

# Resilience of auxiliary nurses caring for intellectually disabled patients

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Mini-dissertation submitted in partial fulfilment of the requirements for the degree *Master in Nursing Science* in Psychiatric Nursing Science at the Potchefstroom Campus of the North-West University

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November 2016

## DECLARATION

I, Steven Dithapelo Mlungu Nthekang (student number 16281527), declare that the mini-dissertation with the title: **Resilience of auxiliary nurses caring for intellectually disabled patients** is my own work and that all the sources that are used, have been indicated and acknowledged by means of a complete referencing method.

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Steven Dithapelo Mlungu Nthekang

November 2016

## DECLARATION OF LANGUAGE EDITING



I, Mari Grobler, hereby declare that I have edited the research study with the title:

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for **Steven Nthekang** for the purpose of submission as a mini-dissertation.

Changes were suggested and implementation was left to the discretion of the author.

Should there be any questions with regard to the language editing, please do not hesitate in contacting me.

Yours sincerely

**Mari Grobler**

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## ACKNOWLEDGEMENTS

This mini-dissertation would not have been possible without the assistance and guidance of many people. My sincerest gratitude goes to the following individuals:

- ❖ My supervisor, Prof. Emmerentia du Plessis, for her continual encouragement, support, guidance and steadfast presence.
- ❖ The North West Department of Health for allowing me to conduct the study.
- ❖ All the auxiliary nurses who participated in this research and shared their perceptions with me.
- ❖ My research mediator, for his support and assistance with recruiting participants.
- ❖ The Nthekang family at Kuruman, who have played a pivotal role in my life by initiating my journey of continual learning.
- ❖ To my wife, Francinah, who always supports me through prayers and for believing in me with love.
- ❖ To my beloved son, Karabo, who I wish will emulate my love for learning.
- ❖ Mr Leepile Sehularo, who assisted me with co-coding of the qualitative data.

## ABSTRACT

**Background:** Although mental health is regarded by the International Council of Nurses (ICN) as a very important element of wellness, healthcare to patients with intellectual disabilities still remains neglected and under-resourced in most societies. Auxiliary nurses are crucial in providing nursing care to patients with intellectual disabilities. These nurses may not be prepared to handle challenges in caring for patients with intellectual disabilities, but their resilience can help them to manage these challenges. Limited research is available with regard to the resilience of auxiliary nurses caring for patients with intellectual disabilities.

**Purpose:** The purpose of this study was to explore and describe the perceptions of auxiliary nurses caring for patients with intellectual disabilities on their resilience as well as on protective mechanisms and vulnerability factors that influence their resilience when caring for these patients.

**Design:** The research project followed a qualitative descriptive inquiry approach. The population comprised of auxiliary nurses caring for patients with intellectual disabilities at mental healthcare institutions. Auxiliary nurses were selected through purposive sampling with the assistance of a mediator. The sample size was determined by data saturation. The data were collected through four semi-structured focus group interviews and captured on a digital recorder and transcribed *verbatim*. Both the researcher and co-coder analysed the data independently by making use of a content analysis and consensus was reached with regard to selected themes and sub-themes.

**Findings:** Five main themes and seventeen sub-themes emerged from the data. The participants apply their practical wisdom when caring for patients with intellectual disabilities. They also make use of different forms of interactions and they apply strategies that help them to remain resilient. Although some protective mechanisms, such as trust in God, influence their resilience when caring for patients with intellectual disabilities, there are also some vulnerability factors, such as impatience, that also play a role.

**Conclusions:** Recommendations to strengthen the resilience of auxiliary nurses caring for patients with intellectual disabilities were formulated from the research findings.

Recommendations for the education of nurses and further research were also formulated.

**Key words:** resilience, caring, auxiliary nurses, intellectual disabilities

## OPSOMMING

**Agtergrond:** Ofskoon geestesgesondheid as 'n baie belangrike komponent van welwees beskou word deur die Internasionale Raad van Verpleegsters, word gesondheidsorg aan pasiënte met verstandelike gestremdhede nog steeds afgeskeep en is daar 'n tekort aan hulpbronne in baie gemeenskappe. Assistent-verpleegsters is noodsaaklik vir die voorsiening van versorging aan pasiënte met verstandelike gestremdhede. Hierdie verpleegsters kan dalk egter nie daarop voorbereid wees om uitdagings te hanteer met die versorging van pasiënte met verstandelike gestremdhede nie, maar hulle veerkragtigheid kan hulle bystaan met die hantering van uitdagings. Beperkte navorsing is beskikbaar oor die veerkragtigheid van assistent-verpleegsters wat pasiënte met verstandelike gestremdhede versorg.

**Doel:** Die doel van die studie was om die persepsies van assistent-verpleegsters wat pasiënte met verstandelike gestremdhede versorg oor veerkragtigheid te verken en te beskryf asook die beskermingsmeganismes en kwesbaarheidsfaktore wat hulle veerkragtigheid beïnvloed wanneer hulle hierdie pasiënte versorg.

**Ontwerp:** Die navorsingstudie het 'n kwalitatiewe beskrywende en ondersoekende benadering gevolg. Die populasie het uit assistent-verpleegsters bestaan wat pasiënte met verstandelike gestremdhede versorg by geestesgesondheidsinstellings. Assistent-verpleegsters is geselekteer deur gebruik te maak van 'n doelbewuste steekproef met behulp van 'n bemiddelaar. Die steekproefgrootte is deur dataversadiging bepaal. Die data is deur middel van vier semi-gestruktureerde fokusgroeponderhoude versamel en deur 'n digitale opnemer vasgelê wat *verbatim* getranskribeer is. Beide die navorser en die mede-kodeerder het onafhanklik die data geanaliseer deur gebruik te maak van 'n data analise en konsensus was bereik met betrekking tot die geselekteerde temas en subtemas.

**Bevindings:** Vyf hooftemas en sewentien subtemas is vanuit die data geïdentifiseer. Die deelnemers pas hulle praktiese wysheid toe wanneer hulle pasiënte met verstandelike gestremdhede versorg. Hulle maak ook gebruik van verskillende vorms van interaksie en hulle pas strategieë toe wat hulle help om veerkragtig te bly. Ofskoon sommige beskermingsmeganismes soos 'n vertrouwe in God hulle veerkragtigheid beïnvloed wanneer hulle pasiënte met verstandelike gestremdhede versorg, is daar altyd kwesbaarheidsfaktore soos ongeduld wat ook 'n rol speel.

**Slot:** Aanbevelings om die veerkragtigheid te versterk van assistent-verpleegsters wat pasiënte met verstandelike gestremdhede versorg, is geformuleer deur van die navorsingsbevindings toe te pas. Aanbevelings vir die opleiding van verpleegsters en bykomende navorsing is ook geformuleer.

**Sleutelwoorde:** veerkragtigheid, versorging, assistent-verpleegsters, verstandelike gestremdhede

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# CHAPTER 1: OVERVIEW OF THE STUDY

## 1.1. Introduction

Chapter 1 provides an overview of the research study. In this chapter, the researcher introduces the study, followed by a background to the research questions. The problem statement is discussed that leads to the purpose of this study. This is followed by a discussion of the methodology that guided the researcher in executing the study. The researcher explains the research design and methodology that were used, followed by measures to ensure rigour and ethical considerations are discussed. The chapter concludes with an outlay of the research study and a summary of the chapter.

## 1.2. Background

In 2012, the International Council of Nurses reiterated its position statement on mental health by declaring that mental health is a very important element for wellness (Kusano, 2013:3). This statement is supported by the World Health Organization (WHO) who defines mental health as a condition in which persons are healthy, able to understand and know their capabilities – visible in the positive results that they can produce from their work – and being able to adapt well even in volatile environments (WHO, 2013:1). However, healthcare that concerns the restoring and maintaining of mental health – including healthcare available to patients with intellectual disabilities – is often characterized by difficult circumstances of being neglected, under-resourced and plagued by stigmatisation in most societies (Seloilwe & Thupayagale-Tshweneagae, 2013:56-67). One such case in England was featured by the BBC in a documentary, which showed the serious abuse and appalling standards of care at a private hospital for people with intellectual disabilities (Parish, 2011:5). Amidst these difficult circumstances, auxiliary nurses continue to provide mental healthcare to all patients – including patients with intellectual disabilities (Stubbs & Dickens, 2008:1). In this regard, Jackson *et al.* (2007:7) conclude that combating these above-mentioned difficult circumstances by minimising vulnerability factors and by promoting protective mechanisms has the potential to have a positive impact on the daily lives of nurses.

Looking closer at the difficulties experienced by nurses taking care of patients with intellectual disabilities, Barlow and Durand (2005:17) mention that there are several causes of intellectual disabilities, including genetic irregularities and complications

during childbirth. Cooper *et al.* (2004:414) mention that people with intellectual disabilities are prone to specific health needs with regard to epilepsy, gastro-oesophageal reflux disorders, osteoporosis, accidents and some common behavioural problems, such as self-injuries and aggression. According to the WHO, up to 3% – almost 200 million people – of the world's population have intellectual disabilities (WHO, 2010:3). In South Africa, persons with intellectual disabilities account to 5-6% of the general population (WHO, 2010:3).

The South African government introduced the Bill of Rights that clearly forbids unfair discrimination on the basis of disabilities to prevent the above-mentioned exploitation and treatments of an abusive nature (Bhabha, 2009:219). The Bill of Rights indicate that in the provision of healthcare to people with intellectual disabilities, dignity, respect and freedom of choice should be the main focus (Hayes & Batey, 2013:384). According to Cooper *et al.* (2004:415) inequalities faced by people with intellectual disabilities need to be dealt with to promote their maximum mental well-being. Cooper *et al.* (2004:415) again mention that maximum mental well-being can be achieved by improving mental healthcare services and conducting more research to ensure the effective provision of mental healthcare services. Jackson *et al.* (2007:1) add that to support these effective provisioning of mental healthcare services, protective mechanisms combined with the reduction of vulnerability factors for healthcare workers should also be considered.

The South African government continues to introduce various legislations to protect the rights of patients with intellectual disabilities when the improvement of mental healthcare services is considered. This includes the Constitution of the Republic of South Africa (108 of 1996) which prohibits unfair discrimination of people with mental or other disabilities and the Mental Health Care Act (17 of 2002). The Mental Health Care Act makes provision for care, treatment and rehabilitation services to persons with mild, severe, and profound intellectual disabilities. According to this Act, patients who are intellectually disabled should be protected from exploitation, abuse and any degrading treatments (Uys & Middleton, 2014:535).

While these legislations are in place to protect patients with intellectual disabilities, it is also true that caring for these patients may pose challenges and can put healthcare professionals under considerable strain (Lin *et al.*, 2006:1499). According to Blair (2012:15) when mental healthcare is provided to patients with intellectual disabilities, nurses have to cope with difficulties, such as conceptual demands – these patients may

not be able to read, write, reason, learn or remember. Furthermore, these patients may present behavioural problems, such as aggression, property destruction and other disruptive behaviour due to the condition of their minds (Smith & Matson, 2010:1062). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) mentions that the condition of the mind of individuals is strongly influenced by how well individuals are able to deal with or handle common demands in life (APA, 2013:1). Common demands in life include social and practical challenges. Social and practical challenges can be explained as follows (APA, 2013:1):

- Social challenges involve the ability to empathise, to evaluate ideas and perceptions, to maintain interpersonal communication skills and to make and retain friendships.
- Practical challenges involve the ability to manage oneself and different tasks, such as self-care, job responsibilities, finance management, recreation, and to systemise school and work tasks.

Health care professionals working with patients who are intellectually disabled report intense emotions due to the aggressive and challenging behaviour of these patients (Storey *et al.*, 2011:235). Aggressive and challenging behaviour can include throwing objects around a room to harming other people physically (Tyrer *et al.*, 2006:296). These aggressive and challenging behaviour is frequently reported in adults with intellectual disabilities (Matson & Wilkins, 2008:5). Negative behaviour threatens the physical, psychological and social well-being of people working in clinical therapeutic environments – including auxiliary nurses (Stubbs & Dickens, 2008:351). According to Cooper *et al.* (2009:230), people with intellectual disabilities are more involved in challenging aggressive behaviour towards staff as a result of their poor mental capacity. Tyrer *et al.* (2006:295) confirm that most of the challenges faced by auxiliary nurses are from patients with intellectual disabilities displaying physical aggression.

Literature reveals a number of protective mechanisms and vulnerability factors that apply to the nurses as it might also apply to patients with intellectual disabilities (Gillespie *et al.*, 2010:183). Violent acts from these patients make auxiliary nurses feel vulnerable and if they are not adequately trained in how to handle violence at their workplace, continual exposure to violence can have a negative impact on their work commitment (Camerino *et al.*, 2008:48; Gillespie *et al.*, 2010:178). Bernstein and

Saladino (2007:301) also highlight that incidents of violence and aggression continue to increase in mental healthcare institutions. It is also important to mention that to counteract these acts of violence and aggression; some auxiliary nurses maintain a no-tolerance policy as a protective mechanism to reduce the risk of physical harm due to aggressive behaviour (Gillespie *et al.*, 2010:181).

In addition, it is well-known that auxiliary nurses are the main source of support and stability in any healthcare system, and the quality of nursing care they deliver, determines the outcomes of patients (Scribante & Bhagwanjee, 2007:1315). When attention is given to auxiliary nurses, it is only fair to focus on the plight of the South African healthcare system as well. In South Africa, the public healthcare sector is characterised by a serious shortage of healthcare workers, including auxiliary nurses, as compared to the private sector (Plaks & Butler, 2012:129). There is a continual shortage of nurses largely due to recruitment from abroad and the dwindling numbers of new nurses joining the nursing profession (Brannigan, 2010:36; Donelan *et al.*, 2008:144). In addition, the duties and workload of doctors are shifting to registered nurses and from registered nurses to auxiliary nurses due to a global shortage in healthcare professionals. This shift in duties and workload is termed “role drift” and also happens in the healthcare of patients with intellectual disabilities (McKenna *et al.*, 2007:1243).

Auxiliary nurses are crucial in providing nursing care to patients with intellectual disabilities (Jackson & O'Brien, 2009:6). However, they are only trained to provide elementary care to patients. The South African Nursing Council (SANC) defines auxiliary nurses as individuals who are (SANC, 2005:10):

- Trained and educated to render basic and uncomplicated nursing duties.
- Accountable and responsible for independent decision-making.
- Registered and licensed as auxiliary nurses under the Nursing Act (33 of 2005).

Auxiliary nurses provide essential nursing care and should be provided under the supervision of professional nurses (SANC, 2005). The primary responsibilities of auxiliary nurses are:

- Helping and providing support to patients with their daily activities and self-care.

- Providing nursing care as prescribed or directed by registered nurses.
- Rendering basic first-aid services according to standards of care.

It is difficult not to exaggerate the importance of auxiliary nurses in caring for patients with intellectual disabilities. According to the Institute of Medicine (2008:199), auxiliary nurses are “the backbone of the formal healthcare delivery system”. Although considered unskilled labourers and despite the fact that they are classified as the lowest category of nursing staff, auxiliary nurses perform complex jobs accompanied with serious responsibilities (Cherry *et al.*, 2007:183). Considering that patients who are intellectually disabled can exhibit aggressive behaviour, auxiliary nurses are particularly at risk of taking the brunt of the aggressive and violent behaviour of these patients, because they often operate on the “front line” of care (Bernstein & Saladino, 2007:301). Furthermore, auxiliary nurses are exposed to a variety of factors that increase their vulnerability to physical and verbal violence from patients with intellectual disabilities (Gillespie *et al.*, 2010:177). Hastings and Horne (2004:53) mention that there is enough literature available to prove that “support staff in mental healthcare institutions experiences a significant amount of stress and other negative psychological outcomes associated with their work”. The consequences of these outcomes may be associated with the increased reports of misconduct reported on by the SANC (2014).

It is, therefore, important that nurses – auxiliary nurses included – who provide mental healthcare develop resilience to adjust successfully to the demanding physical, mental and emotional nature of the mental healthcare environment (Cameron & Brownie, 2010:66). Developing the ability to thrive in an unpredictable healthcare environment is crucial for auxiliary nurses (Coyne, 2008:3157). These nurses work with individuals whose daily lives are characterised by hardships and resiliency is, therefore, urgently needed as a coping mechanism (McGee, 2006:45). Ungar (2010:6) defines resilience as the ability to acquire skills and knowledge and to be able to use these skills in dealing with difficult situations. Individuals with higher levels of resilience appear to be less emotionally exhausted than individuals with lower levels of resilience (Manzano *et al.*, 2012:107). Resilience is a result of interactions between individuals and their environment – their community provides them with the necessary support and resources (Cameron *et al.*, 2007:285). Resilience is encouraged by dynamic processes that take place interpersonally and intrapersonal (Allen *et al.*, 2013:1; Palmer, 2009:7).

In conclusion, it is evident that the care of patients with intellectual disabilities by auxiliary nurses is important. These patients are protected by law against abuse and treatments of a degrading nature. In order to render high-quality care to these patients, auxiliary nurses need to apply their skills and knowledge. Literature shows that the skills and knowledge of auxiliary nurses are limited to the provision of elementary nursing care. However, auxiliary nurses who care for patients with intellectual disabilities have to survive amidst risks of aggressive and violent behaviour of these patients. It is, therefore, necessary that the resiliency of auxiliary nurses in relation to protective mechanisms and vulnerability factors be given serious attention.

### **1.3 Problem statement and research questions**

The researcher is a professional nurse working at a mental healthcare institution. One of his duties is to supervise auxiliary nurses caring for patients with intellectual disabilities (SANC, 2005:10). While auxiliary nurses are performing their caring duties, they can be exposed to the aggressive behaviour of patients with intellectual disabilities. According to Van Wiltenburg *et al.* (2004:1), there is evidence that suggests that auxiliary nurses experience disproportionate levels of patient aggression when compared to other healthcare workers. However, auxiliary nurses are only trained to provide elementary care, and they are not supposed to render specialised services to patients with intellectual disabilities. From personal observations made by the researcher, it is clear that auxiliary nurses are not trained to handle the aggressive behaviour of patients with intellectual disabilities. The training of auxiliary nurses does not prepare them for the spectrum of problems they encounter while performing their duties (Stone & Dawson, 2008:52). The scope of nursing practice stipulated by the SANC expects of psychiatric nurses to treat patients in a manner that shows respect for the constitutional rights of patients, for their dignity, and to perform their duties with psychological integrity and fairness (SANC, 2005). The Nursing Act (33 of 2005) stipulates that only professional nurses with a psychiatric qualification are trained how to manage and handle aggressive and violent patients.

Although direct supervision should be provided to auxiliary nurses by professional nurses, most of the daily routine ward duties are done independently, such as bathing of patients, feeding, and monitoring their vital signs. Their daily routine ward duties put auxiliary nurses at high risk with regard to the aggressive behaviour of patients (Lau *et al.*, 2004:29). As mentioned earlier concerning the training of auxiliary nurses, it is

evident that their training does not prepare them to deal with these kinds of difficulties and they are, therefore, put at risk of applying ineffective coping mechanisms and exhibiting inappropriate behaviour in response to the aggressive and challenging behaviour of patients with intellectual disabilities. In one reported case, for example, an incident occurred in an institution for individuals with intellectual disabilities where three auxiliary nurses were arrested for assaulting patients and they were dismissed from work.

It is clear that auxiliary nurses have to deal with adverse work conditions and they need to obtain resilience to be able to effectively care for patients with intellectual disabilities (Edward, 2005:142-143). However, very limited research is available on the resilience of auxiliary nurses caring for patients with intellectual disabilities. In light of the limited availability of literature, the researcher was prompted to undertake this research study with regard to the resilience of auxiliary nurses caring for patients with intellectual disabilities. Research conducted on the resilience of professional nurses in private and public hospitals showed that professional nurses have moderate to high resilience, but they harbour mostly negative feelings towards the profession and many of them are considering leaving their current job (Koen, 2010:191). Another study done on the resilience of nurses showed that the vulnerability of nurses can be directly related to adverse conditions at work (Hart *et al.*, 2014:728). According to Mealer *et al.* (2012:297) resilience can serve as a protective mechanism to prevent psychological problems due to a stressful work environment.

Auxiliary nurses can actively participate in the strengthening of their own personal resilience to reduce their vulnerability and to enhance their protective mechanisms (Jackson *et al.*, 2007:7). Amidst factors that cause vulnerability, such as the violent behaviour of patients, some auxiliary nurses are likely to experience negative feelings, which can be minimised by mechanisms to protect themselves (Gillespie *et al.*, 2010:181). The fact of the matter is that training does not necessarily prepare auxiliary nurses to manage the aggressive and violent behaviour of patients with intellectual disabilities, but their level of resilience can help them to deal with these challenges and to spontaneously use their own strengths to cope and care for these patients (Mealer *et al.*, 2012a:297). The research questions for this research were:

- How do auxiliary nurses caring for patients with intellectual disabilities perceive their resilience?

- What are the perceptions of auxiliary nurses on protective and vulnerability factors that play a role in their resilience when caring for patients with intellectual disabilities?

#### **1.4 Purpose of the study**

The purpose of this study was to:

- Explore and describe auxiliary nurses' caring for patients with intellectual disabilities perceptions on their resilience.
- Explore and describe the perceptions of auxiliary nurses on protective and vulnerability factors that play a role in their resilience when caring for patients with intellectual disabilities.

This information can serve as recommendations, for nursing education purposes, nursing practice and nursing research to strengthen the resilience of auxiliary nurses caring for patients with intellectual disabilities and can, therefore, contribute to appropriate care for these patients.

#### **1.5 Paradigmatic perspective**

According to Maree and Van der Westhuizen (2007:32), a paradigmatic perspective refers to the worldview of researchers. Grove *et al.* (2013:41) define a paradigmatic perspective as a particular way of viewing a phenomenon or assumptions held by researchers. These assumptions also guide researchers and influence the way they interpret data; these assumptions should, therefore, be clearly stated (Brink *et al.*, 2012:25). The paradigmatic perspective of this study includes meta-theoretical (ontological and epistemological), theoretical and methodological assumptions.

##### **1.5.1 Meta-theoretical assumptions**

Meta-theoretical assumptions refer to the philosophical beliefs of researchers and their view on human beings, the environment, sickness, health and nursing (Polit & Beck, 2012:11). These assumptions are not meant to be tested as they are non-epistemic in nature (Polit & Beck, 2012:13). The paradigmatic perspective of the researcher is based on a Christian worldview. According to this perspective, God created human beings in His image. One of the inherent beliefs is that God created human beings to reign over creation on earth, to fulfil God's plans and to honour His name. In line with this view, the

researcher made use of the theory of nursing for the whole person (Rand Afrikaans University, 1992:2) to formulate his assumptions regarding human beings, the environment, health and nursing.

#### **1.5.1.1 Human beings**

According to the nursing theory for the whole person, humans are spiritual beings who operate in a structured or unified biopsychosocial manner to achieve wholeness (Oral Roberts University, 1990:6). The whole person includes concepts of body, mind and spirit. In this relationship, the concept of “mind” includes emotional, volitional and intellectual processes (Rand Afrikaans University, 1992:7). The concept of “body” includes physiological processes, and the concept of “spirit” refers to a part of human beings created for communion with God (Rand Afrikaans University, 1992:7). In this study, human beings refer to auxiliary nurses who care for patients with intellectual disabilities. Auxiliary nurses are God-created spiritual beings living in physical bodies with a mind, and guided by God to render care to patients with intellectual disabilities.

#### **1.5.1.2 Nursing**

The researcher believes that nursing encapsulates the protection and promotion of the health of individuals. Nursing also includes the prevention of injuries and the facilitation of healing through diagnoses and treatments. The Nursing Act (33 of 2005) stipulates that auxiliary nurses are trained to provide elementary nursing care according to prescribed levels. The Oral Roberts University Anna Vaughn School of Nursing (cited by Poggenpoel, 1991:16) also define nursing as a goal-directed service with the purpose of assisting patients to promote, maintain and restore health. The maintenance of health refers to activities aimed at preserving the health status of patients. The promotion of health refers to nursing activities that contribute to a greater degree of wholeness of patients. The restoration of health refers to nursing activities that help to facilitate the return of patients to previously experienced levels of health. In this study, *nursing* refers to the rendering of care to patients with intellectual disabilities by auxiliary nurses. This caring service can include the promoting, maintaining and restoring of health concerning patients with intellectual disabilities.

### **1.5.1.3 Environment**

An environment can be divided into an internal and external environment (Rand Afrikaans University, 1992:7). An internal environment refers to the totality of processes occurring in the body of persons (Rand Afrikaans University, 1992:7). In this study, the *internal environment* refers to the body, mind and spirit of auxiliary nurses. This environment includes their anatomical structure and physiological process, their intellectual and emotional processes and their relationship with God. An external environment includes situations or conditions outside of individuals that exert physical, social and spiritual influences on their lives (Rand Afrikaans University, 1992:7). For the purpose of this study, the *external environment* of auxiliary nurses refers to their external living environment, organisational structures and significant spiritual elements, such as values, beliefs, ethical principles and relationships with others. Specific examples of an external environment of auxiliary nurses are wards, colleagues, supervisors and patients with intellectual disabilities. The internal and external environments of auxiliary nurses are influenced by the way they provide care to patients with intellectual disabilities.

### **1.5.1.4 Health**

Wholeness is maintained when human beings interact positively with their environment in a resilient way. Health is a complete state of spiritual, mental and physical well-being (Oral Roberts University, 1990:8). The health statuses of persons are determined by their patterns of interaction with their internal and external environment (Oral Roberts University, 1990:8). Health can be described as movement on a continuum from minimum health to maximum health (Oral Roberts University, 1990:8). This means that even if persons are healthy, there is always the possibility that they can become ill. For the purpose of this study, *health* refers to the state of spiritual, mental, and physical wholeness auxiliary nurses achieve when caring for patients with intellectual disabilities. Their resilience while caring for these patients is determined by the way they interact with their internal and external environment. These internal and external environments comprise both protective mechanisms and vulnerability factors.

## **1.5.2 Theoretical assumptions**

A central theoretical statement and conceptual definitions formed the theoretical statements of this study and are discussed below.

### **1.5.2.1. Central theoretical statement**

The central theoretical statement of this study was based on the limited research available with regard to the resilience of auxiliary nurses caring for patients with intellectual disabilities. A qualitative descriptive inquiry was deemed an appropriate design to explore and describe the perceptions of auxiliary nurses on resilience and on vulnerability and protective factors that play a role in their resilience when caring for patients with intellectual disabilities. Understanding the perceptions of these auxiliary nurses and knowing their protective and vulnerability factors, can lead to recommendations on how to strengthen the resilience of auxiliary nurses caring for these patients.

### **1.5.2.2 Definitions of key concepts**

The definitions of key concepts used in this research are as follows:

- **Resilience**

According to Jackson *et al.* (2007:1), resilience refers to the ability of individuals to adjust to unfavourable conditions in a positive way. This definition is confirmed by Fletcher and Sarkar (2013:15) who state that resilience is a trait of individuals, which acts as a protective measure when bad conditions are experienced. Resilience often means the ability to “bounce back” and continue with life after “adversities” were experienced. Pooley and Cohen (2010:34) define resilience as the potential to display coping mechanisms when confronted with unusual problems. For the purpose of this study, *resilience* is referred to as the ability to bounce back from hardships and to overcome negative life experiences (Greeff & Ritman, 2005:38), such as aggressive and violent behaviour of patients with intellectual disabilities. Resilience refers to a pattern of behaviour that demonstrates that auxiliary nurses are doing well despite being exposed to significant risks.

- **Caring**

According to Berg and Danielson (2007:505), caring refers to the process of providing patients with special attention offered by nurses. Caring involves nurse-patient relationships during the provision of nursing care. According to the Watson theory of human care, caring is an intersubjective human process that is reflected in mind, body and soul spheres (Wole, *et al.*, 2012:347). Caring is directed towards the welfare of

patients and takes place when nurses respond to patients in caring situations. Upshur *et al.* (2010) identified the following eight themes with regard to caring: providing a reassuring presence; providing information to patients; demonstrating professional knowledge and skills; assisting with pain; taking more time than is actually needed; promoting autonomy and a sense of freedom; recognising individual qualities and needs; and keeping continual watch of patients. In this research, *caring* means the provision of elementary nursing care and the management of patients with intellectual disabilities by auxiliary nurses.

- **Auxiliary nurses**

The Nursing Act (33 of 2005) defines auxiliary nurses as individuals who are trained to provide elementary nursing care according to prescribed levels. In this research, *auxiliary nurses* refer to individuals employed by mental healthcare institutions to render elementary nursing care – according to the Nursing Act (33 of 2005), Regulation 786 – to patients with intellectual disabilities. Elementary nursing care includes promoting, maintaining and restoring the health of patients with intellectual disabilities while rendering basic nursing care.

- **Intellectual disabilities**

Intellectual disabilities are a reduced quality of general mental abilities that strongly influence how well individuals are able to deal with or handle common demands in life. Mental abilities include conceptual, social and practical skills, which are normally noticeable before individuals are 18 years old (APA, 2014:31). In this research, *intellectual disabilities* refer to the inability of individuals to make sound judgements – leading to a dependence on others for care, and *patients with intellectual disabilities* refer to patients who are admitted to mental healthcare institutions for the long term. These patients are often unable to manage their complex and aggressive behaviour that can include the destruction of property and self-inflicted injuries (Smith & Matson, 2010:1062). Difficulties can occur with regard to the regulation of their emotions and behaviour due to shortcomings in their social domain (APA, 2014:34).

### **1.5.3 Methodological assumptions**

A paradigmatic perspective of researchers (Botma *et al.*, 2010:207) covers meta-theoretical, theoretical and methodological assumptions. Meta-theoretical assumptions

reflect the views and beliefs of researchers regarding human beings, health, nursing and environments. Theoretical assumptions include the central theoretical argument and the definition of concepts. The researcher made use of meta-theoretical and theoretical assumptions in his research project.

Methodological assumptions reflect the view of researchers on what constitutes good research. Based on the proposed research model of Botes (2002:8), nursing takes place on three levels i.e. practice, research, and paradigmatic perspective. The researcher agrees that nursing should make a difference on all three of these levels. The first perspective describes the practice of nursing, which refers to the daily challenges of nursing that need to be addressed. Little is known about the resilience of auxiliary nurses caring for patients with intellectual disabilities and this paucity of information was identified as a problem in this study. The researcher conducted research in accordance to a research process. A research process refers to the theory and methods used in a study. For the purpose of this study, the researcher made use of a qualitative descriptive enquiry to explore and describe the perceptions of auxiliary nurses caring for patients with intellectual disabilities on their resilience; their perceptions on vulnerability factors and protective mechanisms that influence their resilience when caring for these patients. From this research, recommendations can be formulated for nursing practice, nursing education and further research.

## **1.6 Research design and methodology**

The research design and methodology are discussed briefly in this chapter and a more detailed discussion follows in chapter 2.

### **1.6.1. Research design**

The research design of this study was qualitative in nature. A descriptive inquiry was done as described by Botma *et al.* (2010:194) and Sandelowski (2000:335). A qualitative descriptive inquiry was an appropriate design to explore and describe the perceptions of auxiliary nurses caring for patients with intellectual disabilities on their resilience; and their perceptions on protective and vulnerability factors that play role in their resilience when caring for these patients.

## **1.6.2. Research methodology**

The research methodology is the way in which a study is conducted, and it includes a description of the population, sampling, sample size, data collection plan and the data analysis (Polit & Beck, 2012:62). A detailed discussion of the research method follows in chapter 2.

- **Population**

According to Brink *et al.* (2012:131) and Grove *et al.* (2013:44), a population is the whole group of persons or objects that are of interest to researchers or the group or objects that meet the criteria set for a particular research study. In this study, the population was auxiliary nurses caring for patients with intellectual disabilities working in a mental healthcare institution.

- **Sampling**

Brink *et al.* (2012:132) defines sampling as the procedure that researchers follows to select a sample from a population in order to obtain information on a phenomenon. In this research, the researcher used purposive sampling to select participants. Inclusion and exclusion criteria were used to select the sample for this research study (Botma *et al.*, 2010:200).

- **Sample size**

Botma *et al.* (2010:200) are of the opinion that a sample size is determined by data saturation – when the amount of useful information provided by participants is an indication of the quality of data – and no new information is making a difference to the data already obtained. In this study, the sample size was determined by data saturation, which was reached after the completion of four semi-structured focus group interviews.

- **Data collection**

Semi-structured focus group interviews were conducted. Krueger and Casey (2014:6) mention that focus groups are typically composed of no less than four people and no more than twelve people. Focus group interviews involve collaborative interaction between researchers and participants to discuss and gain understanding of a phenomenon by listening and learning from each other (Krueger & Casey, 2014:2). The most appropriate method of gathering data for this research project was focus group

interviews. Focus group interviews are a quick and convenient way of collecting data from several people simultaneously, and also encourage the sharing of information amongst participants (Botma *et al.*, 2010:211). The data collection plan is discussed in chapter 2 under the following headings: the role of the researcher, the mediator and recruitment of prospective participants, obtaining informed consent, the physical environment, the data collection method, field notes, the recording of data, the transcribing of data, and the storage of data.

- **Data analysis**

The process of a data analysis involves putting together the collected data by making the data less complex and more understandable (Grove *et al.*, 2013:279). In qualitative descriptive studies, a qualitative content analysis is the strategy of choice when data are analysed (Sandelowski, 2000:338). An inductive content analysis was applied in this research study (Forman & Damschroder, 2008:40). To verify the identified themes and coding, the researcher requested an experienced qualitative researcher to conduct independent co-coding (see Appendix H). The researcher provided the transcripts and field notes to the co-coder for a data analysis. When the independent co-coder was finished with co-coding, the researcher scheduled a meeting to reach consensus on the codes, themes, and sub-themes that emerged from the data. A detailed discussion follows in chapter 2.

## **1.7 Measures to ensure rigour**

Brink *et al.* (2012:97) define rigour as an application of the principle of trustworthiness in qualitative studies. In qualitative studies, researchers always try to understand and obtain knowledge. This can be done by visiting participants at their own place or inviting them to a meeting, spending enough time with them, and asking additional questions to obtain more knowledge (Creswell, 2009:243). To ensure trustworthiness, the researcher applied the four suggested criteria outlined by Lincoln and Guba (Botma *et al.*, 2010:234; Krefting, 1991:215-222; Polit & Beck, 2014:323): truth value, applicability, consistency and neutrality. A detailed discussion follows in chapter 2.

## **1.8 Ethical considerations**

Ethical aspects were observed throughout the research study as prescribed by the Declaration of Helsinki (Brink *et al.*, 2012:33). According to Brink *et al.* (2012:34), there

are three fundamental principles that guide researchers: respect for persons, beneficence and justice.

Before any research study involving human beings is undertaken, it should first be approved by a research ethics committee (Brink *et al.*, 2012:44). The permission to conduct this research project was obtained from the Health Research Ethics Committee of the Faculty of Health Sciences, North-West University, Potchefstroom Campus. The following reference number was provided: NWU-00043-15-A1 (see Appendix A). Permission was obtained from the North West Department of Health (see Appendix C) and the management of the mental healthcare institution where the research took place (see Appendix E). The ethical aspects are discussed in chapter 2.

## **1.9 Chapter outline**

Chapter 2: Research design and method

Chapter 3: Discussion of research findings and literature integration

Chapter 4: Limitations, conclusions and recommendations

## **1.10 Summary**

Chapter 1 covered the background of the research study, the problem statement, research questions, the paradigmatic perspective and a short description of the research design and methodology. In chapter 2, the research design and method are discussed in detail.

## **CHAPTER 2: RESEARCH DESIGN AND METHODOLOGY**

### **2.1. Introduction**

Chapter 1 provides an overview of the study. Chapter 2 describes in detail the research design, the methodology applied regarding the population, sampling, sample size, data collection and analysis, and the measures taken to ensure that the study complied with the principles of ethics and trustworthiness.

### **2.2. Research design and methodology**

The research design and methodology are discussed in more details on this chapter.

#### **2.2.1. Research design**

According to Brink *et al.* (2012:120), a research design refers to the whole plan for collecting data in a research study. The design of this research study was a qualitative descriptive inquiry as explained by Botma *et al.* (2010:194) and Sandelowski (2000:335). Botma *et al.* (2010:194) maintain that researchers should not try to interpret data, but should describe events or phenomena. Polit and Beck (2014:275) state that the designs of descriptive qualitative studies are likely to be eclectic. This means that these studies often borrow or adapt methodology techniques from other qualitative methods of research. This research study consists of sampling strategies, such as purposive sampling and data saturation, data collection through semi-structured focus group interviews and a data analysis by the categorisation of codes (Chenail, 2011:1180).

A descriptive inquiry provides a clear picture about particular individuals, situations or groups (Botma *et al.*, 2010:194). The goal of a qualitative descriptive inquiry is to summarise specific events experienced by individuals (Lambert & Lambert, 2012:255). By describing what is happening and establishing the nature of phenomena, new meanings of findings can be found (Botma *et al.*, 2010:194). This type of research design is appropriate due to the limited availability of research regarding the perceptions of auxiliary nurses caring for patients with intellectual disabilities on their resilience and protective mechanisms and vulnerability factors. This research study provides a description of the above-mentioned limitation and enables the formulation of recommendations to promote the resilience of auxiliary nurses caring for patients with

intellectual disabilities. A qualitative descriptive inquiry is also appropriate for this study, because self-disclosure amongst participants with multiple viewpoints in a relatively short period of time was promoted (Botma *et al.*, 2010:211).

## **2.2.2. Research methodology**

A research methodology is the way in which a study is conducted and includes a description of the population, sampling and sample size, the data collection plan and the data analysis (Polit & Beck, 2012:62).

### **2.2.2.1. Population**

According to Brink *et al.* (2012:131) and Grove *et al.* (2013:44), a population is the whole group of persons or objects that are of interest to researchers or that meet the criteria set by researchers for a specific study. In this research, the population refers to auxiliary nurses caring for patients with intellectual disabilities in one of South African public mental healthcare institution. The specific institution selected for this study employs approximately 200 auxiliary nurses working in eight wards. Each ward has a maximum of 25 auxiliary nurses and has the capacity to admit 60-70 patients with intellectual disabilities. The degree of impairments of these patients can be divided into four categories: mild, moderate, severe and profound intellectual impairments (APA, 2013:33). Some of these patients display aggressive behaviour due to mental impairments (Matson & Wilkins, 2008:5).

### **2.2.2.2. Sampling**

Brink *et al.* (2012:132) define sampling as the procedure that researchers follow to select a sample from a population in order to obtain information on phenomena. In this research study, the researcher made use of purposive sampling to select participants. The researcher applied purposive sampling in order to choose particular individuals who showed features of importance to the study and who are especially knowledgeable about working with patients who are intellectually disabled. Inclusion and exclusion criteria were applied to select a sample. These inclusion and exclusion criteria were clearly established before the selection of participants took place (Botma *et al.*, 2010:200). In this research, the sampling criteria were as follows:

- **Inclusion criteria**

The researcher, with the assistance of a mediator (an auxiliary nurse working in the same institution), selected auxiliary nurses who met the following inclusion criteria:

- Auxiliary nurses should be employed at a mental healthcare institution that offers long-term in-patient care for individuals with intellectual disabilities.
- Auxiliary nurses should be registered at the SANC as auxiliary nurses.
- Auxiliary nurses should have worked a minimum of six months as auxiliary nurses caring for patients with intellectual disabilities.
- Auxiliary nurses should be willing to sign a consent form to participate in the study.
- Auxiliary nurses should be able to communicate in English.
- Auxiliary nurses should provide consent for focus group interviews to be audio-recorded.

- **Exclusion criteria**

The sample selection excluded auxiliary nurses who were:

- Newly employed or who have worked less than six months in caring for patients with intellectual disabilities.

- **Sample size**

According to Botma *et al.* (2010:200), a factor that determines sample size is data saturation. Data saturation is reached when the amount of useful information provided by participants no longer affects the outcome of research studies. Polit and Beck (2012:62) define data saturation as a guiding principle when a sampling size is determined – sampling is required until no new information is obtained and redundancy is achieved. This means that researchers obtain data saturation when themes and categories in the data become repetitive. In this study, the sample size was also determined by data saturation, which was reached after conducting four semi-structured focus group interviews.

### **2.2.2.3 Data collection plan**

The data collection plan is discussed stepwise under the following headings: the role of the researcher, the mediator and recruitment of prospective participants, obtaining informed consent, the physical environment, and the data collection method.

- **The role of the researcher**

The first step was to submit the research proposal to the INSINQ Research Committee for quality control purposes. The committee approved the proposal. The proposal was then submitted to the Health Research Ethics Committee (HREC) of the Faculty of Health Sciences, North-West University (Potchefstroom Campus) for ethical clearance. After obtaining ethical clearance from the HREC, reference number NWU-00043-15-A1 (see Appendix A), the researcher obtained permission from the North West Department of Health and the mental healthcare institution to conduct the research (see Appendices C and E). A mediator was then identified and asked to sign a confidentiality form (see Appendix F). As soon as consent was obtained from the mediator, the researcher gave the mediator the necessary information documents and consent forms to deliver to prospective participants and to invite them to participate in the research study. This step is described in more detail:

- **The mediator and recruitment of prospective participants**

Participants are recruited by identifying prospective participants who qualify for participation (Polit & Beck, 2014:87). In this study, the researcher recruited participants with the help of a mediator. The researcher identified and negotiated with an auxiliary nurse to act as a mediator between the researcher and the participants. This individual was fulfilling a leadership role amongst the auxiliary nurses at the mental healthcare institution at the time of the research and he had a trust relationship with the researcher and the participants. This individual is an auxiliary nurse who has been working at the mental healthcare institution for a long time, and he often orientates newly employed auxiliary nurses. This individual was not working closely with the researcher, and the power relationship between the researcher and this individual was balanced: the individual's leadership role amongst the auxiliary nurses was acknowledged by the researcher. The researcher informed the individual about the research study and invited him to act as the mediator and informed him of what was expected of him.

The researcher provided the individual with all of the information about the research process and informed him that if he was satisfied with the information and willing to act as mediator, he was required to sign a confidentiality form (see Appendix F). The role of the mediator was to purposively select eligible participants according to the established inclusion and exclusion criteria; to arrange meetings with prospective participants and inform them about the research; to invite prospective participants to participate; to obtain informed consent from the participants should they agree (see Appendix G); and to arrange a first meeting between the researcher and the participants. The researcher arranged follow-up meetings with the auxiliary nurses who indicated their willingness to participate in the research study.

- **Obtaining informed consent**

Obtaining informed consent is an important procedure and a precautionary measure to protect research participants (Polit & Beck, 2014:87). The researcher ensured that the prospective participants – through the mediator during meetings – receive adequate information about the study, had the opportunity to ask questions and understand the research information to enable them to consent to or decline participation voluntarily without any coercion of the researcher (Polit & Beck, 2014:87). When prospective participants agreed to participate in this study, the researcher documented informed consent by having the participants sign consent forms (see Appendix G) provided by the mediator. It was the responsibility of the researcher to provide the information to the prospective participants. This information included information about the purpose of the study, specific expectations regarding participation, the voluntary nature of participation, and potential costs and benefits in connection with participation (Polit & Beck, 2014:87) (see Appendix G).

- **The physical environment**

The researcher ensured that the focus group interviews were held in a private and comfortable venue that was free from interruptions. The researcher booked a well-ventilated, quiet and clean room on the institution premises. To prevent disturbances during focus group interviews, the participants were requested to keep their cell phones switched off, and a written sign “Please do not disturb, research interviews in progress” was displayed on the outside of the closed door. The chairs were arranged in a circle to facilitate eye contact and continual rapport during the interviews.

- **Data collection method**

The researcher used semi-structured focus group interviews with a minimum of four to eight participants per group (Botma *et al.*, 2010:211). The researcher used each group's dynamics to gain information about specific issues, because the interactions that take place within groups can highlight and provide rich data on a specific phenomenon (Doody *et al.*, 2012:1). The answer to the research questions asked in this study lies within a group of auxiliary nurses, and focus group interviews were identified as the most appropriate method to obtain information, because when the participants sit together to discuss issues, they hear one another's perceptions and these perceptions trigger thoughts that provide rich data. According to Brink *et al.* (2012:158) semi-structured focus group interviews are used to obtain qualitative data about the beliefs and perceptions of participants on a particular subject. It is also particularly appropriate for descriptive qualitative research studies when researchers want to explore a topic extensively (Gill *et al.*, 2008:293).

To be able to explore a topic extensively, facilitators of groups should be comfortable and familiar with group processes (Botma *et al.*, 2010:212). The researcher has experience in facilitating group processes; he practiced role-play during group interviews while he was studying for an advanced diploma in nursing education in 2012. In 2013, he also passed a module on research methodology during which focus group interviews were practised. In 2014, the researcher passed a clinical module in advanced psychiatric nursing. In this module, the researcher conducted group and family therapy. Before data collection commenced, the researcher conducted role-play with non-participants to practice the application of the semi-structured focus group interviews.

During the actual interviews, the researcher created rapport with the participants by introducing himself to the participants and by collaboratively developing ground rules with them with regard to partial anonymity, confidentiality and respect during these focus group interviews.

A semi-structured format with clear open-ended questions was used during the interviews (Krueger & Casey, 2014:7). The questions were formulated in line with the research purpose and through discussions with the research supervisor. The researcher also conducted the first focus group interview as a trial run with actual participants to test the questions and to see if the participants understood the questions (Krueger &

Casey, 2014:8). Firstly, the researcher explained the concept of resilience to the participants – “the ability to bounce back during difficult situations” (Cowell, 2013:213). The researcher then asked the participants the following questions:

- What do you think is your resilience when caring for patients with intellectual disabilities?
- What do you see as your protective and vulnerability factors that play a role in your resilience when caring for patients with intellectual disabilities?

The researcher also explained concepts, such as protective and vulnerability factors, by explaining what makes you stronger, what protects you to be resilient, and what makes it more difficult to be resilient when caring for patients with intellectual disabilities. Furthermore, to ensure that rich data were generated, the researcher utilised the following communication techniques during the focus group interviews as described by Okun and Kantrowitz (2014:68):

- Clarify questions and try to focus on or understand the basic nature of statements made by participants.
- Minimal verbal responses to indicate to the participant that the researcher is listening e.g. by using verbal cues such as “Mm”, “I see”.
- Paraphrase verbal statements to highlight what participants said by using synonymous words.
- Reflect on the concerns and perspectives shared by participants to highlight understanding, for example by making use of: “It sounds as if ...”
- Use open-ended questions to initiate discussions of thoughts and feelings, for example: “Tell me more about ...”
- Summarise everything that has been shared by participants.

- **Field notes**

Field notes are written during the course of data collection to describe what researchers hear, see, feel and experience (Polit & Beck, 2014:294). The purpose of taking field notes is to support identified themes and subthemes and to provide a description of the process of data collection (Polit & Beck, 2012:550). The researcher made field notes in three categories: descriptive notes, reflective notes and demographic notes (see Appendix K). In his descriptive notes, the researcher objectively described the events, conversations, and the context in which these events and conversations occurred during the focus group interviews (Polit & Beck, 2014:294). In his reflective notes, the researcher shared his personal experiences and the progress made in his research study – his speculations, feelings, impressions and ideas (Polit & Beck, 2014:294). In his demographic notes, the researcher documented information regarding the time, place and dates of focus group interviews as well as the demographic information of the participants, such as gender, age and period working as auxiliary nurses (Botma *et al.*, 2010:219).

- **Recording of data**

Before an audio recorder can be used during semi-structured focus group interviews, permission should first be obtained from participants (Botma *et al.*, 2010:214). In this study, the placement of an audio recorder in the room where the group interviews took place did not distract the participants (Grove *et al.*, 2013:424). Soon after the focus group interviews took place, the researcher listened to the audio-recorded interviews to check for problems with regard to audibility and completeness and to allow time for self-evaluation concerning his own interviewing style and any need to schedule follow-up interviews (Polit & Beck, 2012:543).

- **Transcribing data**

The researcher transcribed the data contained in the audio recordings *verbatim* (word for word) (Polit & Beck, 2012:543). The researcher transcribed important additional data to improve the quality, depth and context of the transcriptions, such as when the participants cried, when there was silence, when the participants sighed, the group dynamics and the atmosphere (Polit & Beck, 2012:543). While transcribing, the researcher left enough space available in both the left and right margins of the document to be able to make notes during the data analysis (Botma *et al.*, 2010:214).

- **Storage of data**

The researcher followed recommended principles about data storage and handling that were especially well-suited for qualitative research (Creswell, 2013:175):

- Store electronic data during and after the research on a password-protected computer.
- Develop backup copies of the computer files.
- Store hard copies of the data during and after the research in a locked cupboard in the researcher's office.
- Use a high-quality recorder to audio record information during interviews.
- Develop a master list of information gathered.
- Protect the anonymity of participants by concealing their names in the data.
- Store data for at least seven years.

#### **2.2.2.4 Data analysis plan**

The process of data analysis involves putting together collected data by making data less complex and understandable (Grove *et al.*, 2013:593). In qualitative descriptive studies, a qualitative content analysis is the strategy of choice when analysing data (Sandelowski, 2000:338). Forman and Damschroder (2008:40) mention that a data analysis in descriptive qualitative research takes place when researchers derive categories from data that were carefully read and analysed qualitatively. In this study, the audio recorded data of the focus group interviews were analysed and transcribed according to a process of inductive content analysis (Forman & Damschroder, 2008:45). In qualitative descriptive studies, a process of content analysis involves generating codes from data during the course of a study and by applying these codes systematically (Sandelowski, 2000:338). The data were categorised by making use of categories that were derived from the data (Forman & Damschroder, 2008:40).

After the data were organised (transcribed), the researcher became immersed in the data – trying to obtain a sense of the interviews before breaking these interviews into parts (Creswell, 2013:183). To be immersed, means that researchers are fully devoted to the data and they spend a lot of time reading and thinking about the data (Grove *et al.*, 2013:280). The researcher wrote memos that assisted him in obtaining a sense of

the data. These memos contained early thoughts and ideas obtained from the data (Forman & Damschroder, 2008:47).

In the second step, which is referred to as the reduction phase, the researcher developed a systematic approach to reduce the amount of data to relevant data by answering the research questions (Forman & Damschroder, 2008:48). This reduction involved the coding of data which gave the researcher an opportunity to rearrange the data into categories (Forman & Damschroder, 2008:49). A process of coding involves reading through the text, highlighting or underlining passages that can be potentially important and relevant in answering research questions, identifying small topics of information in the text, and then assigning labels to these codes (Creswell, 2013:184, Forman & Damschroder, 2008:49). The first level of coding was descriptive – the phrases of participants were used as labels for determining codes (Grove *et al.*, 2013:281).

A final step in a data analysis involves the explanation of data or when meaning is attached to data (Creswell, 2009:186). During this phase of an analysis, codes are put together to improve an understanding of the data (Forman & Damschroder, 2008:56). It is a process that includes the formation of themes from codes, and then these themes are organised into larger units of abstraction to make sense of the data (Creswell, 2013:187).

To verify the themes and coding that took place, the researcher requested an experienced qualitative researcher to conduct independent co-coding (see Appendix H). He provided the co-coder with his transcripts and field notes for a data analysis. A consensus process takes place when two independent coders code the data, when they compare their coding and when they discuss possible discrepancies in order to resolve these issues (Forman & Damschroder, 2008:55). After the independent co-coder was finished with the co-coding, the researcher requested a meeting to reach consensus on the codes, themes and subthemes that emerged from the data.

### **2.3 Measures to ensure rigour**

Brink *et al.* (2012:97) define rigour as a principle of trustworthiness in qualitative studies. In a qualitative study, researchers always try to understand and obtain knowledge either by visiting participants at their own place or inviting them to neutral ground, spending enough time with them or and asking more questions to obtain more knowledge

(Creswell, 2009:243). To ensure trustworthiness, the researcher used the four suggested criteria outlined by Lincoln and Guba (Botma *et al.*, 2010:234; Krefting, 1991:215-222; Polit & Beck, 2014:323): truth value, applicability, consistency and neutrality. These four criteria are discussed in Table 1 and shows how the researcher ensured trustworthiness in his research study:

**Table 2.1: Criteria and strategies to ensure trustworthiness**

<b>Criteria</b>	<b>Strategies</b>	<b>Application</b>
<p><b>Truth value</b> Truth value is the criterion that ascertains whether the data reflect the knowledge of participants to ensure that researchers have established trust in the research results. This criterion is obtained by using strategies to reach credibility, such as prolonged engagement, triangulation and reflexivity (Botma <i>et al.</i>, 2010:233).</p>	Credibility	<p><i>Prolonged engagement</i> To generate data, the researcher engaged himself with the participants and the data for a prolonged time. This included building a trust relationship with the participants by introducing himself to create rapport and to facilitate in-depth discussions.</p> <p><i>Reflexivity of the researcher</i> The researcher ensured reflexivity by compiling comprehensive field notes and discussing the findings with the co-coder during the consensus meeting.</p>
<p><b>Consistency</b> Consistency is concerned with whether research results are consistent or congruent; if interviews can be replicated with the same participants or in a similar context. For this criterion to be achieved, a strategy of dependability was used (Botma <i>et al.</i>, 2010:233) by describing the research process thoroughly.</p>	Dependability	<p><i>Dense description</i> The researcher comprehensively described the whole research process, including the exact methods used when the data gathering and the data analysis took place.</p>
<p><b>Neutrality</b> Neutrality refers to the extent in which qualitative research findings are solely due to interactions with participants and not due to biases, self-motivation, and perspectives of researchers. A strategy of confirmability was used to achieve this criterion (Botma <i>et al.</i>, 2010:233).</p>	Confirmability	<p><i>Audit strategy</i> For the purpose of this research, the researcher used strategies, such as an inquiry audit, to ensure confirmability. The researcher involved a co-coder who is experienced in qualitative research by giving the co-coder the raw data and audio recordings for an independent analysis. The researcher also comprehensively described the research process.</p>
<p><b>Applicability</b> Applicability is the criterion that researcher uses to measure if it is possible to achieve research results in similar contexts with similar participants. The extent to which research findings can be achieved by using similar participants, can be achieved through a strategy of transferability (Botma <i>et al.</i>, 2010:233).</p>	Transferability	<p><i>Providing a rich and thick description</i> The researcher provided a detailed description of the research process and context to allow readers to make decisions regarding transferability.</p> <p><i>Purposive sampling</i> The researcher used purposive sampling to select participants to maximise the range of specific data obtained about the research topic.</p>

## **2.4 Ethical considerations**

Before research studies involving human beings can be undertaken, these studies should first be approved by a research ethics committee (Brink *et al.*, 2012:158). This proposal was submitted to and approved by the Health Research Ethics Committee (HREC) of the Faculty of Health Sciences, North-West University, Potchefstroom Campus, and permission to conduct the research study was obtained from the North West Department of Health and the management members of the mental healthcare institution where the research took place (see Appendices A, C and E). To conduct research ethically, the researcher (Brink *et al.*, 2012:158):

- carried out the research in a methodological strict and skilled way.
- used resources with respect and integrity.
- acknowledged authors and individuals who contributed guidance or assistance to prevent plagiarism.
- communicated results accurately – meaning no fabrication, falsification or forgery took place.

The researcher further ensured that the research was conducted in an ethical manner by applying ethical principles as prescribed by the Declaration of Helsinki (Brink *et al.*, 2012:33). This declaration provides the foundation for ethical research guidelines by incorporating conditions for the inclusion of people who can be regarded as vulnerable during research studies: children and patients with intellectual disabilities. According to Brink *et al.* (2012:34), there are three fundamental principles that guide researchers: respect for persons, beneficence and justice. These principles are based on basic human rights that need to be protected during research studies.

### **2.4.1 Principle of respect for persons**

As the researcher viewed prospective participants as autonomous, they were provided with adequate information with regard to the aims and methods of the research study so that they chose independently whether they wanted to participate in the study or not (Polit & Beck, 2014:84). The researcher obtained informed consent during the recruitment stage (see Appendix G). The procedure to obtain the informed consent is discussed in this chapter (see 2.2.2.3).

According to Brink *et al.* (2012:35), if power relations are present in a research study, potential participants can be left vulnerable. In this case, the study population was auxiliary nurses and the researcher is a professional nurse. These auxiliary nurses can be viewed as a vulnerable group because they are in a subservient position in relation to the researcher at their place of work. To counter a possible ethical risk, the researcher recruited participants through the assistance of a mediator. The mediator recruited auxiliary nurses who are not working in the researcher's own ward or under his supervision. The researcher also ensured that they participated voluntarily in the research study and that they were not threatened by the information given to them about the proposed study provided by the mediator and they were allowed to choose whether they wanted to participate or not (Polit & Beck, 2014:84).

The mediator is an auxiliary nurse who the researcher trusts and the researcher gave him information about the research process to explain to the participants. Although the mediator recruit participants and refer to the researcher, it always stays the responsibility of the researcher to provide the correct information to participants before signing informed consent. Potential participants can only execute the right to self-determination and act autonomously if they receive all of the information regarding a proposed research (Polit & Beck, 2014:87). This was achieved by compiling an informed consent letter and explaining the content verbally in a language that the prospective participants understood (Polit & Beck, 2012:158) (See Appendix G).

#### **2.4.2 Principle of beneficence**

Researchers should protect the well-being of participants – in a physical, psychological, emotional, spiritual, economic, social and legal context (Brink *et al.*, 2012:35). The researcher used his clinical judgement and skills as a professional nurse to manage all of the focus group interviews. He organised counsellor support from the employee assistance programme at the mental healthcare institution where the research took place in case of emergencies – should a research participant be emotionally traumatised during an interview. The researcher tried to limit potential harm to the participants by carefully monitoring the location of where the focus group interviews took place, by giving attention to the formulation of questions and by continuously monitoring the participants for signs of physical and/or emotional distress (Brink *et al.*, 2012:35). If distress occurred, the researcher was prepared to provide comfort breaks and/or the facilitation of a debriefing by giving the participants an opportunity to ask questions or to

mention their complaints and, if necessary, by referring them for counselling (Brink *et al.*, 2012:35). The benefit of using auxiliary nurses as participants in this research study was the opportunity for these participants to share their views on resilience and they indirectly provided recommendations to strengthen the resilience of auxiliary nurses caring for patients with intellectual disabilities.

### **2.4.3 Principle of justice**

Botma *et al.* (2010:13) mention that the principle of justice, namely the fair selection of participants, should apply to a sampling process. This means that researchers should select participants for reasons directly related to the research and not because participants are easily accessible (Brink *et al.*, 2012:35). In this study, the researcher recruited auxiliary nurses caring for patients who are intellectually disabled through the aid of a mediator to participate in the study. The researcher respected all of the agreements that he made with the participants, such as being punctual and terminating sessions on the agreed time.

The researcher also respected the right of participants to privacy (Brink *et al.*, 2012:35). Informed consent was provided for the recording of conversations using an audio recorder during focus group interviews, and the researcher did not collect any data covertly. In focus group interviews, absolute anonymity is not possible; however, the researcher processed the data anonymously (Brink *et al.*, 2012:37). The researcher discussed the information with the participants that should be kept confidential during focus group interviews and ground rules were also highlighted. To ensure anonymity during the data analysis, the researcher made use of the following safeguards:

- Each participant was provided with a code name in the transcripts.
- Code names were used when data were discussed.
- The master list containing the names of the participants linked to their code names is kept in a safe place.

Confidentiality means that the real names of participants are not used and access to the data is severely limited to only the individuals who are directly involved with the research study (Polit & Beck, 2012:158). In this study, the data were only accessible to the researcher, his supervisor and co-coder. According to Brink *et al.* (2012:38), the process of ensuring confidentiality refers to the responsibility of researchers to prevent

that the data gathered during the research are made available to other persons. The co-coder was requested to sign a confidentiality agreement (see Appendix H).

Botma *et al.* (2010:4) are of the opinion that ethics should be applied in every phase of research – during the conceptual, empirical, interpretation and communication phase.

- **Conceptual phase**

Researchers should establish a collaborative partnership with participants to ensure that the research will be of social value too and to minimise the possibility of social harm (Botma *et al.* 2010:13). In this study, the researcher commenced with his research only after approval was granted by the HREC, North-West University (Potchefstroom Campus), the North West Department of Health, the mental healthcare institution and the auxiliary nurses who consented to participate in the study.

- **Empirical phase**

Brink *et al.* (2012:50) maintain that the standard element in this phase is a research design – researchers implement the plans they made to collect data. Although the researcher's inclusion criteria included auxiliary nurses willing and able to communicate in English, he realised during the data collection that his study will be high-principled if he allowed the participants to express themselves in a language of their own choice. The researcher granted the participants the opportunity to speak in a language they preferred to ensure rich data. The researcher collected data according to a pre-established plan – through focus group interviews with auxiliary nurses caring for patients with intellectual disabilities, informed consent was obtained and questions were asked related to the goal of the study.

- **Interpretation phase**

This is the phase in which data collected during an empirical phase is summarised and categorised for an analysis (Brink *et al.*, 2012:55). In this study, the researcher provided true findings to generate sound scientific knowledge. He did not falsify or fabricate the results. This preventative measure was insured by involving an independent co-coder during the data analysis.

- **Communication phase**

In the last phase of research – the communication phase – the researcher published and reported the research results (Botma *et al.*, 2010:27). The dissemination of results to the stakeholders and target population took place in vocabulary that was understood by them to enrich the meaning of the data. After completing this study, the researcher will provide feedback to the auxiliary nurses who participated in the study. The feedback will be presented in the form of PowerPoint presentation during a meeting arranged with them and the feedback will also be available in writing. The researcher will also submit the report to the mental healthcare institution where the study took place, the North West Department of Health and to the North-West University, Potchefstroom Campus.

## **2.5. Summary**

This chapter discussed the research design, the research method, the data collection methods, the measures taken for ensuring trustworthiness and ethical considerations were scrutinised. Chapter 3 presents a discussion of the research findings and the literature integration.

## CHAPTER 3: DISCUSSION OF RESEARCH FINDINGS AND LITERATURE INTEGRATION

### 3.1 Introduction

In chapter 2, the research design, the research methodology and the data collection methods were discussed. The measures taken for ensuring trustworthiness received attention and ethical considerations were scrutinised. In this chapter, the findings are discussed. The findings are supported by direct quotations from the semi-structured focus group interviews conducted with the participants working at a mental healthcare institution. Furthermore, the researcher compares and confirms the results with existing literature to integrate the findings with literature.

### 3.2 Realisation of the data

Semi-structured focus group interviews were conducted at a mental healthcare institution as planned. The researcher secured a private room in collaboration with an operational manager. The researcher identified prospective participants with the help of a mediator as planned and informed consent was obtained from the participants. All of the focus group interviews started with the researcher welcoming the participants. They were re-informed about the research topic, ground rules were repeated and ethical considerations were highlighted, such as confidentiality and anonymity. Lastly, the researcher explained difficult terms such as resilience. Although the researcher communicated in English, he gave the participants the opportunity to respond in their language of choice. Most of the participants responded in Setswana and Sesotho. An audio recorder was used to record the interviews for the purpose of a data analysis and the recordings were transcribed *verbatim* and translated into English. To ensure trustworthiness of translations, the researcher used his advantage of being bilingual and adopted dynamic equivalence approach to do the translations (Sutrisno *et al.*, 2014:1340). The researcher selected bilingual person (fluent in English, Setswana, and Sesotho) whom together they corroborated the translation results (Sutrisno *et al.*, 2014:1340).

Four semi-structured focus group interviews (see Appendix J), including the trial run, were conducted for data collection. Brink *et al.* (2012:57) mention that trial runs are viewed as part of the planning phase of a study with the purpose of addressing

problems to improve the study or to make adjustments to how interviews will take place. The researcher conducted a trial run and no adjustments were necessary after a review took place with the research supervisor. The first focus group interview was conducted on 21 September 2015, the second focus group interview was conducted on 13 October 2015, the third focus group interview on 27 October 2015, and the last focus group interview was conducted on 30 October 2015. The researcher informed the participants that all of interviews were audio-recorded and made a request to all of the participants not to mention names when referring to each other. The researcher used data from all of the focus group interviews for the analysis. The field notes (see Appendix K) were divided into three categories, namely descriptive, reflective and demographic notes. These field notes supported the themes and sub-themes and provided a thick description of the data collected (Polit & Beck, 2012:550). The reflective and demographic notes helped the researcher to document interpretive efforts to attach meaning to the observations he made. The data were analysed independently and a consensus meeting was held by the researcher and the co-coder to compare the results (Creswell, 2013:184). Consensus was reached on the research findings and the main themes and sub-themes that emerged from the data (see Tables 3.3.1 and 3.3.2).

### **3.3 Research findings and literature integration**

The research findings were derived from the responses of the participants when they were asked open-ended questions. The researcher asked the participants the following two questions:

- What do you think is your resilience when caring for patients with intellectual disabilities?
- What do you see as your protective mechanisms and vulnerability factors that play a role in your resilience when caring for patients with intellectual disabilities?

These two questions, in combination with probing questions, stimulated lively discussions. Five main themes and related sub-themes emerged from the responses of the participants to these questions (see Tables 3.3.1 and 3.3.2). These themes and sub-themes are discussed in this chapter and illustrated with direct quotations from the participants. Quotations are indicated as “fg” with the number of the focus group and the number of the participant next to it: if the quote was from focus group interview 2,

participant 1, then it is indicated as “fg 2 p1”. If answers were provided in either Setswana or Sesotho, the words were translated into English. The researcher explored relevant literature and integrated literature with the findings of the study.

The findings of this qualitative descriptive inquiry describe the perceptions of the participants on their resilience and protective mechanisms and vulnerability factors that play a role in their resilience while caring for patients with intellectual disabilities. Summative tables of the different themes and sub-themes are provided.

**Table 3.1 Perceptions of the participants caring for patients with intellectual disabilities on their resilience**

<b>Themes</b>	<b>1. The participants use practical wisdom when caring for patients with intellectual disabilities</b>	<b>2. Interactions used by the participants</b>	<b>3. Strategies used by the participants to remain resilient</b>
Sub-themes	1.1 A positive mindset	2.1 Parent-child relationships	3.1 Utilising inductions
Sub-themes	1.2 Self-awareness	2.2 Calmness and politeness	3.2 Willingness to learn
Sub-themes	1.3 Assertiveness	2.3 A safe physical distance and maintaining clear boundaries	
Sub-themes	1.4 Being passionate	2.4 Sympathy and empathy	
Sub-themes		2.5 Providing informal rewards	

**Table .3.2 Perceptions of the participants on protective mechanisms and vulnerability factors that play a role in their resilience when caring for patients with intellectual disabilities**

<b>Themes</b>	<b>4. Protective mechanisms</b>	<b>5. Vulnerability factors</b>
Sub-themes	4.1 Trust in God	5.1 Lack of appreciation
Sub-themes	4.2 Knowing and loving patients	5.2 Impatience
Sub-themes	4.3 Positive peer working relationships	
Sub-themes	4.4 Discipline	

### **3.4 Themes and sub-themes: resilience of the participants caring for patients with intellectual disabilities**

#### **3.4.1 Theme 1: The participants use practical wisdom when caring for patients with intellectual disabilities**

The following sub-themes were identified: a positive mindset, self-awareness, assertiveness and being passionate about their work. These characteristics are not acquired skills, but innately part of the participants and could, therefore, be termed “practical wisdom”. Literature confirms that practical wisdom refers to the tendency of being morally skilful when challenges are anticipated (Moberg, 2007:535). Practical wisdom includes aspects, such as loyalty, self-control, courage, fairness, generosity, gentleness, motivation, friendliness, kindness and truthfulness, which form part of resilience (Aldwin & Igarashi, 2012).

##### **3.4.1.1 A positive mindset**

The participants revealed that exhibiting a positive mindset at work is a practical wisdom that keeps them motivated to go on. Their positive mindset are characterised by feelings of hope towards the future. The participants also shared what motivates them: their love for the patients with intellectual disabilities. They mentioned that even if situations are fraught with difficulties – at home or at work – they make sure that these difficulties do not affect their duty for caring for patients with intellectual disabilities. In difficult situations, the participants prefer to remain hopeful and they choose to ignore or forget their life challenges at home. The participants revealed their positive mindset by mentioning that they want to leave a legacy when working with these patients. In one focus group interview, for example, the participants shared that they feel happy when helping other persons.

The following quotations support the above-mentioned theme:

*Se se ntirang strong ... Ke batla go achive se seng se e leng goreng mo nakong e e tlang at least go bonagale gore ke berekile ka patient. (What makes me strong is that I want to achieve something that in future it can be noticed that I worked with the patient.) (fg 2 p1)*

*Wa itse go itumedisa jang gore e ka re o etsa difference in somebody's life. (You know it*

*makes me happy to make difference in somebody's life.) (fg 4 p3)*

*At least ke contribute something towards another human being. (At least I am contributing something towards another human being.) (fg 4 p1)*

*Ke sone se se re tiisang ... Wa ba missa le go ba missa bana ba. Ka lerato le o le setseng le godile ebile le senang selekano. (That is what motivate us ... these children you even miss them with that grown love that is beyond measurement.) (fg 3 p6)*

Literature supports these findings. According to Cameron and Brownie (2010:69), nurses use optimistic and positive thinking as important characteristics to remain resilient when they experience negative emotions. Nurses appear to be motivated despite the fact that there is no mention of a universal definition of work motivation in nursing research (Toode *et al.*, 2011:256). This motivation of nurses increases the frequency of them showing affection while at the same time their sense of purpose is improved (Burtson & Stichler, 2010:1829). In a study to determine the relationship amongst emotional intelligence, job characteristics, burnout and engagement within a nursing environment in South Africa, it was found that if nurses possess strong self-motivation, they are more dedicated to their work and they are more motivated to accomplish goals – even under difficult circumstances (Nel, 2005:53). Similarly, in a study that was done to determine the prevalence of resilience in a group of professional nurses, nurses manifested high levels of resilience although their feelings about the nursing profession were mostly negative (Koen, 2010:191).

#### **3.4.1.2 Self-awareness**

From the responses of the participants, it was evident that the participants made use of their conscious knowledge of their own feelings and desires as practical wisdom to build their resilience when caring for patients with intellectual disabilities. This conscious knowledge helps them to be aware that they should not return aggressive behaviour when patients display aggressive and challenging behaviour. The participants mentioned that being aware of who they are – their core personality – helps them to care for themselves before they can care for others. The participants acknowledged that when they are caring for these patients, it is true that they can behave inappropriately to such an extent that it makes the participants angry. By being aware of their emotions, the participants highlighted their method of applying self-talk to calm themselves.

The following statements confirm these findings:

*... ke go ipaakanya fela fa o tla mosebetsing ... Sengwe le sengwe se se go tshwenyang ko gae, o se tlogela mo gate. (It's just to correct yourself when you come to work. Everything that bothers you at home, you leave it when you enter the gate.) (fg 1 p4)*

*Ke go ikitse nna. Gore ke motho o o yang. (It is to know myself. What type of person am I.) (fg 2 p7)*

*... o ithata pele, pele ga o rata yo mongwe. Ha o na le lerato go tswa mo go wena, o na le lone mo bathong ba bangwe. (... you have to love yourself first before you can love others. If there is love within you, then you will have same love for others, or patients.) (fg 3 p1)*

*... patient ha e etsa ntho e eleng gore e ya go nkwatisa ... ke nako e e leng gore ke tlamehile gore ke bue le nna pele. Ke diga maikutlo. (If a patient does something that is going to make me angry ... it is the time when I must talk to myself first. I calm down.) (fg 2 p7)*

These findings are supported by literature. Fletcher and Sarker (2013:301) support these findings by confirming that self-awareness was indicated in previous research studies as an aspect that promotes resilience in a working environment. Grafton *et al.* (2010:702) add that self-awareness is needed in nurses to be able to manage their responses when exposed to unavoidable stress and for them to maintain their jobs for an extended period of time. Cooper (2015:38) also mentions that knowing how to manage your emotions is very important to thrive in a nursing profession. Managing emotions by applying a conscious knowledge of their own strengths and weaknesses assists nurses in employing innovative strategies that contribute to the management of stress at work (Zander *et al.*, 2010:101). These innovative strategies include self-awareness as an important characteristic to enhance resilience in nurses (McDonald *et al.*, 2013:137). As a result of applying innovative strategies, nurses are able to recognise when they are negatively affected by stress and are able to manage their own adaptive and maladaptive responses to stress (Epstein & Krasner, 2013:301).

#### **3.4.1.3 Assertiveness**

The participants mentioned that their practical wisdom of being able to express themselves effectively and standing up for their point of view helps them to remain

resilient when caring for patients with intellectual disabilities. They added that they are able to express themselves effectively to reprimand patients who are behaving inappropriately by addressing them directly. The participants also said they face these patients directly and talk to them in an authoritative manner. The participants felt that this firm approach sends a clear message to patients how they feel and they never waver from decisions taken. In addition, they mentioned that not only should they be assertive when speaking to patients, but their assertiveness should also be visible in their scope of practice when caring for patients with intellectual disabilities.

The above-mentioned theme is supported by the following quotations:

*No is no. If the patient does a wrong thing and I realise that he is doing it intentionally, I confront him.* (fg 2 p1)

*O be firm. Ha o re no, ke no. (You must be firm to her. She must know that when you say: "no", the answer is "no".)* (fg 1 p3)

*Ke gore ha o bua le ena, o sa buela ko tlase o le soft. (It means when you talk to her, you must not speak with low voice or softly.)* (fg 1 p4)

*Ha o re no, ke no e felela moo. (When I say no, I mean it. It ends there.)* (fg 2 p1)

*O tshwanetse o nne bonolo. Le ha patient a ka go utlwiswa pelo bothoko. (You need to be polite. Even if the patient hurt you.)* (fg 3 p5)

These results concur with McCabe and Timmins (2006:33) who found that nurses are able to show their knowledge and skills when making use of assertive behaviour at their workplace despite the presence of factors that promote and inhibit the use of assertive behaviour. Similarly, in a workshop conducted to enhance the resilience of nurses, assertiveness was identified as one of the important characteristics that were mentioned by the participants (McDonald *et al.*, 2013:137). These authors mentioned that their participants reported they feel more confident and assertive in their duties after participating in workshops to enhance their resilience. Assertive nurses believe they can handle situations when conflict arises at their workplace or when they believe that some aspects of a work environment can jeopardise the safety of patients (McDonald *et al.*, 2013:138). Moreover, it was also found in research that although nurses are assertive, aspects such as expressing their own sentiment, disagreeing with others and making

suggestions are less frequently used in a work environment (Timmins & McCabe, 2005:66).

#### **3.4.1.4 Being passionate about their work**

The participants identified passion for their work as a practical wisdom and it helps them to remain resilient when caring for patients with intellectual disabilities. Their intense love for their profession made them realise the reasons they are employed to render care to patients with intellectual disabilities and to always remember that. They also mentioned that irrespective of the challenges they face when caring for these patients, their passion for their work helps them to remain resilient. The participants highlighted the necessity of passion for their work, because they spend most of their time at their workplace. When they are passionate about their work, it helps them to get to know their patients – the true nature of each patient. Giving love to these patients and seeing them in a happy mood strengthens their passion and ultimately their resilience.

The above-mentioned finding is highlighted by the following quotations:

*... and then o ba tihaloganye. O be le lerato. O itse gore o tletse eng. O be prepared. (You must understand them. You must have love. You must know why you are here, and you must be prepared.) (fg 2 p7)*

*I think ke tshwanetse ke be le ho rata mosebetsi wa teng. Ha ke rata mosebetsi, ke kgona go tswelapele although dipatient di re etsa metlholo 1, 2, 3 e re leng mo go yone. (I think must love my work. Because if I love my job I can continue although the patients continue to do those things to us.) (fg 3 p3)*

*O rate mosebetsi wa gago and o rate dipatient tsa gago. Because ke mo re tiholang teng mo. (You must love your patients. You must love your work, because that is where we spend most of our time.) (fg 3 p5)*

*Passion for my work. (fg 4 p6)*

*... and e tsamaya le gore o rata mosebetsi wa gago how much, gore o kgone go ba tihaloganya. (It also depends on how much you love your job so that you can be able to understand them.) (fg 2 p6)*

These findings are supported by literature. Koen *et al.* (2013:401) found that passion for own work can be a characteristic of resilient nurses. Their findings also showed that nurses with a high level of resilience were passionate about the nursing profession. Ramalisa (2014:83) explored in her study the resilience of nurses providing mental healthcare to involuntary mental healthcare users and her findings confirm that nurses are passionate about their profession and are proud in reaching their goals. Passion is very important in the lives of individuals, including patients with intellectual disabilities, because passion sends a message of love (Searle, 2009:93). In a study conducted to explore the lived experiences of nurses who care for mental healthcare users, nurses reported that despite their workplace adversities, they remained passionate about their nursing profession (Sobekwa & Arunachallam, 2015:4).

### **3.4.2 Theme 2: Interactions used by the participants**

These interactions include parent-child relationships, calmness and politeness, a safe physical distance and maintaining clear boundaries, sympathy and empathy, discipline and providing informal rewards.

#### **3.4.2.1 Parent-child relationships**

In all four of the focus group interviews, the participants mentioned that their nurse-patient relationships with patients who are intellectually disabled can be viewed as parent-child relationships. From their responses, it was evident that the participants prefer and enjoy this type of relationship with patients who are intellectually disabled. They revealed that they prefer to treat patients with intellectual disabilities the same way they treat their own children. They explained that parent-child relationships are used as a method of interaction between patients and nurses and helps them to be resilient when caring for these patients. The participants also mentioned that they enjoy being called mothers and fathers by the patients – they are reminded on a continual basis of parenthood and their responsibilities concerning their own children at home and their “children” at work.

The following quotations support the above-mentioned findings:

*Obviously o ya go mo treata jaaka ngwana wa gago. (So obviously you are going to treat him like your child.) (fg 1 p1)*

*A re re o ba tsaya jaaka bana ba gago. O ba nka ska bana ba gago or ngwana, ha o ne o le ko*

*gae. (Let's say you treat them like your children or your child if you were at home.) (fg 2 p1)*

*O phela o tsaya fela gore ke ngwana, jaaka re ba bitsa gore ke bana, and then wa mo kgalemela jaaka o mo kgalemela e le ngwana. (You always take him like a child, as we usually call them children ... You reprimand him as you can reprimand your child.) (fg 4 p3)*

*Ga gona ntho e e utlwisang botlhoko jaaka ha re kena ba re bitsa bo mma, bo eng. ntho eo nna e mpha tlotlo e ngwe, and then e mpha maikarabelo a mangwe a ntseng kena le one. Ke gore e a a oketsa ka gore fa ke gopola gore ke tlogetse bana ba ka ko tlong, and gape kena le bana ba bangwe mo gape. (There is nothing as hurtful as when we arrive on duty and they call us mothers, etc. personally it gives more responsibility, in fact it increase responsibilities that I already had ... because when I think that I left children at home and I have children here too.) (fg 3 p6)*

No literature was found to support the existence of parent-child relationships between nurses and patients with intellectual disabilities. This can be viewed as a unique finding of this study. In a study that investigated the characteristics of mental health staff interactions with their patients, Gildberg *et al.* (2010:361) found that nurses tend to regard patients with intellectual disabilities as persons who are not aware of their own behaviour and do not follow rules and that is why nurses focus on the behaviour of patients as “parents”. Alfandre (2012:259) differentiated between “parenting behaviour” and “patient care” – dedication and love are associated with parents compared to education, licensing and training associated with nurses. Briant and Freshwater (1998: 211) explored the concept of boundaries within nurse-patient relationships and concluded that it is common for individuals to intermesh the dynamics of caring relationships from mother-child relationships.

#### **3.4.2.2 Calmness and politeness**

In all four of the focus group interviews, the participants mentioned that when they remain calm and polite during conflict situations, they are able to manage aggressive and challenging behaviour of patients with intellectual disabilities effectively. They agreed that this therapeutic measure enhances their ability to remain resilient in their work environment despite the challenges experienced. The participants highlighted that effective nurse-patient communication, proper interaction and good relationships are

important factors that have significant impact on the quality of nursing care rendered to these patients. The participants provided an example by stating that if nurses become aggressive too when patients with intellectual disabilities show aggressive behaviour, the situation is worsened. In one of the focus group interviews, the participants mentioned that patients with intellectual disabilities do not stay angry for too long.

The following quotations support the above-mentioned sub-theme:

*... behaviour ya ka, e tshontse e be sharp mo di patienteng, ko re, ke sa re ke under risk just because ha ke nna aggressive mo ho bone, like patient e dira dilo tse dingwe tse di ikelang kwa, ha ke a tshwanela ke mo shout. Ke tshwanetse ke bue le e na sentle. (I think I must behave in good manners towards the patients. It means I must not think that I am at risk. I am not supposed to get aggressive towards a patient who do something wrong. I am not supposed shout at him. I must talk to him in a polite manner.) (fg 1 p4)*

*You must be calm and talk to that patient in a polite manner, and you will see later that he will withdraw. (fg 2 p1)*

*... if o ba approach o tshontse o ba approach in a polite manner, ke gore not as they are. Ke gore wena o be cool. (When you approach them, you must approach them in a polite manner, and not as they are. You must be cool.) (fg 4 p1)*

*Like a ke re go na le yo mongwe a ka tsena hela a bo a go roga"... The best thing ke gore o mo ignore, o mo rotolele matlho. (Other one can just come in and swear at you ... The best thing is to ignore him ... just stare at him.) (fg 3 p1)*

Although no literature was found that confirms this finding in healthcare, conflict situations can be handled more effectively when nurses establish harmony by behaving calmly and politely (Konishi *et al.*, 2009:632). A qualitative study explored the views from the perspective of hospitalised children with regard to qualities of "good" nurses and the findings revealed that politeness was identified as one of the most important characteristics of "good" nurses (Brady, 2009:555). These nurses are able to develop quality therapeutic relationships within mental health nursing environments by always being polite (Dziopa & Ahern, 2009:17). This politeness is an effective communication skill necessary for nurses, including being kind and friendly (Waters & Whyte, 2012:18).

### 3.4.2.3 A physical distance and maintaining clear boundaries

There seems to be a common understanding amongst the participants who participated in this study to remain resilient. The participants maintain an appropriate physical distance when interacting with patients who are intellectually disabled. During one of the focus group interviews, one of the participants explained to his colleagues how to maintain a physical distance when interaction takes place between nurses and patients. The participants indicated “a physical distance” as an appropriate therapeutic measure that assists nurses when patients are physically aggressive. It was also evident that the participants were aware of the importance of setting boundaries when interaction takes place between them and patients with intellectual disabilities. The participants mentioned that a physical distance protects them and enable them to continue with their work.

The above-mentioned finding is supported by the following quotations:

*... ha patient eo e tla mo morago gaaka, ke alertenyana. (If the patient is coming behind my back, I am always alert.) (fg 1 p3)*

*... seka wa ba wa ba letlelela gore ba nne mo morago ga gago. Everytime ba nne ko pele ga gago. (... you must never allow them to be behind you, all the time they must be in front. (fg 2 p1)*

*There must be a distance e e rileng, for wena, for in case fa go tlhaga this thing ya fighting. (There must be a certain distance between you and the patient in case a fight broke and among themselves.) (fg 2 p1)*

*Patient DD, o etse gore a seke a, ko gore a go tlwaele. A go rate. Sentle. wa bona gore o dutse kae?. Wa bona gore ke dutse kae?. O sharp ha a le mo o. because go na le nako e ngwe a ka go patreka, a bo a go betsa ka mpama., o sa mo lebelela. (Patient DD must not get used to you. He must love you, in appropriate manner. Do you see where you are sitting? You are at the correct distance. Because there is a time that he can betray you and slap, unexpected.) (fg 2 p1)*

*... ke tshwanetse ke emele kgakalanyana ke tla re motlhomongwe ka moragonyana ka kgona ke buisana le ene ke le mo gaufi. (It means I must stay far away. I will maybe come to him later to talk to him while nearer.) (fg 3 p3)*

Literature supports these findings. In a study conducted to describe and comprehend how fear influences nurse-patient interactions in a psychiatric setting (Jacob & Holmes, 2011:75), the results show that nurse-patient interactions rely on and are changed with regard to the context as well as the types of patients being cared for. Nurses also revealed in this study that in a psychiatric setting, one needs to be on high-alert when rendering nursing care to patients (Jacob & Holmes, 2011:75). When rendering nursing care, Briant and Freshwater (1998:211) concluded that in order to stop the occurrence of inappropriate behaviour, it is important that nurses develop awareness with regard to physical boundaries.

#### **3.4.2.4 Sympathy and empathy**

The participants revealed their feelings of sympathy and empathy as therapeutic factors when caring for patients with intellectual disabilities. They acknowledged the importance of putting themselves in the shoes of other persons – to have an understanding of the condition or situation of patients with intellectual disabilities. They revealed that this therapeutic measure helps them to bounce back and continue with their daily routine. The participants also indicated that they are aware that some of their patients are unable to perform simple tasks, such as bathing and feeding themselves. The participants feel empathy for these patients and their feelings prompt therapeutic interactions to assist these patients.

The following quotations support the above-mentioned theme:

*Nna ke ba kryela jaarmer. Naa bothata ba aka Ke kgona ho mo mamella, ke phole.le ha aka lwana, ha kemo rasetse. Ke a phola ... (I feel sorry for them. My problem is that I can be resilient and relax, even if he can fight. I don't shout at him. I just calm down.) (fg 2 p4)*

*... putting yourself in the situation ... thinking about the condition that they are in. When you see them, just think if it was you on the same situation. (fg 2 p7)*

*... ke na le this empathy ya gore ha a dirile phoso ... ha ke bona a nna emotional, ke setse ke felella. (I have this sympathy for them. Even if he made a mistake ... when I notice that he is becoming emotional, I become powerless.) (fg 2 p2)*

*... probably these patients cannot do anything for themselves. So most of the things*

*as a nurse, you are the one who do them. I think it makes one to always have sympathy and urge to come to work. (fg 4 p4)*

Although no specific literature was found that supports this finding, literature highlights that nurses are able to apply a strategy of compromise to patients who are difficult because relationships are not possible without empathy (Michaelson, 2012:96). In addition to that, Van den Heever *et al.* (2013:6) found that the facilitation of therapeutic relationships between nurses and patients with intellectual disabilities lack a deeper sympathetic understanding. In a study that explored and described the lived experiences of student nurses when caring for patients with intellectual disabilities in a public psychiatric institution, the student nurses empathised with these patients and viewed them as human beings – irrespective of their mental and physical disabilities (Temane *et al.*, 2016:8).

#### **3.4.2.5 Providing informal rewards**

The participants agreed with regard to rewarding patients with intellectual disabilities with anything available to encourage them to change their behaviour and to behave appropriately. Another pattern that is followed with patients who are intellectually disabled, is rewarding them with food to behave appropriately and stay calm. The participants emphasised that handing out informal rewards to patients helps them to work in harmony with their patients on a daily basis. The participants offered several examples of the rewards they normally offer to patients. These rewards are not always physical items, but promises are also made to patients.

The above-mentioned finding is supported by the following quotations:

*... nako e ngwe ke tla bo ke mo bribe ka tsone dijo tse. Ke re ke ye go go direla litara ya kofi. (I can sometimes bribe them with food and asking them not to do wrong things.) (fg 2 p5)*

*Le ha e le gore yo mongwe o tla bo a batla rewardnyana ya gore neh coffee, wa tlhaloganya. Ha e ka re o mongwe a gana go tlhapa pele bikinyana o bo o bolelela gore ha o hetsa go tlhapamo o tllile go apara dia paro tse skone tse dintsha. (Though he would expect at least a small reward like coffee ... if one of them initially refuses to bath, then you tell him that after bathing you will get dressed with clean and new clothes.) (fg 1 p2)*

*... calming them down and whatever he need, you give him immediately. (fg 3 p2)*

*O kgona go mo fa disweets, cigarette, or sengwe le sengwe se se kgonang go dira a be calm. (You can give him sweets, cigarette, or anything that can make him calm). (fg 3 p4)*

Several studies support the above-mentioned finding. In a study that explored the experiences and attitudes of mental health nursing students towards using cigarettes to change the behaviour of patients, 84% of the participants confirmed that they make use of doling out cigarettes to change the behaviour of patients (Nash & Romanos, 2010:686). Similar to this, Ramalisa (2014:75) found that nurses interact with patients to gain their cooperation by sometimes bribing them. The participants also reported that other measures, such as coffee or access to the TV, are used to change the behaviour of patients (Nash & Romanos, 2010:686).

### **3.4.3 Theme 3: Strategies used by the participants to remain resilient**

The participants shared strategies in remaining resilient by utilising inductions and a willingness to learn.

#### **3.4.3.1 Utilising inductions**

The participants revealed that the induction given to them as new employees helped them to be resilient and continue to render care to patients with intellectual disabilities. They also highlighted the importance of inductions rendered informally by nurses who are working with these patients for a long time. The participants find it easier to get to know the patients due to the information provided by experienced nurses. One of the participants underlined the importance of inductions by stating that she nearly resigned on her first day at work after working with these patients and the reduction she received pulled her through.

The following quotations support the above-mentioned theme:

*Ke nagana gore a kere ha re tla mo, ba a re orientate, ba re bontsha dipatients ...(I think firstly when we arrive here, they orientate us and show us the patients.) (fg 1 p1)*

*... when I was appointed here, my first day when I entered the TV room, I felt like leaving immediately. (fg 2 p6)*

*... if I am new I will start to be afraid of them, because I don't know them and I feel they are rough and might be danger to me (fg 3 p2)*

*Manurse a kgale, they help you out. Ba a tseba gore patient e na, ga e rate 1, 2, 3 ... (Nurses who have been working for a long time can help you because they knows that this particular patient.) (fg 1 p3)*

This finding is supported by literature. An induction process is essential in guiding new employees to understand the culture and practice of an institution (Maguire, 2013:649). An induction helps them to be more comfortable in rendering quality services. Although induction processes differ, a good induction provided at the beginning of employment can influence the self-confidence of individuals positively and resilience is enhanced (Maxwell *et al.*, 2011:433). An induction increases the job satisfaction of nurses by impacting positively on occupational health and as a result, commitment to their work is increased (Kamau *et al.*, 2015:308). In a study that investigated the impact of inductions in mental health nursing, Kamau (2014:381) revealed that inductions that take the form of in-service training, improve job performance and influence the attitude of mental health nurses positively – leading to lower levels of job-related stress. A supportive work environment characterised by informal inputs from role models is able to reduce feeling overwhelmed by responsibilities in the daily work situation of nurses (Bjerknes & Bjørk, 2012:5).

#### **3.4.3.2 Willingness to learn**

The participants mentioned that they empower themselves by reading the files of patients. By reading the files of patients, they obtain insight about the patients they are caring for, their level of intellectual disability, and the reasons for the way they are behaving in a certain way. The participants also revealed that with time, they get to know their patients better and learn more things about them even though they did not receive formal psychiatric training. They also mentioned that some of their patients are very intelligent, and as they try to learn about them, the patients too are busy learning about the staff. Learning more about the patients helps them to resolve the problems so that it must not reoccur. This is one of the strategies that they use and helps them to be resilient.

The following quotations support the above-mentioned theme:

*Re bala di faele tsa bone. Then wa bona gore bamo scorile gore kelello ya gagwe ke ya ngwa yo mo kae. (We read their files and check how much is the patient scored regarding the level of intellectual disability.) (fg 1 p1)*

*...reinforcing yourself, going back, trying to understanding what caused the patient to do things that ... (fg 2 p2)*

*But when time goes on, then that thing eo, ke a ba ithuta, ke a ithuta le nna, even though ke sa etsa psych. (When time goes on, I get to know them and I start to learn also, even though I am not trained for psychiatry.) (fg 3 p2)*

*Thuto e ntsi mo baneng ba. Re ithuta go le gontsi mo baneng ba. (Learning is abundant from these patients. We learn a lot from these patients). (fg 3 p1)*

*Sometimes you must check for the cause of his aggression so that it can be avoided (fg 4 p2)*

Literature supports this finding. Nurses with a high resilience use positive coping skills, such as identifying resilient role models to learn from them, to enable them to continue working in a stressful environment (Mealer *et al.*, 2012b:1449). This attitude of willingness to learn, and in combination with support from co-workers, help nurses to rise above daily challenges experienced in a stressful environment (Jose, 2011:127). Despite having to deal with a stressful environment, resilient individuals are proactive learners who learn from their successes and failures, and they rather focus on their strengths than on their weaknesses (Cope *et al.*, 2014:92). When individuals are prepared to deal with challenges ahead, unnecessary stress is prevented (McAllister *et al.*, 2011:3). To be prepared to deal with challenges means that nurses are able to learn to manage their workplace environment and to develop strategies that assist them to remain resilient (Jackson *et al.*, 2011:105).

### **3.4.4 Theme 4: The perceptions of the participants on protective factors that play a role in their resilience when caring for patients with intellectual disabilities**

Protective factors used by the participants include trust in God, knowing and loving their patients, and positive peer relationships.

#### **3.4.4.1 Trust in God**

The participants mentioned in all of the focus groups interviews their trust in God through continual prayer. According to them, God is their protector who they rely on. They added that God always gives them strength to remain resilient despite the difficulties they encounter when caring for patients with intellectual disabilities. The participants revealed that all the staff members pray together in the morning before they start their work. They feel that without God, they cannot perform their tasks, because God provides them with the power to do their job well. They emphasised that prayer is part of their daily lives.

The above-mentioned finding is supported by the following quotations:

*Ha o tla mosebetsing le ha o fitlha mo mosebetsi wa re ke a go leboga morena ka gore o ntlosetse ko gae wa mphitlisa mo. A ke tseye gore thapelo, ha rebele ramasedi ko pele, everything is alright. Modimo o re fa maatla and ke ena a re phedisang gore re tle mosebetsing, a re fang le tsoselletso eo gore le vandaga se, re be re santse re tswelotse ka mosebetsi. (When you come to work and also when I arrive at work, you say thank God that he took me from home and brought me here. Let me say prayer, when we put God ahead of us, everything is fine. God give us power. He gives us strength to come to work, so that even today we are still working.) (fg 3 p1)*

*Sometimes when you go mo diwardeng tse dingwe, you will get go a rapelwa before ba starta ka mosebetsi. (Sometimes when you go to other wards, you will see people pray first before starting to work.) (fg 2 p1)*

*... ya thapelo e a mperekela and e mperekela ka metlha le matsatsi ka gore ha ke tswa ke a rapela, and then ke a kopa ka gore nna ga kena maatla. (Of prayer because I saw that it works for me. It works for me forever because when I leave I pray. I make a plea from God because I don't have strength.) (fg 3 p4)*

*... I always pray ha ke tla mosebetsing. (I always pray when I come to work.) (fg 4 p7)*

Literature supports this finding. In a study that explored the work-faith integration amongst Christians, the findings revealed that people bring their entire selves to work (Lynn *et al.*, 2011:694). In a descriptive survey conducted to explore the views of nursing practitioners with regard to the role of spirituality in nursing practice and education, Chandramohan and Bhagwan (2015:6) found high levels of personal religiosity and spirituality amongst South African nurses. These nurses indicated a need to be provided with workplace spirituality to help them love their job and to continue working without quitting (Altaf & Awan, 2011:99). If nurses have access to spirituality at work that allows them freedom of action, then perhaps the quality of nursing care rendered can increase (Shabani *et al.*, 2016:1).

#### **3.4.4.2 Knowing and loving patients**

The participants emphasised the importance of knowing and loving their patients. They mentioned that it helps them to respond effectively to the needs of patients. They added that when they know their patients, it makes things easier for them to understand the behaviour of patients and to respond appropriately – they know what to expect. They view their knowledge of patients as a professional strength that protects them and enable them to remain resilient and to continue rendering care to patients with intellectual disabilities. Through this professional strength, they can love their patients and help them without being scared.

The following quotations support the above-mentioned theme:

*You must know the patient, and you must know what to do as a nurse when the patient is acting on that particular manner. (fg 2 p2)*

*Dipatient tsa rona di difficult. And if di le difficult, o tlamehile wena o itse patient. Wa bona? O itse behaviour ya patient. And then behaviour ya patient, o tlamehile o itse gore o mo calm down how. (Our patients are difficult. As they are difficult, then you supposed to know your patient. Do you see it? You must know his behaviour and know how to calm him down.) (fg 3 p2)*

*Gape le resilience e busiwa fela ke gore ha o tlile mmereko, o a itse ha o tswa ko o nnang ko*

*teng, o tla o itse gore o tla ko bathong ba ba ntseng jang. (Again what makes resilience is when you came to work, you know exactly from where you stay, knowing what type of patients you are working with.) (fg 4 p3)*

*Ke go itse se o se etsang. Ke go itse mmereko wa gago. Go a go thusa. (It is to know what you are doing. To know your work. It helps you.) (fg 4 p5)*

*... ha bana ho ho ntsha dikotsi ka hore ba a nrata le nna ke a ba rata. (They won't cause harm on me because I love them and they love me too.) (fg 3 p3)*

*... and le lerato la ka for bone. Ke ba rata like bana ba a ka. (... and also my love for them. I love them the way I love my children.) (fg 4 p7)*

*Obviously mo gare ga dipatient re a ba rata botlhe, maar go na le wa gago o o tlileng go mo itlhopelang, o o tlileng go mo rata go ba feta botlhe. (Although we love them all, there would be one specific patient that you will select. You will love her more than other patients.) (fg 1 p1)*

*Ha o ka bona ... wa tshoga. But ga ke batle go go bolelela maaka, ha o ka mo ithuta, o tlile go go tlwaela, lo tlile go ratana. (If you can see ... you will get afraid. But I don't want to lie. If you can get to know him, you will get used to him and you will love each other.) (fg 2 p6)*

Literature was found that highlights this core aspect of the participants dealing with their patients. Zolnierek (2014:7) maintains that knowing patients involves a very personal process within auxiliary nurses, which include thoughts, an awareness, experiences and reflections. Bundgaard *et al.* (2012:2287) are of the opinion that knowing patients is important because it helps nurses to restrict their efforts to the needs of patients and allows them to render care to patients as unique individuals. Rendering care with love and seeing to the needs of patients are key characteristics of resilience identified in nurses in a study that explored why nurses chose to remain in the Western Australian workforce (Cope *et al.*, 2014:91).

#### **3.4.4.3 Positive peer working relationships**

The participants highlighted the importance of working in harmony with their peers. They view positive working relationships with peers as a strength that empowers them

to bounce back despite adversities and to continue rendering nursing care to patients with intellectual disabilities. The participants emphasised team work and cooperation as important factors that give them strength to continue with their job. One of the participants revealed that it makes her happy when she knows the persons who are working with her, because then they can help each other. The importance of communication was also mentioned by the participants. One of the participants shared how frustrating it can be when she has to work with someone and they are not on good terms.

The above-mentioned finding is supported by the following quotations:

*Working harmoniously with others ... (fg 2 p1)*

*Hape ke nahana le ha o sebetsa le colleague ya haho, le tshwanetse le be team e one, gore le kgone go thusana mo bothata bo leng teng. (Again I think when you work with your colleague you must be a one team, so that you can help each where there is a problem.) (fg 4 p7)*

*... ha lo le manurse, lo communicatana, go sena dikgogakgogano, mosebetsi o nna easy, le dipatient di nna easy. (If you as nurses communicate well, with no arguments, the work becomes easy and the patients become controllable.) (fg 3 p1)*

*Ke sone se se re tiisang. Kgotlelelo le team work. Ha le berekisana. (That is what makes me strong – perseverance and team work. It is when you work together harmoniously with your colleague.) (fg 3 p6)*

Literature supports this finding. In a study that investigated how nurses in relationally demanding jobs viewed work engagement combined with their experiences in terms of maintaining engagement, nurses regarded their fellow-nurses as the most important resource suitable to adapt to work conditions in order to remain resilient (Bjarnadottir, 2011:32). Shirey (2012:181) found that support from fellow-nurses and individuals allows nurses to function resilient. This positive view of a working environment (Emold *et al.*, 2011:362) helps to protect nurses against emotional exhaustion. Similarly, in a workplace (particularly a long-term care setting), it is possible for employees to experience companionate love at their workplaces, which may result in important outcome for both employees and clients (Barsade & O'Neill, 2014:587).

#### 3.4.4.4 Discipline

The participants mentioned that another form of protective mechanism that they use when caring for with patients who are intellectually disabled is by implementing disciplinary measures that help them to take control of these patients. The participants stated that they discipline patients who display unruly behaviour. They added that sometimes they make use of the assistance of other patients to ensure appropriate behaviour. When the participants notice that patients do wrong things intentionally, they would discipline these patients. They mentioned different disciplinary measures that they usually implement. In one of the focus group interviews, the participants mentioned that sometimes they refuse to give patients their meal when they did something wrong. They also mentioned that to discipline patients appropriately, helps them to keep situations under control in wards.

The following quotations support the above-mentioned theme:

**... Whenever ha a sokodisa fela, o tla bo o bitsa patient o one, o e le gore o tough, and wa itse gore le ena wa mo tshaba.** (*When the patient becomes unruly, you just call one patient, the one that you know that he is fearsome by other patients.*) (fg1 p3)

**... Because they know that if he does something wrong, he will get certain form of punishment.** (fg 1 p2)

**... patient ha e entse hosa, discipline. Wa itse hona le di patient tse tje ka batho. rona yaanong re ba solve ka hore tje ka a entse bothata, hona le ntho e a e entseng, o mo tima dijo. A ka setlhole a e entse hape ntho eo.** (*If the patient has done something wrong, I discipline him ...you know that there are those patient who are just like normal people. we solve him by not giving him his food. After that, he won't repeat the same mistake.*) (fg 2 p4)

**... like ha patient a etsa wrong thing and ke bona gore o, o etsa ka bomo, ke go bolelela ke re ntate, bona,dijo tsone ga ke go time. Ke tla go fa tsone sentle. But net one thing for sure, o tla tshwara lebota and le seka la ba la wa. O tla tshwara lebota for few minutes. Fa dijo ditla, ke tla go fa tsone.** (*If the patient do*

*a wrong thing and I realise that he is doing it intentionally I tell him that I won't refuse you with your food but one thing for sure is that you will hold a wall and make sure it doesn't fall down.) (fg 2 p1)*

*... once o kena ngwana a go fa smile, then wa itse gore ngwana o itumetse. Then o mongwe once e re ke re nurse e ngwe e e tlhola a mo betsa a kena, wa sulafalelwa. (When you arrive and notice that she gives you a smile, then you would know that she is happy. But when the nurse who usually beat him arrives in the ward, you will notice the child becoming sad.) (fg 3 p2)*

Limited empirical evidence is available that support disciplining of patients as protective mechanism for nurses. However, Campbell *et al.* (2015:1) found that nurses may decide to punish patients who do not live up the 'good patient persona of being obedient, polite, listening or behaving appropriately. Again, in a qualitative survey to examine violence in nursing, 94,9% of the participants reported that they have witnessed prejudice nursing interventions, and they have also witnessed situations where nurses refused to render care because of the behaviour of patients (Khalil, 2009:440). Similar situations of unfair treatment of patients are acknowledged by auxiliary nurses, who believed that physical abuse towards patients was unacceptable, but punishment and control strategies were seen as acceptable (Lee-Treweek, 2008:110).

### **3.4.5 Theme 5: The perceptions of the participants on vulnerability factors that play a role in their resilience when caring for patients with intellectual disabilities**

Vulnerability factors include a lack of appreciation and impatience.

#### **3.4.5.1 A lack of appreciation**

The participants mentioned they are unable to handle situations when poor communication is used, usually caused by a lack of appreciation and when individuals do not listen properly. These situations cause the participants to lose focus and their resilience is weakened when they care for patients with intellectual disabilities. The participants are of the opinion that demoralisation is a huge risk factor that influences their work performance and resiliency. They revealed that sometimes they feel disheartened at work for not being rewarded with bonuses or not being valued by their

supervisors. They tend to lose focus and their resilience is weakened. The participants shared that sometimes they go through adverse circumstances due to the nature of their work, but their supervisors never recognise or acknowledge the challenges they face and instead focus on mistakes that occur during difficult times. One adversity that the participants mentioned is when they are faced with a high workload due to high volumes of patients in a ward or a lack in staff members.

The above-mentioned finding is supported by the following quotations:

***Some, e ka nna gore maybe like e le rona staff re le babedi, communication ya rona between the two e sa utlwagale. (Maybe it can be both of us as staff members not having good communication between us.) (fg 1 p2)***

***Ha o bereka mo tlase ga motho yo o sa go tshwarang sentle le wena ha o tla yana, o tlhaga ka ntho eo. (When you are working under the supervisor who does not treat you well, you end up coming with that bad attitude.) (fg 3 p5)***

***Nako e ngwe ke ha o sa relate sharp le batho ba o berekang le bone. It makes go tla gago mo mmerekong difficult. (Sometimes it's when you are not in good relationship with your colleague. It makes your coming to work very difficult.) (fg 4 p4)***

***... like something se se tshwanang le dilo tse tsa di performance bonus tse ... ha o tla mosebetsing o gopola gore waitse ke eng? Ga go thusi. Year in year out, batho some ba kryiya something. Wena ga o kgone. Ya go demoraliza somewhere somehow. (Something like PMDS. When you come to work and you begin to have this idea that it doesn't help, because every year same people gets bonus. It demoralise you somewhere somehow.) (fg 1 p2)***

***Nako e ngwe ga ba re appreciate. O dirile sentle, maar phoso e nyane ba e dira tona ha o tla go nagana gore o fitile mo nthong e tona tona jang. Ha a e bone stokinyana se se kana. (Sometimes they don't appreciate us. when you think about the difficult situation that you passed through, but instead they turn blind eye on that. It makes your day a hell.) (fg 3 p2)***

Literature confirms this finding. In a study conducted to explore the lived experiences of nurses who care for mental healthcare users, the nurses felt unappreciated by their supervisors (Sobekwa & Arunachallam, 2015:7). This issue of not being given the

necessary support by supervisors was also mentioned by participants in a study that identified – from the perspectives of nurses – occupational stressors and ways in which they can be reduced (Happell *et al.*, 641). A lack of support was also felt by nurses in a study when they mentioned they were regarded and treated by their authorities as worthless to the organisation (Kristiansen *et al.*, 2006:250). When nurses are provided with adequate support with regard to appreciation, it can lead to resiliency (Shirey, 2012:552).

### 3.4.5.2 Impatience

The participants revealed that in some days, they would run out of patience due to some work-related factors. They mentioned that this impatience put them at vulnerable to impulsive decisions. They revealed that their impatience is usually triggered by work-related factors, such as poor relationships with supervisors, a shortage in staff members and a high workload. They shared that their supervisors sometimes do not assist them even if they are aware that they are working long hours due to the absence of co-workers. When their supervisors pay them no heed, the participants sometimes lose their temper or stay at home. The participants revealed that their temper is sometimes unleashed unintentionally towards patients. The participants feel vulnerable when they are impatient at work and their resilience in caring for these patients is affected negatively.

The following quotations support the above-mentioned theme:

*... o theogetse maar ga a mphe break. O tla bo o feleletsa o nna short tempered. (She is on duty too, but she is not giving me a break. You will end up being short tempered.) (fg 1 p2)*

*A ke re o tlile go feleletsa o lofa le wena. Just because motho yo o berakang le ene. (Isn't it that you will end up absenting, because of your colleague.) (fg 1 p4)*

*... nako e ngwe kena le go felelwa ke pelo. Sometimes e le gore patient e go kgotle kgakala. (... Sometimes I lose temper. There are times when patient irritate you too much.) (fg 2 p6)*

*I try to do something and she doesn't help me. She just leaves me. It means that I am not better. She just leaves you and ignoring the issue to grow until you get angry. (fg 3*

p1)

*Ha o na le bothata and o be o gopola gore ke the very same supervisor, o feletsa o tlogela go kopa thuso (whenever you encounter problems and you remember that it is the very same supervisor, you end up being unable to ask for help). (fg 4 p7)*

This finding is confirmed by literature. Abdalrahim (2013:35) conclude that nurses experiences workplace stress that can lead to poor daily functioning such as impatience. This sign of job dissatisfaction is triggered by social factors, such as a poor working relationship, and organisational factors, such as a lack of resources (Molefe & Sehularo, 2015:476). The consequences of these work-related factors is impatience on nurses as one of the emotional symptoms of workplace stressors (Lambert & Lambert, 2008:39). Abraham and D'silva (2013:92) also refers impatience, as one of the personality traits on nurses that put nursing profession at more risk to stressors. These stressors sometimes trigger unethical conduct in auxiliary nurses, such as impatience, lack in self-control and aggressiveness and short-temperedness (O'Donoghue *et al.*, 2004:85).

### **3.5 Summary**

Research findings pertaining to the resilience of auxiliary nurses caring for patients with intellectual disabilities were presented in this chapter. The researcher drew comparisons between the data and existing literature. In addition, support to the findings in the form of direct quotations from the transcripts was provided. Themes and sub-themes identified during the semi-structured focus group interviews were discussed. The next chapter concludes the study. The limitations, conclusions and recommendations are discussed.

## **CHAPTER 4: LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS**

### **4.1. Introduction**

In the previous chapter, research findings are discussed and a literature integration took place. The findings are supported with direct quotations provided by the participants during the focus group interviews. In this final chapter, the study's limitations, conclusions and recommendations are discussed. The conclusions provide evidence that the purpose of the study, namely to explore and describe the perceptions of auxiliary nurses caring for patients with intellectual disabilities on their resilience, as well as the protective and vulnerability factors that play a role in their resilience when caring for these patients was reached. Recommendations for nursing practice, nursing education and nursing research are formulated.

### **4.2. Limitations of the research**

Although this research provides a rich discussion on the resilience of auxiliary nurses caring for patients with intellectual disabilities, some limitations of the study should be noted that can have potential implications on the interpretation of the findings. The following limitations were identified by the researcher:

- ❖ Although the researcher planned to conduct the semi-structured focus group interviews in English (an inclusion criterion), he allowed the participants to communicate in their own language on their request. This can be viewed as a limitation, because some prospective participants were excluded who actually could have participated. Also, there was a risk that the meaning of discussions was lost in translation. A safety measure was, therefore, put in place. Firstly, caution was taken because all the participants who consented to participate in the study were able to hear Setswana and Sesotho. Secondly, the researcher selected bilingual person (fluent in English, Setswana, and Sesotho) whom together they corroborated the translation results. (Sutrisno *et al.*, 2014:1340).
- ❖ A small sample was used in the research study. All of the participants who participated in the semi-structured focus group interviews were from the same mental healthcare institution. Because the study was done with the aid of

participants from a single mental healthcare institution, the generalisation of these findings to other mental healthcare institutions should be done with prudence.

- ❖ During the focus group interviews some of the participants were outspoken and others were shy. This can have an influence on the results, because the persuasive participants can cause other participants to change their original opinions or prevent them from revealing important insights, especially when their thoughts opposed the views of others. Peer pressure can, therefore, influence the answers provided by the participants. A safety measure to counter this limitation was used. Data-collection took place until data saturation was reached.

### **4.3. Conclusions**

The conclusions are based on the research findings discussed in chapter 3 and on relevant literature provided.

#### **4.3.1 Overall conclusion**

Although research regarding the resilience of nurses exists in literature, limited research on the resilience of auxiliary nurses caring for patients with intellectual disabilities is available. The present study revealed that auxiliary nurses view resilience as the application of their practical wisdom (a positive mindset, self-awareness, assertiveness, and passion) when caring for patients who are intellectually disabled. They also perceive protective mechanisms (trust in God, knowing and loving patients, positive peer working relationships, and disciplining patients) to play a role in their resilience when caring for these patients. However, it is evident from the findings that not all of these protective mechanisms are effective. For example disciplining of patients is not constructive at all. Their practical wisdom and protective mechanisms help auxiliary nurses to apply strategies (utilising inductions and a willingness to learn) to keep the best interests of patients with intellectual disabilities at heart.

They also make use of different forms of interactions to provide nursing care to patients with intellectual disabilities, namely a parent-child relationship, calmness and politeness, maintaining a safe physical distance and clear boundaries, sympathy and empathy, and providing informal rewards. However, again it is evident from the findings that not all of these interactions are effective. For example, forms of interactions, such as sympathy

versus empathy and providing informal rewards, are possibly not constructive in the long term. It is important to take note that auxiliary nurses use positive strategies, such as a willingness to learn and a positive attitude towards an induction, to remain resilient. However, vulnerability factors (a lack of appreciation and impatience) dishearten the auxiliary nurses and limit their ability to interact in an effective manner with patients who are intellectually disabled.

When applying the meta-theoretical assumptions of the researcher, namely the nursing theory for the whole person (Rand Afrikaans University, 1992:7), to the findings – see the discussion in chapter 1 – it was evident from the perceptions of the auxiliary nurses caring for patients with intellectual disabilities that protective mechanisms and vulnerability factors play a role in their resilience and that they draw strength from their internal environment (body, mind and spirit). It is further evident that vulnerability factors are present in both their internal environment (impatience) and their external environment (a lack of appreciation). Protective mechanisms and vulnerability factors interact in their internal and external environment to play a role in their resiliency.

#### **4.3.2 Specific conclusions**

##### **4.3.2.1 Conclusion regarding the perceptions of auxiliary nurses caring for patients with intellectual disabilities on their resilience**

The perceptions of auxiliary nurses caring for patients with intellectual disabilities on their resilience are that their practical wisdom enables them to remain resilient. Secondly, their interactions with these patients contribute to their resiliency. Lastly, their perceptions on their resilience are related to strategies that contribute to their resiliency (see conclusions below for more detail).

##### **4.3.2.2 Conclusion regarding the perceptions of auxiliary nurses caring for patients with intellectual disability patients on protective mechanisms and vulnerability factors**

The perceptions of auxiliary nurses on protective mechanisms and vulnerability factors play a role in their resilience when caring for patients who are intellectually disabled. Firstly, they perceive their trust in God, knowing and loving their patients and positive peer working relationship as part of protective mechanisms that play a role in their

resiliency. Secondly, they view a lack of appreciation and impatience as vulnerability factors that play a role in their resilience when caring for these patients.

#### **4.3.2.3 Conclusion regarding the perceptions of auxiliary nurses caring for patients with intellectual disabilities about their practical wisdom**

Their practical wisdom enables the auxiliary nurses to know when to act and how to act and this knowledge enhances their resiliency. It can be concluded that their positive mindset is uniquely embedded in their sense of purpose. They want to make a contribution; they want to make a significant difference in the lives of patients with intellectual disabilities. With a positive mindset; self-awareness, a conscious knowledge of their own emotions and reactions towards patients can be applied in managing themselves and can enhance their resiliency. A positive mindset helps them to be assertive in caring for patients with intellectual disabilities by being able to handle conflict situations. Lastly, their positive mindset is influenced by strong feelings of love for their profession. This passionate love for their work increases their level of resilience despite the daily challenges they face at work.

#### **4.3.2.4 Conclusion regarding the perceptions of auxiliary nurses caring for patients with intellectual disabilities about their interactions with these patients**

Based on the perceptions of auxiliary nurses with regard to their interactions with patients who are intellectually disabled, they prefer to establish parent-child relationships with their patients in order to remain resilient. However, when they treat their patients as children, it makes it difficult to differentiate between the dynamics of caring for patients and caring for their own children. The auxiliary nurses prefer calm and polite interactions between themselves and their patients to foster a harmonious atmosphere and to develop quality therapeutic relationships – even by offering patients informal rewards. They also try to maintain harmony by staying alert, by keeping an appropriate physical distance between themselves and patients, and maintaining clear boundaries.

Although an appropriate physical distance is kept, the auxiliary nurses continue to interact with their patients by offering them support when needed. Support is usually characterised by empathy even if their patients are challenging. The auxiliary nurses view their patients as human beings – regardless of their mental disabilities.

#### **4.3.2.5 Conclusion regarding the view of auxiliary nurses caring for patients with intellectual disabilities on strategies they use to remain resilient**

Firstly, the auxiliary nurses perceive inductions and their willingness to learn as helpful strategies to remain resilient. They utilise informal inductions from their experienced peers to get to know their patients better. These induction processes improve their self-confidence and their resiliency. Secondly, their willingness to learn about intellectual disabilities helps them with caring for their patients and ultimately, they are able to rise above their daily challenges despite the adversities experienced at their workplace. Their resilience while caring for patients with intellectual disabilities is determined by the way they interact with their internal and external environment. Their internal environment (mind) refers to their willingness to learn, and their external environment refers to inductions from their experienced peers.

#### **4.3.2.6 Conclusion with regard to the view of auxiliary nurses caring for patients with intellectual disabilities on protective mechanisms that play a role in their resiliency**

The auxiliary nurses view protective mechanisms as playing a role in their resilience when caring for patients with intellectual disabilities. Their protective mechanisms are prompted by the interaction between their internal environment (strength to know and love for their patients) and external environment (God). It can be concluded that their trust in God is a source of hope for protection against unforeseen circumstances. They trust God to give them strength to know and love their patients in order to understand the needs of their patients better. Their trust in God (external environment) also helps them to develop positive peer working relationships amongst themselves and these relationships promote harmony at work. When they experience harmony at work, they feel protected and these feelings add to their resiliency. However, when their patients make mistakes intentionally, they discipline the patients by applying prejudice nursing interventions or unfair treatments.

#### **4.3.2.7 Conclusion regarding the view of auxiliary nurses caring for patients with intellectual disabilities on vulnerability factors that play a role in their resiliency**

The auxiliary nurses are of the opinion that vulnerability factors, such as a lack of appreciation and impatience play a role in their resilience when caring for their patients.

It can be concluded that a lack of appreciation (external environment) by their supervisors dishearten them. Work-related factors play a role, such as poor communication, a high work load and a shortage in staff. They feel worthless when they do not receive the necessary support and this often leads to impatience (internal environment). When they lose their temper, they become vulnerable as their resilience is negatively affected – leading to job dissatisfaction and poor nursing care.

#### **4.4 Recommendations**

Based on the research findings and the conclusions, the following recommendations for nursing practice, nursing education and nursing research are formulated.

##### **4.4.1 Recommendations for nursing practice**

Recommendations for nursing practice include the strengthening of the resilience of auxiliary nurses. These recommendations are outlined in Table 4.4.1 and the results and conclusions are provided on which these recommendations are based.

Based on the research findings, the following recommendations are made in general:

- Aspects that threaten the resilience of auxiliary nurses (not being appreciated and being impatient) should be given urgent attention by nursing managers and supervisors (see Table 4.4.1 below for more detail).
- Fostering resilience in workplaces through the introduction of informal peer support amongst auxiliary nurses is recommended – especially to novice auxiliary nurses.
- This study identified ethical implications that need to be addressed. This pertains to the application of disciplining measures to modify the behaviour of patients with intellectual disabilities (see Table 4.4.1 below for more detail).
- Appropriate nurse-patient communication should be improved and can have a significant impact on the quality of nursing care.

**Table 4.1 Recommendations to strengthen resilience**

Recommendation	Results	Conclusion
a) Acknowledge the positive mindset of auxiliary nurses – they have hope for the future and they continue to make a difference in the lives of patients with intellectual disabilities.	<b>Theme 1</b> sub-theme 1.1	Overall conclusion (see 4.3.1) and specific conclusion (see 4.3.2.1).
b) Encourage their sense of self-awareness so that their conscious knowledge can help them to correct themselves during difficult times e.g. skills training using self-awareness techniques such as the Johari window.	Sub-theme 1.2	Overall conclusion (see 4.3.1) and specific conclusion (see 4.3.2.3).
c) Strengthen the assertiveness of auxiliary nurses. They should be consistent in sending clear messages about how they feel. This can be practised in role-play, by teaching them how to stand up for themselves or for other people’s rights in a calm way without being aggressive or passive.	Sub-theme 1.3	Overall conclusion (see 4.3.1) and specific conclusion (see 4.3.2.3).
d) Acknowledge the passion of auxiliary nurses for their patients. Continually remind them of the reasons why they are employed here and highlight the fact that they spend most of their time at work.	Sub-theme 1.4	Overall conclusion (see 4.3.1) and specific conclusion (see 4.3.2.3).
e) Conduct in-service training and discuss the potential implications of treating patients like your own children in nurse-patient relationships and help auxiliary nurses to differentiate between love for your own children and love for your patients. These training should also include aspects and skills like therapeutic boundaries.	<b>Theme 2</b> Sub-theme 2.1	Overall conclusion (see 4.3.1) and specific conclusion (see 4.3.2.4).
f) Acknowledge their calm and polite interactions – it is effective in managing aggressive and challenging behaviour of patients with intellectual disabilities and it prevents situations to escalate.	Sub-theme 2.2	Overall conclusion (see 4.3.1) and specific conclusion (see 4.3.2.4).

g) Acknowledge their interactions with patients by keeping safe physical distances and maintaining clear boundaries between themselves and patients. These measures keep them safe especially when patients are physically aggressive.	Sub-theme 2.3	Overall conclusion (see 4.3.1) and specific conclusion (see 4.3.2.4).
h) Acknowledge the communication skills of auxiliary nurses when they have empathy with patients who are intellectually disabled. Conduct training to explain difference between empathy and sympathy and encourage the use of empathy rather.	Sub-theme 2.4	Overall conclusion (see 4.3.1) and specific conclusion (see 4.3.2.4).
i) Conduct in-service training and discuss with auxiliary nurses effective and most appropriate ways of interacting with patients who are intellectually disabled by providing informal rewards, for example token systems, reward systems that are controlled. Maybe small presents or sweets can be used as rewards that can be requested from voluntary organisations, families or friends of the institution.	Sub-theme 2.5	Overall conclusion (see 4.3.1) and specific conclusion (see 4.3.2.4).
j) Acknowledge auxiliary nurses for applying knowledge and skills that they acquired during induction processes. Nursing managers should acknowledge the help of experienced auxiliary nurses and professional nurses who can induct them on the correct way of doing things.	<b>Theme 3</b> Sub-theme 3.1	Overall conclusion (see 4.3.1) and specific conclusion (see 4.3.2.5).
k) Strengthen the willingness of auxiliary nurses to learn by encouraging them to learn through in-service training, and also by reading the files of patients with intellectual disabilities so that they can understand the reasons why patients act in a particular way.	Sub-theme 3.2	Overall conclusion (see 4.3.1) and specific conclusion (see 4.3.2.5).
l) Provide auxiliary nurses with an opportunity to pray before they start to work. Allocate a private room where they can pray. Nursing managers should continue to invite religious pastors (provided it is acceptable to all religions) to their institution to revive the spiritual strength of auxiliary nurses and to enhance their resilience.	<b>Theme 4</b> Sub-theme 4.1	Overall conclusion (see 4.3.1) and specific conclusion (see 4.3.2.5).
m) Acknowledge the efforts of auxiliary nurses to get to know and love their patients. When auxiliary nurses know their patients, it becomes easier to respond to their needs. Nurses will feel safe and protected and	Sub-theme 4.2	Overall conclusion (see 4.3.1) and specific conclusion (see

will enjoy spending time with their patients.		4.3.2.6).
n) Strengthen positive peer working relationships to promote team work, cooperation and communication to improve harmony in the work place e.g. team-building exercises	Sub-theme 4.3	Overall conclusion (see 4.3.1) and specific conclusion (see 4.3.2.6).
o) Discourage the disciplining and mistreating of patients with intellectual disabilities. Nursing managers can do this by: <ul style="list-style-type: none"> <li>• Conducting in-service training to explain the ethical implications of mistreating patients.</li> <li>• Introducing an annual event where all of the nurses should re-affirm the <b>Nurses' Pledge</b> to remind themselves of their moral obligations.</li> <li>• Introducing other ways of changing/addressing patients' unacceptable behaviour such as behavioural programmes</li> </ul>	Sub-theme 4.4	Overall conclusion (see 4.3.1) and specific conclusion (see 4.3.2.6).
p) Nursing managers and supervisors should acknowledge the value of auxiliary nurses by appreciating the work they do. This will reduce vulnerability to workplace adversities and will promote self-care and the development of resilience.	<b>Theme 5</b> Sub-theme 5.1	Overall conclusion (see 4.3.1) and specific conclusion (see 4.3.2.7).
q) Nursing managers and supervisors should assist auxiliary nurses in learning how to adapt to adversities in workplaces and stressful life events without losing patience.	Sub-theme 5.2	Specific conclusion (see 4.3.2.7).

#### **4.4.2 Recommendations for nursing education**

The Nursing Act (33 of 2005) stipulate that the objectives of nursing education are to prepare student nurses to function independently and competently in the rendering of comprehensive nursing care, and to assume responsibility and accountability for providing nursing care. In accordance with these objectives – and based on the findings and conclusions of this study – the researcher makes the following recommendations for nursing education:

- Nursing educators should review the curricula for training auxiliary nurses. Current curricula in South Africa focus mainly on general nursing. Auxiliary nurses are trained to provide elementary nursing care according to prescribed levels. A revision of curricula should include teaching student auxiliary nurses the fundamentals and basics of psychiatric nursing and especially caring for patients who are intellectually disabled.
- Knowledge of resilient behaviour has the potential to enhance the clinical repertoire of auxiliary nurses. Nursing education institutions should, therefore, consider including resilience training to equip their students to be able to handle adverse working conditions when caring for patients with intellectual disabilities.
- Continual education and skills development at workplaces should be encouraged to allow auxiliary nurses to use their practical wisdom to care for patients with intellectual disabilities. Adequate induction programmes for auxiliary nurses should be developed and implemented.

#### **4.4.3 Recommendations for nursing research**

To improve psychiatric care and practice, research should encourage and promote evidence-based nursing. Based on the research findings of this study and relevant literature, further research is needed to explore and describe the resilience of auxiliary nurses caring for patients who are intellectually disabled at mental healthcare institutions. This research was conducted in only one mental healthcare institution and it is recommended that research should be conducted on a larger scale to improve the quality of care rendered to patients with intellectual disabilities.

Furthermore, nursing researchers pursuing studies focusing on resilience should identify how the strengthening of the practical wisdom of nurses, interactions with

patients who are intellectually disabled and strategies used by auxiliary nurses affect the resilience of nurses.

Mental healthcare institutions need to ensure that all auxiliary nurses receive appropriate training regarding the caring of patients with intellectual disabilities. Training should be accompanied by ongoing in-service training. Institutions who train auxiliary nurses should ensure that the highest standards of practice are maintained.

#### **4.5 Evaluation and final conclusion**

In chapter one, an overview of the study is provided by outlining the introduction and background to the study. The research problem was formulated, the research questions and the purpose of the study are discussed. In the section pertaining to the background of the study and the problem statement, the researcher indicated that having to deal with aggressive patients while not trained to do so, is experienced by auxiliary nurses as an adversity and they need to develop resiliency. The outcome of the study indicated that auxiliary nurses need to be resilient. Resilience can be achieved by applying their practical wisdom, interacting with patients who are intellectually disabled, and by using their own strategies and protective mechanisms. Although the auxiliary nurses did not emphasise having to deal with aggressive patients as an adversity in their workplace, they endure vulnerability factors on a continual basis when caring for these patients.

The paradigmatic perspective of the researcher was discussed, including meta-theoretical assumptions, theoretical assumptions and methodological assumptions. These assumptions guided the research, and were clearly stated to portray the stance of the researcher. In the overall conclusion, the researcher reflected on the meta-theoretical assumptions, and how these assumptions were linked with the findings of the study. It is clear from the outcomes of the research study that there is limited research available concerning the resilience of auxiliary nurses caring for patients with intellectual disabilities. A descriptive inquiry yielded valuable results and recommendations were formulated for nursing practice, nursing education and nursing research. The research design and the research method were followed. The research methodology comprised of a population, sampling, sample size, data collection and a data analysis. The measures to ensure rigour were discussed followed by ethical considerations, the literature review, the significance of the study and the report outline.

A discussion of the research design and the research methodology followed and were briefly discussed in chapter one and in detail in chapter two. The population, sampling, data collection methods, the data analysis, measures ensuring trustworthiness and ethical considerations were highlighted. The research was executed as planned and due acknowledgements were given to the limitations of the study – discussed in chapter four.

Chapter three presents the research findings and a literature integration. The researcher drew comparisons between the data and existing literature. The findings were supported with direct quotations from the participants provided during the semi-structured focus group discussions. The final chapter concludes the study by discussing the limitations, conclusions and recommendations.

In conclusion, the declaration can be made that the purpose of this mini-dissertation was reached, namely to explore and describe the perceptions of auxiliary nurses caring for patients with intellectual disabilities on their resilience; and to explore and describe the perceptions of auxiliary nurses on protective mechanisms and vulnerability factors that play a role in their resilience when caring for these patients.

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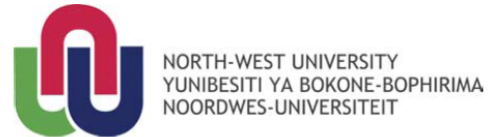
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# APPENDIX A: ETHICAL APPROVAL FROM NWU: POTCHEFSTROOM CAMPUS



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 4849  
Email [Ethics@nwu.ac.za](mailto:Ethics@nwu.ac.za)

## ETHICS APPROVAL OF PROJECT

The North-West University Research Ethics Regulatory Committee (NWU-RERC) hereby approves your project as indicated below. This implies that the NWU-RERC 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.

<b>Project title:</b> RESILIENCE OF AUXILIARY NURSES CARING FOR INTELLECTUALLY DISABLED PATIENTS.																															
<b>Project Leader:</b> Prof E du Plessis																															
<b>Ethics number:</b>	<table border="1"><tr><td>N</td><td>W</td><td>U</td><td>-</td><td>0</td><td>0</td><td>0</td><td>4</td><td>3</td><td>-</td><td>1</td><td>5</td><td>-</td><td>A</td><td>1</td></tr><tr><td colspan="3">Institution</td><td colspan="5">Project Number</td><td colspan="2">Year</td><td colspan="5">Status</td></tr></table> <small>Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation</small>	N	W	U	-	0	0	0	4	3	-	1	5	-	A	1	Institution			Project Number					Year		Status				
N	W	U	-	0	0	0	4	3	-	1	5	-	A	1																	
Institution			Project Number					Year		Status																					
<b>Approval date:</b> 2015-05-19	<b>Expiry date:</b> 2016-11-30																														

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-RERC:
  - 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-RERC. 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-RERC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-RERC 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-RERC 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

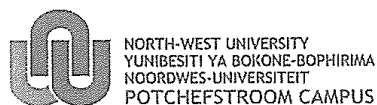
**Linda du Plessis**

Digitally signed by Linda du Plessis  
DN: cn=Linda du Plessis, o=North-West University, ou=Vice-Rector:  
VTC,  
email=Linda.duPlessis@nwu.ac.za,  
c=ZA  
Date: 2015.05.21 19:51:41 +0200

**Prof Linda du Plessis**

Chair NWU Research Ethics Regulatory Committee (RERC)

# APPENDIX B: REQUEST TO THE DEPARTMENT OF HEALTH-NORTH- WEST



INSINQ Research focus area

Private Bag X6001

Potchefstroom

2520

25 May 2015

THE DIRECTOR OF RESEARCH, POLICY & PLANNING

NORTH WEST DEPARTMENT OF HEALTH

PRIVATE BAG 2068

MMABATHO

2735

Dear Sir/Madam

REQUESTING PERMISSION TO CONDUCT RESEARCH PROJECT

TITLE OF THE RESEARCH PROJECT: Resilience of auxiliary nurses caring for intellectual disabled patients

ETHICAL CLEARANCE REFERENCE NUMBER: NWU-00043-15-A1 (E DU PLESSIS-SDM NTHEKANG)

RESEARCHER: STEVEN DITHAPELO NTHEKANG

I am Steven Nthekang from the North-West University (Potchefstroom campus). I am planning to do research on "Resilience of auxiliary nurses caring for intellectual

disabled patients” as a requirement for the Magister Curationis (Psychiatric Nursing Science) degree. I am also a registered professional nurse working at [redacted].

The purpose of this research is to:

- Explore and describe the perceptions of auxiliary nurses caring for intellectually disabled patients on their resilience.
- Explore and describe the perceptions of auxiliary nurses on the protective and vulnerability factors that play a role in their resilience when caring for intellectually disabled patients.

The direct benefits for participants will be to get the opportunity to share their views on resilience. In a focus group interview, they may learn how other auxiliary nurses resile in working with intellectually disabled patient. The indirect benefit will be the benefits to larger community. The researcher will be able to formulate guidelines to strengthen the resilience of auxiliary nurses caring for intellectually disabled patients.

The risk in this study is that participants might experience physical discomfort due to their participation in the focus group interview. A further risk is that it might be emotionally upsetting for them to talk about their experiences of working with intellectual disabled patient. There will be a skilled counsellor on standby that will provide debriefing if needed. The benefits outweigh the risks involved.

Anonymity in situations such as focus group interviews is always partial, and absolute anonymity is not possible; however, the researcher will process data anonymously. The researcher will furthermore use the following mechanisms to limit access to the data:

- Storing electronic data during and after the research on a password protected computer
- Developing backup copies of computer files
- Storing hard copies of the data during and after the research in a locked cupboard in the researcher's office.
- Using a high-quality recorder for audio recording information during interviews.
- Develop a master list of types of information gathered
- Protecting the anonymity of participants by concealing their names in the data

- Storing data for at least seven years

The researcher undertakes to identify the mediator who will identify possible participants according to inclusion and exclusion criteria and have meetings with potential participants during which he will explain the research to them, invite them to participate, explain to them about research participation, what will be expected from them, obtain informed consent and arrange appointments between the researcher and them.

The following are the inclusion and exclusion criteria according to which the mediator will be requested to identify and recruit potential participants:

- **Inclusion criteria**

- Auxiliary nurses employed at a provincial mental health care institution that offers long-term in-patient care for intellectually disabled patients;
- Auxiliary nurses registered with the South African Nursing Council as auxiliary nurses;
- Auxiliary nurses working a minimum of at least six months as auxiliary nurses caring for intellectually disabled patients;
- Auxiliary nurses willing to sign a consent form to participate in the study;
- Auxiliary nurses willing to be audio-recorded during a focus group interview; and
- Auxiliary nurses willing and able to communicate in English.

- **Exclusion criteria**

- Newly employed or have worked less than six months in caring for intellectually disabled patients.

The researcher undertakes to disseminate the results to the stakeholders and the target population in simple layman's language in order for them to understand the results. He will also provide feedback to auxiliary nurses who participated in the study, by means of a PowerPoint presentation during meetings arranged with them and in writing. He will also submit the report to the institution where the study took place, the North-West Department of Health, as well as the North-West University.

Ethical permission to conduct this research has been obtained from the North-West University (NWU-00043-15-A1).

Hereby permission is requested to conduct the above-mentioned research at . Please feel free to contact the researcher at 072 546 1655, or send an e-mail to

[snthekang@yahoo.com](mailto:snthekang@yahoo.com). Please inform the researcher if permission from any other authority needs to be obtained to conduct the above-mentioned research at your facility.

Herewith find attached the following documents in request for permission and approval to conduct research:

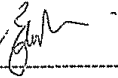
1. Clearance certificate from NWU-ethics committee
2. The research proposal

Thank you in advance

Yours sincerely



Mr S.D.M. Nthekang (Researcher)



Prof. E. du Plessis (Supervisor)



Date

# APPENDIX C: PERMISSION FROM DEPARTMENT OF HEALTH- NORTH-WEST



**health**

Department of  
Health  
North West Province  
REPUBLIC OF SOUTH AFRICA

3801 First Street  
New Office Park  
MAHIKENG, 2735

Enq: Keitumetse Shogwe  
Tel: 018 391 4504  
kshogwe@nwp.gov.za  
www.nwhealth.gov.za



## POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

Name of researcher : Mr SDM Nthekang  
North West University

Physical Address 17065 Majala Street  
(Work/ Institution) IKAGERY  
2531

Subject : **Research Approval Letter- Resilience of auxiliary nurses caring for intellectual disabled patients.**

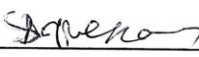
This letter serves to inform the Researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The Researcher is expected to arrange in advance with the chosen facilities, and issue this letter as proof that permission has been granted by the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

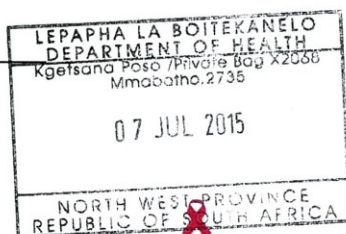
This letter of permission should be signed and a copy returned to the Department. By signing, the Researcher agrees, binds him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively, the Researcher can also provide the Department with electronic summary highlighting recommendations 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

07/07/2015  
Date

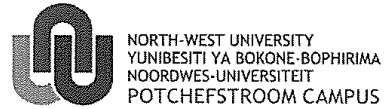
  
\_\_\_\_\_  
Researcher



20/09/2015  
Date

Healthy Living for All

# APPENDIX D: REQUEST LETTER TO MENTAL HEALTH INSTITUTION



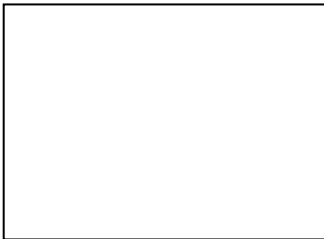
P O BOX 11062

RIVERWALK

2538

08 July 2015

THE NURSE MANAGER



Dear Sir/Madam

**REQUESTING PERMISSION TO CONDUCT RESEARCH PROJECT AT WITRAND HOSPITAL**

**TITLE OF THE RESEARCH PROJECT: Resilience of auxiliary nurses caring for intellectually disabled patients**

**REFERENCE NUMBER: NWU-00043-15-S1 (E DU PLESSIS-SDM NTHEKANG)**

**RESEARCHER: STEVEN DITHAPELO NTHEKANG**

Dear Sir/Madam

I am **Steven Nthekang** from the North-West University (Potchefstroom campus). I am doing research study on "**Resilience of auxiliary nurses caring for intellectual disabled patients**" as a requirement for the Magister Curations (Psychiatric Nursing Science) degree. I am also a registered professional nurse working at  .

The purpose of this research is to:

- Explore and describe the perceptions of auxiliary nurses caring for intellectually disabled patients on their resilience.
- Explore and describe the perceptions of auxiliary nurses on the protective and vulnerability factors that play a role in their resilience when caring for intellectually disabled patients.

The direct benefits for participants will be to get the opportunity to share their views on resilience. In a focus group interview, they may learn how other auxiliary nurses resile in working with intellectually disabled patient. The indirect benefit will be the benefits to larger community. The researcher will be able to formulate guidelines to strengthen the resilience of auxiliary nurses caring for intellectually disabled patients.

The risk in this study is that participants might experience physical discomfort due to their participation in the focus group interview. A further risk is that it might be emotionally upsetting for them to talk about their experiences of working with intellectual disabled patient. There will be a skilled counsellor on standby that will provide debriefing if needed. The benefits outweigh the risks involved.

Anonymity in situations such as focus group interviews is always partial, and absolute anonymity is not possible; however, the researcher will process data anonymously. The researcher will furthermore use the following mechanisms to limit access to the data:

- Storing electronic data during and after the research on a password protected computer
- Developing backup copies of computer files
- Storing hard copies of the data during and after the research in a locked cupboard in the researcher's office.
- Using a high-quality recorder for audio recording information during interviews.
- Develop a master list of types of information gathered
- Protecting the anonymity of participants by concealing their names in the data
- Storing data for at least seven years

The researcher undertakes to identify the mediator who will identify possible participants according to inclusion and exclusion criteria and have meetings with potential participants during which he will explain the research to them, invite them to participate, explain to them about research participation, what will be expected from them, obtain informed consent and arrange appointments between the researcher and them.

The following are the inclusion and exclusion criteria according to which the mediator will be requested to identify and recruit potential participants:

- **Inclusion criteria**

- Auxiliary nurses employed at a provincial mental health care institution that offers long-term in-patient care for intellectually disabled patients;
- Auxiliary nurses registered with the South African Nursing Council as auxiliary nurses;
- Auxiliary nurses working a minimum of at least six months as auxiliary nurses caring for intellectually disabled patients;
- Auxiliary nurses willing to sign a consent form to participate in the study;
- Auxiliary nurses willing to be audio-recorded during a focus group interview; and
- Auxiliary nurses willing and able to communicate in English.

- **Exclusion criteria**

- Newly employed or have worked less than six months in caring for intellectually disabled patients.

The researcher undertakes to disseminate the results to the stakeholders and the target population in simple layman's language in order for them to understand the results. He will also provide feedback to auxiliary nurses who participated in the study, by means of a PowerPoint presentation during meetings arranged with them and in writing. He will also submit the report to [redacted], the North-West Department of Health, as well as the North-West University.

Ethical permission to conduct this research has been obtained from the North-West University under the RISE study (Professor E. du Plessis and Professor M.P. Koen, NWU-00043-15-S1).

Hereby permission is requested to conduct the above-mentioned research at

Please feel free to contact the researcher at 072 546 1655, or send an e-mail to [snthekang@yahoo.com](mailto:snthekang@yahoo.com). Please inform the researcher if permission from any other authority needs to be obtained to conduct the above-mentioned research at your facility.

Herewith find attached the following documents in request for permission and approval to conduct research:

1. Research approval letter from North West Department of Health
2. Clearance certificate from NWU-ethics committee
3. The research proposal

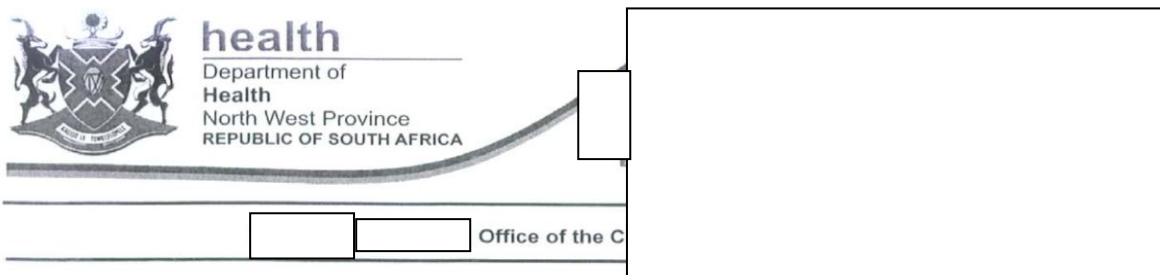
Thank you in advance

Yours sincerely

Mr S.D.M. Nthekang (Researcher)

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# APPENDIX E: APPROVAL FROM THE MENTAL HEALTH INSTITUTION



07/08/2015

ATTENTION: MR S NTHEKANG

Dear Mr Nthekang

**RESEARCH REQUEST: RESILIENCE OF AUXILIARY NURSES CARING FOR INTELLECTUALLY DISABLED PATIENTS**

1. Your request to the Ceo for approval and your presentation to our Research and Ethics meeting dated 07/08/2015 on the above-mentioned refers
2. You already obtained ethics approval from the North West Department of Health and after your presentation dated 07/08/2015 you are hereby granted approval to conduct your research in [redacted] Hospital
3. The contact person will be at all times the Acting Nurse Manager at tel no [redacted] 0
4. Please note that you need to submit a copy of your research outcome to the office of the Ceo

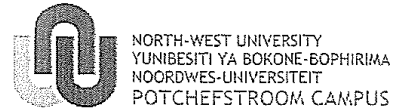
Yours sincerely

[redacted signature box]

CHIEF EXECUTIVE OFFICER: [redacted]

[redacted box]

# APPENDIX F: CONFIDENTIALITY FORM FOR RESEARCH MEDIATOR



<p><b>Health Research Ethics Committee</b> Faculty of Health Sciences NORTH-WEST University (Potchefstroom Campus)</p> <p>2015 -05- 18</p>
--

## CONFIDENTIALITY FORM FOR RESEARCH MEDIATOR

**TITLE OF THE RESEARCH PROJECT:** Resilience of auxiliary nurses caring for intellectual disabled patients

**REFERENCE NUMBER:** NWU-00043-15-A1

**RESERACHER:** STEVEN DITHAPELO NTHEKANG

**ADDRESS:** School of Nursing Science, Private Bag X6001, Potchefstroom, 2520

**CONTACT NUMBER:** 0725461655

Dear Sir

I am **Steven Nthekang** from the North-West University (Potchefstroom campus). I am doing research study on "**Resilience of auxiliary nurses caring for intellectual disabled patients**" as a requirement for the Magister Curations (Psychiatric Nursing Science) degree.

I invite you to be the mediator of my research project. I would like you to identify possible participants and invite them to participate, explain to them about research participation, what will be expected from them, obtain informed consent and arrange appointments between myself and them.

To follow is information about the study and what will be expected of you should you accept this invitation, so that you can make an informed decision.

Please ask me any questions about any part of this project and your involvement 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 be involved. 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.....) 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.

#### **1.1 What is this research study all about?**

- *This study will be conducted at a safe, comfortable room at the mental health care institution where you work and will involve semi-structured focus group interviews. This means that six to eight auxiliary nurses will be interviewed as a group.*
- *The objectives of this research are to:*
  - Explore and describe the perceptions of auxiliary nurses caring for intellectually disabled patients on their resilience.
  - Explore and describe the perceptions of auxiliary nurses on the protective and vulnerability factors that play a role in their resilience when caring for intellectually disabled patients.

#### **1.2 Why have you been invited to act as mediator?**

- *You have been invited to act as mediator because you are an auxiliary nurse fulfilling a leadership role at the mental health care institution where this research will take place, and*
- *You are in established, professional relationships with potential participants.*

This approach will ensure that potential participants may feel free to ask questions about the research, and may feel free to decide whether they want to participate or not.

The following are the inclusion criteria according to which you will be requested to identify and recruit potential participants:

- Auxiliary nurses employed at a provincial mental health care institution that offers long-term in-patient care for intellectually disabled patients;
- Auxiliary nurses registered with the South African Nursing Council as auxiliary nurses;
- Auxiliary nurses working a minimum of at least six months as auxiliary nurses caring for intellectually disabled patients;
- Auxiliary nurses willing to sign a consent form to participate in the study; and
- Auxiliary nurses willing to be audio-recorded during a focus group interview;

➤ ***Auxiliary nurses will be excluded as participants if they are:***

- Newly employed or have worked less than six months in caring for intellectually disabled patients.

**1.3 What will your responsibilities be?**

- *You will be expected to* identify possible participants according to inclusion and exclusion criteria and have meetings with potential participants during which you explain the research to them, invite them to participate, explain to them about research participation, what will be expected from them, obtain informed consent and arrange appointments between myself and them.

**1.4 Will they benefit from taking part in this research?**

- The direct benefits for participants will be to get the opportunity to share their views on resilience. In a focus group interview, they may learn how other auxiliary nurses resile in working with intellectually disabled patient.

- The indirect benefit will be the benefits to larger community. The researcher will be able to formulate guidelines to strengthen the resilience of auxiliary nurses caring for intellectually disabled patients.

**1.5 Are there risks involved in your taking part in this research?**

- The risk in this study is that participants might experience physical discomfort due to their participation in the focus group interview. I will do my best to ensure that the room is comfortable, comfort breaks will be allowed as needed and refreshments will be served.
- A further risk is that it might be emotionally upsetting for them to talk about their experiences of working with intellectual disabled patient. There will be a skilled counsellor on standby that will provide debriefing if needed.
- The benefits outweigh the risks involved.

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

- Should participants have the need for further discussions due to emotional upset; an opportunity will be arranged for them to meet with a skilled counsellor on standby that will provide debriefing.

**1.7 Who will have access to the data?**

*Anonymity* in situations such as focus group interviews is always partial, and absolute anonymity is not possible; however, the researcher will process data anonymously. The researcher will furthermore use the following mechanisms to limit access to the data:

- Provide each participant with a code name
- Use code names when discussing data
- Keeping the master list of participants' names and matching code in a safe place
- Set the ground rules that information discussed during group interviews should not be discussed anywhere outside the group.
- Destroy the list of real names

The researcher will respect the participants' right to privacy. The recording of conversations using audio recorder during focus group will be done with informed

consent, and the researcher will not collect any data covertly. Confidentiality means no names of research participants will be used and access to the data will be highly limited to those who are directly involved with the research. The data will only be accessible to the researcher (who will also transcribe the data), his supervisor, and co-coder. This process of ensuring confidentiality refers to the researcher's responsibility to prevent all data gathered during the study from being divulged or made available to any other person. Reporting of findings will be anonymous by not disclosing the names of research participants in the report. The researcher will provide feedback to auxiliary nurses who participated in the study verbally and in writing through meetings with participants. I will also submit the report to the institution where the study took place, the North-West Department of Health, as well as the North-West University.

**1.8. Will you be paid to act as mediator in this study and are there any costs involved?**

No, you will not be paid to act as mediator in the study. There will also be no costs involved for you, if you do act as mediator.

**1.9. Is there anything else that you should know or do?**

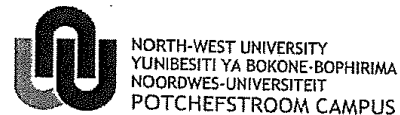
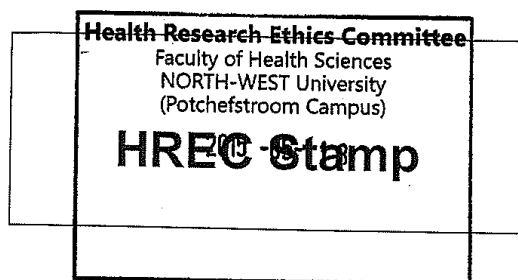
- You can contact: STEVEN DITHAPELO NTHEKANG at 0725461655 if you have any further queries or encounter any problems.
- You can contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 2094; carolien.vanzyl@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.
- You will receive a copy of this information and consent form for your own records.

If you have any questions regarding participation in the study, you are welcome to ask me (Steven Nthekang) or my supervisor (Dr Emmerentia Du plessis) any questions before you decide to give consent. You are also welcome to contact me at 0725461655 or my supervisor at 018 299 1882.

Declaration by mediator



# APPENDIX G: INFORMATION LEAFLET AND CONSENT FORM FOR PARTICIPANTS



## PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

**TITLE OF THE RESEARCH PROJECT:** Resilience of auxiliary nurses caring for intellectual disabled patients

**REFERENCE NUMBER:** NWU-00043-15-A1

**RESEARCHER:** STEVEN DITHAPELO NTHEKANG

I am a M.Cur (Psychiatric nursing) student and a professional nurse.

**ADDRESS:** School of Nursing Science, Private Bag X6001, Potchefstroom, 2520

**CONTACT NUMBER:** 0725461655

You are being invited to take part in a research project doing research study on **"Resilience of auxiliary nurses caring for intellectual disabled patients"** that forms part of my studies as a requirement for a Magister Curationis (Psychiatric Nursing Science) degree. Resilience means 'the ability to bounce back in spite of difficulties'.

Please take some time to read the information presented here, which will explain the details of this project. Please ask me 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.....) 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.

#### **1.1 What is this research study all about?**

- *This study will be conducted at a safe, comfortable room at the mental health care institution where you work and will involve semi-structured focus group interviews. This means that six to eight auxiliary nurses will be interviewed as a group.*
- *The objectives of this research are to:*
  - Explore and describe the perceptions of auxiliary nurses caring for intellectually disabled patients on their resilience.
  - Explore and describe the perceptions of auxiliary nurses on the protective and vulnerability factors that play a role in their resilience when caring for intellectually disabled patients.

#### **1.2 Why have you been invited to participate?**

- *You have been invited to participate because you are an auxiliary nurse caring for intellectually disabled patients*
- *You have also complied with the following inclusion criteria:*
  - Auxiliary nurses employed at a provincial mental health care institution that offers long-term in-patient care for intellectually disabled patients;
  - Auxiliary nurses registered with the South African Nursing Council as auxiliary nurses;

- Auxiliary nurses working a minimum of at least six months as auxiliary nurses caring for intellectually disabled patients;
- Auxiliary nurses willing to sign a consent form to participate in the study;
- Auxiliary nurses willing to be audio-recorded during a focus group interview; and
- Auxiliary nurses willing and able to communicate in English.

➤ ***You will be excluded if you are:***

- Newly employed or have worked less than six months in caring for intellectually disabled patients.

**1.3 What will your responsibilities be?**

- *You will be expected to share your view on resilience and on protective and vulnerability factors that play a role in your resilience when caring for intellectually disabled patients. This will happen in a focus group interview that will last once off for about one hour. You will be expected to share your perceptions. The group will consist of 6-8 participants.*

**1.4 Will you benefit from taking part in this research?**

- The direct benefits for you as a participant will be to get the opportunity to share your views on resilience. In a focus group interview, you may learn how other auxiliary nurses resile in working with intellectually disabled patient.
- The indirect benefit will be the benefits to larger community. The researcher will be able to formulate guidelines to strengthen the resilience of auxiliary nurses caring for intellectually disabled patients.

**1.5 Are there risks involved in your taking part in this research?**

- The risk in this study is that you might experience physical discomfort due to your participation in the focus group interview. I will do my best to ensure that the room is comfortable, comfort breaks will be allowed as needed and refreshments will be served.

- A further risk is that it might be emotionally upsetting to talk about your experiences of working with intellectual disabled patient. There will be a skilled counsellor on standby that will provide debriefing if needed.
- The benefits outweigh the risks involved.

**1.6 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 due to emotional upset; an opportunity will be arranged for you to meet with a skilled counsellor on standby that will provide debriefing.

**1.7 Who will have access to the data?**

*Anonymity* in situations such as focus group interviews is always partial, and absolute anonymity is not possible; however, the researcher will process data anonymously. The researcher will furthermore use the following mechanisms to limit access to the data:

- Provide each participant with a code name
- Use code names when discussing data
- Keeping the master list of participants' names and matching code in a safe place
- Set the ground rules that information discussed during group interviews should not be discussed anywhere outside the group.
- Destroy the list of real names

The researcher will respect the participants' right to privacy. The recording of conversations using audio recorder during focus group will be done with informed consent, and the researcher will not collect any data covertly. Confidentiality means no names of research participants will be used and access to the data will be highly limited to those who are directly involved with the research. The data will only be accessible to the researcher (who will also transcribe the data), his supervisor, and co-coder. This process of ensuring confidentiality refers to the researcher's responsibility to prevent all data gathered during the study from being divulged or made available to any other person. *Reporting of findings will be anonymous by not*

*disclosing the names of research participants in the report.* The researcher will provide feedback to auxiliary nurses who participated in the study verbally and in writing through meetings with participants. He will also submit the report to the institution where the study took place, the North-West Department of Health, as well as the North-West University.

**1.8. 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 provided. Travel expenses will be paid for those participants who have to travel to the mental health care institution i.e. those auxiliary nurses who will be off-duty on the day of focus group interview. There will thus be no costs involved for you, if you do take part.

**1.9. Is there anything else that you should know or do?**

- You can contact: STEVEN DITHAPELO NTHEKANG at 0725461655 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.

**Declaration by participant**

By signing below, I ..... agree to take part in a research study entitled: **Resilience in auxiliary nurses caring for intellectual disabled patients** and I consent that the focus group interview may be audio-recorded.

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 researcher**

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.

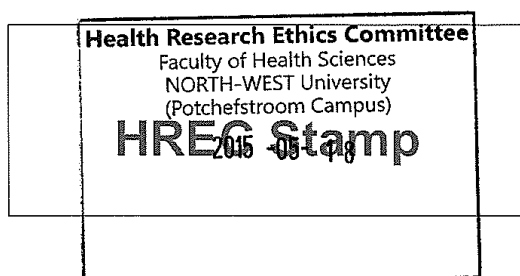
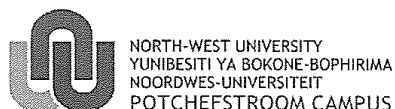
Signed at (*place*) ..... On (*date*) ..... 20....

.....

Signature of researcher

Signature of witness

## APPENDIX H: REQUEST FOR CO-CODING



REQUEST TO BE CO-CODER OF MY RESEARCH PROJECT

TITLE OF THE RESEARCH PROJECT: Resilience of auxiliary nurses caring for intellectual disabled patients

REFERENCE NUMBER: NWU-00043-15-A1

RESEARCHER: STEVEN DITHAPELO NTHEKANG

ADDRESS: School of Nursing Science, Private Bag X6001, Potchefstroom, 2520

CONTACT NUMBER: 0725461655

Dear Sir/Madam

I am **Steven Nthekang** from the North-West University (Potchefstroom campus). I am doing research study on "**Resilience of auxiliary nurses caring for intellectual disabled patients**" as a requirement for the Magister Curations (Psychiatric Nursing Science) degree. I would like to invite you to act as independent co-coder in this study. To follow is information about the study so that you can make an informed decision.

### 1. PURPOSE OF THE STUDY

The purpose of this study is to:

- Explore and describe the perceptions of auxiliary nurses caring for intellectual disabled patients on their resilience.
- Explore and describe the perceptions of auxiliary nurses on the protective and vulnerability factors that play a role in their resilience when caring for intellectually disabled patients.

Audio-recorded data of semi-structured focus group interviews will be transcribed. You will be expected to analyze the data according to the process of content analysis. You will be expected to follow the following steps during data analysis, namely:

- Pick one transcription. Try to get a sense of the interview as a whole before breaking it into parts (Creswell, 2013:183).
- Spend extensive time reading and thinking about the data.
- Code the data. The process of coding involves identifying small topics of information in the text, and then assigning a label to the code. The first level of coding should be descriptive, using participants' phrases as the label for the code.
- Repeat this process with all transcriptions.
- Form themes from the codes, and then organise the themes into larger units of abstraction to make sense of the data.

When you are finished with co-coding, you will be expected to arrange with the researcher for a meeting to reach consensus on the codes, themes, and subthemes that emerged from the data. The research will be conducted under the supervision of experts in Psychiatric Nursing Science and Nursing Research at the School of Nursing Science at North West University.

If you have any questions regarding participation in the study, you are welcome to ask me (Steven Nthekang) or my supervisor (Prof Emmerentia Du plessis) any questions before you decide to give consent. You are also welcome to contact me at 072 54616 55 or my supervisor at 018 299 1876.

**Declaration by the co-coder**

By signing below, I ..... agree to be the co-coder in a research study entitled: **Resilience of auxiliary nurses caring for intellectual disabled patients**

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 undertake to keep all information relating to this research confidential.

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

.....

Signature of co-coder

Signature of witness

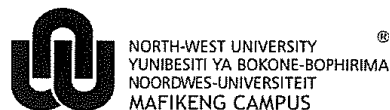
Signed at (*place*) ..... On (*date*) .....  
20...

.....

Signature of researcher

Signature of witness

## APPENDIX I: CONFIRMATION LETTER FOR CO-CODING



Private Bag X2046, Mmabatho  
South Africa, 2735

Tel: +2718 389-2642 / 0603470183

Fax: +2786 621-4308

Web: <http://www.nwu.ac.za>

To whom it may concern,

This letter serves as a confirmation that I was requested by Mr SDM Nthekang (Student Number: 16281527) to act as co-coder and that I co-coded data collected in the study entitled **“Resilience of auxiliary nurses caring for intellectually disabled patients”**

Yours sincerely

Mr Leepile Alfred Sehularo (MCur, BNSc)

Lecturer: Mafikeng Campus of the North West University

Tel: 0183892642 Cell: 0603470183 Email: [Leepile.Sehularo@nwu.ac.za](mailto:Leepile.Sehularo@nwu.ac.za)



08 February 2016

## APPENDIX J: TRANSCRIPT FOR FOCUS GROUP INTERVIEWS

Example of third focus group session

RES- Researcher

P- Participant

RES: Thank you for coming. This research, like as I have explained to you, there are things that I need to clarify first before we start. Things like anonymity. Anonymity means no names are going to be mentioned here. This is to protect participants at all costs, so that nobody can say somebody said what, even me. Otherwise the information that I am going to record here is going to be only between me and my supervisor at the university. Second thing is confidentiality. Confidentiality means everything that we are going to discuss is going to end here. There is nowhere somebody will go and talk about things that we discussed somewhere else. Privacy is like we are sitting in a private room now to discuss this. So we are not going to mention any names and we are going to discuss only what is supposed to be discussed in this research. So you are free to answer me in your language. I will be speaking English but I will try to explain difficult words so that you can understand. If you don't understand you can ask me questions. The other thing is time. I need to check time. Can anyone help me with a watch? The research that I am doing here, the title is resilience of auxiliary nurses caring for intellectually disabled patients. Isn't that we are calling them M.Rs? In our research we call them intellectually disabled patients. So you are the participants who are eligible to participate in this research. Resilience is just a simple English word meaning the ability to bounce back or just focus again and continue with your work. I think all of us here know what type of patients that we are working with. We are working with patients who are very difficult, sometimes aggressive or violent. So my question is going to be around how do you bounce back? how do you focus again and continue to work with these patients? So I am going to ask only two questions, but i will ask few questions if I don't understand. I am going to start with my first question. I don't know if you are ready? My first question is: please listen carefully ok? What do you think is your resilience when caring for intellectually disabled patients? What do you think makes you to be able to bounce back? What makes you to continue to work with these patients? What makes you to continue to focus? I don't know if it is a difficult question?

P1: Our patients, to make them calm you must try to make them at ease. They are violent and they are absconding. Make sure that the doors are closed. You will be trying to calm him down you and asking him what makes him to feel well. Others will be telling you that it is long time since his family visited him and that is why he is starting to be aggressive, assaulting other patients. Let me give you an example, this patient is going home, and the other one is not going. This patient would be told that he is not going anywhere. These are the things that sometimes make them aggressive. Do you understand? Some parents would be bringing presents for their children. These other patients would start to become thieves. They steal. They fight, and do funny things that may causes injuries to other patients.

RES: Ok. Maybe I must go back to my question again. If I feel that you didn't give me the answer, I will go back to the question. I want all of you here; you must talk about yourself on how you focus. As I have explained, resilience means the ability to bounce back after difficult situation. Like situation whereby patients were violent or aggressive. How do you come back and start work again?

P1: It is to try to calm them down. You can take him aside. It not an easy works to do because you can't work alone. Always you must be two. Like during the night. During the night we can manage. You alone you can't manage. Not that you can't manage, But because they are too many. They are forty and you have only two eyes.

P2: The other thing is that our patients are difficult. If they are difficult, then you must know your patient. You must know his behaviour and know how to calm him down. Let me give you example, they like coffee. If you don't give him coffee by the time he want it, he will start to be aggressive and can end up injuring another patient. So you must know when he want a coffee you must give him otherwise he will injure another patient and it goes back to nurses. Then we will be in a situation whereby there is an injury. Do you see how it is? We manage by calming them down and whatever he need, you give him immediately.

RES: Ok. So that thing of being able to calm down the patient it makes you to continue to work? Is it what you are saying?

P2: yes

P3: Can I maybe pause you a little bit. I want to understand your question very well. Isn't it that you want specifically a nurse?

RES: Yes.

P3: You want me to say when the patient was aggressive; I did one, two, and three. Maybe they fought and injured each other. Things that I see on the patient. You want me to say what pushes me to continue with my work. I think that is how your question is. You have not yet talked about the patients on what are they doing or how must I cool them down so that they must not fight. You want me as a nurse what must I do? Pardon me; you say how I continue with my work after a patient has done one, two, and three.

RES: Yes. Let me give an example. Somebody can say I am somebody who prays. I am a churchgoer. It helps me to continue with my work. I always pray and that thing helps. Maybe I can give another example that the lady here has just mentioned that you must know your patient. It helps her. Maybe there might be other ways of being resilient, being able to bounce back and continue to work.

P4: Sometimes when patients are aggressive and when I want to calm them down, always I take that patient to the other side for a few minutes. When he is fine I bring him back to other patients. You give them whatever they want, as she mentioned. You can give him sweets, cigarettes, or anything that can make him calm.

RES: Ok. I will come back to you. I just want to give others a chance to hear what they are saying.

P3: I think for me to bounce back and continue with my work even though there are things that are done by the patients I think as a nurse, perseverance is needed in me as a nurse, because if I can run short of perseverance, I will end up being unable to continue with my work. Maybe I wouldn't have reached ten years due to the way these patients are in [REDACTED]. I would have left and went to work at a general hospital. But because I am perseverant, I manage to persevere and that is why I have more than seven years with them. So for me to be patient helps me to continue with my work even though patients are rough. That is my first point. Another point is that I think I need to love my job. It is also important because if I love my job I can continue although the patients continue to do those things to us. Because I have that thing of loving my job I can continue even if they do those things. I think it goes hand in glove with missing my job. It

helps me to continue. I think perseverance and to love my job allows me to continue with my job. Let me cut it there so that I must not repeat it many times.

P1: I think for one to be perseverant at work, communication is needed also .because if you as nurses communicate well, with no arguments, the work becomes easy and the patients become controllable. Cooperation

P3: Cooperation

P1: Yes. Cooperation. Do you understand? If there is no communication between you, with infightings, nothing will be right because even patient are going to suffer. They are also able to see you. They are more observant than us. You guard them, only to find out that they are guarding you. Do you understand? That is why I say if we work together, the work become enjoyable and when you come to work, you come freely, you don't even think back at home you just think about at work and your patient because you know how do you work together with your colleague. Communication also is important

RES: Correct me if I am wrong. Are you saying what makes you to be able to go on is your ability to be able to communicate with others?

P1: Yes

RES: OK. I got your point. Did you mention team work too?

P1: Yes. Team work

P5: Sometimes you need to be polite. Even if the patient hurt you, you just need to pretend as if you are not hurt

RES: can you please explain, if you talk about being hurt, are you referring to being hurt by patients or other staff members?

P5: The patients. Just pretend as if you are not hurt

P2: Just like those who have high IQ are more than others, he might say something that might hurt you even though he is a patient. You will try to calm down because once you get angry you will end up assaulting the patient, of which it is wrong. Do you see how it is? The other thing, we must love them because once you work with thirty patient and you don't love twenty of them we will end up having injuries. So it is important that we

must love them. That is why when you love your patients you are able to continue with your job

RES: Ok. Let's hear what others are saying

P6: P1 took my words. I was also going to say same words. I think they said it all. She summarised everything. That is what makes me strong i.e. perseverance and team work. It is when you work together harmoniously with your colleague. It makes you even happy when you know that you are working nurse P1. When you start to work, you help each other, especially with love. Isn't it that I have been working here for a long time, you end up loving them. You miss them with that grown love that is immeasurable. The way we love them you end up missing them even if they can do something wrong. I think that is what makes me to bounce back even if they can do something wrong. That love.

RES: Ok. So if I have to summarise what you are saying, you need to have passion for your work?

P6: Yes. You must love your patients. You must love your work, because that is where we spend most of our time.

P3: In another words, if you have children you love them the way you love your children. If you don't have children you will love them like you love your family something like

P1: Isn't it that in Setswana they say you love yourself first before you can love others. If there is love within you, then you do have for others. That is not only your love. That love of yours, you must share it for others

RES: So, that thing keeps you going on?

P1: Yes

P2: The other thing is that we are not trained for psychiatry. Being not trained for psychiatry, but we can stay with them for the whole day. For example if I am new I will start to be afraid of them, because I don't know them and I feel they are rough and might be danger to me. But when time goes on, I get to know them and I start to learn also, even if I am not trained for psychiatry. For example I know one of our patients. If he is not given a T-shirts with knobs, he will start to be aggressive. He just wants that

thing and nothing else. I know how I must treat him. The other one you know that you must give something with a collar. If it is not available he will be aggressive. He will start to hit the walls, biting himself. Do you understand it? So you must know how to treat him. He will calm down and you also feel that you satisfied him.

RES: Ok. So it is important that you must know your patients?

P2: Yes

P6: Let me add on what P1 has just said that these patients are intelligent. Yes they are intelligent. We learn them and they also learn us. Do you see it? That is their intelligence. I always get emotionally taken when we arrive on duty and they call us mothers, etc. That thing gives me such honour and also it increases the responsibilities that I already have. I ask myself that I left my children at home I also have children here. It gives me honour and pride inside. That is the thing that makes me to bounce back with a positive note, because when I think that I left children at home and I have children here too. Do you see it?

RES: Ok. I want to come back to that thing that you said you ignore them. Maybe you can explain much further that how does it helps you? Or what do you mean you ignore them? Like I have been explaining that they might be aggressive or violent

P5: Isn't it that Sometimes he would be looking for attention. When he looks for attention then I realise that if I can start to respond and follow him, I would be giving him a chance to do whatever he want to do.

RES: Ok.

P1: Like he just explained, the other one can just come in and swear at you. Do you understand? Not knowing exactly what is the problem. But if you continue to give him attention he will continue. The best thing is to ignore him. From there if he can see that you don't respond to him and you don't do anything he will see and he will begin to keep quiet. Once you start to respond he will begin to be naughtier. The best thing is to stare at him and then look at others. When he realise that you don't recognise him, he become quiet. The very same patient who was swearing at you, would come back at ask something from you. You don't remind him what he just said. When he come and ask water from you, you just have to answer in polite manner saying go and drink. You

don't have to say that shouting at him. He will realise that this person is not fighting. It is me who is fighting her. They like to change frequently these patients.

P7: They don't get angry for a long time.

RES: Come again, I didn't hear that please.

P7: I was saying they don't get angry for a long time. If he is angry and you ignore him as the lady just said it, later he will come and talk to you.

P1: Yes. They always do that. I don't know if they want to test you or not. But it is true that he come back.

P2: Then the other thing, spastic patients also, because they are unable to behave like high functioning patients. Isn't it that they are unable to respond like high functioning patient? When you arrive and notice that she gives you a smile, then you would know that she is happy. But when the nurse who usually beat him arrives in the ward, you will notice the child becoming sad. These patients are able to identify us even though they are unable to speak. Do you see how it is? It makes you happy when you approach him with a smile and he also smiling back. That thing that the nurse have just said that she left her children at home and here there are children too, makes you happy when you see them smiling. When you knock off duty you feel happy because this patient can't speak but you managed to make him show certain sign. It makes me to be able to bounce back and work with these patients.

RES: Ok, then it means we can move on, because others said their words are already taken by others.

P2: There is a lot to talk about it just that once you have finished speaking something else comes up

RES: Ok its fine. We will go back on it. Unless you want to go on, if you want to say something

P2: LAUGHING!!!!!!

RES: Or it will come back later

P2: Yes. It will come back later. Learning is something that is very important

P1: Yes. Learning is abundant from these patients. We learn a lot from these patients.

RES: What do mean when you say you are learning?

P1: You can notice what kind of patient is he. If he is somebody who is violent, you can notice that he violent by birth. We do have him in the ward. The one that yesterday I showed you. Do you understand? He is a violent patient. He came with that behaviour from home. It's like he has been taught that way. Do you know how whites are? Whites are disrespectful. He can assault other patient, but once you try to stop him, he will start to assault you. He will fight with you. He will stop fighting with the person he was fighting with, and continue to fight you. You didn't realise that this patient is going to injure you.

P3: I am not opposing anything. I would like to know if whether we are automatically on the question of how to handle them?

RES: No. We are still on the first question. But I cannot cut whoever wants to say something. I will give him/ her time to say whatever he/she want to say. As long as in whatever you are saying there is an answer that I am looking for. Or maybe we must go to my second question

P3: Because I sense that it is getting much deeper

RES: Even if it's getting deeper. There might be an answer that will be coming because I need to identify a theme in what you are saying.

P3: Ok.

RES: Maybe I need to go to my second question. My second question is very long but I will try to divide it in to two. It says: what do you see as your protective and vulnerability factors that plays role in your resilience when caring for this patients. So what do you see as you protective and vulnerability factors. Maybe I must split it into two. What do you see as your protective factor? When I talk about protective factor, I am talking about what make you stronger. What makes you feel protected when caring for these patients? Just think about yourself what you think these, protects you?

P2: According to my job?

RES: According to the way you handle your work so that you can always remain resilient.

P1: Isn't it that on the first question, when P3 answered you that she put everything before God. That is what I am doing. When I come to work and also when I arrive at work I thank God that he took me from home and brought me here. Please be with me so that these patient, everything that I do, they must cooperate. Let me say prayer, when we put God ahead of us, everything will be fine. Do you understand? God give us power. He gives us strength to come to work, so that even today we are still working.

RES: Ok. So you, it means your protective factor is prayer?

P1: yes. Prayer.

P2: The other thing, I can add that one of not assaulting them. I can say it is also important because once you beat him; he will get more aggressive and beat the others. You will end up losing your job.

P1: Yes, you end up losing your job

P2: Yes. You could have protected him by making him calm so that he can be fine and not to beat other patients

RES: Ok. So that thing of avoiding to beat them, it protects you?

P2: Yes.

RES: So you need to be calm as a nurse and continue to work?

P2: Yes

P3: I want to know this. When you talk about how to protect yourself, are you talking about protecting yourself from the patient or about losing your job is it general?

RES: Isn't it that I said from the beginning I said everybody must talk about him or herself. When I say protective factors, I am referring to within you. What do you think within you protects you? Like she said she prays. I am just giving an example: somebody can say: me, ek moer hulle terug."

GROUP: LAUGHING!!!

RES: That thing protects me. I don't know if you understood me?

P3: Yes. I understand now.

P6: Yes. I also want also to add on that one of prayer because I saw that it works for me. It works for me forever because when I leave I pray. I make a plea from God because I don't have strength. I have the one who protects me. I have the one who is stronger than me. I always bring him nearer. Even when I arrive I bring him nearer. Because I think he is the one who gave me this job and that is why I go back to him, asking for protection and wisdom. I request for two things. Protection when I am here and wisdom so that I can know how to handle the situation because I think I don't have strength and he is the one who knows everything. Everything on earth was created by him. I have full belief that everything will be fixed by him. So I think he is the one who give me such strength so that I can continue to love my job. So that I can continue to love my job even if something happen. Another thing what I noticed about this patients is that for you to be protected, when they come with aggression, you must remain calm

P4: You must smile and laugh

P2: Yes

P4: The other thing is as nurses working with this type of patients, I think nursing is a calling.

RES: Ok. Yes sir

P5: Sometimes when you arrive you will just see them being happy for you and you will realise that they are not in the mood that can put you in danger.

P1: like he just mentioned it, immediately when we arrive on Wednesday you will just see them jumping to us. That shows me that if I am on duty, these patients become happy. It is true that P6 have said it earlier. They don't call us by our names. They call us mothers and fathers. They can differentiate us, but they prefer to call us mom or dad. Do you understand? That is how patients in [REDACTED] are. Even the spastic patient, as she said it, when you just come inside the ward there are those who can jump when they sees you. He doesn't have such strength to stand up, but he will kick those legs to show happiness. The other one would try to move those small hands to show happiness that his mother has arrived. Do you understand?

RES: Ok. So being able to love your patients, it helps you to be as a protective factor for you?

Yes. So that they can love you back

P3: let me just comment a little bit. As a nurse when I speak to them, I must speak to them in a good way. I must speak to them softly and be polite. I think that part makes them to be happy. They know that Jacob is coming. They would know that tomorrow is Wednesday, when I am working night duty. They would boast around telling people that Jacob is coming today, and it is Jacob who is very kind. They would tell you immediately that Jacob is coming today because when Jacob arrives they become happy. Because they know that if I have arrived they would be happy because they enjoy my company with them. Do you understand? So that is the thing that assist me if they become violent, it makes them unable to injure me or cause harm because they love me. I become neutral between them. There is a mutual relationship between me and them. I also become safe because they won't cause harm on me because I love them and they love me too. So I talk to them in a good way. The other thing is that although the lady here said we have not be trained for psychiatry, it is only people who have done psychiatry that have the understanding of the point that I am raising. When he fights, for me to protect myself for example he would be throwing objects on me, starting to fight, it means I must stay far away. I will maybe come to him later to talk to him while nearer. But When I see that he is throwing objects, for me to stay protected I must stay I am far away, because if I am nearer he might cause harm on me. So when I am far from him, I think I would be safe. When I see that he is calming down I would come closer talking to him politely and start again, because we are used to that. As she said they don't get angry for a long time at certain time he gets angry and again at certain he is fine. So I must stay far when he is angry and throwing objects.

RES: Ok. Not to interrupt you. If I have to summarise on what you have just said, as a nurse you one of your protective factors is to be always observant?

P3: yes

P1: Because if don't become observant, a fist will hit you. Do you understand?

P2: You must make sure that when the patient is angry he must not be behind you. Because you don't know whether he might pull you or cause harm on you. Always make

sure he is in front because if he is behind you, he might cause harm on you. Do you see how it is?

P1: Even if you are walking together, he must in front of you. You must follow him.

RES: Ok. Have they taken your words?

GROUP: yes

RES: Ok. I think I have heard your protective factors. Maybe we can go to vulnerability factors. Vulnerability factors are what put you at risk. What you can say this, within me, put me at risk? I can give an example. Somebody can say I am a person who is short tempered. So it put me at risk because I get angry quickly. There might be many factors within you that you know to be resilient.

P2: The other thing that I can say is about things that are dangerous. Things that they can use when they fight and that might injure you. Those things that are dangerous like scissor, spoons, knife. He might take it and hit you. We must remove sharp instruments them from their eyes, so that when he start to be aggressive, then we would be on a safe side with them.

RES: Ok. What others can say? Vulnerability factors.

P6: What makes me vulnerable maybe on that day can be your supervisor. It depend how that person is on that day, or how he treats you. Because if you are working under the supervisor who does not treat you well, you end up coming with that bad attitude. Do you understand? Especially when she can do something that might anger you. When you go to the patients, you go to them with that negative attitude. Do you understand?

P1: Also every time when you come to your supervisor trying to report something and she instead crush your point. Do you understand? Not even giving you a chance and listen to you. Or when you give her a report and she end up not doing follow up on it. That thing it hurts you. I try to do something and she doesn't help me. Do you understand? She just leaves me. It means that I am not better. She just leaves you and ignoring the issue to grow until you get angry. Do you understand? Even if the patients do something. I am giving example about the patient who can be reported to be doing several wrong things. The supervisor would be asking you whom did he injure? Then

you come again and report something about the same patient who did something wrong. What are you saying as supervisors if the same patient is reported several times? Can't they call the doctor and prescribe something that might calm the patient down.

RES: I want to bring it into my question. Maybe I did not understand. When you say supervisors do not support you or do not listen to you, are you saying the vulnerability factor there, you can say maybe for you not to be listened by your supervisors, it can makes you to lose focus? Is it what you are saying? Like she said she will be angry and having that grudge against the supervisor?

P1: Yes. It makes me to lose focus

P6: Yes. Sometimes they don't appreciate us. That thing of not appreciating us after doing something right, it's not good. They are able to blow small mistake out of proportion. It angers you when you think about the difficult situation that you passed through, but instead they turn blind eye on that. It makes your day a hell.

P2: The other thing is when your supervisor comes in and finds you with patients, and there is one patient who is sick. Instead of asking you about the patients, she asks you about the staff members. Do you understand? That thing makes us end up hating each other. The most important thing is that she must ask about the patients so that I can give her the report about what is happening. But once he starts to ask about the staff, their whereabouts, or what are they doing, is wrong. The important thing is when the patients are safe, with no injuries or something that might put us at risk.

RES: Ok. Is there anybody who wants to add on Vulnerability factors? What put you at risk? Within you. Or there are no more additional points?

P1: These things of gossiping. Those things affect me. People gossip about others. They talk about life of other people. Do you understand? These things affect you. Other people's life. You find that this lady met me here at work, but she knows my life more than me. You will hear a person telling you that this other person says you are doing these and that. I would be responding saying but that person does not know me. It is gossips. These things makes you to feel angered when you realise that you are going to work with somebody who is always looking at my life and I don't know what does she want in my life. Those things don't sit well with me.

RES: Bring it to my question. How does that play role in your resilience?

P1: It makes you to lose focus

RES: HHMMM!!! It makes you lose focus?

P1: Yes. Isn't it that I will be working with her? So I won't enjoy my work. She is not talking to me and I am not talking to her. There is no communication between us. You won't enjoy your work if both of you are not in good terms. Even when you climb a taxi coming to [REDACTED] once you remember that you are going to work together with Steve, you begin to feel sad if we can just focus on one thing, that we are here for the patient. We are not here for somebody else. We are here for the patient. All of us here, we are here for the patient, to nurse him, to give him life. Not life, because it is only God who knows life. We must work together, so that it becomes enjoyable. It must be like a place that I don't know. Like at church when we meet, you know when someone sings a Zion hymn, all of us join the song. It must be like that.

RES: Ok. I don't know if there is somebody who wants to add something, because I am looking at a time. I have exceeded time now. Is there anyone who wants to say something before I close this meeting?

P3: I don't have facts and I don't know if it is valid. I have worked in [REDACTED] for a long time. I am the one who have an experience. I worked at ward 10 and there was nothing to sign. In [REDACTED] sometimes lot of policies appears. When they bring them, they bring lot of policies at the same time. It becomes difficult to read them all. I just sign them and go inside. Isn't it that sometimes when you have done something wrong, they are able to draw that policy and find that you have signed, meaning that you agreed with it, although I didn't read it. I just signed it, I couldn't read them because they were too many. I think for me to avoid being in danger I must read and understand the policy before I sign it. I think it is dangerous to sign for something and at a later stage it binds me. Let me put it that way. The other thing even though we can't defeat it, although somebody here mentioned it earlier, you find that maybe it is 100 patients or more than forty in the block and it is only one nurse. After that, if something wrong happened, they don't look on the fact that I was alone. I must fill the injury forms even though I was alone and find myself under pressure, even though I was alone. I couldn't manage. Actually I was not supposed to manage because isn't it that according to the nursing

language there is a ratio that one nurse is supposed to nurse specific number of patients, but I end up nursing more than fifty patients alone in the block. When I am at the kitchen making tea or doing something for the patients, I can't see what is happening at the back. When I go back and find something happening, these things bind me. I must come and sign injury forms that they need supervision even though there is shortage of staff. Lastly just to be quick, we as nurses it very much important and we know it that we must know our scope of practice. If we don't know our scope of practice we end up in much trouble because we do everything and it is not our things. It is fine if you know your scope of practice, even though in [REDACTED] we end up ignoring it, and not following our scope. If you did something wrong, they don't want to hear anything from you because you did that thing and it is above your scope of practice. You get my point? But if I follow my scope of practice I am going to work according to the work that I was taught and I don't see myself being in trouble because I have an experience of those things and I read them. Let me leave it there.

P1: Now as you say that, with us here it is exactly the same situation. For example during December, I was working alone and the patients of our ward have tendency of absconding. One patient can tell the other one to run away. I have reported all these doors, that even if they are locked they open it as if they were not locked. They can just easily pull them and throw it away, and they go out. When you inform the manager he will tell you that the people on the other shift are not complaining. It happened that God made it that I worked alone on the very same shift. I found all doors locked with chains and padlocks. The very same shift that he said is not complaining, they are using chains and padlocks. One of our patients usually jumps the walls. He does not like to see chains. These doors are not safe even if you can push it with a chair; it is going to get opened, even if it is locked. It is not safe here. They would force you to write a report and tell where you were when the patient absconded. I ask my manager that but here you take chance. How can you ask me to write a report whilst I was alone? The whole month I was alone. You tell me to write a report that the patient absconded. How many eyes do you I have? I have two eyes and these patients are forty. You are not glad that I am on duty; instead you want me to write a report? Then they told me not to write it because they see that it is true that I was alone.

RES: I think I must close this meeting. Thank you for participating. Let me lock off before I close.

## **APPENDIX K: FIELD NOTES**

### **DESCRIPTIVE NOTES**

The focus group interview was attended by auxiliary nurses caring for intellectually disabled patients. Most of them have an experience of more than ten years working with intellectually disabled patients. Only one of them once worked under the supervision of the researcher, and rest were new to researcher's eyes. They maintained eye contact quite well throughout the focus group interview. One nurse was outspoken. Although some participants did not answer some questions, one would conclude that they were actively listening, shown by nodding their heads or saying "yahhh" as a sign of agreeing with a statement said by the other. There were no interruptions as they respected each other and gave each other a chance to speak. Auxiliary nurses appeared more relaxed after the interview when the recording devices was switched off.

### **REFLECTIVE NOTES**

Some participants were transported from different wards and others were already in the ward where the focus group interview was held. All of them arrived on time. They looked relaxed and ready for the interview. After the researcher asked his first question, there was few seconds of hesitation as no one was willing to start. The focus group interview started after the researcher explained difficult terms such as resilience and highlighting matters of confidentiality and anonymity. Although all of them were friendly and willing to share their perceptions regarding their resilience while caring for intellectually disabled patients, some of the participants were too quiet to share their perceptions. At the end of the focus group interview, after the audio recorder was switched off, some participants expressed their gratitude for being given an opportunity to be heard and they also requested that more sessions like this one be organised again.

### **DEMOGRAPHIC NOTES**

The focus group interview was conducted with seven auxiliary nurses on the 27 October 2015 between 19:30 and 20:30. Participants of the focus group interview were five females and two males. This interview lasted for 47 minutes. All participating auxiliary nurses were on duty for night shift at different wards, and the time was convenient for all of them researcher met with participants. Participants were transported from different

wards to the ward were private room was reserved for interview. Participants were seated around the table in such a way that everybody had a full view of one another. The researcher was speaking English and participants were responding in a language of their choices. They were answering in Setswana and Sesotho. The researcher used two audio recorders for improved audio quality and for backup. The room was noise free, well ventilated, and with warm temperature, thereby conducive for group interview.