcher will not interfere with the patient-nurse consultation but will only sit in an isolated corner and observe.

The benefits outweighs the risks

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

- *Should you have the need for further discussions after the or example feeling uncomfortable with video recordings or disclosing personal and emotional information during the semi-structured interviews, an opportunity will be arranged for you to voluntarily consult with the clinic psychologist available on a Tuesday every week.*

Who will have access to the data?

- *Confidentiality and Anonymity will be ensured by researcher at all times and names of members will not be mentioned in the study, the semi-structured interview and video recordings will be done in a room with the door closed to constantly maintain confidentiality. When feedback is given to management on recommendations on how to foster caring presence and resilience in the workplace, the names of the participants will be withheld from the recommendations.*
- *Only the researchers J. Villaflares and supervisor Dr. E. du Plessis will have access to the data. Data will be kept safe and secure by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. As soon as data has been transcribed it will be deleted from the recorder. Data will be stored two years.*

Will you be paid to take part in this study and are there any costs involved

No, you will not be paid to take part in the study. The study will be conducted at the clinic depending on what time and date will the participant will be available. There will thus be no costs involved for you, if your clinic does take part.

Is there anything else that you should know or do?

- You can contact J Villaflores at 074 074 5450 if you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 2094; carolien.vanzyl@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.
- You will receive a copy of this information and consent form for your own records.

How will you know about the findings?

- *The findings of the research will be shared with you as manager through a written as well as a verbal feedback and will you will be advised on these recommendations to improve the quality care given by professional nurses as well as of the patients of your community.*

Declaration by participant

By signing below, I agree to take part in a research study Fostering a Caring Presence and Resilience among professional nurses working in primary health care.

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) On (*date*)
20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I (*name*) declare that:

Annexure G:

Consent form of patients

TO THE PATIENTS OF THE CLINIC

PARTICIPANT INFORMATION LEAFLET AND CONSENT

TITLE OF THE RESEARCH PROJECT:

FOSTERING A CARING PRESENCE AND RESILIENCE AMONG PROFESSIONAL NURSES WORKING IN PRIMARY HEALTH CARE

REFERENCE NUMBER: NWU-00152-14-S1

PRINCIPAL INVESTIGATOR:

JENNIFER VILLAFLORES

ADDRESS:

North West University
Faculty of Health Sciences
Private Bag X6001
Potchefstroom
2522

CONTACT NUMBER:

074 074 5480

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

You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University **NWU-00152-14-S1** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records.

What is this research study all about?

- *This study will be conducted in clinics around the area of Potchefstroom and will involve video recording and semi-structured interviews with experienced health researchers trained in caring for patients. Three to four participants will be included in this study from every clinic within the Potchefstroom area.*
- *The objectives of this research are:
To explore and describe the perceptions on caring presence and resilience of professional nurses in PHC in Potchefstroom on caring presence and resilience.
To explore and describe how caring presence is enacted among professional nurses in PHC in Potchefstroom*

Why have you been invited to participate?

- *You have been invited to participate as your consultation with a professional nurse is needed for the researcher to conduct her research*
- *You have also complied with the following inclusion criteria:
A patient of any age, race and gender that is able to communicate in English or Afrikaans. You must be in stable condition at the clinic to either collect chronic medication or for an antenatal visit.
You will be excluded if you do not wish to participate in the study and also if you are unwell and/or need urgent attention from your health care provider.*

What will your responsibilities be?

- *You will be expected to be observed during your consultation with the professional nurse and the consultation will be video recorded with the camera focus on the professional nurse.*

Will you benefit from taking part in this research?

- *Unfortunately, there will be no direct benefits for you as a patient as this research focuses solely on the fostering caring presence and resilience of primary health care professional nurses.*
- *However, the indirect benefit will be established once individual nurses enact and foster caring presence and resilience in their workplace to inspire other nurses which will then improve the quality care at the clinics which will then benefit the patients of the community.*
- *Are there risks involved in your taking part in this research?*

The risks in this study are

- 1. Fear that confidentiality will be breached*

The researcher will ensure that confidentiality is kept at all times and names of the patients will not be mentioned in the study, the semi-structured interview and video recordings will be done in a room with the door closed to constantly maintain confidentiality. When feedback is given to management on recommendations on how to foster caring presence and resilience in the workplace, no names of the professional nurses or patients will be mentioned from the recommendations.

- 2. Fear that the study will interfere with patient consultations and will be time consuming*

In the mornings, researcher will ask the assistance of the clerks to thoroughly inform the patients at the reception area in a group that a study for professional nurses is going to be done and at least eight patients will be needed that are at the clinic for antenatal visits, receiving chronic medications where nurses will be assessed during their consultation. Once patients are established, consent forms will be read and signed before they are consulted to save time. The video recording will be done facing the professional nurse and not the patient and the researcher

will not interfere with the patient-nurse consultation by sitting in an isolated corner to observe the professional nurse.

The benefits however outweighs the risks

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

- *Should you have the need for further discussions after the or example feeling uncomfortable with video recordings or disclosing personal and emotional information during your consultation, the patient may at any time ask the researcher to stop the video recordings and may at any point of the study withdraw without any implications to his/her health.*

Who will have access to the data?

- *Confidentiality and Anonymity will be ensured by researcher at all times and names of members will not be mentioned in the study by video recordings during the consultation being done in a room with the door closed to constantly maintain confidentiality. When feedback is given to management on recommendations on how to foster caring presence and resilience in the workplace, the names of the professional nurses and patients will be withheld from the recommendations.*
- *Only the researchers J. Villaflares and Supervisor Dr. E. du Plessis will have access to the data. Data will be kept safe and secure by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. As soon as data has been transcribed it will be deleted from the recorder. Data will be stored two years.*

Will you be paid to take part in this study and are there any costs involved

No, you will not be paid to take part in the study. The study will be conducted at the clinic depending on what time and date the professional nurse will be available. There will thus be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

- *You can contact J Villaflores at 074 074 5450 if you have any further queries or encounter any problems.*
- *You can contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 2094; carolien.vanzyl@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.*
- *You will receive a copy of this information and consent form for your own records.*

How will you know about the findings?

- *The findings of the research will be shared to the community by giving a written as well as a verbal feedback to each manager of the clinic and if you are interested in these findings you can access to the information through the managers of the clinic you are attending.*

Declaration by participant

By signing below, I agree to take part in a research study Fostering a Caring Presence and Resilience among professional nurses working in primary health care.

I declare that:

- I have read this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions to both the person obtaining consent, as well as the researcher and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) On (*date*)
20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I (*name*) declare that:

Annexure H:

Letter to the Primary Health Care
Managers



To The Primary Health Care Manager

**PERMISSION TO CONDUCT RESEARCH AT THE PUBLIC CLINICS SITUATED IN
THE SEMI-URBAN AREA OF THE NORTH-WEST PROVINCE**

TITLE OF THE RESEARCH PROJECT:

**FOSTERING A CARING PRESENCE AND RESILIENCE AMONG PROFESSIONAL
NURSES WORKING IN PRIMARY HEALTH CARE**

REFERENCE NUMBER: NWU-00152-14-S1

PRINCIPAL INVESTIGATOR:

JENNIFER VILLAFLORES

ADDRESS:

North West University
Faculty of Health Sciences
Private Bag X6001
Potchefstroom
2522

CONTACT NUMBER:

074 074 5480

Good day

I would kindly like to take this opportunity to introduce myself briefly and also explain my research study before asking your permission to do my research.

My name is Jennifer Villaflores, I am a full time primary health care professional nurse currently working in Promosa CHC and also part time master's student. I am also

currently now studying at the University of Bloemfontein forensic nursing. My study is about Fostering a caring presence and resilience among primary health care professional nurses. I am very passionate in my work and therefore I chose this researcher topic as I feel that if this research is implemented, this could positively benefit the work environment for primary health care professional nurses which could then improve patient quality care.

This study has been approved by the Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University NWU-00152-14-S1 and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki and the ethical guidelines of the National Health Research Ethics Council. I recently received permission from the Department of Health ethics committee at Mafikeng that my study has been approved and that I may conduct my study at the clinics, however I would kindly like to ask your permission as well so that you are aware of my study.

What is this research study all about?

- *This study will be conducted in clinics around the area of Potchefstroom and will involve video recording and semi-structured interviews with experienced health researchers trained in caring for patients. Three to four participants will be included in this study from every clinic within the Potchefstroom area.*
- *The objectives of this research are:*
 - To explore and describe the perceptions on caring presence and resilience of professional nurses in PHC in Potchefstroom on caring presence and resilience.*
 - To explore and describe how caring presence is enacted among professional nurses in PHC in Potchefstroom*

Why has the clinics been chosen by researcher?

- *The clinics has been invited to participate, because the experiences, nursing knowledge and opinions of primary health care professional nurses are highly essential for the study.*
- *The inclusion criteria are the following:*

A primary health care facility within the area of Potchefstroom with qualified and registered professional nurse working in a clinic of any age, race, culture, gender and years of nursing experience.

Will the department of health benefit from taking part in this research?

- *The direct benefits will be once caring presence and resilience is enacted and practiced in the clinics, there will be job satisfaction among your staff which could decrease absenteeism and thus solve staff shortages and therefore decrease work overload.*
- *The indirect benefit will be established once individual nurses enact and foster caring presence and resilience in their workplace to inspire other nurses which will then improve the quality care at the clinic which will then also benefit the patients of the community*

Who will have access to the data?

- *Confidentiality and Anonymity will be ensured by researcher at all times and names of members will not be mentioned in the study, the semi-structured interview and video recordings will be done in a room with the door closed to constantly maintain confidentiality. When feedback is given to management on recommendations on how to foster caring presence and resilience in the workplace, the names of the participants will be withheld from the recommendations.*
- *Only the researchers J. Villaflores and supervisor Dr. E. du Plessis will have access to the data. Data will be kept safe and secure by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. As soon as data has been transcribed it will be deleted from the recorder. Data will be stored two years.*

If there are any inquiries, my number is 074 074 5480.

Thank you for your time

God bless

Jennifer Villaflores

Annexure I:

PowerPoint presentation on
fostering a caring presence and
resilience among primary health
care professional nurses

FOSTERING A CARING PRESENCE AND RESILIENCE AMONG PRIMARY HEALTH CARE PROFESSIONAL NURSES

By JENNIFER VILLAFLORES

TABLE OF CONTENT

1. Introduction
2. The problem
3. Purpose of the study
4. The anticipated outcome of the study
5. Conducting of research
6. Role of the managers, participants and patients of the study
7. Ethical considerations
8. Feedback
9. Questions
10. Thank you

INTRODUCTION

- Nurse = care
- Community = leaders, health care providers, role models, educators, counsellors, referral resources, and advocales
- Multiple roles = mothers or fathers, wives or husbands and/ or active community members
- Nurses = develop resilience = positive coping skills to manage with pressures and stress experienced everyday
- Nurses = 'be there' in order to provide care



'BE THERE?'

- Example: driving a car in auto mode = nurses being in the consultation room with the patient, but not 'being there' completely
 - Reasons:
 - Human = train of thought
 - Time = quantity vs. quality care
 - Biomedical health care system = focused on the physical - medicine to make the body better
- BUT as nurses: taught to look at a person as a whole being
- 'Caring presence is the mutual act of intentionally focusing on the patient through attentiveness to their needs by offering of one's whole self to be with the patient for the purpose of healing'*
- Tavernier (2006:154)

HOW?

- INTERGRATION OF RESILIENCE AND CARING PRESENCE

Self-aware and self-knowing= able to overcome obstacles through = balancing personal and professional obligations= thus remaining free from burnout, compassion fatigue, or preoccupation

"She was unstoppable, not because she did not have failures or doubts, but because she continued on despite them."

THE PROBLEM

Things that cannot change:

- Busy = endless multi-tasking and multiple priorities
- Challenge = |patients and |nurses
- Nursing profession = associated with the terms 'stress' and 'burnout'

Things that can change:

- Risk = caring presence and resilience may not come across effectively to patients, families & communities
- Causing: poor miscommunications - patient and nurse = negative impact on patient care = communication, trust, support, safety and advocacy will be compromised and needs of patients will not fully be met
- Causing medical errors due to miscommunication, increased stress and poor coping skills of professional nurses

PURPOSE

Voices to professional nurses by:

Exploring and describing the caring presence and resilience

- Enacted (consultations)

After, the consultations, exploring and describing how caring presence and resilience can be fostered in the work place

- Perceptions (semi-structured interviews)

THE ANTICIPATED OUTCOME OF THE STUDY

Caring presence enacted by professional nurses

Perceptions of professional nurses of caring presence and resilience

Formulate recommendations to foster caring presence and resilience

Improve quality patient care and own well-being

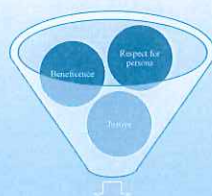
CONDUCTING THE RESEARCH

- Ethnographic study (form part of the nurse culture)
- Participants = professional nurses working in PHC willing to participate
- Divided in 2 sections:
 - Two separate patient – nurse consultations with patients that are in stable condition willing to participate (video recorded)
 - Semi-structured interview with the professional nurse after the consultation duration (audio recorded)
- Duration of the semi-structured interview: 30mins – 1 hour

ROLE OF THE MANAGERS, PARTICIPANTS, CLERKS & PATIENTS OF THE STUDY

- Managers = mediators for PHC professional nurses – inform PHC nurses about the study and voluntary as well as the clinic of the study
- PHC professional nurses = participants – video recorded during 2 separate consultations and 1 semi-structured interview.
- Clerks = mediators for patients – select patients in stable condition willing to participate in the study
- Patients = consultations – the patient-nurse consultation will be video-recorded

ETHICAL CONSIDERATIONS



Ethical Principles

FEEDBACK

- After collecting, transcribing and analysing data – report and recommendations will be given to the following:
 - Mafikeng Department of health ethical committee
 - Sub-district PHC managers
 - Operational managers of the clinics

ANY QUESTIONS
OR
SUGGESTIONS?

Consent forms for clerks
and psychologists
Audio record voices
during ANCs

THANK YOU FOR
YOUR TIME

Annexure J:

Certificate on the certifying of
language edited in this dissertation

To Whom It May Concern

I hereby certify that I have language edited the following text:

A dissertation titled

**"FOSTERING A CARING PRESENCE AND RESILIENCE AMONG
PROFESSIONAL NURSES WORKING IN PRIMARY HEALTH CARE"**

by

J Villaflores

Date: 2015 11 12



<p>Prof SW Vorster, Pr Eng BA (Hons), MMet, MSc (Eng), PhD</p> <p>Accredited Member No. 1000923 South African Translators' Institute</p>
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Accredited Member:
South African Translators' Institute
SATI -- Bridging Language Barriers

Annexure K:

Interview guide for semi-structured
interviews

Interview guide used during the semi-structured interviews

1. How do you think you enacted a caring presence during this consultation?
2. What made it easy/difficult for you to enact caring presence in this consultation?
3. What were the difficulties that challenged your resilience?
4. What are your views on caring presence and resilience?
5. Tell me of a time when you enacted a caring presence and resilience at work.
6. In your opinion, what do you recommend on fostering a caring presence and resilience in the workplace?