

Professional nurses' lived experience of practising caring presence in a rural public hospital

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DECLARATION

I, Petronella Susara Hobbs, student number 24544167, hereby declare that this dissertation is my own work and that all the sources that I used or quoted, are indicated or acknowledged in the list of sources.

RHobbs. November 2017

Ronél Hobbs

Date

DEDICATION

***"... JULLE KRAG LÊ IN STIL WEES EN VERTROUE
HÊ..."***

JESAJA 30:15

***"... IN QUIETNESS AND CONFIDENT TRUST IS
YOUR STRENGTH..."***

ISAIAH 30:15

AMEN

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ABSTRACT

Background: Practising a caring presence is an important nursing intervention that is currently gaining more recognition in nursing science. Different nursing authors support the opinion that a caring presence is indispensable to high quality nursing care and patient-centred care and that meaningful relationships enhance wholeness and healing. However, a clear and rich description of what caring presence unique to nursing within the South African context would entail, is becoming increasingly important.

Purpose: The purpose of this study is therefore to explore and describe professional nurses' lived experience of practising caring presence in the context of a rural public hospital in the North West province, South Africa. New insights gained from this study may be used to guide nurses in the art of this nursing skill and in developing this attitude. The study aims to illuminate how caring presence can improve the quality of nursing care and enhance professionalism among nurses, and it makes recommendations on how to encourage nurses to implement the practice of caring presence within the nursing profession.

Methodology: In order to achieve the goal, a descriptive phenomenological design, specifically Husserl's approach, informed this study. Data were collected in a natural setting at a rural public hospital by means of audio-recorded, semi-structured interviews, aiming to capture the nuances of this lived experience. A purposive sampling method was utilised and the sample comprised of ten eligible (n=10) professional nurses, with varying years of working experience and qualifications, identified from a target population of fifty-nine (N=59) professional nurses. Furthermore, the researcher took field notes directly after the interviews and personally transcribed each semi-structured interview verbatim. Both the co-coder and researcher analysed and coded the transcribed interviews using Colaizzi's seven-step method.

Trustworthiness: Trustworthiness was demonstrated by providing rigour and strength to the study in accordance with the principles of credibility, dependability, confirmability, transferability and authenticity.

Ethics: The researcher adhered to various international and national health research ethics guidelines to ensure and maintain integrity throughout the life cycle of the project.

Data analysis: The findings of this research study were derived from the participants' responses. From the transcribed interviews, 319 significant statements were extracted, leading to the development of 319 formulated meanings that reflect the lived experiences of these professional nurses. Eleven theme clusters were formed from the formulated meanings, which further merged into five emergent themes.

Findings: The emergent themes include *professional caring presence, ethical caring presence, personal caring presence, healing caring presence and what caring presence is not*. All the themes are illustrated in a final thematic map. Each theme is discussed, supported by direct quotes and relevant data obtained from literature, and reduced to an exhaustive description. These descriptions provide a deeper understanding of these professional nurses' experiences regarding the practice of caring presence in this specific context.

Conclusions: The conclusion from the exhaustive description of the participants' lived experience of practising caring presence is that *professional nurses experience practising caring presence as fulfilling, professionally as well as personally, as an expression of their passion for the profession, as a way of portraying ethical care, a willingness to be personally present for patients, and as a healing experience that involves being dedicated and taking care of patients holistically. In addition, they indicated what caring presence is not: unprofessional and unethical behaviour or the depersonalisation of patients. These are barriers that hinder the practise of caring presence.* These research findings and conclusions serve as the basic structure for the derived recommendations for nursing education, nursing practice and nursing research. The rich information and insight gained from this study add to nursing's body of knowledge regarding caring presence.

Key words: caring presence, nursing presence, lived experience, descriptive phenomenology, rural public hospital.

OPSOMMING

Agtergrond: Die beoefening van 'n sorgsame teenwoordigheid is 'n belangrike verpleegintervensie wat algaande meer erkenning in die verpleegwetenskap ontvang. Verskillende outeurs binne die verpleegveld ondersteun die siening dat 'n sorgsame teenwoordigheid onontbeerlik is vir hoë kwaliteit verpleegsorg en pasiëntgesentreerde sorg en dat betekenisvolle verhoudinge heelheid en genesing versterk. 'n Duidelike en ryk beskrywing van wat sorgsame teenwoordigheid spesifiek binne verpleging in die Suid-Afrikaanse konteks behels, word dus toenemend belangrik.

Doelwit: Die doelwit van die studie was daarom om professionele verpleegkundiges se geleefde ervaring van die beoefening van sorgsame teenwoordigheid binne die konteks van 'n landelike openbare hospitaal in die Noordwes provinsie van Suid-Afrika te ondersoek. Insigte voortspruitend uit die studie kan bruikbaar wees vir die begeleiding van verpleegkundiges in die kuns van hierdie verpleegvaardigheid en vir die ontwikkeling van hierdie ingesteldheid. Die studie het ten doel om te belig hoe sorgsame teenwoordigheid die kwaliteit van verpleegsorg en professionalisme onder verpleegkundiges kan versterk. Die studie maak aanbevelings oor hoe verpleegkundiges aangemoedig kan word om sorgsame teenwoordigheid toe te pas binne die verpleegprofessie.

Metodologie: Ten einde die doelwit te bereik, is die studie ingelig deur 'n beskrywende fenomenologiese navorsingsontwerp, spesifiek Husserl se benadering. Data is ingesamel binne 'n natuurlike omgewing by 'n landelike openbare hospitaal deur middel van klankopgeneemde, semigestruktureerde onderhoude wat ten doel gehad het om die nuanses van hierdie geleefde ervaring vas te vang. 'n Doelgerigte steekproefmetode is gebruik en die steekproef het bestaan uit tien (n=10) geskikte professionele verpleegkundiges met verskillende jare se werkervaring en verskillende kwalifikasies. Die steekproef is geneem uit 'n populasie van nege-en-vyftig (N=59) professionele verpleegkundiges. Die navorser het verder veldnotas geneem direk na afloop van elke onderhoud en het elke semigestruktureerde onderhoud self verbatim getranskribeer. Beide die medekodeerder en die navorser het die onderhoude geanaliseer en gekodeer aan die hand van Colaizzi se sewe-stap metode.

Betroubaarheid: Vertrouenswaardigheid is geïllustreer deur die studie nougeset uit te voer ooreenkomstig die beginsels van geloofwaardigheid, bevestigbaarheid, oordraagbaarheid en outentisiteit.

Etiëk: Die navorser het verskeie internasionale en nasionale etiëkrylyne vir gesondheidsnavorsing nagevolg om die integriteit van die navorsing te verseker deur die loop van die navorsingsproses.

Data-analise: Die bevindinge van die navorsing is afgelei uit die deelnemers se response. Driehonderd-en-negentien betekenisvolle stellings is uit die getranskribeerde onderhoude onttrek, en dit het gelei tot die ontwikkeling van 319 geformuleerde opinies wat die geleefde ervaringe van die professionele verpleegkundiges weergee. Elf temagroepe is gevorm om die betekenis te formuleer, en dit is weer saamgevoeg in vyf opkomende temas.

Bevinding: Die opkomende temas sluit in *professionele sorgsame teenwoordigheid, etiese sorgsame teenwoordigheid, persoonlike sorgsame teenwoordigheid, genesende sorgsame teenwoordigheid en wat sorgsame teenwoordigheid nie is nie*. Al die temas is in 'n finale tematiese skema geïllustreer. Elke tema is bespreek, ondersteun deur direkte aanhalings en relevante data uit die literatuur, en vereenvoudig tot 'n uitvoerige beskrywing. Hierdie beskrywings bied dieper insig en begrip van hierdie professionele verpleegkundiges se ervaring van die beoefening van sorgsame teenwoordigheid binne hierdie spesifieke konteks.

Gevolgtrekkings: Die gevolgtrekking uit die uitvoerige beskrywing van die deelnemers se geleefde ervaring van sorgsame teenwoordigheid is dat *professionele verpleegkundiges die beoefening van sorgsame teenwoordigheid beleef as vervullend, professioneel en persoonlik, en as 'n uitdrukking van hulle passie vir die professie, as 'n manier om etiese sorg toe te pas, as 'n gewilligheid om persoonlik teenwoordig te wees vir hulle pasiënte, as 'n genesende ervaring wat toegewydheid aan holistiese pasiëntsorg insluit. Verder het hulle aangedui dat sorgsame teenwoordigheid onprofessionele gedrag en die verontpersoonliking van pasiënte uitsluit. Hierdie aspekte is struikelblokke wat die beoefening van sorgsame teenwoordigheid moeilik maak*. Hierdie bevindinge en gevolgtrekkings dien as 'n basiese struktuur vir die aanbevelings vir verpleegopleiding, verpleegpraktyk en verpleegnavorsing. Die ryk inligting en insigte wat uit hierdie studie blyk maak 'n bydrae tot die verpleeg kennis van sorgsame teenwoordigheid.

Sleutelwoorde: sorgsame teenwoordigheid, verpleegteenwoordigheid, geleefde ervaring, beskrywende fenomenologie, landelike openbare hospitaal.

ABBREVIATIONS

CEO	Chief Executive Officer
GHWA	Global Health Workforce Alliance
HIV	Human Immunodeficiency Virus
HIS	Health Systems and Innovation
HREC	Health Research Ethics Committee
INSINQ	Quality in Nursing and Midwifery Research Focus Area
MRC	Medical Research Council
NDOH	National Department of Health
NWU	North-West University
SA	South Africa
SANC	South African Nursing Council
SDS	Service Delivery and Safety
WHO	World Health Organization

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CHAPTER 1:

INTRODUCTION AND OVERVIEW OF THE RESEARCH STUDY

1.1 Introduction

The concept of caring presence is recognised as an extremely significant, valued core attitude in nursing practice and a crucial element in quality healthcare (Rowe & Kellam, 2013:135; Kostovich, 2012:167). Bright (2012:1) assumes that the state of *being present* with someone in need characterises the practice of professional nursing. A heart-touching example that illustrates *caring presence* can be found in the following moment of understanding:

“I have a patient, Bob, a high school teacher and soccer coach. He is 29 years old. He was admitted to our neurosurgical ICU with a broken neck. It was the last day of school. The teachers were having a party at the principal’s cottage at the lake. Bob dived into shallow water. One day an independent, active man, whole and mobile. The next, he lies in a hospital bed, motionless. No longer able to speak, blinking became his only means for communication—one blink for yes, two for no.

One day I sensed that Bob was having a rough time—I just knew. I could feel the tension. He was experiencing a lot of pent-up frustration. Just before leaving I bent over and said: ‘Bob, when I go for coffee..... I’ll scream for you.’

‘I’ll scream for you.’ What an odd thing to say. And yet, how perfectly appropriate did the nurse sense what was this person’s suffering predicament: the need to vocalize his feelings. Later, when Bob was breathing on his own, and able to talk again, he told this nurse: “I have been waiting all this time to tell you this: I was so grateful for your willingness to scream for me. This I will never forget! I had indeed the feeling that someone understood me. My desire to yell, scream, and cry out of utter desperation was heard.’ What the nurse did was lend the patient her voice, her throat” (Hawley, 2009:1).

Koerner (2011:xviii) agrees that the art and science of nursing have long been recognised as the hallmark of the health profession, but it is the *presence* of the nurse that is central to the discipline. She adds that when there is congruence between “who they are, and what they do, nurses bring their soul to work” (Koerner, 2011:xviii). The goal of this inquiry is to make known the significance and transformative potential of caring presence in the nursing profession by exploring and describing nurses’ lived experience of practising caring presence in a rural public hospital for future use in the practice, education and the research field.

The background and rationale, problem statement, research question and the research purpose are discussed in the sections to follow. This is followed by an explanation of the key terms and a discussion of the research design and methods. This chapter concludes with sections on rigour, ethical considerations, and outline of the dissertation, and a summary.

1.2 Background and rationale for the study

Pressed by the demands of performing endless tasks and practising numerous technological skills, nurses question how their *“being with”* can make a difference to a patient’s quality of life. They wonder if giving of themselves is an appropriate use of their time (Melnechenko, 2003:18). According to Parse (2011:1), caring presence is a *“standing with”* during a journey. The phenomenon of *caring presence in nursing* challenges the professional nurse to explore what it means to practise caring presence in the nursing profession. Campbell (2011:15) adds that offering caring presence is a complex expression of virtue ethic or moral excellence, and nurses should be guided in the art of this nursing skill. The qualities of nurses who practise caring presence include personal and professional maturity, self-knowledge and professional competence, an ethical orientation, and inter- and intrapersonal competence (Bright, 2012:26).

In addition, recognising the depth of the challenges facing nursing, the South African Department of Health highlighted professional ethos and ethics in nursing as one of seven important themes when they convened a National Nursing Summit in 2011 with the aim of *“Reconstructing and revitalising the nursing profession for a long and healthy life for all South Africans”* (NDOH, 2011a). There was a national call towards increased professionalism in nursing. However, the need to enhance professionalism in nursing is not unique to South Africa. Gokenbach (2010:1) emphasises that nurses should reshape their image within the global community as a matter of urgency. Therefore, in order to truly uphold professionalism in nursing, caring presence is a necessary approach for nurses that they should practise on a daily basis.

Similarly, in an effort to improve the efficiency and effectiveness of health systems, the World Health Organization Programme Budget 2014–2015 of the Health Systems and Innovation (HIS) Cluster launched Service Delivery and Safety (SDS), a new department as a *“centre of excellence”* within the World Health Organization. This department works externally and across the Organization to gather evidence and promote models and solutions for improved health service delivery across the care continuum. The objective is to help countries *“rethink health care”* (WHO, 2014). Consequently, patient outcomes are benchmarked to strive to achieve excellent results (Valentine, 2013:35). In this regard, Palmieri and Kittleley (2012:282) maintains that an attitude of *“true being”* and a gift of *“true presence”* enable the nurse to provide quality patient-centred care. Furthermore, the experience of caring presence is positively associated with quality of care by the patient and family, as well as increased job satisfaction by the nurse (Fingeld-Connet, 2006:12). Bright (2012:12) adds that when nurses practise caring presence in health institutions, these institutions are reformed in a profound and much needed way.

Recognising this crucial need in South African healthcare as well, the South African International Caritas Consortium, co-hosted by the Watson Caring Science Institute, USA, the University of

South Africa, the University of Johannesburg, and the International Association in Human Caring, addressed the importance of caring presence in nursing (Du Plessis, 2015; South African International Caritas Consortium, 2015). Also, a large private hospital initiated “Presence Communication – 50 seconds to connect” (Herselman *et al.*, 2015). The aim of this campaign is to enhance caring presence in nursing practice so that nurses establish a mutual understanding with patients within seconds. They have to be present and really connect (Herselman *et al.*, 2015).

Different authors support the opinion that caring presence in its multitude of meanings is indispensable to quality nursing care and that healthy therapeutic relationships enhance wholeness and healing (Boeck, 2014:1; Bright, 2012:5; Klaver & Baart, 2011:309; Kostovich, 2012:2; Parse, 2011:1; Rowe & Kellam, 2013:135; Tavernier, 2006:152; Taylor-Haslip, 2013:2; Turpin, 2014:14; Zybblock, 2010:122). According to Turpin (2014:14), caring presence capability is a nurse’s competence to create an inter-relational experience with a patient that produces positive patient outcomes. This capability is often equated to an individual’s ability to demonstrate the art of nursing practice. She further argues that the concept of caring presence has been explored and analysed using several methods over half a century, yet even with this effort, caring presence continues to retain a quality of sacredness with an internally *experienced nature* that up to now has been believed to be too internal to fully describe, understand, or enumerate (Turpin, 2014:14). However, clear and accurate knowledge regarding caring presence unique to *nursing* is becoming increasingly important. Rutherford (2012:193) makes it very clear that the capability of nurses to create caring and effective moments and environments is currently of crucial importance in all healthcare settings.

McMahon and Christopher (2011:72) base their view of caring presence on that of Dochterman and Bulechek (2004), namely that it is a nursing intervention that takes the form of being with another, both physically and psychologically, during times of need. They identify three levels of caring presence: physical (body-to-body), psychological (mind-to-mind), and therapeutic (spirit-to-spirit). Most researchers highlight the fact that nurses must be professionally, morally, relationally and personally mature to be able to enact caring presence (Bright, 2012:27; McMahon & Christopher, 2011:75). McMahon and Christopher (2011:75) state that professional maturity is the first characteristic integral to a nurse’s potential to offer caring presence. Consequently, an experienced nurse, who has sound theoretical knowledge and is comfortable practising as a nurse, has an advantage when faced with a clinical scenario in which caring presence is indicated. Therefore, the more expert the nurse is, the more likely he/she is to see the value that “being present” has for patients (McMahon & Christopher, 2011:75). However, it is also possible that the capacity to *be present* with a patient can be cultivated through reflective practices and an ethical orientation (Bright, 2012:27). Nurse scholars and authors have attempted to depict nurses’ experiences, actions, behaviours, communication styles, and the emotional attitudes that they

incorporate during caring presence (McMahon & Christopher, 2011:72). Nurse educators and professional nurses can utilise such knowledge to help novice nurses facilitate a caring presence experience between nurse and patient.

When focusing on professional nurses' lived experiences of practising caring presence in a South African context, the nature of the South African healthcare system and the effect it has on professional nurses, should be considered. According to Flood and Gross (2014:288), South Africa's two-tier healthcare system is highly inequitable. It is divided into a well-resourced private system that aims to meet the needs of a wealthy minority and an under-resourced public system that aims to meet the needs of the country's poor majority. The private sector is a profitable sector, as clients have a medical insurance that pays for services rendered by the healthcare providers, while the public sector is a state system that is publicly funded and free to all unemployed citizens or at a small fee to those who are able to pay. Flood and Gross (2014:300) maintain that the public healthcare sector is buckling under the weight of free services to the majority of the population, resulting in overcrowded clinics and hospitals, saddling personnel with unbearable workloads. Furthermore, the extraordinary additional disease burden created by HIV/AIDS, the decrease in training of nurses, and the increased migration of healthcare workers, result in a negative progress in relation to health outcomes and in a decrease in the quality of patient care outcomes (Flood & Gross, 2014:301). Leebov (2009:1) warns that nurses run the risk that their connection to their caring mission can fade because of pressured work environments, endless multi-tasking and intense workloads, as seen in South Africa. Nurses find this draining.

Similarly, research findings of a four-year-long research programme known as *Research on the State of Nursing* (RESON) show that nursing is a profession in peril. The profession requires urgent attention and revitalisation (Rispel & Bruce, 2015:8). Rispel and Bruce argue that the challenges that nurses and the nursing profession face include weaknesses in the policy capacity of the main institutions responsible for the leadership and governance of nursing in South Africa and a nursing practice environment that is fraught with resources, management and quality of care problems. Nurses in South Africa make up the largest single group of health service providers and their role in promoting health and providing essential health services is undisputed (NDOH, 2013). Unless nursing education reforms are implemented without further delay, and professionals who are workplace-ready and who have the relevant competencies to deliver appropriate healthcare are produced, a major crisis is looming in the nursing profession (GHWA & WHO, 2013). Rispel and Barron (2012:616) illuminate the fact that the country faces a "nursing crisis," characterised by shortages, a decline in professionalism, lack of a caring ethos, and an apparent disjuncture between the needs of nurses on the one hand and those of the communities they serve on the other. The context of this nursing crisis is South Africa's quadruple disease burden, the multiplicity

of health sector reforms, gender stratification and the existence of strong professional silos and hierarchies (National Planning Commission, 2011).

Furthermore, the National Department of Health has estimated a registered nurse shortage of 44 780 in the public health sector in 2011. This implies a severe shortage of registered nurses across all healthcare services (NDOH, 2011b). Another challenge is an ageing nursing workforce. The current national nursing strategy indicates that 43.7% of registered nurses are over 50 years of age (NDOH, 2013). According to the South African Nursing Council, a total population of 54 956 920 was served by 136 854 registered nurses in 2015, with a ratio of 402 persons to one registered nurse (SANC, 2015). This is of significance as South African registered nurses form the backbone of the South African healthcare system. Rispel and Bruce (2015:117) maintain that South Africa's quest for universal health coverage (NDOH, 2015b) to improve the population's health and to achieve equity and social justice cannot be achieved unless these issues are confronted.

As expounded in the discussion above, it is clear that nurses in the South African healthcare system are challenged by numerous factors that jeopardise their ability to render professional, high quality healthcare. Du Plessis (2016:3) emphasises that the essence of improving the quality of healthcare is the caring attitude and values of the nurse. Nurses experience positive consequences when they practise caring presence, such as enhanced resilience, leadership capacity, job satisfaction, learning and maturation, and self-confidence, which in turn lead to improved quality in nursing care (Brown *et al.*, 2013:E1; Finfgeld-Connet; 2006:527; Zikorus, 2007:209). Journaling, meditation, exercises, and mindfulness practices such as prayer, walking, breathing, and reflection are suggested to enhance caring presence (McCollum & Gehart (2010:347). Bright (2012:95) maintains that presence in nursing should be encouraged by describing it, praising it, and by providing practical support whenever possible. The implications of presence for nursing practice are strikingly described by Bright (2012:96):

“Nurses, as expert technicians and scientists, have been at the forefront of application of that technology. And yet, the best technology available cannot connect with a frightened person to gain their trust and soothe their fears before surgery, cannot discern the subtle nuances in a patients’ condition that signal despair, and cannot choose the right moment to hold the hand of a person who has just lost a limb, share the grief of that moment and affirm the humanity and resilience of that person. This is the art of nursing, and it is every bit as important as the skills and technologies nurses use to save lives. This humanitarian mission is at the heart of nursing practice. Nurses should embrace it and value it. To do otherwise is to remain voiceless.”

1.3 Problem statement and research question

The researcher experiences in her own professional practice that nursing devoid of caring presence may result in a profession with a catastrophic decrease in professionalism and inferior patient outcomes. The meaning of caring presence is often unseen or taken for granted in practice.

Nurses at rural public hospitals in South Africa are challenged by factors such as the shortage of personnel and resources, high patient-to-nurse ratios, unbearable workloads, poor management and the burden of HIV/AIDS and tuberculosis (Rispel & Bruce, 2015:117). Peterson *et al.* (2011:318) confirms that healthcare services in South African rural areas are particularly underserved. Many studies conducted in both the public and private healthcare sector describe the poor working environment and organisational climate in the South African healthcare sector (Jooste & Jasper, 2012:56; Peterson *et al.*, 2011:318). A critical look at the image of the nursing profession in South Africa furthermore portrays nurses in general as “overworked, uncaring, lazy, ruthless, incompetent and suffering from burnout” (Oosthuizen, 2012:53). In addition, reports of caring presence are often overlooked and/or not disclosed (Du Preez, 2014; Tjale & Bruce, 2007:46; Tokpah & Middleton, 2013:81).

Caring presence is discussed throughout literature as valuable to nurse-patient interactions (Curtis & Jensen, 2010:49; Andrus, 2013:14; Hansbrough, 2011; Monareng, 2012, 2013; Turpin, 2014:14; Reis *et al.*, 2010:675). However, the main focus of previous research has been the patients’ experience of presence (Andrus, 2013:14; Cantrell & Matula, 2009:E304; Crane-Okada, 2012:15; Granick, 2011:1; Kostovich, 2012:174; Newman, 2008:1; Rutherford, 2012:193; Williams *et al.*, 2011:3473). The professional nurses’ experience of caring presence has not been extensively explored, resulting in the need for research in this area. International literature confirms that interventions to promote caring presence should be developed because relational and caring aspects in nursing are currently at risk (Klaver & Baart, 2011:309; McMahon & Christopher, 2011:71; Rowe & Kellam, 2013:135).

Leebov (2009:1) assumes that nurses run the risk of their caring not coming across effectively to the patients and families they serve. She adds that spending more time with patients is not the answer and that suggestions that nurses should spend more time—time that they do not have—are maddening and breeds resistance to improvement strategies. Therefore, the focus should not be on the quantity of time, but on the quality of that time (Leebov, 2009:1). She advocates that advancing the skill of “presence,” will create breakthroughs in the patient experience and job satisfaction (Leebov, 2009:2). Parse (2011:1) states that true presence is a non-intrusive gentle glimpse that reaches the other with dignity, it is a “standing with,” during a journey.

Du Plessis (2016:47) maintains that it is important to reflect on how presence can be cultivated and suggests that further research is needed, specifically to explore and describe the enactment of presence by nurses. There is a huge gap in the South African literature on phenomenological studies exploring nurses’ lived experiences of caring presence in a South African context, especially in rural areas in the public healthcare sector where professional nurses have to cope with very limited resources and a heavy workload. Furthermore, Boeck (2014:2) states that

clarifying the significance of caring presence in nursing invites the prospect of additional evidence-based research that may place the intrinsic value of caring presence as a continuing theoretical foundation. Addressing the deficiencies in this body of evidence may have positive implications for nursing practice, education and research. Consequently, this knowledge may assist policy-makers, educators, researchers, and health organisations to preserve and enhance the therapeutic nursing intervention of caring presence, while ensuring that the art of nursing is not only sustained, but flourishes. Turpin (2014:15) concludes that presence leads to improved patient outcomes and additional improved professional satisfaction for individual nurses, and it is of vital importance to all healthcare settings. The above discussion leads to the following research question:

How do professional nurses working in a rural public hospital in the North West province, South Africa, experience practising caring presence?

1.4 Research purpose

This research study aims to explore and describe professional nurses' lived experience of practising caring presence within a rural public hospital in the North West province, South Africa. The purpose is to illuminate how professional nurses who care for large numbers of patients with a high acuity within a complex rural healthcare system, experience caring presence within a rural public hospital. The researcher therefore departs from the stance that there are nurses in this context who do practise caring presence.

1.5 Paradigmatic perspective

Botma *et al.* (2010:186) assume that no research is value free and the researcher has beliefs and assumptions about the world that reflect in his or her paradigm or worldview. According to Beck (2013:293), a paradigm offers the researcher a conception of reality (ontology) and an idea of scientific knowledge (epistemology), before generating specific procedures for research (methodology). The researcher supports the school of Husserl, who developed descriptive phenomenology, where everyday experiences are described while preconceived opinions are set aside or bracketed (Reiners, 2012:1). Converse (2012:30) assumes that in Husserlian or descriptive phenomenology, the phenomenon being studied is believed to be reality – a truth that exists as an essence and that can be described. Husserl's phenomenology therefore, emphasises getting to know a phenomenon by actually experiencing it (experiential epistemology) with the aim of describing the experience of the phenomenon.

The researcher's paradigmatic perspective is further described by meta-theoretical, theoretical and methodological statements.

1.5.1 Meta-theoretical statements

The researcher's meta-theoretical assumptions are based on her conception of reality, namely a Christian philosophy that is based on the Bible as the source of truth. Her assumptions regarding human beings, the environment, health, and nursing are described below.

1.5.1.1 Human beings

The researcher's view of human beings is connected to her view of God. God the Father, Son and Holy Spirit, is the Creator of heaven and earth. In Exodus 3:14–15b, God said to Moses: "**I AM WHO I AM and WHAT I AM, and I WILL BE WHAT I WILL BE**; This is My name forever, and by this name I am to be remembered to all generations". The Great I AM created man in his image and perfectness, but it is up to us to rise to the challenge; to be. He created human beings in His image and He has given us a free will to choose to stand in a relationship with Him. As all human beings are born sinful, we are only able to stand in a relationship with God through redemption in Jesus Christ. God has given us the command to love him above all else, and to love our fellow humans as we love ourselves.

For the purpose of the study, the term human beings refers to professional nurses, who are complex, magnificent, unique, multi-dimensional beings with the capacity to practise caring presence. Each human being is created for a specific purpose, with unique talents and gifts, and God provides us with the means, time and energy to fulfil this purpose. Human beings live within societal relationships and structures.

1.5.1.2 Environment

The environment is the sphere in which human beings live and serve God. It can also be referred to as society. Human beings are placed by God within societal structures such as workplaces, marriages, families, schools and governments. For the purpose of this study, the environment refers to the professional nurses' workplace within a rural public hospital.

1.5.1.3 Health

Based on a Christian philosophy, the researcher supports the World Health Organization's definition of health as "a (dynamic) state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, 1978). Health within a Christian perspective involves healing and wholeness, and therefore the physical, emotional, social and spiritual dimension of human beings are considered. In this research, health is seen as the outcome of caring presence practised by nurses, leading to a healing experience for both the nurse and the patient.

1.5.1.4 Nursing

For the purpose of this study, nursing is an art (authentic presence, compassionate care) and science (interventions, skills, nursing process, pharmaceuticals), and include activities that the nurse carries out for the benefit of the individual, family and community to promote, maintain and restore health, as well as care for the dying. Therefore, the researcher agrees with the statement of the pioneer of modern nursing that “nursing is an art: and if it is to be made an art, it requires an exclusive devotion as hard a preparation, as any painter’s or sculptor’s work; for what is the having to do with dead canvas or dead marble, compared with having to do with the living body, the temple of God’s spirit? It is one of the Fine Arts: I had almost said, the finest of Fine Arts” (Florence Nightingale, 1820–1910).

1.5.2 Theoretical statements

The theoretical assumptions in this research include the central theoretical statement and definitions of key terms, including caring presence, lived experiences, professional nurses, and rural public hospitals in the North West province, South Africa.

1.5.2.1 Central theoretical statement

The exploration and description of professional nurses’ lived experience of practising caring presence while working at a rural public hospital will address the need for research on how professional nurses experience caring presence. Such research is needed to gain insight into a moment of the now—not a generalization, but a description of a specific and unique moment of the experience (Van Manen *et al.*, 2016:5). It can therefore make known the significance and transformative potential of caring presence in the nursing profession for future use in the practice, education and research field. This research therefore has the potential to contribute to the improvement of quality healthcare within the nursing profession.

1.5.2.2 Definition of concepts

1.5.2.2.1 Caring presence

The Oxford Advanced Learner’s Dictionary (2016:1155) defines presence as “the state or fact of existing, occurring or being present.” The word originates from the Latin word *praesentia*, which means “being at hand.” Caring presence is defined by Kostovich (2012:169) as “an intersubjective, human connectedness shared between the nurse and the patient.” For the purpose of this study, caring presence is a connection to one’s own heart *to be* felt by patients and is enacted in special moments of *being there*, or *being with* another in times of need (Dochterman & Bulechek, 2004:580) and has three levels: physical, (body-to-body), psychological (mind-to-mind), and

therapeutic (spirit-to-spirit) (McKivergen & Daubenmire, 1994:65). It portrays the art of nursing and is the gift of one's self (Nelms, 1996:368) within the nursing profession.

1.5.2.2.2 Experience

Experience is the process of gaining knowledge or learning a skill by doing, seeing, or feeling things (Oxford Advanced Learners' Dictionary, 2016:514). Phenomenologically, Kisiel and Sheehan (2015:312) hold that in all of the psyches, pure lived experience (in the perceiving of something, in the remembering of something, in the passing of judgement about something, in the willing of something) is an intrinsic directedness towards something. Therefore, lived experiences are intentional and present to the individual what is true or real in his/her life. In this research, the lived experience of professional nurses working in a rural public hospital of practising caring presence was explored and described.

1.5.2.2.3 Professional nurse

A professional nurse is a nurse who is registered with the South African Nursing Council (SANC) in terms of Section 31 of the Nursing Act of 2005. Therefore, a professional nurse is qualified and competent to practice comprehensive nursing independently, in a manner and at a level prescribed to him/her and who is capable of assuming the responsibility and accountability of nursing. The focus in this research will be on professional nurses working in a rural public hospital in the North West province, South Africa.

1.5.2.2.4 Rural public hospital

For the purpose of this study, a rural public hospital is defined as a hospital funded by the National Department of Health that charges patients based on their income and number of dependents. A rural hospital is situated in an area located outside of the metros and lacks "urban characteristics," such as the availability of amenities and infrastructure (Eagar *et al.*, 2015:103). This research took place at a rural public hospital in the North West province.

1.6 Research design

In working with people, researchers have long realized that certain questions cannot be answered using quantitative research, as many of the problems that researchers face can only be studied in real-life situations (Brink *et al.*, 2012:120). The aim of the phenomenological approach in qualitative research is to describe accurately the lived experiences of people, and not necessarily to generate theories or models of the phenomenon being studied (Kisiel & Sheehan, 2015:344). In attempting to describe the lived experiences, the researcher focuses on what is happening in the life of the individual, what is important about the experience, and what alterations are needed,

all through the eyes of that person (Brink *et al.*, 2012:121). The phenomenological approach can be either descriptive, seeking to describe the lived experience, or interpretive, seeking to find meaning in the context of the lived experience (Gerrish & Lathlean, 2015:221). Descriptive phenomenology was developed by Husserl, who was primarily interested in the question: "What do we know as persons?" (Polit & Beck, 2014:270). Descriptive phenomenology was used to inform this study, as descriptive phenomenologists insist on the careful portrayal of ordinary conscious experience of everyday life (Polit & Beck, 2014:270), as is needed in this case. This design is discussed in more detail in Chapter 2.

1.6.1 Context of the research

The context of this research is a rural public hospital in the North West province of South Africa. This 120-bed, level-two district hospital forms part of the public healthcare sector. Approximately 59 professional nurses are employed at this hospital. This facility provides a comprehensive healthcare service that includes two operating theatres, trauma and emergency care, a high care unit, neonatal unit, maternity, medical, surgical, gynaecological and paediatric wards. This hospital serves large numbers of patients with a high acuity within a complex rural healthcare system.

1.7 Research method

The research method is discussed in detail in Chapter 2. The following is a summary of the research method in relation to the activities of sampling, data collection, data analysis and ensuring rigour.

1.7.1 Population and sample

The population for the research study included professional nurses in a rural public hospital in the North West province, South Africa. This rural hospital was selected as it represents a context where limited resources and equipment heighten the need for professional nurses to utilise caring presence to create a healing environment for patients. Furthermore, the researcher assumed that a sufficient sample (see explanation under 1.6.1) and 'information rich' participants (Borbasi & Jackson, 2012:135) could be found at this specific hospital. As generalizability in the statistical sense is not necessary or justified in this qualitative research study, non-probability, purposive sampling, also known as judgemental sampling, was used to recruit participants (Burns & Grove, 2009:355; Polit & Beck, 2014:284). Participants were selected for their knowledge about the phenomenon. They also had to have the ability to articulate and explain the nuances of their perspective on the phenomenon of interest (Brink *et al.*, 2012:139). During the Power point-presentation, presented at the specific rural public hospital, which formed part of the recruitment process, the researcher described and explained her definition of caring presence in detail with

the mediators, thus enabling them to identify suitable participants for this research study. According to Polit and Beck (2012:35) and Borbasi and Jackson (2012:135), purposeful selection of participants is used where the researcher aims to get in-depth and new information to answer the research question and the researcher purposely seeks typical and divergent data. Therefore, the eligible participants were selected purposefully (Grove *et al.*, 2013:365).

The criteria for inclusion in this study were that each participant had to be:

- a professional nurse;
- currently employed for at least one year in this rural public hospital, in the North West province, South Africa;
- proficient in English;
- willing to have interviews recorded on an audio recorder;
- voluntarily participating and willing to give written consent to participate in the study after being informed about the purpose and procedures of the research; and
- identified by a mediator as a professional nurse who practises caring presence as evidenced by behaviour such as not treating their patients as “a body in a bed” but as a holistic person, checking on patients regularly, comforts patients, responding to the needs of patients, making eye contact and portraying true interest and genuine care in the nursing profession.

The exclusion criteria were:

- nurses who form part of other nursing categories than professional nurses;
- professional nurses who are employed in the private hospital sector or any other sector than a rural public hospital;
- professional nurses who are employed part-time;
- professional nurses who had been working in a rural public hospital for less than a year; and
- those who were not proficient in English.

Polit and Beck (2014:286) state that data saturation consists of sampling to the point at which no new information is obtained and redundancy is achieved. Data were collected until adequate, quality-rich data were generated and when the repetition of data was apparent. The researcher aimed to include at least 12–14 participants (Latham, 2013:16) to ensure data saturation, keeping

in mind that the sample size of a qualitative study cannot be predetermined, as it depends on the availability of nurses who meet the inclusion criteria. Samples in qualitative research tend to be small and are often selected using purposive techniques (Borbasi & Jackson, 2012:135), like in this case.

1.7.2 Data collection

Permission to conduct the research was obtained from the North West Department of Health (see Annexure **A**) and from the management of the relevant rural public hospital (see Annexure **B**). In this research study, the manager of the rural public hospital acted as gatekeeper and the unit managers were asked to act as mediators to recruit participants and to obtain informed consent (see Annexure **C** for confidentiality agreement with mediators). The mediator had to be a person who could provide a link between the researcher and the possible participants who suited the inclusion criteria of the study (Botma *et al.*, 2010:203). The mediators were trained by the researcher and informed about the aim of the study and how to share the information. The mediators recruited the participants by sending an invitation (see Annexure **D**) to all possible participants who met the inclusion criteria and the identified participants were given time to consider if they want to participate (at least 24 hours). The willing participants gave written informed consent with a witness present (see Annexure **E**). An appointment was made with them for the purpose of data collection. Data collection took place during working hours in a private office or boardroom at the hospital with sufficient light and air conditioning.

Semi-structured, face-to-face individual interviews were preferred as a means of data collection because of the rich data they provide, such as nuances of the participants' experiences that may be conveyed by facial expressions, gestures, blushing, or tears (Polit & Beck, 2014:290). This gave the interviewer more insight into the participants' experience and it provided the participants with an opportunity to tell their story in their own words while ensuring that a specific topic is covered (De Vos *et al.*, 2011:351; Botma *et al.*, 2010:208). Qualitative researchers are research instruments and attempt to get as close to the data as possible (Creswell, 2014:237). Giorgi (2009:95) asserts that the questions that form part of a phenomenological interview should meet the criteria of description. According to Englander (2012:25), the researcher should ask for a description of a situation in which a participant has experienced the phenomenon, because asking for a description of a situation is vital in descriptive phenomenology, since the discovery of the meaning of a phenomenon has to be connected to the specific context in which it was experienced. Therefore, the researcher used open-ended questions to encourage participants to describe their experience fully (Welch, 2015:31). The focus questions of the interview included: "Can you please describe a situation where you practised caring presence as a professional nurse?" and "How do you experience practising caring presence?" Subsequent questions for clarification were guided

by the participants' responses to the initial questions and the phenomena were probed with the participant until it was illuminated and described (Botma *et al.*, 2010:208; Polit & Beck, 2008:208). Merriam and Tisdell (2016:124) assume that working from an interview schedule allows the researcher to gain the experience and confidence needed to conduct an interview. A copy of the interview schedule is included (see Annexure F). The interview schedule and questions were developed in line with the research question and purpose, and were reviewed by the supervisors and peers (INSINQ scientific research committee). The purpose of the first focus question was to verify the eligibility of the participants and to gain insight into the *lifeworld* of the participant. The purpose of the second question and following probing questions were to explore the professional nurses' lived experience of practising caring presence. The approach of semi-structured interviews with only two open-ended questions is similar to recent phenomenological research conducted by Welch (2015:31) and Webb *et al.* (2014:731-741).

The interviews were audio-recorded and the participants were made aware that the interview would be recorded prior to the beginning of the interview. In addition, the researcher reminded the participants of a second contact with them via telephone to discuss the study findings and to make sure the findings reflect their own experiences. The researcher took notes during the interview, but this was kept to a minimum in order to maintain attentiveness and openness to what the participant was saying. De Vos *et al.* (2011:345) recommend that the researcher should employ communication strategies to glean in-depth descriptions from participants, encouraging them to reach into their own perspectives and express their thoughts, such as minimal verbal responses, for example occasional nodding, or responding with: "yes, I see." Paraphrasing that enhances meaning, clarification, reflects back on something, encourages the participant to pursue a line of thought, comments, spurs, listens, provides reflective summary or probes were also utilised (De Vos *et al.*, 2011:345). Immediately following the interview, the researcher took field notes in the form of detailed personal, observational and reflective notes on her own impressions of the interview. This ensured that all observations as well as the ideas in the interviewer's mind were noted, allowing the researcher to reflect on her own biases, preconceived ideas, behaviour and experiences so that she could separate it from the findings.

The researcher evaluated the applicability of the interview questions during the first interview. This enabled her to identify any shortcomings and problems and to adjust and implement changes to increase the effectiveness and efficiency of the interview to benefit the study.

1.7.3 Data analysis

Gerrish and Lacey (2010:180) point out that phenomenologists use the term "lifeworld" or "lived experience" instead of the term *data*, and that individual experiences are the starting point for inquiry. According to Polit and Beck (2014:270), phenomenological analysis involves the following

four steps: bracketing, intuiting, analysing and describing. Descriptive phenomenologists strive to bracket preconceived beliefs and opinions about the phenomenon under study in an effort to confront their data in pure form (Polit & Beck, 2012:228). Intuiting occurs when researchers remain open to the meanings attributed to the phenomenon by those who have experienced it. The researcher analysed the data as discussed below, and described the results in the dissertation.

In qualitative research, data analysis is almost always conducted concurrently with gathering data (Botma *et al.*, 2015:220). As participants were interviewed, the process of data analysis was conducted by reflecting on their responses and making memos and notes. Transcripts and field notes were sent to an independent and experienced qualitative research co-coder. A confidentiality agreement between the researcher and co-coder was utilised to maintain the confidentiality of any confidential information (see Annexure G). Following the interviews, the data were transcribed and the researcher engaged in prolonged immersion with the data, while identifying and describing the true *essence* (or essential structure) of the experience (Gerrish & Lacey, 2010:181).

Each of the interviews was transcribed from the audio recorder to a Microsoft Word document by the researcher. Data were coded and analysed using Colaizzi's seven-step method (Colaizzi, 1978:48-59), which entails the following steps:

1. Each transcript should be read and re-read to get a general feeling for the content.
2. Review each transcript, and extract significant statements.
3. Spell out the meaning of each significant statement and formulate meanings.
4. Organize the formulated meanings into clusters of themes.
 - Refer these clusters back to the original transcripts to validate them.
 - Note discrepancies among or between the various clusters, avoiding the temptation of ignoring data or themes that do not fit.
5. Integrate results into an exhaustive description of the phenomenon under study.
6. Formulate an exhaustive description of the phenomenon under study in a clear and unambiguous statement as possible.
7. Ask participants about the findings thus far as a final validating step. This step aims to validate study findings using "member checking" technique. Participants' views on the study results will be obtained and discussed via telephone calls. If necessary, new findings from

these conversations should be integrated into the final description of the interviewee's experience.

1.7.4 Literature integration

In qualitative phenomenological studies, a literature review *after* data collection and analysis assists the researcher in limiting preconceived ideas about the phenomenon under study and to set aside biases that might influence the research (Botma *et al.*, 2010:196; Burns & Grove, 2009:91; Creswell, 2014:29; Speziale & Carpenter, 2007:97). Therefore, literature integration was done after data analysis in order to compare, contrast and merge the unique findings of this research with similar studies. Ebscohost, Google Advanced Search and Science Direct were used as search engines for articles, theses and dissertations reporting similar studies. The literature included journals, books, policies, newspaper articles, and conference presentations relevant to this research.

1.7.5 Trustworthiness

The concept "trustworthy" refers to the rigour of qualitative research (Polit & Beck, 2012:583). Rigour involves the principle of the truth value of the research outcome (Brink *et al.*, 2012: 97). Burns and Grove (2009:39) maintain that it is the "striving for excellence in research" that requires discipline, adherence to detail and meticulous accuracy. Trustworthiness in qualitative research was proposed by Guba and Lincoln (1994) as a substitute for reliability and validity. They identified five criteria to determine trustworthiness in qualitative research, namely credibility, dependability, confirmability, transferability and authenticity (Polit & Beck, 2014:323).

A number of strategies were employed to comply with these criteria to ensure the trustworthiness of the study, such as "member checking" by getting telephonic agreement from the participants on the results before finalising the research report (Polit & Beck, 2012:591) as described in the last step of Colaizzi's seven-step method of data analysis (Colaizzi, 1978:59). The researcher strived to achieve credibility with activities such as reflexive journaling, prolonged engagement, peer debriefing and enabling an audit trail (Lincoln & Guba, 1985:304-313). Therefore, the researcher kept a journal during the research process to reflect on herself as an interviewer and to ensure that her own experiences, background and perceptions were separated from those of the participants. Prolonged engagement refers to spending sufficient time collecting data in order to obtain a more accurate understanding of the participants and the phenomenon under study (Polit & Beck, 2012:589). Participants were allowed as much time as they needed to tell their story, as this also allowed the researcher sufficient time collecting rich data and to develop a relationship of trust and rapport with them. Misperceptions and distortions were also detected and clarified

through prolonged engagement. Field notes, a clean set of transcriptions, and the interview schedule were made available for auditing.

In addition, the researcher identified and held in abeyance preconceived beliefs and opinions of caring presence using bracketing (Polit & Beck, 2014:270). Furthermore, peer group discussions were utilised as a strategy to support credibility in this study. The researcher used an opportunity to present the study to peer Masters degree students at the NWU, defending her arguments and receiving feedback on the study proposal. Also, the researcher and co-coder had discussions after the interviews when coding took place.

Dependability was ensured by keeping a detailed account of the research process in order for the process to be traceable and clearly documented to allow another researcher to follow the research process. This was done by documenting the research in the form of a dissertation, and by keeping field notes as discussed under "Data collection."

Furthermore, confirmability was established by clear and well-prepared documentation (Gerrish & Lacey, 2010:355). The written field notes and verbatim capturing of the semi-structured interviews made auditing possible.

In order to achieve transferability in this study, a highly descriptive and detailed report of the findings of the demographic information of the participants and of the context of the research, was presented (Polit & Beck, 2014:333) for evaluation at the NWU.

Authenticity refers to the extent to which the researchers indicate a range of realities in a fair and faithful manner (Brink *et al.*, 2012:173). Therefore, the researcher's report conveyed the lived experiences and feelings of the participants as they were lived.

1.8 Ethical considerations

Creswell (2014:92) highlights that researchers involved in research with human participants should have special concerns related to the protection of human beings' rights as ethical issues can manifest in any study. Commonly accepted international ethical principles of health research were applied as outlined in the Helsinki Declaration, the Belmont Report and the Nuremberg Code as described by Burns and Grove (2009:184-185) and Brink *et al.* (2012:33-34). At a national level, the researcher adhered to the code of ethics as stipulated by the National Health Research Ethics Council (NDOH, 2015a). A research proposal was submitted to the INSINQ research committee, after which it was sent to the NWU Faculty of Health Sciences Health Research Ethics Committee (HREC), Potchefstroom Campus (Annexure H). Ethical approval was obtained from the North West Department of Health (Annexure I) and the management of the rural public hospital gave

written permission (see Annexure J). Specific ethical principles were also adhered to, as discussed below.

1.8.1 Respect for the autonomy of participants

The participants' decision to take part or to decline was respected, as was the fact that the partakers could withdraw from the study at any time if they wished, without any threats to their wellbeing (Brink *et al.*, 2012:39). The participants were allowed to withdraw from the research if they felt uncomfortable or too anxious to continue. Mediators was involved, as discussed, and written informed consent was obtained. The principle of respect for persons was very important in this study and the dignity of the participants was honoured and preserved at all times during the research study. Consequently, the researcher fulfilled all promises, was punctual for appointments and the participants' culture and traditions were respected (Botma *et al.*, 2010:17). The researcher considered the interests of the participants and no physical harm or exploitation occurred (Grove *et al.*, 2013:125). Therefore, all participants were treated tactfully and courteously at all times (Botma *et al.*, 2010:17).

1.8.2 Justice

According to Brink *et al.* (2012:36), the "principle of justice" refers to the fair selection and treatment of participants. Therefore, the selection of participants was based on reasons directly related to the research problem, and not on whether they were readily available or could easily be manipulated. The right to privacy was respected and all information collected remained anonymous and strictly confidential.

Creswell (2014:96) maintains that an informed consent form should contain a standard set of elements that acknowledges the protection of human rights. Therefore, the researcher utilised the informed consent form provided by the HREC, NWU of the Potchefstroom Campus. This form stipulated clearly the ethical principles of voluntary participation and protection from harm (see Annexure E).

1.8.3 Favourable risk–benefit ratio

The participants did not benefit directly from the research. Potential benefits included the fact that the participant contributed to the generation of increased knowledge regarding caring presence in the nursing profession. This can lead to recommendations for nursing practice, education and future research to illuminate and enhance the therapeutic and much needed nursing intervention of caring presence. Walliman (2006:148) states that researchers are ethically obliged to ensure that they are competent. The researcher was supervised to undertake the proposed investigation. Furthermore, the researcher maintained the wellbeing of the participants by protecting them from

harm and discomfort on physical, psychological, emotional, spiritual, economic, social or legal level (Brink *et al.*, 2012:35). Participants were informed of the risks by means of the informed consent form. The risks of this study were minimal, and included the possibility of emotional discomfort due to participating in an individual interview. The researcher was on the outlook for cues of physical discomfort or emotional distress of the participants during the interviews. If distress occurred, the researcher facilitated debriefing by giving them the opportunity to attend debriefing sessions after each interview if they needed to (Jooste, 2010:279). Furthermore, the participants were given the opportunity to ask questions or air complaints (Brink *et al.*, 2012:36). As semi-structured interviews can take more than 45 minutes, breaks were provided and all interviews were conducted in a private, quiet area with no disturbances. The interviews were conducted during work hours for the convenience of the participants and to ensure that no financial costs were involved.

The *safety* of the participants was considered as the venues where the interviews took place had safety and evacuation plans in place and the participants were orientated on them as it was part of the rural hospital's protocol and policies.

1.8.4 Anonymity, confidentiality and privacy

Only the researcher and mediators knew the identity of the participants and the researcher assured the participants that the records and transcripts would be coded and numbered and all data would be kept confidential (Burns & Grove, 2009:196). Consequently, there were no clues or links regarding their identity. Confidentiality agreements were signed by the researcher, co-coder and mediators. The audio recordings were destroyed by deleting it from the audio recorders after the transcription process. All the information and data were stored on the researcher's password-protected computer and it is stored in a locked cupboard in the office of the research director of the INSINQ research focus area, for a period of 5 years. The rights of privacy of participants were maintained by ensuring that the private information was not shared (Burns & Grove, 2009:194).

1.8.5 Role player engagement

The researcher requested permission from different role players to conduct this study (see Annexures **A** and **B**). After the potential participants were informed about this study and a positive response to the invitation was received, the mediator explained the aim and method of data collection to them. The participants were requested to give written informed consent. The physical setting for data collection was identified beforehand. The research setting, according to Burns and Grove (2009:362), is the location where a study is conducted. According to Polit and Beck (2012:8), a physical setting is an environment within which human behaviour unfolds and it should not be inhibited. The environment was set to cultivate psychological autonomy and enhance

participation. Therefore, scheduled interviews were conducted by the researcher in a relaxing and well-ventilated office in the hospital. The interviews were held during work hours for the convenience of the participants.

1.8.6 Researcher expertise and competence to conduct the research

The researcher completed a module on research methodology at Master's degree level and conducted role-plays to practice semi-structured individual interviews. These were presented to the supervisors for feedback. Both supervisor and co-supervisor have experience in conducting qualitative research and were able to guide the researcher in this research.

1.8.7 Remuneration

Participants were not paid to take part in the study, but refreshments were provided after the interview in the form of cold drinks.

1.8.8 Scientific integrity

The researcher aimed to utilise scientifically appropriate methods in conducting the research in an effort to enhance the integrity of the research. Furthermore, the research proposal was submitted to the scientific committee of the relevant research focus area, namely INSINQ, for scientific approval to increase integrity.

1.8.9 Relevance and value of the research

This study is relevant in nursing, as professional nurses' experience of caring presence in the context of a rural public hospital has not been explored extensively, necessitating research in this area. Consequently, this research study may contribute to the understanding of the concept and the experience of caring presence in the South African context. Furthermore, this research will benefit professional nurses by providing more information with regard to practising caring presence in their work environment.

1.8.10 Management and dissemination of research results

Results were not masqueraded, made up or falsified, and all the participants and co-workers were acknowledged. Policies regarding plagiarism and copyright as described in the Manual for Master's and Doctoral Studies (NWU, 2016:23) were taken into consideration. The findings of the research are available in the form of a dissertation and the researcher aims to publish an article in a relevant peer-reviewed journal. The research report was handed to the hospital's management. In addition, the researcher conducted a PowerPoint presentation of the results to management and invited professional nurses, including the participants, to this presentation.

Furthermore, strategies and recommendations to implement and enhance the practice of caring presence were shared with them.

1.8.11 Monitoring plan and progress report

The progress of the research and adherence to the ethical aspects as set out in the ethical guidelines of INSINQ and HREC were monitored by the supervisor and co-supervisor of this study during regular meetings with the researcher. The researcher documented the research in the form of a dissertation and kept field notes as discussed under “Data collection.” The research supervisors submitted bi-annual reports on the progress of the study to the faculty of Health Sciences and the HREC. Should any unfortunate events have occurred, the researcher would have reported it immediately to HREC. Should a need for any amendments have occurred (Grove *et al.*, 2013:351), the researcher undertook to put a request in writing and send it to HREC for approval before any amendments would have been made. No unfortunate events occurred, and no amendments were necessary.

1.8.12 Conflict of interest

There was no personal or financial conflict of interest in this study, as the researcher was not employed in the public hospital sector and did not have any hierarchical or power relationship with the population under study.

1.9 Outline of the dissertation

The division of chapters is the common structure used for a dissertation that involves empirical research (Burns & Grove, 2009:111).

The chapters are divided as follows:

Chapter 1: Introduction and overview of the research study

Chapter 2: Research methodology

Chapter 3: Report on research findings and literature integration

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

1.10 Summary

This chapter presented the reader with an outline of the study. The introduction provided a short description of the study, followed by the background, problem statement, research question, purpose and paradigmatic perspective. The design, data collection methods and analysis of data

were also discussed. This was followed by a cursory overview of the measures to ensure trustworthiness and ethical considerations. Chapter 2 discusses the research methodology in detail.

CHAPTER 2:

RESEARCH METHODOLOGY

2.1 Introduction

Chapter 2 provides a discussion of the methodology used in this study. According to Burns *et al.* (2013:270), research methodology is the process or plan the researcher follows to undertake the specific steps of the study. This chapter begins with a discussion of the rationale for selecting a descriptive phenomenological design for this study. The subsequent sections discuss the use of phenomenology in nursing and descriptive phenomenology as a research method. This is followed by a description of the research setting, population, the sample and the procedures for data collection and data analysis. The chapter concludes with a discussion of how trustworthiness was established and the ethical considerations pertaining to this study.

2.2 Research design

Creswell (2014:5) assumes that the research design consists of philosophical assumptions as well as distinct methods or procedures. The broad research approach is the plan or proposal to conduct research and involves the intersection of philosophy, research designs and specific methods. Polit and Beck (2008:17) submit that qualitative research is a type of scientific research and investigation that seeks to understand a given research problem or topic from the perspectives of the population it involves. According to Botma *et al.* (2010:182), health professionals often ask questions about the reality they face in healthcare or a reality they would like to understand better. Qualitative research sheds light on such issues and produces data in the form of words related to a specific phenomenon—data in the form of feelings, behaviour, thoughts, insights, and actions, as is needed in this research study (Creswell, 2014:190). The rationale of this qualitative study is not to quantify the data or to generalize the findings (Brink *et al.*, 2012:121), but the purpose is in-depth description and understanding of professional nurses' beliefs, actions and events with respect to practising caring presence in all its complexity (Leedy & Ormrod, 2010:135). Consequently, the researcher relied on the utilization of intuitive and felt knowledge of the participants, because the nuances of their multiple realities could be appreciated most in this way (Creswell, 2014:205).

Furthermore, qualitative research occurs in natural settings and qualitative researchers collect data in the field at the site where participants experience the issue under study (Creswell 2014:205). A qualitative phenomenological research design would be most suitable for this research as the research study aimed to explore and describe professional nurses' lived experience of practising caring presence within a specific context. Leedy and Ormrod (2010:135)

rightly suggest that “we need to dig deeper,” and that is exactly what a researcher does when choosing a qualitative method. Marshall and Rossman (2011:2) and Brink *et al.* (2012:11) confirm that this type of research design is useful when the focus is on describing the subjective experiences of the participants. Therefore, the strength of the present qualitative research is its ability to provide rich descriptions of how people experience the given research issue (Brink *et al.*, 2012:121) and it provides information about the human side of this issue.

Qualitative research involves basic characteristics as explained by Marshall and Rossman (2011:2-3), Brink *et al.* (2012:11) and Creswell (2014:205-206). Creswell (2014:205) states that in qualitative research, participants are not brought into a lab, nor do researchers typically send out instruments for individuals to complete. In the natural setting, the researcher has face-to-face interaction with the participants. The research question guiding this study can only be answered in the real-life situation and in a natural setting. Therefore, during this study, the researcher had face-to-face interaction with participants at a private location in the hospital by means of individual semi-structured interviews. The researcher is the key instrument in data collection (Creswell, 2014:185). In this research study, the researcher attempted to get as close to the data as possible by conducting the interviews herself, listening to the individual descriptions of the phenomenon through the interview process and by personally transcribing the audio-recorded data verbatim. As qualitative research is based on assumptions that are very different from quantitative designs, the focus in this research study is on participants’ perceptions and experiences, and the way they make sense of their lives. The attempt is therefore to understand not one, but multiple realities of practising caring presence.

In addition, qualitative research focuses on the process that is occurring and on the outcome. In this case, the researcher was particularly interested in describing and exploring the lived experience of practising caring presence as it occurred in a rural public hospital. In addition, the study aimed to illuminate how caring presence can improve the quality of patient-centred nursing care and enhance professionalism among nurses. Idiographic interpretation was thus utilised (Creswell, 2014:206) and data were interpreted by considering the unique particulars of a case rather than generalizations. The researcher makes knowledge claims of individual experiences in this research report with the aim of providing a thorough description of the phenomenon that was examined. Therefore, preconceived ideas and assumptions were bracketed to gain insight into the universal essences or common features of the phenomenon under investigation. This enabled the researcher to describe the true nature of the experience (Wojnar & Swanson, 2007) of practising caring presence.

The research tradition thus relies on the utilisation of tacit knowledge (intuitive and felt knowledge), because often the nuances of the multiple realities can be appreciated most in this way (Creswell,

2014:206). Therefore, the data gathered in this study were not quantifiable in the traditional sense of the word, but the purpose was to explore and describe professional nurses' lived experience of practising caring presence.

Furthermore, qualitative research is an emergent design in its negotiated outcomes (Creswell, 2014:207). In other words, meanings and interpretations were negotiated with human data sources in this current research study, because it is the realities of the participants that the researcher attempted to reconstruct and describe.

2.3 The use of phenomenology in nursing

Phenomenology, as a form of qualitative inquiry, seeks to describe and understand the meaning of human experience and provides rich data regarding the phenomenon of interest (Lanzara, 2014:45), namely the professional nurses' lived experience of practising caring presence. Furthermore, the philosophical underpinnings of phenomenological thought are consistent with the values of nursing and caring presence, which include the "uniqueness of the person, the importance of personal discovery, acceptance of life situations, the need for exploration of the meaning of experience, interpersonal relating, and the potential for personal growth" (Edward, 2006:237). In addition, the researcher supports the use of phenomenological methods of enquiry, because they are ideally aligned with the purpose of this research, where creativity and self-actualisation will be valued, and knowledge of professional nurses' unique experience will be accessible through conversation (Kim & Kollack, 2005:141; Sokolowski, 2000:26).

Phenomenologists subscribe to the notion that the true meaning of a phenomenon is rooted in the daily experiences of human beings and the interaction of these human beings is the essence of truth (Parè, 2015:1). Phenomenology explores these truths through a specific rigorous process (Sokolowski, 2000:20). Therefore, during this study, knowledge was generated by recounting experiences, an act that is subjective in nature, recognising that the meaningful experiences of individuals can only be understood through their situation and context (Creswell, 2014:206; Richards & Morse, 2013:68). Based on the nature of the study, qualitative phenomenological research was therefore the best approach applicable to this study.

2.4 Descriptive phenomenology as a research method

According to Gerrish and Lathlean (2015:221), the phenomenological approach can be either descriptive, seeking to describe the lived experience, or interpretive, seeking to find meaning in the context of the lived experience. Four significant historical figures in the development of phenomenology include Edmund Husserl, Martin Heidegger, Jean-Paul Sartre, and Maurice Merleau-Ponty (Lewis & Staehler, 2010:111). Edmund Husserl (1855-1938), a philosopher and

mathematician, is often regarded as the “father of phenomenology” (Beck, 2013:133; Davidson *et al.*, 2011:319).

Coming back to this study, the purpose of this research study was to explore and describe professional nurses’ lived experiences of practising caring presence in a rural public hospital in the North West province, South Africa. The research question that guided this study was: “How do professional nurses working in a rural public hospital in the North West province, South Africa, experience practising caring presence?”

In order to achieve this aim, a descriptive phenomenological method, specifically Husserl’s approach, was chosen to inform this study. Descriptive phenomenology is concerned with the careful portrayal of ordinary conscious experience of everyday life (Polit & Beck, 2014:270; Reiners, 2012:119). Therefore, this method allowed the researcher access to the lived experience of professional nurses practising caring presence within the nursing profession.

Since many of the core concepts commonly used in Husserl’s phenomenological methodology may be unfamiliar to the reader, definitions for these concepts and terms are provided below. The following concepts associated with this approach are defined:

- *Lifeworld*: Phenomenological research begins with gathering examples of everyday experiences, describing them and reflecting on them (Gerrish & Lacey, 2010:178). Husserl called these everyday experiences the “*lifeworld*,” while other phenomenologists have used the term “lived experience” (Speziale & Carpenter, 2007:97; Van Manen *et al.*, 2016:35). This lifeworld includes taken-for-granted assumptions about everyday life (Rice & Ezzy, 1999:15). Therefore, the natural language of the participants is used to come to a genuine understanding of their world (De Vos *et al.*, 2011:66). With regard to this research, practising caring presence in the context of a rural public hospital occupies a large part of the professional nurses’ everyday lifeworld and lived world. According to Husserl, the lifeworld is complex and it is the task of the researcher to attach linguistic meaning to the phenomenon in the lifeworld or world of lived experience. Consequently, the researcher focuses on the exact words of the participants who experienced and lived practising caring presence in order to explore and describe the phenomenon (Wertz, 2005:169). This will allow new understanding of the phenomenon to emerge from its raw state and thereby emphasise both the unique and the essential about the lifeworld of the individual.
- *Essences*: According to Husserl’s beliefs, the purpose of focusing on experiential phenomena is to find insights that apply more generally beyond the cases that were studied to emphasise what we may have in common as human beings (Gerrish & Lacey, 2010:178). Such common themes are called *essences or significant statements*. Husserl believed that bracketing helps

to gain insight into common features of any lived experience. In this case, the explicit elements of the experience of practising caring presence (i.e., as shared by many) provided an understanding of the reality of the experience from the participant's perspective (Lewis & Staehler, 2010:112). In addition, Husserl referred to these common features as universal essences and considered them to represent the true nature of the phenomenon under investigation (Shosha, 2012:32). In this study, the researcher thus aimed to reveal universal essences of the phenomenon of practising caring presence and not to generalize the findings.

- *Epochè*: This is a Greek word meaning to refrain from judgement, to abstain from or stay away from the everyday, ordinary way of perceiving things (Moustakas, 1990:33). *Epochè* is an essential component of Husserl's phenomenological methodology, as he stated that beliefs about an event are frequently a result of what we are told about that event, rather than analysing that event for ourselves; or of an individual interpretation based on prior experiences that resulted in prejudices (Gerrish & Lacey, 2010:178). In this study, the procedure known as *epochè* was utilised to suspend the researcher's acceptance of the natural attitude or naïve metaphysical attitude (Zahavi, 2003:43). The researcher applied this principle by exploring taken-for-granted statements during data collection by making use of communication techniques such as reflection, paraphrasing and clarification.
- *Bracketing and phenomenological reduction*: According to Gerrish and Lacey (2010:178), the idea of bracketing is another important concept that describes the efforts of researchers to suspend their preconceptions so that they approach the phenomenon to be studied with "fresh eyes." Husserl called this *phenomenological reduction*, where a certain open-mindedness is achieved. He argued that in such openness, something new could be discovered that is not tainted by previous theory or taken-for-granted assumptions. In practical terms, this involves a certain self-discipline similar to true listening in which one lets the information and data "speak" more fully before imposing one's own understanding or interpretation (Polit & Beck, 2012:228). In this research the researcher strove to engage in *an attitude of phenomenological reduction and open-mindedness* by compiling and keeping records of her thoughts, feelings and involvements, and about her own preconceptions (Hammil & Sinclair, 2010:18) in the form of a reflexive journal (see Annexure **M**). Speziale and Carpenter (2007:96) agree that the reflexive journal assists the researcher to facilitate the phenomenological reduction and to exclude bias (Polit & Beck, 2012:228).
- *Intuiting*: Husserl regarded *intuiting* as the ultimate principal of phenomenology. It refers to the act of describing an experience without interpretation or judgement. He believed that *intuiting* is the only method of knowing from a phenomenological perspective because it is devoid of things we have been told or that we inherited from other sources (Speziale & Carpenter,

2007:76). In this study, the researcher avoids all criticism and prejudices, and pays strict attention to the phenomenon as it is described by the participants. This mode of bracketing and intuiting forms part of an ongoing discipline throughout this research process to ensure that the phenomenon is studied in its pure form, as it is lived (Gerrish & Lacey, 2010:179; Polit & Beck, 2012:496).

As the expression, “to the things themselves”, is often associated with the work of Husserl (Speziale & Carpenter, 2011:76), the researcher applied *epochè*, bracketing and intuiting by staying close to what is given to her in all its richness and complexity, and restricted herself from “making assertions which are supported by appropriate intuitive validations” (Giorgi, 1986:9). Therefore, it is hoped that by utilising this method of inquiry, the essence of the professional nurses’ experience of practising caring presence within a rural public hospital in the North West province, South Africa is captured. Such research is needed to contribute to the understanding of the concept and the experience of caring presence in the South African context and to make known the significance and transformative potential of caring presence in the nursing profession for future use in the practice, education and research field. Consequently, this research study has the potential to contribute to the improvement of quality healthcare within professional nursing and to enhance professionalism among nurses.

2.4.1 Research setting

This study was carried out at a rural public hospital in the North West province, South Africa. South Africa has nine provinces and an estimated total population of 54,96 million, of which 6,8% is in the North West province (Statistics South Africa, 2015). As 59% of the population in the North West province lives in rural areas (Eager *et al.*, 2015:101), this hospital serves patients from remote and poverty-stricken areas. This 120-bed, level-two district hospital forms part of the public healthcare sector. This facility provides a comprehensive service that includes two operating theatres, trauma and emergency care, a high care unit, neonatal unit, and maternity, medical, surgical, gynaecological and paediatrics wards. This rural hospital represents a context where limited resources and equipment heighten the need for professional nurses to utilize the practice of caring presence to create a healing environment for patients. The interview setting was an environment that was private and comfortable for the participants. Locations included an office and boardroom at the public hospital, used during working hours. The researcher ensured that this was a private and non-threatening setting, free of interruption, well ventilated and clean.

2.4.2 Population

Two guiding principles in identifying the population were appropriateness (the identification and use of participants who can best inform the research) and adequacy (enough data would be

available to develop a full and rich description of the phenomenon) (Morse & Field, 1995:80). According to Botma *et al.* (2010:200), the sample criteria define the population and could include both inclusion and exclusion criteria. For the purpose of this study, the targeted population (Grove *et al.*, 2013:351) was professional nurses practising in a rural public hospital in the North West province, South Africa, who met the criteria that the researcher was interested in studying and who were available as participants for the study.

2.4.3 Sampling method

The researcher used a purposive sampling method to select participants to represent the population for this study. This sampling method was selected in order to get rich information regarding the lived experience of practising caring presence from the specific group (Grove *et al.*, 2013:365) of professional nurses according to the inclusion criteria (Botma *et al.*, 2010:201), to prevent sampling errors, and to avoid biases in the selection of the participants. Brink *et al.* (2012:141) posit that the advantage of purposive sampling is that it allows the researcher to select a representative and knowledgeable sample group that is more likely to provide the needed information about the phenomena being studied.

The population of this study was small and well-defined (Grove *et al.*, 2013:352) and the sample was selected according to the following essential characteristics that ensured inclusion in the target population (Burns & Grove, 2009:344).

The participants had to be:

- a professional nurse;
- currently employed for at least one year in a rural public hospital in the North West province, South Africa;
- proficient in English;
- willing to have interviews recorded on an audio recorder;
- voluntarily participating and willing to give written consent to participate in the study after being informed about the purpose and procedures of the research; and
- identified by a mediator as a professional nurse who practised caring presence as evidenced by behaviour such as not treating their patients as “a body in a bed,” but as a holistic person, checking regularly on patients, comforting patients, responding to the needs of patients, making eye contact and portraying true interest and genuine care in the nursing profession.

Nurses were excluded from participation if:

- they formed part of nursing categories other than professional nurses;
- they were employed in the private hospital sector or any sector other than a rural public hospital;
- were employed part-time with or had worked in a rural public hospital for less than a year; and
- they were not proficient in English.

Consequently, the sample in this study purely represented the professional nurses who were personally and professionally more mature and gained experience for more than one year in this specific healthcare context. This means, the participants were purposeful selected on their knowledge and experience. They were thus *living* the experience of practising caring presence in a rural public hospital in the North West province, South Africa.

2.4.3.1 Sample size

Polit and Beck (2014:286) state that in qualitative research, sample size is usually determined by certain informational needs. As such, a guiding principle for sample size is data saturation. Data saturation means that data are collected until no new information comes to the fore and redundancy is achieved. In this study, data were collected until quality-rich data had been generated and repetition of data became apparent (Burns & Grove, 2011:317; LoBiondo-Wood, & Haber, 2010:236). The researcher aimed to include 12–14 participants (Latham, 2013:16) to ensure data saturation, keeping in mind that the sample size of a qualitative study cannot be predetermined as it depends on the availability of nurses who meet the inclusion criteria.

2.4.4 Data collection

The researcher obtained ethics approval from the NWU HREC see (Annexure **H**; NWU -00331-16-A1). Permission was also granted by the North West Department of Health (Annexure **I**) and by the management of the rural public hospital (Annexure **J**). As participation is influenced by the recruitment methods used in a research project (Hill & Nutt Williams, 2012:71), the researcher involved a gatekeeper (Byrne, 2012:210) to gain access to the participants. Within the context of this research study, the Chief Executive Officer of the public hospital acted as gatekeeper. The CEO appointed unit managers as mediators to assist the researcher with the recruitment process. Soon after permission had been granted and the appointment of the mediators had been confirmed, the researcher made an appointment with the mediators to explain the nature and purpose of the research. Consequently, the mediators provided a link between the researcher and the participants who met the inclusion criteria of the study (Botma *et al.*, 2010:203). The mediators

were trained by the researcher and informed about the details of the research process, the aim of the study, and how they should share the information with the eligible participants. The mediators recruited the participants by sending an invitation (Annexure **D**) and an informed consent document (Annexure **E**) to all participants who met the inclusion criteria. The invitation served as an “introductory letter” (Rubin & Rubin, 2012:103), aiming to create a subjective interest in the focus of the study among participants. Deschaux-Beaume (2012:105) describes this as “real-life” recruitment characterised by researcher mobility.

The informed consent documents were in English on a level that the participants would find easy to understand, as the medium of formal communication at the rural public hospital is English. The mediators explained the informed consent document and what the participants could expect, as well as the risks and benefits of the research. Furthermore, prospective participants were allowed to take the informed consent document home for two days to discuss it with their families and friends so that they could make an informed decision before giving their consent. They were ensured by the mediators that participation was voluntary and that if they did not wish to participate, it would not affect them negatively (Brink *et al.*, 2012:39). Prospective participants were also informed that they may withdraw from the study at any stage, even after signing informed consent, without being discriminated against (Brink *et al.*, 2012:39). The mediators reassured the potential participants that continuous voluntary consent, anonymity, privacy, confidentiality and attending to the ethics rights of the participants would be ensured by the researcher (Burns & Grove, 2009:196; Creswell, 2014:96; Grove *et al.*, 2013:125). If the prospective candidates needed more information about the research or about the process, they could contact the researcher to clarify their questions. The researcher’s details were visible on the informed consent document (see Annexure **B**). The identified professional nurses who were willing to participate gave written informed consent to the mediators with a witness present. Subsequently, the researcher collected all the informed consent documents from the mediators and made initial telephonic contact with the participants to arrange a suitable date and time to meet at the public hospital for a semi-structured interview. Prior to scheduling the interviews, the researcher arranged for suitable venues with the CEO of the particular public hospital. The researcher ensured that comfortable, private venues were selected where the scheduled interviews would not be interrupted (Botma *et al.*, 2010:212). An available boardroom or office at the facility was used for the interviews.

2.4.4.1 Method of data collection: semi-structured interviews

Semi-structured, face-to-face individual interviews were preferred as means of data collection for this research study for the rich data this method provides, such as the nuances of the participants’ experiences that may be conveyed through facial expressions, gestures, blushing, or tears

(Bevan, 2014:137 Polit & Beck, 2014:290;). This gave the interviewer more insight into the participants' experience and it provided the participants with an opportunity to tell their story in their own words while ensuring that a specific topic was covered (Botma, *et al.*, 2010:20; De Vos *et al.*, 2011:3518). The researcher concurs with Merriam and Tisdell (2016:105), who argue that qualitative data are conveyed through words. Therefore, the data in this research study consisted of direct quotations from people about their experiences, opinions, feelings, and knowledge obtained through interviews (Patton, 2015:14).

Qualitative researchers are research instruments and attempt to get as close to the data as possible (Creswell, 2014:237). Giorgi (2009:95) asserts that the questions that are part of a phenomenological interview should meet the criteria of description. According to Englander (2012:25), the researcher should ask for a description of the situation in which a participant had experienced the phenomenon. Asking for a description of the situation is vital in descriptive phenomenology, since the discovery of the meaning of a phenomenon should be connected to the specific context in which it was experienced. Bevan (2014:136) confirms that contextualizing questioning enables a person to reconstruct and describe his or her experience as a form of narrative that will be full of significant information. Therefore, the researcher used open-ended questions to encourage participants to describe their experience fully (Welch, 2015:31).

The focus questions of the interview included:

“Can you please describe a situation where you practised caring presence as a professional nurse?” and

“How do you experience practising caring presence?”

The responses of the participants were probed further with the use of the following communication strategies (Burns & Grove, 2009:514):

- Subsequent questions for **clarification** were guided by the participants' responses to the initial questions and participants were requested to clarify their statements by repeating what they had just stated.
- The phenomenon of practising caring presence was **probed** to assist the participants to express their experience openly by posing open-ended questions. Consequently, participants were encouraged to give more information to substantiate their point of view (Botma *et al.*, 2010:208; Polit & Beck, 2008:392).
- **Minimal verbal responses**, for example occasional nodding or responding with: “yes, I see” were employed to glean in-depth descriptions from participants, encouraging them to reach into their own perspectives and express their thoughts (De Vos *et al.*, 2011:345).

- **Paraphrasing** was utilised to enhance meaning and to test whether the researcher understood what the participant attempted to communicate (De Vos *et al.*, 2011:345).
- By repeating the participants' statement using their exact words, **active listening** was used, encouraging the participant to pursue a specific line of thought and to ensure correct interpretation and meaning of the data (Streubert & Carpenter, 2011:340).
- The researcher made use of the "**SOLER**" technique (Egan, 2010:134-135) during the semi-structured interviews. "SOLER" is an acronym meaning: **S**= square faced, **O**= open, **L**= lean forward, **E**= maintain good eye contact, **R**= relax. In short, it implies that the interviewer adopts a position that shows participants during the interview that she is there and is *with* them. This is indicated by the interviewer sitting squarely facing the participant with an open posture, leaning forward, maintaining good eye contact, with minimum verbal responses and with a relaxed demeanour. This position encourages active participation and cooperation by participants.

Merriam and Tisdell (2016:124) explain that working from an interview schedule allows the researcher to gain the experience and confidence needed to conduct an interview. A copy of the interview schedule is included (see Annexure **F**). The interview schedule and questions were developed in line with the research question and purpose, and were reviewed by the supervisors and peers (INSINQ scientific research committee). The purpose of the first focus question was to verify the eligibility of the participants and to gain insight into the *lifeworld* of the participant. The purpose of the second question and the subsequent probing questions was to explore the lived experience of the professional nurses with respect to practising caring presence. The approach of semi-structured interviews with only two open-ended questions is similar to recent phenomenological research conducted by Welch (2015:31) and Webb *et al.* (2014:731-741).

On commencement of an audio-recorded interview, the interviewer drew the attention of the participant to the fact that the interview would be audio-recorded to make sure that the participant was comfortable with this fact. The researcher also explained that a telephone call would follow some time after the interview to give the participant a chance to verify that the findings reflect the authenticity of the participant's experiences. Although the researcher did take field notes during the interviews, this was limited to the bare essentials to keep note taking as unobtrusive as possible so that the researcher could reflect an attitude of attentiveness and openness towards the participant.

2.4.4.2 Field notes

The researcher utilised field notes as suggested by Creswell (2009:181-192). It is a format for recording the multiple forms of observed data gathered by the researcher. The researcher concurs with Botma *et al.* (2010:217) that such field notes are a written account of the things the researcher hears, sees, feels, experiences and thinks about during the course of the interview. In this study, the researcher was attentive to tone of voice, body language, emotional expression, attitude and the free flow of language. Immediately following the interview, the researcher set aside adequate time to complete field notes in the form of detailed descriptive notes, reflective notes and demographic information (Creswell, 2014:181-192). The field notes compiled in this study can be viewed under Annexure **K**.

2.4.4.2.1 Descriptive notes

Descriptive (or observational) field notes includes the portraits of the participants, a reconstruction of dialogue, a description of the physical setting, and accounts of particular events or activities (Botma *et al.*, 2010:218). These notes contain the “who,” “what” and “how” of a situation and as little interpretation as possible (De Vos *et al.*, 2011:12; Polit & Beck, 2008:406). In this study descriptive field notes described the physical layout of the rural public hospital, the characteristics of the setting and particular events during the interview.

2.4.4.2.2 Reflective notes

According to Botma *et al.* (2010:218), reflective notes consist of the researcher’s personal thoughts such as speculations, feelings, problems, ideas, hunches, impressions, and prejudices.

During this study the researcher utilised a useful structure for reflective notes as provided by Polit and Beck (2008:406-407), namely:

- Methodological notes

Methodological notes are reflections about strategies and methods used for the observations. For this study, the researcher applied methodological notes to document thoughts about new strategies and to record methods that worked really well in the specific research context. It involved instructions to the researcher herself, a critique of the tactics applied and reminders about methodological approaches that may be fruitful in the current research project.

- Theoretical notes

Theoretical notes document the thoughts of the researcher about how to make sense of what is going on. Consequently, the theoretical notes served as a starting point for subsequent

analysis in this study and represented the researcher's efforts to attach meaning to observations while interacting with participants and conducting semi-structured interviews at the rural public hospital.

- **Personal notes**

Personal notes are comments about the researcher's own feelings and perceptions while in the research field. In this study, the researcher's reflective field notes included her insights, reactions and thoughts during the interviews. These commented on the researcher's own feelings while in the field. In addition, field experiences give rise to personal emotions and challenge the researcher's assumptions (Polit & Beck, 2008:407).

2.4.4.2.3 Demographic information

The third section of the field notes suggested by Creswell (2009:182) involves the demographic information about the time, place and date of the field setting. In this study it included demographic notes about the participants who took part in the semi-structured interviews during this study.

2.4.4.3 Trial run

The researcher evaluated the applicability of the interview questions during the first interview. One professional nurse who suited the inclusion criteria for the present research study was purposively selected for the trial run and was briefed on the function of the interview to be conducted. The interview was conducted at the rural public hospital using the interview guide.

The professional nurse participant was asked to comment on the clarity of the language and the questioning technique employed by the researcher. This information enabled the researcher to identify any shortcomings and problems and to adjust and implement changes that could increase the effectiveness and efficiency of the interview and benefitted the study. Consequently, this participant commented that the questions were applicable and that she was able to share her lived experience of practising caring presence in the context of a rural public hospital.

2.4.5 Data analysis

Qualitative data are non-numerical in nature and valued for its richness, depth and complexity (Quinlan, 2011:155). The researcher concurs with Gerrish and Lacey (2010:180), who observe that phenomenologists use the term "lifeworld" or "lived experience" instead of the term *data*. Therefore, the individual experiences of professional nurses with respect to practising caring presence became the starting point for inquiry in this study. Characterised as a dynamic process,

data analysis in phenomenological studies requires deeper thinking (Bergin, 2011:8) and can be described as a multistep, sense-making endeavour (DeCuir-Gunby *et al.*, 2011:137).

In qualitative research, data analysis is almost always conducted concurrently with gathering data (Botma *et al.*, 2010:220). Therefore, as participants were interviewed in this study, the process of data analysis was under way as the researcher reflected on their responses and made memos and notes. Transcripts were sent to an independent and experienced qualitative research co-coder (see Annexure L for request to the co-coder). A confidentiality agreement (Annexure G) between the researcher and co-coder was utilised to maintain the confidentiality of information. Following the interviews, the data were transcribed and the researcher engaged in prolonged immersion with the data, while identifying and describing the true *essence* (or essential structure) of the experience (Gerrish & Lacey, 2010:181).

Three frequently used methods for descriptive phenomenology are the methods of Colaizzi (1978), van Kraam (1966), and Giorgi (1985), all of whom are from the Duquesne school of phenomenology, which adheres to Husserl's philosophy (Polit & Beck, 2012:565). According to Polit and Beck (2012:566), Colaizzi's strategy of descriptive phenomenological data analysis, as outlined below, consists of extracting, organising and analysing data. The process helps to integrate significant statements and clusters of themes to formulate overall themes that describe the phenomenon thoroughly. Furthermore, Colaizzi's method is the *only* phenomenological analytic method that calls for a validation of results by returning to study participants.

In this study, each of the interviews was transcribed from the audio recorder to a Microsoft Word document by the researcher. Data were coded and analysed using Colaizzi's seven-step method (Colaizzi, 1978:48-61), which consists of the following:

1. Each transcript should be read and re-read to get a general feeling for the content.
2. Review each transcript and extract significant statements.
3. Spell out the meaning of each significant statement—formulate meanings.
4. Organize the formulated meanings into clusters of themes.
5. Integrate results into an exhaustive description of the phenomenon under study.
6. Formulate an exhaustive description of the phenomenon under study in a clear and unambiguous statement of identification as possible.
7. Ask participants about the findings as a final validating step in order to compare the researcher's descriptive results with their experiences. This step aims to validate study findings

using a “member checking” technique. In this study, participants’ views on the study results were obtained and discussed via telephone calls. New findings were integrated into the final description of the interviewee’s experience.

Below is the schematic summary of the data analysis approach employed in this study as framed from Colaizzi’s data analysis method (Colaizzi, 1978:48-61):

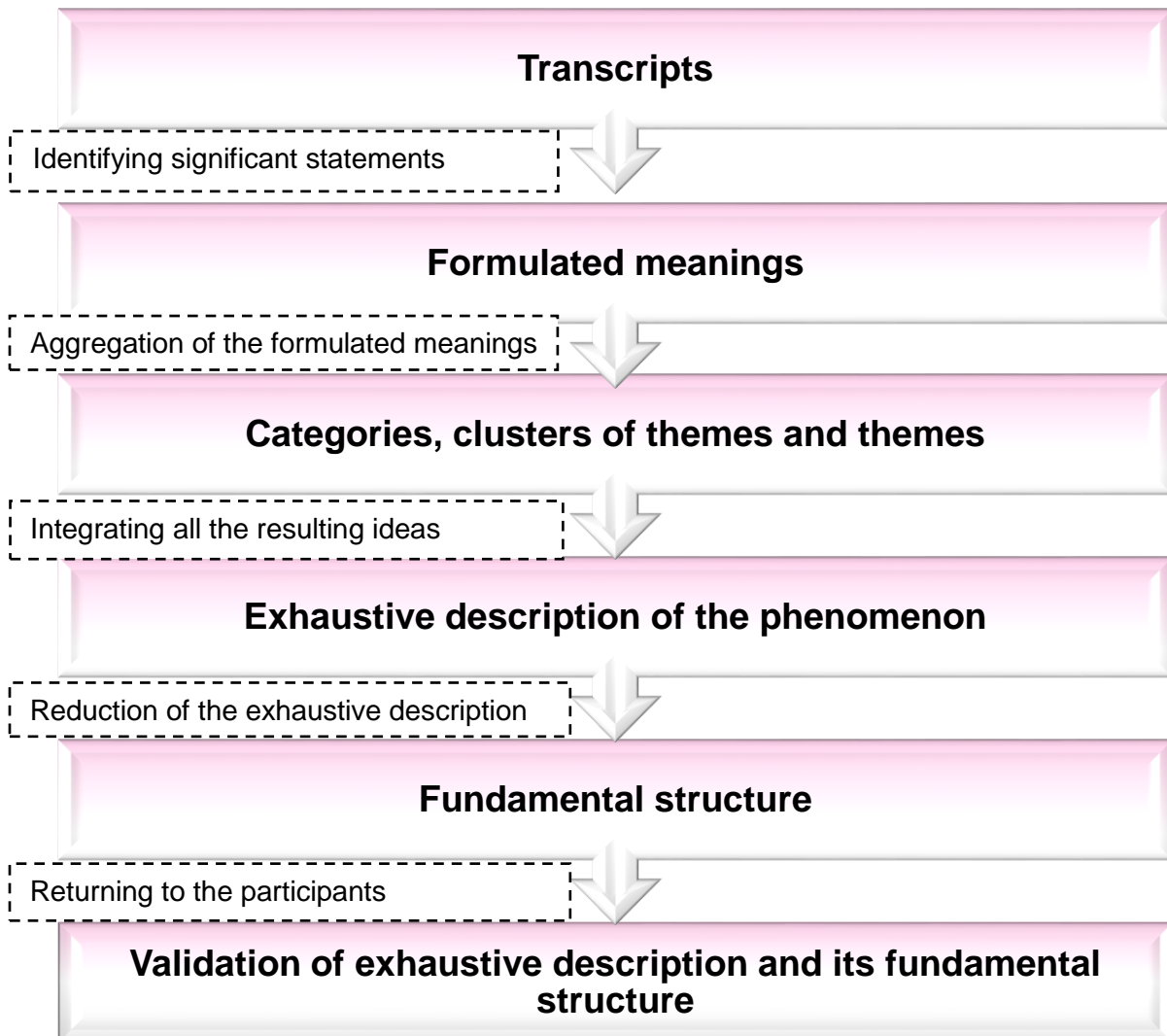


Figure 2.1: Schematic summary of Colaizzi’s method for phenomenological data analysis (Colaizzi, 1978:48-61)

2.4.5.1 The practical approach employed for data analysis in this study

Prior to commencement of the data analysis, each transcribed interview was cross-checked with the original audio recording to establish accuracy.

The following flow of activities was employed during the data analysis process of this study:

Step one

This step involved reading each transcript several times to gain a sense of the content as a whole and to get a feeling and gain an understanding of the meaning of the experience behind the words. During this stage, any thoughts, feelings, and ideas that arose in the researcher due to assumptions regarding the phenomenon under study, were added to the reflexive journal (see Annexure M) as suggested by Chan *et al.* (2013:3). This helped to bracket or deliberately put aside the researcher's own beliefs and existing knowledge (Polit & Beck, 2012:495) regarding practising caring presence in the nursing profession. The ultimate goal with carrying out this descriptive phenomenological research was to formulate an in-depth description of professional nurses' lived experience of practising caring presence in a rural public hospital. The researcher as a human being inevitably influences the research process. Bracketing her own knowledge and experience helped to minimise the influence of the researcher throughout the research process. Bracketing according to Beck (1993:263) is a process that involves peeling away the layers of own interpretations so that the phenomena can be seen as they are, not as reflected through preconceptions. Moustakas (as cited in Baillie 1996:1301) explains that bracketing is also called the *Epoché process*, *Epoché* being a Greek term, denoting, *to refrain from judgement*. Therefore, in the context of this study, the researcher rigorously attempted throughout the research process not to impose her own values on the emerging data.

According to Gerrish and Lacey (2010:178) and Rivas (2012:370), intuiting involves a certain self-discipline similar to true listening in which one lets the information and data "speak" more fully and observe the experience with wide-open eyes. Husserl called this *phenomenological reduction* where a certain open-mindedness is achieved and something new regarding an experience can be discovered (Giorgi, 2008:34). This includes bracketing and intuiting. The researcher adopted this *phenomenological attitude*, which is unique to the phenomenological approach (Giorgi, 2008:34), in order to gain a sense and understanding of the lived experience or lifeworld of professional nurses working in a rural public hospital in the North West province, South Africa. Chan *et al.* (2013:7) further argue that no one in the world has better knowledge regarding the lived experiences and perceptions of participants than they themselves.

Step two

In this stage of analysis, Colaizzi's data analysis process continues with extracting significant statements and phrases from each interview transcript to be compiled and organised for later theme development. This was also done with the transcripts pertaining to the lived experience of practising caring presence. Significant statements are defined as statements that "directly relate to the phenomenon under investigation" (Edward & Welch, 2011:165). These statements were written on separate sheets and coded based on their "transcript, page, and line numbers" (Shosha, 2012:34). Thereafter, the researcher and co-coder compared their work and reached consensus.

Figure (2-1) provides examples of the significant statements that were identified and extracted from participants' data.

Table 2.1: Examples of significant statements

Significant statements	Transcript No	Page No	Line No.
1. "You can compare it to nursing at home your very own mother..." T1, P1, L23–24.	1	1	23-24
2. "...and you take care of her in totality." T1, P1, L24.	1	1	24
3. "And if you don't do it, I mean total caring, (silence) it is something that keeps us alive. I don't know how to say it." T1, P1. L26–27.	1	1	26-27
4. "Caring, eee, it does not mean just doing a patient's wound. It is sympathy, empathy, communication (silence). It includes so many things." T1, P2, L34–35.	1	2	34-35

Step three

At this point of the process, Colaizzi recommends taking each significant statement and re-stating the general meaning (Edward & Welch, 2011:165). This is a very creative process that requires a thoughtful review on the part of the researcher to determine the meaning behind the words of each research participant (Parè, 2015:2). Meanings were thus formulated from the significant statements and each underlying meaning was coded in one category as they reflect an exhaustive description of the true essence of the lived experience. The researcher and co-coder compared the formulated meanings with the original meanings, maintaining the consistency of descriptions. Table (2.2) provides examples of how significant statements were converted into formulated meanings.

Table 2.2 Examples of the process of creating formulated meanings from significant statements

Significant statements	Formulated meanings (Fm)
1. "Yes, caring is a very important part of nursing. You can compare it to nursing at home your very own mother..." T1, P1, L23-24.	Caring is compared with giving nursing care for our own mother at home. Fm 1.

Significant statements	Formulated meanings (Fm)
2. "...and you take care of her in totality." T1, P1, L24.	Practising caring presence is grounded in a holistic nursing approach. Fm 2.
3. "And if you don't do it, I mean total caring (silence) it is something that keeps us alive." T1, P1, L26-27.	Commitment to total care is seen as an essential component of practising caring presence. Fm3.

Step four

After reaching agreement with the co-coder on all formulated meanings, the process of grouping together these formulated meanings into categories that reflect a unique structure of clusters of themes was initiated (Shosha, 2012:35). In order to include all formulated meanings related to that group of meanings, each cluster of themes was coded. After that, groups of clusters of themes that reflected a particular vision or idea, were incorporated to form a distinctive construct of theme (Edward & Welch, 2011:165). Table 2.3 illustrates how the first emergent "professional caring presence" theme was constructed.

Table 2.3: Example of how the first theme "professional caring presence" was constructed from different clusters of themes and formulated meanings.

Formulated meanings (Fm)	Theme cluster	Emergent theme
Passion is fundamental to the nursing profession in order to build meaningful relationships. Fm 5 Without passion for the nursing profession, it is not possible to render quality nursing care, and 100% dedication and commitment is emphasized. Fm 13 The participant explains her passion for the nursing profession, for becoming everything for her patients, and displays a willingness to give of herself. Fm 48	Passion for the nursing profession	Professional caring presence

Later, the researcher and co-coder compared their clusters of themes and checked the accuracy of the overall coding table (see Table 2.4).

Table 2.4: Coding table

Professional nurses' lived experience of practising caring presence											
		Interviews									
Themes	Meaning units	1	2	3	4	5	6	7	8	9	10
Professional	Passion for the nursing profession	■	■		■			■		■	■
Caring	Dedication and commitment to the best nursing care	■	■	■	■		■	■	■		■
Presence	Being a role model (showing integrity and responsibility)	■	■					■			■
Ethical caring presence	Advocacy/referral	■	■		■	■		■	■	■	■
Personal	Feel appreciated/satisfied with -/proud of care provided	■			■		■	■	■		
caring presence	"Walk the extra mile"		■		■			■	■	■	
Healing caring presence (holistic nursing care)		■	■	■	■		■	■			■
Physical presence - attend to physical needs (time/eye contact/touch)		■	■	■	■	■	■	■	■	■	■
Emotional presence - attend to emotional needs	Sensitivity	■					■	■	■		■
	Empathy/sympathy/compassion	■	■	■	■		■		■	■	■
	Care/comfort/love/rapport/trust	■	■	■		■	■	■	■	■	■
	Self-disclosure and openness		■				■	■	■		
	Communication/encouragement	■	■		■	■	■	■	■		■
	Respect/dignity/non-judgemental		■			■		■	■		
Cognitive presence - attend to cognitive needs	Advice/guidance		■	■			■	■	■		
	Health education		■	■			■	■	■		
Spiritual presence - attend to spiritual needs (creation of hope/prayer)		■	■	■							■
Attend to social needs			■				■	■	■	■	■
What caring presence is not											

The coding table was further refined into emergent themes, which formed the basis of the research findings. The five main themes that emerged from this research study resulted in an exhaustive description of the lived experiences of professional nurses with respect to their practice of caring presence in a rural public hospital.

The final thematic map developed for this study is illustrated in Table **2.5**

Table 2.5 The final thematic map

First emergent theme: <i>Professional caring presence</i>	Second emergent theme <i>Ethical caring presence</i>	Third emergent theme <i>Personal caring presence</i>	Fourth emergent theme <i>Healing caring presence</i>	Fifth emergent theme <i>What caring presence is not</i>
Theme clusters	Theme clusters	Theme clusters	Theme clusters	Theme cluster
<p>1. Passion for the nursing profession</p> <ul style="list-style-type: none"> • Nursing is a calling • Professional commitment • Professional responsibility • Integrity • Core driving force <p>2. Self-awareness</p> <ul style="list-style-type: none"> • Therapeutic use of self • Maturity and personal growth • Professional growth <p>3. Dedication and commitment to the best nursing care</p> <ul style="list-style-type: none"> • Patients are priority • Professional competence • Interact with patients like family • Safe and effective nursing interventions • Problem-solving skills and caring attitude <p>4. Being a role model</p> <ul style="list-style-type: none"> • Lead by example • Motivate and inspire colleagues 	<p>5. Ethical responsibility</p> <ul style="list-style-type: none"> • Humanity • Dignity and respect • Advocacy • Being non-judgemental • Safeguarding the best interest of patients 	<p>6. Willingness to be personally present</p> <ul style="list-style-type: none"> • Personal satisfaction • Pride • Fulfilment • Personal responsibility/commitment <p>7. Walk an extra mile and offering the gift of the self</p> <ul style="list-style-type: none"> • Willingness to give a little extra (walk an extra mile) • Meeting the personal challenges of being present requires a willingness/commitment to offer the gift of the self 	<p>8. Patient-centred /holistic care</p> <ul style="list-style-type: none"> • Holistic nursing • Conscious intention <p>9. Connection and intention-setting technique (mindfulness)</p> <ul style="list-style-type: none"> • Pause and focus on patient/being fully present • Willingness to create a healing milieu <p>10. Dimensions of being a healing caring presence</p> <ul style="list-style-type: none"> • Physical caring presence • Emotional caring presence • Cognitive awareness • Spiritual caring presence • Presence within the social realm 	<p>11. Uncaring, unprofessional behaviour and dehumanisation of patients, which creates barriers that hinder the practice of caring presence</p> <ul style="list-style-type: none"> • Neglecting patients • Violating human rights • Unprofessional conduct • Lack of integrity • Uncaring attitude • Staff shortages and limited resources • Low personnel morale

Step five

At this stage of analysis, all emergent themes had been defined into an exhaustive description. All study themes had been merged, and the whole structure of the phenomenon of professional nurses' lived experience of practising caring presence had been extracted. The next step was to seek validation from the research supervisors, who reviewed the findings in terms of the richness and completeness of the exhaustive description (Shosha, 2011:41). The exhaustive description is provided in Chapter 3.

Step six

According to Shosha (2011:41), step six is quite similar to the previous step, but no exhaustive meanings were sought. This step involved a reduction of findings in that redundant, misused or overestimated descriptions were erased from the overall structure. Thereafter, a description of the fundamental structures or the essence of the experiential phenomenon was formulated through a rigorous analysis of the exhaustive description (Edward & Welch, 2011:165).

Step seven

This step aimed to validate the study findings using the "member checking" technique (Colaizzi, 1978:59; Edward & Welch, 2011:165). It entailed returning the research findings to the participants and discussing the results with them. Participants' views on the study results were obtained directly via telephone calls. The researcher obtained approval for the phone calls from the participants during the first semi-structured interviewing session. All participants indicated their satisfaction with the exhaustive description as a description that entirely reflects their feelings and experiences regarding practising caring presence in a rural public hospital. They agreed that the written summary captured the essence of their experience.

2.5 Trustworthiness

Streubert and Carpenter (2011:48) state that "rigor in qualitative research is demonstrated through researchers' attention to and confirmation of information discovery, and involves accurately representing study participants' experiences." Essentially, the qualitative researcher has to demonstrate trustworthiness by providing rigour and strength to the study during every stage. The researcher agrees with Grove *et al.* (2013:58), who confirm that trustworthiness is characterized by openness, demonstration of methodological congruence, scrupulous adherence to a philosophical perspective, thoroughness in collecting data, consideration of all the data in the analysis process, as well as the self-understanding of the researcher.

Trustworthiness in qualitative research was proposed by Lincoln and Guba (1985:218) as a parallel for the principles of rigour in quantitative research, namely reliability and validity. They identified five criteria to ensure trustworthiness in qualitative research, namely credibility,

dependability, confirmability, transferability and authenticity (Polit & Beck, 2014:323). Adhering to these criteria strengthens the trustworthiness of the research by ensuring that the research has truth value, applicability, consistency and neutrality (Lincoln & Guba, 1985:218).

In this qualitative study, the researcher attempted to ensure that the study yields data that reflect the truth. Therefore, the researcher aimed to apply the following strategies to adhere to these criteria to enhance trustworthiness in this research study:

2.5.1 Credibility

According to Botma *et al.* (2010:233) truth value is obtained from the discovery of human experiences as lived and perceived by the participants. Credibility thus refers to the confidence in the truth of the data and the interpretations (Polit & Beck, 2012:585). Therefore, it includes activities that increase the probability that credible findings would be produced (Streubert & Carpenter, 2007:49; Brink *et al.*, 2012:172). Consequently, the researcher strove to achieve credibility in this study through reflexive journaling, prolonged engagement, peer debriefing, member checks and enabling an audit trail (Lincoln & Guba, 1985:304–313).

- Reflexive journaling

The researcher identified all the presuppositions, biases or assumptions about the practice of caring presence in the nursing profession by maintaining a reflexive journal from the outset of the study and in an ongoing fashion (Polit & Beck, 2012:589). Thoughts about the impact of previous life experiences and previous reading about the phenomenon of practising caring presence were continually recorded and addressed to concentrate and focus on the specific experience and to obtain the purest description of the phenomenon under investigation (Polit & Beck, 2014:270). Consequently, the researcher utilized the *epochè process* (bracketing) and intuiting in this reflexive journal to set aside her own values, interpretations and preconceptions (Chan *et al.*, 2013:6). She therefore refrained from judgement and did not impose her own personal beliefs on the emerging data. She rigorously attempted throughout the research process to hold in abeyance those elements that define the limits of the experience of practising caring presence. The use of bracketing thus provided a useful methodological device to demonstrate credibility in this phenomenological study (Chan *et al.*, 2013:6). The reflexive journal compiled in this study can be viewed under Annexure **M**.

- Prolonged engagement

Polit and Beck (2012:589) remark that prolonged engagement refers to spending sufficient time to collect data in order to obtain a more accurate understanding of the participants and the phenomenon under study. The researcher stayed in the research field until data saturation was

reached (Brink *et al.*, 2012:172). She gained an in-depth understanding of the phenomenon and of specific aspects of the participants, such as views, perceptions and experiences of practising caring presence in the context of a rural public hospital. She spent time with each participant in the unit where the participant was employed while completing the informed consent form. The researcher also assured the participants that she was available in the office where the interviews were conducted after the interviews had taken place. This would enable the participant to come back if he/she wanted to share more information regarding the experience of practising caring presence. Brink *et al.* (2012:172) agree that such actions may build trust and rapport between the researcher and participants, which is needed in the gathering of rich data.

- Peer debriefing

The role of a peer debriefer is to act as a devil's advocate as the researcher is questioned on bias, meanings, and interpretations (Walsh, 2009:79). According to Lincoln and Guba (1985:309), the role also includes testing working hypothesis, helping with testing of the next steps in emerging methodological design, and providing an opportunity for catharsis. During this research study, the researcher used an opportunity to present the study to peer Master's students at the NWU, defending her arguments and receiving feedback regarding the study. Furthermore, the supervisors of this study also acted as peer debriefers. The researcher and the supervisors met several times during the study to review the work to date, to discuss procedures and to examine methodological design. In addition, the researcher and co-coder had discussions while coding took place.

- Member checking

According to Lincoln and Guba (1985:314), this activity involves that "data, analytic categories, interpretations, and conclusions" are tested with study participants from whom the data were gathered for comments and reactions. Colaizzi (1978:59) and Welch (2011:165) confirm that member checking aims to validate study findings. Soon after the data analysis process, the accuracy of the captured data were discussed and confirmed with the participants telephonically. This process was done twice. The participants agreed that the written summary captured the essence of their experience of practising caring presence within a rural public hospital in the North West province, South Africa.

- Audit trail

An audit trail involves the scrutiny of data and relevant supporting documents of all aspects of the research study by an external reviewer (Botma *et al.*, 2010:232; De Vos *et al.*, 2011:346). Field notes (Annexure **K**), a clean set of transcriptions (Annexure **N**), as well as the interview schedule (Annexure **F**) are available for auditing.

2.5.2 Dependability

Brink *et al.* (2012:172) state that dependability refers to the stability of data over time, should data collection be repeated with the same or similar participants in the same or a similar context. Dependability was ensured by keeping a detailed account of the research process in order for the process to be traceable, thus allowing another researcher to follow the research process used by the researcher (Polit & Beck, 2012:585). This was done by documenting the research study in the form of a dissertation, and by keeping field notes (Annexure K) as discussed under “Data collection.” Furthermore, a thick, dense and contextualized description of the methodology concerning this study is provided (Botma *et al.*, 2010:232).

2.5.3 Confirmability

According to Brink *et al.* (2012:173) and Polit and Beck (2012:585), confirmability refers to the potential for congruency of data in terms of accuracy, relevance or meaning. The data should thus represent the voice of the participants, and the interpretations should not be fuelled by the researcher’s imagination. Botma *et al.* (2010:233) agree that it refers to the degree to which the findings are solely a function of the informants and conditions of the research, and not representative of the researcher’s biases, perspectives and motives. The following activities increased the confirmability of the study:

- Use of a co-coder

In this research study, the utilization of a co-coder for independent data interpretation ensured confirmability of the data (Polit & Beck, 2012:589). This was ensured by collecting in-depth, rich and comprehensive data during the interviews as described under “Data collection.” Soon after the data were obtained by means of semi-structured, individual interviews, the researcher transcribed it verbatim and sent it to a co-coder for independent interpretation. The researcher had a consensus discussion with the co-coder in order to confirm that the results were entrenched by the data and not the subjectivity of the researcher (Creswell, 2014:192; Lincoln & Guba, 1985:298). The findings in this research study thus reflect the information provided by the participants and not the voice of the researcher. **Table 2.4** provides the coding table that resulted from the consensus discussion between the researcher and the co-coder.

- Reflexive journal

In addition, the researchers’ personal biases, perceptions and motivations were separated by recording all of those in a reflexive journal (Annexure **M**) to facilitate a process of bracketing (Chan *et al.*, 2013:6).

2.5.4 Transferability

Transferability involves the extent to which this research may be applied in another context (Brink *et al.*, 2012:173). Comprehensive and sufficient data are provided in this study report so that readers and other researchers may evaluate the applicability of the data in different contexts (Klopper & Knobloch, 2010:323). In addition, Creswell (2014:67) assumes that qualitative researchers seek to provide an understanding from the participants' perspective rather than generalizing findings across a population. The following strategies were used by the researcher to enhance the transferability of the research study:

- Thick dense descriptions

Transferability is achieved through thick/dense descriptions as a result of data saturation. According to Polit and Beck (2012:595), a thick description refers to a rich, thorough, and vivid description of the research context, the people who participated in the study, and the experiences and processes observed during the research process. Therefore, the researcher included lucid and textured descriptions of the research context, as well as verbatim quotes from study participants in order to contribute to the extent to which these findings can be transferred to or have applicability in other settings or groups (Polit & Beck, 2012:585).

- Data saturation

Data saturation occurred when additional participants provided no new information and when themes that emerged became repetitive (Brink *et al.*, 2012:173). In this study, data saturation was reached after 10 interviews.

- Purposive sampling

Thick and descriptive data relating to the context of the study was ensured through purposive sampling (Brink *et al.*, 2012:173; Polit & Beck, 2014:270-323) as this sampling method maximizes the range of specific information obtained from and about the particular context. This was done by purposefully selecting the participants in terms of knowledge of the phenomenon under investigation within a specific context.

- Comprehensive field notes

The researcher prepared field notes (Annexure K) that were rich with transcriptions of what transpired in the research field (Botma *et al.*, 2010:218; Polit & Beck, 2014:327). Even though the interviews were the only source of data, the researcher recorded descriptions of the participants' behaviours and demeanour during the interactions in the interview context by means of field notes. After the interviews had been conducted, the researcher set aside adequate time to write down

her impressions and the sequence of events. This enhanced the quality of the descriptions. This thoroughness in record keeping helps readers to develop confidence in the faithfulness of the data in this research study.

2.5.5 Authenticity

Polit and Beck (2012:585) suggest that authenticity refers to the extent to which researchers fairly and faithfully show a range of realities. Therefore, authenticity emerges in a report when it conveys the feeling or tone of participants' lives as they experience it. Botma *et al.* (2010:234) argue that a text has authenticity if it invites readers into a vicarious experience of the lives being described and enables readers to develop a heightened sensitivity to the issues being depicted. The researcher utilised the following strategies to increase the readers' confidence in the integrity of the study (Polit & Beck, 2014:324-325) namely:

- Reflexive journalling

The most widely used strategy for maintaining reflexivity and delimiting subjectivity is to maintain a reflexive journal or diary (Polit & Beck, 2014:326). A reflexive journal was used by the researcher to record and bracket personal beliefs and opinions about practising caring presence from the outset of the study and in an ongoing fashion. Through self-interrogation and reflection, the researcher strived in this study to probe deeply and to grasp the experience under study through the lens of the participants (Polit & Beck, 2014:326). Consequently, the researcher strove to confront the data in pure form and to hold in abeyance presuppositions by maintaining a reflexive journal (Annexure **M**).

- Prolonged engagement

Prolonged engagement is an important step in establishing integrity, to test for misinformation and distortions, and to ensure saturation of important categories in qualitative studies (Polit & Beck, 2014:325). Therefore, the researcher invested sufficient time in the data collecting process.

In order to increase the authenticity of the research study, the researcher took steps to record data from the semi-structured interviews accurately via careful verbatim transcriptions of audio-recorded interviews.

2.6 Ethical considerations

According to McGuire *et al.* (2010:361), ethics in research is as much about the process as the final product. The emphasis is on maintaining integrity throughout the life cycle of the project. Underpinned by morals, ethics is an integral part of every step of the research process within a specific research context (Alderson & Marrow, 2011:65; Hammond & Wellington, 2013:59-60).

Therefore, professional integrity within this study related to the need for and commitment to ethically conducted research (Harding, 2013:24-27; Holt, 2012:102). As an interwoven aspect of each step in the research process, this implied a moral responsibility on the part of the researcher towards the participants, as well as future research efforts (Marais & Van Wyk, 2014:734). According to the South African Medical Research Council (MRC, 2007), ethics in health research provide values and norms that guide researchers to undertake research with honesty and integrity. Therefore, ethical considerations should be promoted and included from the conceptualization of the research until the research results are communicated (Botma *et al.*, 2010:4; Grove *et al.*, 2013:159). This section provides a summary of international and national ethics guidelines as applied in this research and it discusses the specific application of ethics principles.

2.6.1 International and national ethics guidelines adhered to in this study

International ethics guidelines have been formulated to ensure that equivalent standards are upheld across the world. In this research study, the researcher adhered to various international and national health research ethics guidelines. The international and national guidelines for ethics in health research and the core principles of each are summarised in Table 2.6 and Table 2.7.

Table 2.6: International research ethics adhered to in this research

Guideline	Core principles as applied in this study
Nuremberg Code (Grove <i>et al.</i> , 2013:160; Botma <i>et al.</i> , 2010:2; Brink <i>et al.</i> , 2012:33).	The participants provided voluntary informed consent for the research study and the research study did not bring unnecessary mental or physical harm to the participants.
Belmont Report (Botma <i>et al.</i> , 2010:3).	The participants' autonomy was protected, and all participants were treated with dignity and respect. Furthermore, the research study did not harm the participants in any way, and all participants were treated fairly.
Declaration of Helsinki (Grove <i>et al.</i> , 2013:160; Botma <i>et al.</i> , 2010:3).	The wellbeing of the participants took precedence over all interests regarding this research study.

Table 2.7: National ethics guidelines adhered to in this research study

Guideline	Core summary adhered to
South African Constitution and the Bill of Human Rights (SA Constitution, 1996).	The researcher obtained ethical approval and permission from all the relevant authorities to protect participants. All the role players and participants were treated with dignity and utmost respect and their human rights were respected throughout the research process. The participants were not abused or exploited based on race, religion, gender, age, class or sexual orientation.

Guideline	Core summary adhered to
Medical Research Council (MRC, 2007).	The researcher ensured that the privacy and confidentiality of participants were respected. A sound and appropriate research proposal was provided as blue print for the research process. Furthermore, the researcher was competent and skilled regarding this research process.
National Health Research Ethics Council (NDOH, 2015).	The human rights of all participants were respected. Therefore, the participants provided voluntary informed consent and no abuse or exploitation of participants took place during the entire research process.

2.6.2 Research ethics criteria considered in this research study

Grove *et al.* (2013:159) affirm that ethical research involves the actions of submitting a research proposal for review by an institutional review board, obtaining informed consent from the research participants and the protection of human rights. Therefore, ethical considerations were adhered to in the following way:

2.6.2.1 Submitting a research proposal for review

The research proposal for the study was submitted and permission to pursue the study was granted from the NWU HREC Potchefstroom Campus, Reference number NWU-00331-16-A1 (Annexure **H**). In addition, the North West Department of Health (Annexure **I**) and the CEO of the rural public hospital (Annexure **J**) granted permission to conduct the research.

2.6.2.2 Informed consent

All participants who took part in this research study were briefed individually. They received information about the research project and gave written consent for participation in the study (Annexure **E**). According to Creswell (2014:96), an informed consent form should contain a standard set of elements that acknowledges protection of human rights. Consequently, the researcher utilised the informed consent form provided by the HREC of the NWU, Potchefstroom Campus. This consent form stipulates clearly the ethical principles of voluntary participation, respect for people, beneficence and justice (Brink *et al.*, 2012:35-37). Furthermore, the consent form (see Annexure **E**) included the following:

- The title of the research project
- An introduction to the activities and procedures followed in the research, extending the invitation to participate in the study

- Confirmation of voluntary participation
- A detailed explanation of what the research study is all about, and the purpose and aim of the study
- The selection of the study population and sample
- Method of data collection
- A description of the indirect benefits, risks and discomfort involved, be it physical, psychological, emotional
- Confirmation of confidentiality and anonymity
- Management and dissemination of research results
- Name of the contact person should the participant need more information regarding his/her participation
- A clearly delineated space for the signature of the researcher, the participant, the person who obtained the informed consent and the witness.

Each participant who wished to be involved in this research study, agreed to sign a consent form (Annexure **E**) prior to the commencement of the semi-structured interview.

2.6.2.3 The protection of human rights

According to McGuire (2013:362), the ethics principles enshrined in the Belmont Report remain the cornerstone of contemporary research practice. The Belmont Report identified three fundamental ethics principles in relation to research involving human participants (Burns & Grove, 2009:184-185). These are respect for persons, beneficence and justice (Beauchamp & Childress, 2009:37).

Respect for persons

Autonomy and the right to self-determination is based on the principle of respect for persons (Creswell, 2014:19). Therefore, an individual has the right to decide how they want to conduct their lives (Grove *et al.*, 2013:164-168). During a training and information session held in the boardroom at the hospital, the researcher conducted a PowerPoint presentation (Annexure **Q**) to share an introduction to the research activities, the purpose of the project, selection of the study population, as well as the methods and procedures of data collection. Furthermore, she provided an explanation of the risks and benefits of the study, confirmed anonymity, confidentiality and voluntary participation of the participants. The mediators agreed to sign confidentiality agreements

(Annexure **C**) to protect the identity of the participants and to recruit the participants by sending an invitation (Annexure **D**) to all participants meeting the inclusion criteria. Furthermore, the identified participants were given time to consider if they want to participate (at least 24 hours).

After receiving full disclosure of information regarding the research study, voluntary, written informed consent was obtained from all the participants in the presence of a witness. The voluntary consent was also confirmed prior to the audio-recorded semi-structured interviews. Participants were ensured that they could withdraw from the study at any time if they wished, without any threats to their wellbeing (Brink *et al.*, 2012:39). Consequently, the researcher fulfilled all promises, was punctual for the scheduled appointments and the participants' culture and traditions were respected (Botma *et al.*, 2010:17). The researcher considered the interests of the participants by involving mediators to ensure that no coercion or exploitation took place (Botma *et al.*, 2015:17).

Beneficence

The principle of beneficence seeks to provide benefits, promotes the good of others and is suggestive of altruism, love and humanity (Cullity, 2007:20). Therefore, research should include all forms of action intended to benefit individual participants and society as a whole (Beauchamp & Childress, 2009:152). Elmir *et al.* (2011:12) and Rosetto (2014:482) claim that it is common in qualitative research that participants may not directly benefit from their involvement in a research study, but it is worth noting that participants often experience a cathartic effect when telling and having their story heard. In this research study, benefit was interpreted in the broadest sense, as the researcher offered a greater potential benefit to the nursing profession than to individual participants. Consequently, the indirect benefit for the participants was the fact that they would assist the researcher to gain a better understanding of their lived experience of practising caring presence. Furthermore, the information generated in this research will be used for future formulation of recommendations to develop proper interventions and strategies to implement and enhance the implementation of the crucial nursing intervention of practising caring presence among nurses. The benefit for society at large is the possibility that these research findings may be used to improve and enhance the quality of patient-centred care. In addition, by illuminating the practice of caring presence, professionalism among nurses may be enhanced.

“Non-maleficence” means that the researcher seeks to do no harm. Therefore, the researcher aimed to balance potential benefits against potential risks to reduce possible risk and to safeguard the protection of participants (Parahoo, 2014:89). In this research, no excessive physical, emotional or psychological demands were placed on participants (Polit & Beck, 2012:114). Furthermore, the researcher guaranteed confidentiality by undertaking that any information supplied by the participants would be used with discretion and not to “embarrass or harm them” (Fraenkel *et al.*, 2012:438).

Justice

According to the principle of justice, researchers are obliged to treat participants fairly and equitably throughout the research study (Butts & Rich, 2008:48). Therefore, justice was applied when providing equal opportunity for participants to partake in this research. Furthermore, anonymity, privacy and fair treatment were also ensured (Dempsey & Dempsey, 2000:170). Alperovitch *et al.* (2009:7) describe two elements of the principle of justice, namely equality and equity, which require research participants to be justly chosen based on the purpose and the expected outcome of the research. Research participants in this study were thus selected for reasons related to the phenomenon being investigated, not for convenience (Pratt & Loff, 2011:76).

2.7 Summary

The researcher aimed to implement the research in accordance with what Marshall and Rossman (2011:39) refer to as “an ethical mindfulness.” According to Tong *et al.* (2007:355), the application value of qualitative research for future decision-making is embedded in an appropriate design, execution and reporting of the study. Therefore, “methodological mastery” proved to be vital at each stage of this research study and guided participant engagement throughout the study (Huy, 2012:285). This shared relationship bridged “the space” between those being researched and those doing the research through circled engagement (Corbin Dwyer & Buckle, 2009:60). As co-creators of knowledge, both the researcher and the participants entered into a trusting relationship (Rubin & Rubin, 2012:82). In this study, the challenge was to move beyond the mere gathering of facts to allow the participants’ “authentic voice” to be heard (Atkins & Wallace, 2012:88).

This chapter discussed the research methodology in detail. Furthermore, the chapter expounded the research design, population, sampling, data collection and data analysis of the study. The research study aimed to explore and describe professional nurses’ lived experience of practising caring presence in the context of a rural public hospital in the North West province, South Africa. Therefore, the purpose was to illuminate how professional nurses, caring for large numbers of patients with a high acuity within a complex rural healthcare system, experience practising caring presence. Measures and considerations that the researcher adhered to in order to ensure trustworthiness, as well as ethical considerations appropriate to this study were explained comprehensively. Chapter 3 presents the research findings and literature integration.

CHAPTER 3:

RESEARCH FINDINGS AND LITERATURE INTEGRATION

3.1 Introduction

Chapter 2 offered a discussion of the research methodology. This chapter explains the realisation of the data collection and presents the research findings and the literature integration. The research findings are presented and discussed alongside the available literature to support the results of this study or to identify the results of this study as unique. The purpose of this study was to explore and describe professional nurses' lived experiences of practising caring presence in a rural public hospital in the North West province, South Africa.

3.1.1 Realisation of data collection

This study was conducted in a rural public hospital in the North West province, South Africa among a target population of fifty-nine (N=59) professional nurses. In this qualitative research study, purposive sampling, also known as judgemental sampling, was used to recruit participants. The mediators, identified by the CEO of this hospital, identified ten eligible participants (n=10), who all gave written, voluntary, informed consent to participate. Participants were identified because they knew the most about the phenomenon of practising caring presence, and they were able to articulate and explain specific situations where they experienced this phenomenon. The researcher collected the data by means of semi-structured interviews.

3.1.2 Demographic profile

Table 3.1 below outlines the demographic data of the participants who voluntarily participated in the semi-structured interviews.

Table 3.1: Demographic profile

No of participant	Age and race	Gender	Nursing qualifications	Work experience	Nursing unit
1	58, Black	Female	Nursing Diploma	23 years	Neonatal
2	32, Black	Female	Nursing Degree	10 years	Gynaecology
3	30, Black	Female	Nursing Diploma	8 years	Theatre
4	27, Coloured	Female	Nursing Diploma	5 years	HIV wellness clinic
5	31, Black	Female	Nursing Diploma	9 years	Out patients eye clinic
6	56, Black	Female	Nursing Diploma	26 years	Outpatients eye clinic
7	31, Black	Female	Nursing Diploma	8 years	Theatre
8	25, Coloured	Female	Nursing Degree	3 years	Oncology
9	30, Black	Male	Nursing Degree Trauma specialized	8 years	Casualty
10	31, Black	Male	Nursing Diploma Theatre specialized	9 years	Casualty

3.1.3 Research findings and literature integration

Colaizzi's methodological approach to phenomenological inquiry was utilised for analysing the data collected as part of this study. All transcriptions were read multiple times to get a feeling for the content. Significant statements were extracted from participants' transcripts pertaining directly to the research phenomena. Formulated meanings were constructed from the significant statements and arranged into cluster themes, which then evolved into emergent themes. The results were incorporated into a rich and exhaustive description of this lived experience. Validation of the exhaustive description was sought from the participants involved in this research. After the coding process was finalised and confirmed with the co-coder, the researcher contacted the professional nurses telephonically to validate if the emergent themes represent their lived experiences. All the participants stated that the themes and exhaustive description captured their lived experiences regarding the practice of caring presence accurately.

The findings of this research study originated from the participants' responses during the semi-structured interviews. From the transcribed interviews (Annexure **N**), 319 significant statements were extracted (Annexure **O**), leading to the development of 319 formulated meanings (Annexure **P**) that reflect the lived experience of these professional nurses. Eleven theme clusters were

formed, which were further merged into five emergent themes (Annexure P). The theme clusters and emergent themes are illustrated in the final thematic map (see Table 2.4).

3.1.4 Emergent themes

The findings are discussed thematically with the arrangement of mutual experiences grouped into emergent themes forming the basis of the findings. The emergent themes are discussed by presenting the theme cluster, consisting of formulated meanings, followed by direct quotes and a literature integration. The discussion includes references to quotes. The demarcation T1, P2, L48-50 refers to the transcript (T), the page number (P) and the line numbers (L) where the quote can be found.

It is evident from these emergent themes that the participants answered the two semi-structured interview questions, namely: “Can you please describe a situation where you practised caring presence as a professional nurse?” and “How do you experience practising caring presence?” in an interwoven manner. The findings are therefore presented as an integrated unit/whole in terms of these two questions.

3.1.4.1 Emergent theme 1: Professional caring presence

In the interviews, participants shared their lived experience of practising caring presence and one of the emergent themes is that they experience caring presence as a ‘Professional caring presence.’ This theme emerged from four theme clusters, namely: passion for the nursing profession, self-awareness, dedication and commitment to the best nursing care, and being a role model.

3.1.4.1.1 Theme cluster: Passion for the nursing profession

In their experience of practising caring presence, participants felt that *passion is fundamental to the nursing profession*. It enables them to care, to build meaningful relationships with patients and to become a specialised nurse. They felt that without the expression of their passion for the nursing profession, it is not possible for them to render quality nursing care. A hundred percent dedication and commitment was emphasised. They further explained that this passion requires an intersubjective human connecting with whatever they are doing and a focus on a meaningful relationship with patients. One participant explained that this passion for the nursing profession means becoming everything for the patients and displaying a willingness to give of herself.

This passion for the nursing profession is driven by viewing nursing as a calling and not merely as work. Nursing within a rural area is experienced as challenging, but compassion for patients and passion for the nursing profession enable participants to cope. Passion is seen as the core characteristic that enables nurses to practise caring presence. The participants indicated that the

professional nurse should have a willingness to be professionally present for patients before caring presence can be established. Core driving forces involve integrity, professional commitment and responsibility. In addition, one participant shared his whole-hearted commitment to the nursing profession. Participants agreed that a sense of professional pride and feelings of fulfilment and self-worth were gained from the experience.

The following direct quotations are indicative of how participants described how passionate they feel about their role as professional nurses and how they practise professional caring presence:

“Yes, without passion, I could not do it...Passion goes for everything...You do it 100% (silence) everything comes with passion.” T1, P2, L48-50.

“...I think passion in general is having a connection with whatever you are doing. For instance, we, as nurses, focus on the patient...If you do have a connection with the patient (silence) that is passion (silence).” T1, P3, L72-73.

“I told her one thing, when you are a nurse, you become everything...” T2, P10, L46.

“As a team leader, I always say to the assistant nurses, the staff nurses, guys, we don’t have to fake things, we have to, just have to be there, for our patients. That is our responsibility.” T7, P42, L264-266.

A vast amount of literature confirms that passion is the core characteristic that enables nurses to practise professional caring presence (Ferguson-Parè, 2012:393; Ketchem, 2016:125; Mahon, 2011:5; NANB, 2012; Robertson, 2016:35; Shearer & Crawford, 2011:11; Spitzer, 2012:17; Thompson *et al.*, 2008:38; Vaughan, 2017:35; Wang, 2017:43). Walsh (2009:127) and McCaffrey (2012:230) agree that nurses who practise caring presence love being nurses and coming to work every day brought meaning to their professional role. Bigby (2015:37), as well as Jansen and Blair (2015:283), support the participants’ view that understanding and having passion for the nursing profession establishes professional nursing presence. Literature also highlights that professional presence involves the demonstration of compassion, respect, confidence, competence, integrity, optimism and passion (College of Registered Nurses of Nova Scotia, 2012; Lachman, 2010; Wadsworth *et al.* 2017:8).

3.1.4.1.2 Theme cluster: Self-awareness

The participants reflected on the importance of *self-awareness* and the therapeutic use of the self within the nursing profession. They confronted the reality that a lack of self-awareness can result in a decrease in professional care, which means that the aim to support patients to reach healing will not be achieved. Furthermore, they shared that they utilized own personal experiences, self-disclosure and self-knowledge, which indicates professional maturity and growth, to assist and connect with patients through responsive communication. Therefore, they felt that their life experiences and professional experiences helped them to be professionally present for patients. The following quotes illuminate this theme cluster:

“...I also shared some of my experiences, just to easy [sic] her. But I was doing it out of love, go reh...and just be talking to her, go reh, she told me, you know what, you should have been a social worker.” T2, P10, L38-44.

“The other thing neh, is that you cannot nurse in a rural village, with a broken heart or with anger, it is so (silence) wrong.” T2, P12, L135-36.

“So, my experience with patients here in the rural area, caring for them, it is tough (silence). Short staff, but if you are loving, you love your profession, then everything becomes so smooth. Because I am doing it from the bottom of my heart. I do understand what nursing wants from me, I understand what I have to do for my profession. What I should not do.” T2, P14, L193-196.

Literature reports that self-awareness has long been addressed as fundamental for the professional nurse, with the accepted view that self-awareness will lead to greater professional competence (Robertson, 2016:330; Clancy, 2014:15; Rego *et al.*, 2010:1420; Eckroth-Bucher, 2010:298). The research analysis similarly indicated that *self-awareness* is a dynamic transformative process of self, as well as a professional competence that facilitates, sustains and enhances the care experience (Bright, 2012:93; Palmiery, 2014:70; Praissman, 2008:212).

Other authors (Boeck, 2014:4; Du Plessis, 2016:49; Finfgeld-Connet, 2008:714; McMahon & Christopher, 2011:75) agree with the participants that life experiences and personal and professional maturity are crucial antecedents to the enactment of professional caring presence. Dossey and Keegan (2016:467) reinforce the importance of self-awareness in a similar way as one of the participants by stating: “If we are to act in a way that is therapeutic, in a way that promotes healing, we ourselves must be whole and healed.”

3.1.4.1.3 Theme cluster: Dedication and commitment to the best nursing care

Participants identified dedication and commitment to deliver the best nursing care as a fundamental element of the practice of caring presence. The participants emphasized that the patients are their priority and revealed their close interaction with patients by denoting that they treat them like family. Other participants shared a willingness to ensure the best nursing care and wellbeing of the patients and confirmed their passion for the profession by revealing their professional responsibility, commitment and dedication to care for patients with compassion.

Participants’ reflections illuminated professionally competent and effective teamwork as fundamental to safe and effective nursing interventions. This includes the use of problem-solving skills and a portrayal of a caring attitude. One participant echoed the value of professional responsibility and commitment of the whole nursing team. The following direct quotations relate to this theme cluster:

“...I said to her, no, no, no, I am not here for the paper work, I am here for the patients, you see.” T1, P4, L126-127.

"I think as a nurse, you made a vow that you will always care for your patients. So you must always be there for them, and practice caring for them. It is important that you make a point that you always care for and that you are always there for your patient if they need anything from you." T3, P18, L37-40.

"I want to be there, and even in the evenings it will haunt me if I did not do 1, 2, 3, for them. They even have my contact number. I want to take care of whatever the situation is." T4, P24, L104-106

"Yes, because we got the telephonic order while the doctor is still not there, we will not leave the patient like that. No. We must take care of him, we started giving oxygen, we started giving TNT, we started giving aspirin. The patient was still sweating and after the medication was given, we were still monitoring and the patient recovered. Then the patient was stabilized." T7, P36, L37-55

"Yes, yes, that is my way of showing my caring presence. I did not wait for the doctor, I acted and used the protocol that are [sic] available." T7, P37, L80-81.

The participants' experience as recounted above corresponded closely to findings reported in the studies of Jafaragae *et al.* (2012:477) and Numminen *et al.* (2015:118) who reported that the concept of professional commitment to nursing involves offering the best nursing care and trying to spend all their potential to improve their profession. This concept is also illuminated by Aiken *et al.* (2013:144), Chang *et al.* (2015:474) and Satoh *et al.* (2016:56). Other research studies confirm the lived experiences of professional satisfaction and pride, and professional accountability and responsibility towards the challenges and issues of the profession (Bergmann *et al.*, 2011:17; Eley *et al.*, 2012:1550; Paterson & Zderad, 1988:15; Rahimaghaee *et al.*, 2010:10; Turpin, 2014:15; Walsh, 2009:129).

3.1.4.1.4 Theme cluster: Being a role model

The participants indicated the necessity of being a role model in order to establish caring presence. Furthermore, the role of motivating and inspiring colleagues was illuminated as fundamental factors in strengthening relationships within the nursing profession. The participants' experiences included the practice of leading by example to enhance professionalism and to inspire a caring attitude among nurses. Also, one participant shared that while she was a patient herself, she was inspired by certain nurses who portrayed professionalism as well as a positive and caring attitude towards patients. The following quotes best represent this theme cluster:

"Role-modelling is so important for me. You must check and be an example. If you come late, who is taking the report? So you must be a role model. Yes, sometimes you will come late, but it must not be a habit." T1, P4, L138-144.

"Then the nurses came in, I followed their routine very well. They came in the morning, they will greet us and they will be (silence) only few of them had a positive attitude...I liked the way they communicated with patients, and care for them...and then I loved nursing..." T2, P12, L112-113.

"We must be role models to the younger nurses to show them that we really care for our patients, ee, (silence)." T 10, P53, L70-71.

“But the moment we, as professional nurses, motivate the staff, the absenteeism went down. Because even our juniors can say, now we enjoy nursing. We must motivate the staff to care and to be motivated.” T7, P43, L289-291.

Literature confirms that role modelling lies at the heart of being professional (Kenny *et al.*, 2003:1203) and inspires people and the hearts of others (Secretan, 1999:512). Therefore, inspiring and encouraging others serves as a foundation to encourage and facilitate the practice of professional caring presence (Bright, 2012:53; Turpin, 2014:15). According to Dossey and Keegan (2016:598), the holistic role model, being an inspirational presence, can cultivate a commitment and passion for the nursing profession and can create a positive and engaging environment. In response to the question how the participants would go about fostering the ability to practise caring presence, many proposed that role modelling is the most effective way.

Bright (2012:95) and McMahon and Christopher (2011:75) support the idea that caring presence can be enhanced by setting an example to connect with patients by describing the practice of caring presence, praising it, and providing practical support whenever possible. Ketchem (2016:125), Priest (2012:16), and Istomina *et al.* (2011:37) agree with the experiences of the participants that nurses’ professional presence has the power to affect change within the health environment because their caring demeanour to patients and their families and the way they provide care, can inspire nurse colleagues to maintain and improve the quality of patient-centred care.

Consequently, the findings of the theme clusters and first emergent theme of professional caring presence support the existing literature, indicating that the practice of professional caring presence can become the driving force for high quality patient-centred, competent, and compassionate care.

3.1.4.2 Emergent theme 2: Ethical caring presence

The second theme that became visible from the participants’ responses during their semi-structured interviews was: ‘Ethical caring presence.’ This theme emerged from the theme cluster: *ethical responsibility*.

3.1.4.2.1 Theme cluster: Ethical responsibility

The participants revealed that portraying ethical care was a way to practise caring presence. This involved they acknowledged patients as unique individuals and revealed a commitment to conducting nursing practice morally. They reported that sharing reality, being non-judgemental, honesty and transparency are important principles to facilitate ethical caring presence. One participant specifically referred to the implementation of the *Batho Pele* principles, which means “people first,” in describing her openness and ethical responsibility towards her patients. Participants focused on the principle of valuing patients as persons, treating them with love, dignity and respect and warned against depersonalization of patients.

Other participants revealed their humanity and shared a willingness to move beyond the objective aspects of care to provide sincere, non-judgemental and honest care in order to establish meaningful relationships with patients. The participants in this study further regarded the advocacy role as an important strategy to safeguard the best interest of patients and indicated a deep desire to act on behalf of their patients. Furthermore, the value of being an intercessor between the doctor and patient and enthusiastic persistence to fight for the human rights of patients were apparent. Advocacy is also described as part of having a personal and close connection with patients and an availability so that they are ethically present for them. This is supported by the following direct quotations:

“But I put my humanity, like, I put it up front. Whenever the patient is different or not, you must understand why is this patient so difficult. So you can get to the bottom of the problem. Ok, on that issue of Batho Pele principles, agree, the principles are there. They help us (silence) to reach good quality continuous nursing care. You put the patient first, people first.” T2, P14, L198-206.

“Then I have to advocate for them. I beg them to give them a chance.” T4, P22, L59-60.

“You must not call the patient by his diagnosis. You must say, Mr So-and-so and Mrs So-and-so. Whoever the name, but not by the diagnosis. If you call them the laparotomy patient, they don't feel all right. It is not fair to the patient.” T5, P29, L87-92.

“But if I know I am fighting for my patients, their right to life, to get a chance (silence).” T7, P42, L261.

According to literature, ethical responsibility and moral sensitivity are particularly relevant to the concept of caring presence (Ray & Turkel, 2015:461; Sellman, 2011:245; Zyblock, 2010:122; Walsh, 2009:129). Bright (2012:975) agrees with the participants that caring presence results from a moral and ethical capacity and nurses should have an ethical orientation towards connecting in a helpful a Covington, 2003:301nd compassionate way with another human being.

It was apparent from most participants' accounts that there seems to be a strong connection between being a good nurse and “doing the right thing,” which supports the recent popularity of virtue ethics (Begley, 2010:525; Bouchard, 2016:81; Smith & Godfrey, 2002:301). The importance of patient advocacy and defending the infringements of patient rights are confirmed by Cole *et al.* (2014:576), Josse-Eklund *et al.* (2014:673) and Hebert *et al.* (2011:325).

3.1.4.3 Emergent theme 3: Personal caring presence

The mutual experience of ‘practising personal caring presence’, is the third theme that surfaced from the data collected from the interviews. Personal caring presence includes the theme clusters of a willingness to be personally present, to walk an extra mile and offering the gift of self.

3.1.4.3.1 Theme cluster: Willingness to be personally present

In their experience of practising caring presence, some participants revealed a desire to meet the personal challenge of being present, which requires a willingness to become vulnerable. Therefore, they shared the intimacy of the relationship with their patients by being personally available for them and treating them as if they are family.

In addition, participants confronted the reality of professional challenges and issues in the remote rural area, but also shared a personal sense of commitment and feelings of pride, satisfaction and fulfilment, when they felt that they have made a difference in the lives of those they care for. One participant indicated that the positive comment of the manager regarding her personal presence and confidence motivated her and confirmed her career choice. The participants clarified their experiences as follows:

"I try to become part of their family, or like a family member who cares genuinely. Yes, yes. I will go that far to come close to my patient." T8, P49, L134-136.

"It's on a daily basis, neh, usually I am happy when I go home...I go home seeing a difference in the patients' condition." T1, P2, L53-55.

"So I can say I feel fulfilled, because I have started it from nowhere. Our hospital is a regional hospital. So our nearest hospitals, they are referring to me. I was able to make a difference...So what makes me happy, is that patients who could not see a thing, can see now. They will say, Sister, I have been hearing your voice, but now I can see you! That makes nursing so worthwhile." T4, P22, L39-44.

"Then she replied that first thing in the morning when I came in the ward, I saw the way you were standing, the way you wear your uniform (silence) I saw (silence) this is a nurse. Then she said she went after me the whole day and she saw this is a nurse. You know that manager made my day! (silence). I became motivated. I did not come to nursing by mistake." T1, P3, P95-100.

Palmieri (2014:66) states that "as human beings, our presence is automatically care: it expresses the way in which we are, who we are, able to be, given our limits, and the context, both material and relational, in which we live." Therefore, research revealed that when a nurse is personally present, compassionate care becomes real, and this state is needed for those who intend to facilitate healing (Boeck, 2014:4; Halifax, 2014:124; Eisler & Potter, 2014:12; Finfgeld-Connet, 2008:527; Welch, 2015:93).

What these professional nurses experienced is not unique to this study. Other research studies also found that nurses who focus primarily on engaging in personal presence establish optimal milieus for intimate caring-healing interactions between the nurse and patient (Da Silva Borges, & Soares dos Santos, 2013:608; Finfgeld-Connet, 2008:533; McDonough-Means *et al.*, 2004:S34; Sofhauser, 2016:32; Trout, 2013:166; Walsh, 2009:112). In addition du Plessis (2016:1), Bright (2012:86), Trout (2013:11) and Deloach and Monroe (2004: 209) confirm the experiences of the

professional nurses, who indicated feelings of personal revitalization, fulfilment, and a sense of purpose when they shared moments of caring presence.

3.1.4.3.2 Theme cluster: Walking an extra mile and offering the gift of the self

The professional nurses who participated in the study further indicated that when they felt connected with patients, they were willing to go beyond the call of duty and to walk an extra mile. Furthermore, they stated that they would persist in giving everything and becoming everything for their patients. Other participants revealed a commitment to leaving no stone unturned in the process of facilitating caring presence and creating a healing environment. In addition, the practice of caring presence was described by the participants as offering the gift of the self.

The experiences described above were regarded as meaningful and enriching moments. One participant revealed that once he discovered nursing as a caring profession, he started experiencing meaningful relationships with his patients. These professional nurses acknowledged the holistic needs of patients and were committed to being actively present as a whole person and participating holistically in the healing process. This means they made themselves personally available, showed genuine interest and concern and strove to be an instrument of healing. This is evident in these direct quotations from the semi-structured interviews:

“You must feel that you are fully there for them, being everything for them (silence). You must put yourself in the patients’ shoes. Feel what they feel, if it was me, having this problem, what was I going to do? So always when a patient is suffering (silence), sometimes I even cry, because I will put myself in that patient’s shoes. Or eh, this patient is experiencing this and that.” T2, P11, L82-91.

“I feel I walked an extra mile for that patients, because remember within our scope of practice there are things that we are not supposed to do...I gave everything.” T4, P23, L97-100.

“I was actually giving my all for this patient. That is caring presence for me.” T7, P41, L226-227.

“You must give everything when you are really there for your patients. Ja just give the whole of yourself, emotionally, physically, everything.” T8, P49, L131-134.

These findings are not unique to this study. Tavernier (2006:154) defines presence as “the mutual act of intentionally focusing on the healthcare user through attentiveness to their needs by offering of one’s whole self to be with the healthcare user for the purposes of healing.” The nursing literature supports these experiences of the participants with the use of different phrases such as “use of self as an instrument of healing” (Du Plessis, 2016:1; McKivergin, 2005:233; McKivergin & Daubenmire, 1994:66), “gift of the self” (Osterman & Schwartz-Barcott, 1996:28), and the “active presence of the nurse’s whole being,” as called for by Paterson and Zderad (1988:132) and Vaillot (1962:500).

3.1.4.4 Emergent theme 4: Healing caring presence

The fourth emergent theme that resulted from the professional nurses' lived experience of practising caring presence in a rural public hospital involved the concept of: 'Healing caring presence.' This theme emerged from the following four theme clusters: patient-centredness, holistic care, connection and intention-setting techniques, and the dimensions of healing caring presence, which involves a willingness to be physically, emotionally, cognitively, and spiritually present, and acknowledging social needs.

3.1.4.4.1 Theme cluster: Patient-centred, holistic care

The participants in this study further described the practice of caring presence in a rural public hospital as an experience grounded in a holistic nursing approach. They shared a willingness to render patient-centred care to establish a healing caring presence. Dedication to take care of the patient holistically and thereby assisting the patient to function independently was emphasized. Furthermore, one participant reflected on the reality that patients have to be taken care of "from head to toe." Another participant revealed that caring presence is a conscious effort to focus on the total needs of patients and suggested that being there for patients as a whole creates meaningful relationships. The participants emphasized that the holistic philosophy of highly individualized care enhances the practice of caring presence. Patient-centred care is also highlighted as the core of the healing process. The following direct quotations confirmed these experiences:

"This way you can write even on your notes, this patient is stable holistically...you nurse the patient in totality. You take care of all his needs. You will not only look at the physical part and leave the emotional and spiritual part. So it is very important for us to do. That is what I do (silence). I nurse the patient from head to toe." T2, P13, L152-158.

"Yes, to see the patient with physical, spiritual and emotional needs. Not only a body, but a person with more needs. Like I say to help the patient to heal." T4, P24, L124-125

"All patients, sister, do have physical, emotional and spiritual needs, ok? So we take care, as professional nurses, of the patient holistically, sister, I take care of all the needs and is [sic] present for the patient holistically (silence)." T9, P53, L63-66.

Several studies support the above findings that patient-centred care is an important principle that underpins the provision of caring presence (Kostovich & Clementi, 2014:70; Mohammadipour *et al.*, 2017:19). A study conducted by Mohammadipour *et al.* (2017:19), who did a concept development of nursing presence with the application of Schwartz-Barcott and Kim's hybrid model, confirmed this finding by concluding that nursing presence can be explained as co-constructed interaction identified by deliberate focus and patient-centred approaches.

In addition, Bullington and Fagerberg (2013:493) and Morgan and Yoder (2012:6) equate patient-centred care with holistic nursing practices. According to Dossey and Keegan (2016:484),

cultivating a holistic healthcare environment that involves individual patient-centred care is fundamental to create a healing milieu for patients. This confirms that powerful healing could be facilitated, even while engaging in task-orientated nursing activities. Furthermore, Kostovich (2012:167), who developed an instrument to measure nursing presence (Presence of Nursing Scale), confirms that both being and doing, the essence of nursing presence, are reflected in the profession's holistic approach to individualised care for patients and families. Therefore, the practice of caring presence is considered to be an avenue that supports and fosters a healing environment (Bright, 2012:1, Zyblock, 2010:120).

3.1.4.4.2 Theme cluster: Connection and intention setting techniques (mindfulness)

The other important experience that the participants shared regarding their lived experience of practising caring presence in a rural public hospital is the practice of connecting and intention setting technique. This was described as a technique that involves focusing their energy on the holistic needs of their patients, to be there, and to connect not only in the physical sense but also in the psychological, emotional and spiritual realms.

In addition, participants revealed that caring presence is a conscious effort to focus on the total needs of patients. They suggested that being there for patients as a whole creates meaningful relationships and a healing milieu. The participants highlighted that a conscious and intentional decision to pause and focus on being present provided a powerful basis for the practice of caring presence. The participants clarified their experiences as follows:

“Before you come to work, you must focus to be present. You must talk to yourself, you know what, today I am going to work for my patient, I am going to treat that patient that needs me, because I am a nurse. You just come with that attitude then everything will just fall into place. If you just treat them their physical, their emotions, their spirit (silence). If their mind is ok, their body follows. It becomes ok. So it is important for us nurses to just be there.” T2, P13, L144-149.

“You know that sometimes we are in a hurry. We must pause and care for the patients. We must spend sufficient time with them. Yes, just stop at the patient, and show your love.” T5, P29, 111-114.

“That is very important, but more important is to focus on not only on [sic] the condition of the patient, but focus on the wellbeing of the patient holistically. To focus physical, psychological, social, even the cultural needs of the patient.” T7, P44, L358-361.

These experiences are in line with literature that confirms that caring presence is an interpersonal, intersubjective human experience of connection within a nurse-patient relationship that makes it safe for sharing oneself with another (Covington, 2005:169; Hooper, 2013:255; Kostovich, 2012:169; Leebov, 2009:1; McCollum & Gehart, 2010:348; Welch, 2015:93). Similar to the participants' views, Welsh and Wellard (2005:7) and Finfgeld-Connett, (2008:530) propose that the nurse brings conscious awareness (intentionality) and is available and attentive in the moment to provide opportunity for deep connection between the nurse and patient in the relationship.

The importance of the nurse “pause” as an intention-setting technique is highlighted by participants and supported by nursing literature (Bright, 2012:17; McMahon & Christopher, 2011:74). Leebov’s (2009:1) work corresponds with participants’ experiences when stating that “the practice of caring presence, makes *every moment of connection* with the patient precious, so that caring comes across loud and clear.”

3.1.4.4.3 Theme cluster: Dimensions of being a healing caring presence

The participants mentioned several *dimensions of being a healing caring presence*.

- Physical caring presence

The participants in this study further shared experiences that revealed their willingness to engage in intentional physical presence, offering physical availability and approachability. They described that they connected with the patients physically by means of therapeutic verbal communication, eye contact, therapeutic touch and assuring physical comfort.

The professional nurses who participated in this study kindly attended to the physical needs of the patients and reflected on the importance of spending sufficient time with patients to establish a meaningful and trusting relationship. One participant shared her physical connection with her patient, by performing a simple action such as rubbing her back to soothe the pain. Other participants indicated their willingness to be present at the bedside of patients and offered authentic, personal attention. They revealed that checking in frequently with patients and the performance of safe, effective nursing interventions, facilitated caring presence and enhanced helping-trusting relationships. The following quotes support this finding:

“I took his hand and say you will be ok, I will take care of you. At Casualty we put him on the bed and I stayed near him. We took vital signs.” T1, P7, L253-255

“Akere, most of the time it is cold in theatre. So we make patients feel nice and comfortable so that they are not cold. We use the warmer, the “bed-hugger” to warm the patients in theatre.” T3, P19, L79-82.

“You must talk to them. You must not work with patient as if he is an object. He is not an object. You know sometimes, you must touch them (she bent and touch my arm). Then you must sit with them, you must show that he is not an object.” T5, P28, L72-82.

“Yes, because we did not sit down in the nurses’ bay, and say no, we have done our routine (silence). We can relax now. No, every minute, if we know we have a patient who is critically ill, we always went to him...and every 15-20 minutes I must be at his side. I did not leave his side. I monitored him, stay near him.” T7, P39, L190-194.

Literature confirms the fact that the physical presence of nurses is recognized as a primary objective in the practice of caring presence (Easter, 2000:362; Godkin *et al.*, 2002:17; Hooper, 2013:255; Merrill *et al.*, 2012:35; Yesilot & Oz, 2016:97). A study done by Kostovich (2012:167),

who did a concept analysis on the concept of caring presence and proposed a conceptual framework, found that caring presence is evident from direct and indirect physical availability, physical comfort and competent performance of nursing procedures. Therefore, it is not surprising that the participants practise caring presence in these ways.

- Emotional caring presence

In their experience of practising caring presence, participants revealed a willingness to be emotionally present for their patients and indicated an openness to connect with patients unconditionally. Some participants shared the intimacy of the interaction, the unique bond and the close contact with their patients by comparing this experience with providing care for your own mother at home. They agreed that the practice of caring presence involve emotions of empathy, sympathy, sensitivity and compassion and warned against dehumanisation of patients.

Consequently, they explained that genuine interest and unconditional acceptance are necessary to understand and connect with a patient therapeutically. Furthermore, a positive attitude, genuine support and concern, responsive listening and “tuning in” with the patient were highlighted by participants as core elements of therapeutic communication skills, utilised to foster meaningful relationships and caring presence. In addition, one participant confronted the different context of working in theatre, but still she revealed a commitment to showing compassion and she shared a heart-centred desire to be there for her patients. This is evident from the following direct quotations:

“Yes, yes, to be still caring and being there for your patients...I remember last year I was so hurt (silence). I was standing at the Help desk and I saw a white man coming. He was wandering, wandering. Something that comes to my mind, is that I wondered if this is a psychiatric patient? Because when I looked at him, he was shivering... The first thing that I did, was saying, father, just come and sit down. He was so confused, man, and then fortunately he sat down. But he was still (shaking her hands in shivering movements). T1, P7, L225-242.

“Yeah, that is why I said that you must be there. Be there to comfort hurting stories, be the comforter of that patient too. But that only happens when you are approachable.” T2, P15, L267-269.

“Caring is being there for the patient...being empathic with the patient. Sympathize with her and help her...Mmm. Always relieve their anxiety, comfort them, make them comfortable wherever they are in hospital. It means like understanding the situation of the patient that they are in. Yes, and then put yourself in the same shoes as the patient. It means just being there, feel as they feel.” T3, P18, L42-55.

“Then you must show love, show patience to them. Not just treat them as an object, you see?” T5, P27, L43-44

Several studies support the above findings (Papastavrou *et al.*, 2011:1026; Cantrell & Matulla, 2009:E303; Hain *et al.*, 2007:19; MacKinnon *et al.*, 2005:28). In a cross-cultural study conducted by Papastavrou *et al.* (2011:1026) in six different European Union countries investigating patients’

and nurses' perspectives on the concept of caring through behaviours, indicated factors for assurance of presence, included "being with" (emotional presence), and therapeutic communication.

These findings were affirmed in a hermeneutic study on the meaning of nurses' presence during childbirth, done by MacKinnon *et al.* (2005:28). Nurse presence was the way in which a nurse was "there for them" (the patients), and the nurses described this as being emotionally involved, hearing and responding to concerns, and helping to create special moments. To further support this lived experiences of the participants, Hobbs (2009:55) and Bright (2012:20) posit that emotional engagement is the key process in avoiding and alleviating dehumanisation and illuminate therapeutic connection between the nurse and patient as one of the mechanisms through which caring presence occurs.

- Cognitive awareness

The participants experienced that cognitive attentiveness facilitated caring presence. Their dedication to share knowledge and give appropriate advice and guidance to patients was highlighted during the interviews. Therefore, the utilisation of their cognitive abilities and skills was identified as fundamental elements in creating and maintaining meaningful relationships with patients. Some of the participants further explained that their attempts to offer health information and education enhanced the healing process of patients. In this regard, a participant indicated that she felt she empowered her patients by means of knowledge sharing and encouraged their autonomy, thereby facilitating their independent functioning. Another participant acknowledged the fact that a lack of knowledge and insufficient access to information lead to medical conditions that could be prevented.

Some participants pointed out that sharing knowledge regarding traditional beliefs may prevent serious health conditions. Most of the participants identified the importance of assuring that patients cognitively understood their unique situation as patients and their treatment plan. In addition, the professional nurses who participated in this research study emphasised their responsibility in obtaining authentic informed consent and highlighted their effort to ensure that patients were sufficiently informed pre-operatively. Consequently, they confirmed that being cognitively present for their patients and sharing a cognitive connection with them fostered the practice of caring presence. The following quotations reflect this theme cluster:

"She will talk to me about it. I will give her advice on what to do, what to be careful for. I will tell her no, no don't do that, you are inviting germs and infection into your body. Then I sit down and I talked to her. You must not do this or that. She even tell me then, now you are not a social worker now, now, you are even a teacher." T2, P10, L51-58.

“Because most of all they lack information. They don’t have access to information. So you must share your knowledge with them.” T2, P14, L185-188.

“...and to explain the procedures to the patients so that they understand what the doctor will do. He gives you this injection, after this one you will sleep and you will not feel any pain during the procedure. So we make sure we explain the procedure to them so that they can be as comfortable as possible...Yes, because some of them they become very anxious. Maybe they have this myth that it is very scary in the theatre. They will make you die and then you come back, so (silence) we try our best to explain to them.” T3, P19, L79-9.

“Let’s talk about when the patient must go for an operation. Some patients don’t understand so you must advocate and explain so that the patient feels free and understand what is happening. What is going to be done to him.” T5, P27, L52-55.

“We must educate them that it is the traditional medicine that caused that condition of renal failure...the lack of knowledge leads to this actions.” T7, P45, L363-368.

In this regard, Van Graan *et al.* (2016:280), Potter and Frisch (2007:213) and Bridges *et al.* (2013:760) confirm that cognitive reasoning skills and the provision of patient education are essential nursing practice standards that meaningfully impact a patient’s health and quality of life. Therefore, the experiences of the participants are also in line with an observation by Covington (2005:169) that caring presence is mutual trust, sharing, transcending, connectedness, and experience. In further correspondence with the views of the participants of this study, she states in her study that this special way of being a caring presence involves devotion to a patient’s wellbeing, while bringing scientific knowledge and expertise to the relationship. Robinson (2003:200) agrees that no technology in healthcare replaces the critical thinking of a human mind, the caring of a human soul, the proficiency and skill of a human hand, and the warmth of a human heart in healing the sick and injured.

- Spiritual caring presence

The participants also shared the importance of spiritual presence in the practice of caring presence. They revealed that connecting in the spiritual dimension led to a deeper level of connectedness between the nurse and patient. Furthermore, one participant indicated that spiritual presence was fundamental to nursing babies, and revealed that she regained inner strength when praying. Some participants denoted that they prayed for and together with patients for healing during difficult times. They commented that they utilised opportunities for spiritual counselling and support whenever they sensed that patients experienced spiritual needs. In addition, the professional nurses who participated in this study felt that they fostered a caring presence for patients by being spiritually there with them, and by instilling hope. The participants clarified their experiences as follows:

“We are still praying, we are still praying, fortunately, in peads, we are dealing with babies. We must pray for the babies (silence) they cannot talk... they cannot pray for themselves... with adult, agree, she can just go in the bed: “my God, what, what.” (holding her hands together, eyes closed).

I pray that I can get strength (silence) to do nursing, and I pray on behalf of babies, they cannot pray (silence).” T1, P5, L166-169.

“The patient will be hopeless and you will explain to her that things will get better and they must believe in God. Yes, that they can get better and heal and go home in a better condition. Yes, if you are a Christian you will explain that they must pray every day, and believe God will also help them to heal.” T3, P19, L70-74.

“You can share with the patient that maybe where there is life, there is hope. I also take care of the patients’ spiritual needs. It is important to listen and if he needs to pray, let him pray and support him.” T10, P53, L56-58.

In line with what the participants in this study experienced, Du Plessis (2016:47) notes that caring presence is an encompassing element in spiritual care. Similarly, Iseminger *et al.* (2009:447) and Tjale and Bruce (2007:45) agree that spiritual care in nursing begins with a perspective of being intentionally present with patients and being caring. Yesilot and Oz (2016:97) suggest that spiritual, holistic, healing, full, and metaphysical presence is the beyond of physical and psychological closeness. Easter (2000:362), who conducted a construct analysis of four modes of being present, also supports the lived experiences of the participants, by assuming that the nurse who strives to be in the spiritual presence mode, help patients to recover, to increase their mental and physical wellbeing, and this enhances the healing process.

- Presence within the social realm of being

In their lived experience of practising caring presence, the participants further indicated a commitment to being present within the social realm of being. This was explained as an ability to identify and attend to the social needs of patients and being there to share knowledge, give support, advice and guidance regarding their social problems. Some participants were confronted by the reality that many people from rural areas have a poor socio-economic status. They revealed a willingness to attend to this multitude of socio-economic problems, and if needed, also referred these patients to the social worker. One participant shared that she bought “baby stuff” for a pregnant woman who was in need.

Furthermore, a participant described that because of the remoteness of the rural area, some patients are not visited frequently by family members during their period of hospitalisation. Consequently, this participant denoted that she kindly assured one patient that she was there for him, and that he should not experience feelings of loneliness. The following quotations provide proof of these experiences:

“I remember there was this patient neh. This patient was, I could tell this patient was from a poor socio-economic standard neh. I could see just by entering (silence). But to her, eeee, I became a nurse. The person that I am.” T2, P9, L29-30.

“Akere, some patients are coming from far, they don’t have family who come to visit them. I tell them I am here for you, don’t worry if your family cannot come visit you. You must not feel lonely and lost. Yes, I am here for you, I am here.” T5, P28, L72-77.

“In rural areas, we have many social-economic problems. We must guide and assist the patients accordingly. It is very important, yes, it is very important.” T7, P45, L380-381.

“Her family was back on the farm, so I asked the social worker to try and contact whoever (silence) so really the background was not good. Fortunately, the social worker managed to get the telephone number of the boyfriend, but he refuses to come to the hospital. Then I spoke to him, and begged him to come, because he must convince her to take the C-section. I advocated for the mother and the unborn baby.” T8, P47, L57-66.

These findings are in line with the grounded theory research study of Backes et al. (2009:13) that aimed to understand the meaning of nursing care as a social practice. According to this study, the meaning of nursing care as social practice is related to the nurses’ active, effective and close contact with the patients’ social reality (Backes et al., 2009:13). The experiences of the participants regarding their practice of caring presence further support the existing literature, confirming that the essence of the nursing system is embedded in the fact that it is an action system that has social, interpersonal and technological dimensions (D’Antonio et al., 2014:311; Renpenning et al., 2016:100;). Therefore, Wright and Neuberger (2012:19) and Brady (2013:30) note that understanding how to connect the mind, body, soul and social realms into one nursing care plan, requires careful and thoughtful engagement with the patient.

3.1.4.5 Emergent theme 5: What caring presence is *not*

‘What caring presence is not’ is the fifth emergent theme that became apparent from the data collected during the semi-structured interviews. This concept involves the following theme cluster: Uncaring, unprofessional behaviour and dehumanisation of patients, which creates barriers that hinder the practice of caring presence.

3.1.4.5.1 Theme cluster: Uncaring, unprofessional behaviour and dehumanisation of patients, which creates barriers that hinder the practice of caring presence.

Participants described situations where they felt that some of their colleagues within the healthcare sector did not bother to practise caring presence and thereby portrayed unprofessional and uncaring nursing conduct. Most of them spoke out strongly against these uncaring role models, negligence with patients, unethical nursing actions, violating the rights of patients, and the lack of integrity in the nursing profession. One participant revealed a situation where she found an elderly patient who was treated disrespectfully and “sent from pillar to post” by nursing personnel until he was confused, anxious, shivering and shaking. Other participants warned against depersonalisation and dehumanisation of patients, and emphasised that patients should not be called by their diagnosis or treated as objects. Therefore, they shared their concern regarding the decrease in compassion, empathy and passion within the nursing profession.

The professional nurses who participated in this research study, further identified barriers that hinder them to practice caring presence in a rural public hospital. Stumbling blocks in the process of being a caring presence for patients identified in this study are unbearable workloads, a shortage of nurses, which results in poor nurse-patient ratios, a lack of time, and a shortage of adequate resources. The participants further revealed that they felt bad when they were not able to deliver competent, high quality and individualised patient-centred care to their patients. In addition, they also identified a lack of appreciation, recognition and support from management and low personnel morale as challenges that compromise their ability to practise caring presence.

They experienced that these barriers make it difficult for them to practise caring presence and inhibited them from creating a healing milieu for their patients. Uncaring, unprofessional behaviour and dehumanisation of patients, which creates barriers that hinder the practice of caring presence, highlighted by the participants are illustrated by the following direct quotations:

“You don’t see if he is bathed, if he has eaten or he is suffering from pain, or whatever. You don’t even ask...or if you hear a patient screaming...you just come: ‘Hey man! Sjarrap!’ Or whatever. You don’t go in detail why is this patient screaming.” T1, P2, L42-44.

What they are doing is, they sit with their phone, (silence) it is WhatsApp? (silence) or Facebook? Uhmm, (silence) or uhmm (silence) I don’t know these things (silence)”. T1, P5, L147-149.

“That the role models also don’t care and that they are also on their phones...and they are also not there for their patients (silence). Even you can go for a lunch for three hours (silence). Because the same manager goes for hours! And when she comes back, she just sits in the office. So you see it is a problem. If you do this, they will follow you. If you don’t care, they also won’t care.” T1, P6, L193-194.

“In the ward, with 30-40 patients, I have to give medication, I have to do vitals, I have to assist the patients. In the mean time I (am) needed with resuscitation. How are we able to cope? We are very much under pressure. We cannot focus, and we cannot care enough. Then the patients feel that we don’t care. At least if we have adequate staff, the workload is less and we can give more quality care.” T6, P34, L151-156.

“But the lack of appreciation by our managers, the public, even the community, the morality [sic] is low. These are the dynamics of nursing today. We need to be appreciated more. That is why our profession is going down.” T7, P43, L289-292.

What these participants experienced was a common element reported by the literature relating to this study. According to Bright (2012:20), who conducted a critical hermeneutic analysis on presence in nursing practice, the pressure on nurses to engage in supporting the system, rather than the patient, reduces caring presence and results in negative consequences for the nurses such as guilt and shame, as well as the depersonalisation and humiliation of patients. Therefore, in agreement with what the participants shared, Van den Heever *et al.* (2013:6) and Vythillingum (2009:450) show that nurses are often described as being insincere or insensitive in relation to patients’ true feelings. Furthermore, Palmieri (2014:64) agrees that nurses tend to occupy themselves with meaningless activities in an attempt to avoid “[caring] for the care experience.”

In their respective studies, Welsh and Wellard (2005:1) and Bright (2012:20) showed that there are many obstacles to being a caring presence for patients within nursing practice.

In addition, Iseminger *et al.* (2009:447), who identified actual and perceived barriers to nursing presence, and Finfgeld-Connet (2006:713), who conducted a meta-synthesis of presence in nursing, support the argument that nurses experience a great deal of pressure to adapt to the increasing workloads, growing nurse shortages and faster-paced healthcare systems. Therefore, these authors affirm that the modern healthcare system with its emphasis on productivity and high patient throughput poses a challenge to the ability of the nurses to practise caring presence for their patients.

3.2 Exhaustive description of phenomena under study

The main themes that emerged from this research study resulted in an exhaustive description of the lived experiences of professional nurses with respect to their practice of caring presence in a rural public hospital.

The participants who participated in this study experience practising caring presence as professionally and personally fulfilling and as an expression of their passion for the profession, as a way of portraying ethical care, a willingness to be personally present for patients, and as a healing experience by being dedicated and committed and by taking care of patients holistically. In addition, these professional nurses indicated what caring presence is not by depicting uncaring, unprofessional and unethical behaviour which creates barriers that hinder the practice of caring presence. Also, a lack of resources, personnel shortages and a lack of recognition by management were revealed as stumbling blocks in the practice of caring presence.

3.3 Summary

This chapter explained the realisation of the data collection and discussed the research findings of the study, exploring and describing professional nurses' lived experience of practising caring presence in a rural public hospital. The results were presented according to the theme clusters and emergent themes that were obtained from the semi-structured interviews with the participating professional nurses. The researcher integrated existing national and international literature with the analysed data to support the results of this study. The researcher further supported the findings with direct quotations from the transcripts as shared by the participants.

This exhaustive description of the phenomena under study provided the fundamental structure for professional nurses' lived experience of practising caring presence in a rural public hospital in the North West province, South Africa, as expressed by the participants in this study. In addition, the exhaustive description and fundamental structure were validated by the participants as a true

reflection of their lived experiences, as recommended by Colaizzi's method for phenomenological data analysis.

The next chapter concludes the research by acknowledging the limitations of this study and drawing conclusions. The chapter also evaluates the study and makes recommendations for nursing practice, nursing education and further nursing research.

CHAPTER 4:

CONCLUSIONS, EVALUATION, RECOMMENDATIONS AND LIMITATIONS

4.1 Introduction

This final chapter includes the conclusions, evaluation, recommendations and limitations of the study. The conclusions drawn from the empirical data are discussed first. Second, the evaluation of the study determines whether the study's objectives have been accomplished. The recommendations include information that may add value to both the nursing practice, education and research and the nursing profession's body of knowledge.

As no study is complete without drawing attention to its limitations and since these limitations may create opportunities for future research in the same field of interest, the researcher describes the limitations that she came across while conducting this study. Finally, the chapter concludes with a summary.

4.2 Conclusions

This study explored the experiences of ten experienced professional nurses regarding their practice of caring presence within a rural public hospital in the North West province, South Africa. The phenomenological concept of the "lived experiences" as a research framework assisted in the development of a rich, exhaustive description of this phenomenon under investigation. Furthermore, it provided a deeper understanding of professional nurses' experiences regarding the practice of caring presence in this specific context.

The findings of the lived experiences of the participants in this study confirmed the initial assumption of the researcher, namely that professional nurses do practise caring presence in the context of a rural public hospital. These participants indicated that despite challenges such as limited resources and heavy workloads, "being there for" and "being there with" patients are inherent to their nursing practice.

4.2.1 Conclusions regarding emergent theme 1: Professional caring presence

The participants who participated in this research study shared their lived experiences, which reflected a vibrant and enthusiastic passion for the nursing profession. It is evident that these professional nurses convey a willingness to be professionally present for their patients, by portraying integrity, competency, whole-hearted commitment and professional accountability

towards their patients. Therefore, they agreed that feelings of self-worth and a sense of professional pride and fulfilment were gained from these experiences.

They indicated their personal and professional maturity by revealing experiences of self-disclosure, self-awareness and the use of the therapeutic self in their practising of caring presence. Their desire to create a positive and engaging environment for their patients was notable during the semi-structured interviews. Furthermore, the participants revealed their dedication and commitment to deliver the best nursing care in their practice of caring presence. They highlighted that the patients are their priority, and shared their close relationship and interaction with patients by denoting that they treat them like their own family.

The necessity of being a role model and an inspirational presence is further illuminated by the participants as fundamental factors in strengthening relationships and fostering caring presence within the nursing profession.

4.2.2 Conclusions regarding emergent theme 2: Ethical caring presence

It was apparent in most participants' experiences that being a good nurse and "doing the right thing," which support the value of virtue ethics, are particularly relevant to the concept of caring presence in nursing practice. Furthermore, patient advocacy and guarding against the infringements of patient rights were emphasised as part of being ethically present for patients.

4.2.3 Conclusions regarding emergent theme 3: Personal caring presence

In order to meet the personal challenge of being present, the participants indicated a willingness to become vulnerable. Their commitment to be a caring presence was evident in their persistence to give everything and become everything for the patients they care for. Therefore, they shared a devotion to be present as a whole person within the holistic healing process of their patients.

4.2.4 Conclusions regarding emergent theme 4: Healing caring presence

Dedication to take care of the patient holistically and to render highly individualised, patient-centred care was highlighted by the participants as the core of being a healing caring presence in nursing practice. Being available and attentive in the moment was also described as opportunities for deep connection between the nurse and patient.

Offering authentic physical presence in order to foster meaningful and trusting relationships was indicated by the professional nurses as a way to enhance the practice of caring presence. Consequently, therapeutic verbal communication, eye contact, touch and assuring physical comfort were identified as means to connect with patients in the physical dimension. Being there with and for patients in the emotional realm of being, was revealed as a crucial component of

being a healing caring presence. The participants felt that cognitive attentiveness also facilitated caring presence and empowered patients to create and maintain their own healing process. In addition, a willingness to be present in the spiritual and social dimensions of being, were highlighted by the participants as special and effective ways of being a caring presence for patients in a rural public hospital.

4.2.5 Conclusions regarding emergent theme 5: What caring presence is not

Despite their efforts and desire to practise caring presence as professionals, the participants identified behaviour and attitudes that do *not* display the practice of caring presence, such as being unprofessional, unethical, uncaring and the depersonalization of patients. In addition, they indicated barriers that hinder them from practising caring presence in the context of a rural public hospital. They experienced unbearable workloads, poor nurse-patient ratios, a lack of sufficient time, shortage of resources, low personnel morale, dehumanization of patients, the decrease of integrity and professionalism among nurses, as well as a lack of management recognition and appreciation. These stumbling blocks compromise their ability to practise caring presence.

4.3 Overall conclusion

The above discussion provides the fundamental structure of the lived experiences of professional nurses practising caring presence in a rural public hospital in the North West province, South Africa. Therefore, the essence that represents the true nature of the phenomenon of practising caring presence in a rural public hospital shared by the participants regarding their lived experiences is: *“A willingness and commitment to be professionally, personally and ethically present for and with patients in order to be a healing caring presence through rendering holistic, patient-centred nursing care.”*

4.4 Evaluation of the research

This research project aimed to explore and describe the lived experience of professional nurses practising caring presence within a rural public hospital in the North West province, South Africa. The purpose was to illuminate how professional nurses caring for large numbers of patients with a high acuity within a complex rural healthcare system, experience the practice of caring presence.

The discussion in Chapter 3 makes it evident that the study's purpose has been achieved. Having selected a descriptive phenomenological design for this study, the researcher was able to incorporate the participants' beliefs, thoughts, insights, actions and multiple realities regarding the practice of caring presence into an exhaustive description of the essence of their lived experiences. Furthermore, the semi-structured interview technique enabled the researcher to draw rich descriptions from the participants about the phenomenon of interest. In addition, the

research findings were confirmed when literature integration was applied. Consequently, the researcher has successfully confirmed the central theoretical statement for this study, namely:

Through this research, the researcher gained insight into the specific and unique moments of this experience and this description makes known the significance and transformative potential of caring presence in the nursing profession for future use in the practice, education and research field.

4.5 Recommendations

The recommendations focus on encouraging and enhancing the practice of caring presence in the nursing profession. Therefore, based on the findings and conclusions of this study, the researcher makes the following recommendations to nursing education, nursing practice and nursing research:

4.5.1 Recommendations for nursing education

- Curriculum planners in charge of all nursing education programmes should put more emphasis on the practice of caring presence in the nursing profession so that the value and transformative potential of this crucial nursing intervention can be understood by students to ensure individualised quality care and professionalism.
- Educators should provide information to nursing students on ways to enhance the practice of caring presence based on research findings.
- There should be a closer liaison between nursing practice and nursing education personnel. This liaison must be aimed at identifying and discussing the ways in which the practice of caring presence can be effectively implemented, such as intention-setting techniques and the practice of mindfulness.
- Educators should put more emphasis on the importance of self-awareness and the therapeutic use of self in the training of nurses. These core characteristics enable nurses to practise caring presence.

4.5.2 Recommendations for nursing practice: measures to encourage nurses to implement the practice of caring presence

The measures to encourage professional nurses to implement the practice of caring presence formulated by the researcher are based on the research findings, relevant literature and conclusions. Furthermore, all the information obtained during the semi-structured interviews

provided the researcher with insight into the practice of caring presence, guiding her to suggest the subsequent recommendations towards improving the quality of nursing practice:

4.5.2.1 Recommendations regarding the first emergent theme: Professional caring presence

- The main aspect that should be illuminated is the importance of cultivating and maintaining a vibrant passion for the nursing profession so that nurses come to practise caring presence and build meaningful relationships with patients.
- Professional nurses should portray professionalism and competence.
- Management should recognise and praise a willingness to be professionally and personally present for patients to promote healing, and high quality patient-centred care.
- Dedication and commitment to take care of patients holistically should be part of hospital policy.
- Professional nurses should engage in continued professional development by means of workshops, in-service training and motivating courses. In this way, they can become role models who motivate and inspire colleagues and practice by leading by example to enhance the practice of caring presence, professionalism and a caring attitude among all nursing categories.
- Professional nurses should realise the importance of acting as role models and mentors for other nursing categories to facilitate the practice of caring presence, professional attitudes and behaviour.

4.5.2.2 Recommendations regarding the second emergent theme: Ethical caring presence

- Hospital and nursing management should provide guidelines to implement and monitor the practice of ethical caring presence among professionals.
- Ethical awareness and moral responsibility towards patients can be encouraged by means of courses and workshops.
- Awareness of the "*Batho Pele principles*" can be implemented successfully in the private healthcare sector as well by inviting public healthcare employees who can provide presentations and information regarding these valuable ethical principles.

- Professional nurses can facilitate and encourage the importance of patient advocacy by being role models to other nursing categories, by setting an example of ways to practise caring presence such as portraying good, ethical conduct and showing genuine interest in the wellbeing of their patients.

4.5.2.3 Recommendations regarding the third emergent theme: Personal caring presence

- A willingness to be personally available, to walk the extra mile and to offer the gift of self should be recognized and encouraged by organisational management.
- The provision of workshops and in-service training regarding the significance of being personally present for patients can enhance the practice of caring presence in the nursing profession and thereby improve the quality of nursing care.

4.5.2.4 Recommendations regarding the fourth emerging theme: Healing caring presence

- Dedication and commitment to take care of patients holistically and to render individualised, patient-centred nursing care should be part of hospital policy.
- Workshops and presentations can provide guidelines regarding intention-setting techniques and the value of practising mindfulness in the nursing profession.
- Awareness of the dimensions of being a healing caring presence can be enhanced by means of inviting experts on this issue, motivating nursing personnel to practise caring presence within the nursing profession.
- Professional nurses should engage in continued professional development by means of workshops and in-service training courses that provide information regarding the healing potential of the practice of caring presence.

4.5.2.5 Recommendations regarding the fifth emergent theme: What caring presence is not

- Hospital and nursing management should identify and address barriers that hinder the practice of caring presence by providing adequate resources, both human and monetary, to foster the practice of caring presence.

- Depersonalisation of patients should be recognized and seriously addressed by nursing management by means of implementing a system where nursing personnel who treat patients in an unethical, uncaring way (as objects) receive negative reports and warnings.

4.5.3 Recommendations for nursing research

The researcher identified a gap in research regarding professional nurses' lived experience of practising caring presence within the nursing profession. There are a number of related topics and issues that need further scientific investigation. These include:

- Research to further explore and develop the fundamental structure of practising caring presence in a rural public hospital that crystallised from this research. This fundamental structure may be validated in other contexts and an instrument to measure caring presence in a South African context, may ultimately be developed.
- Research on the relationship between passion for the nursing profession and the practice of caring presence.
- The lived experiences and perceptions of other nursing categories regarding the practice of caring presence.
- Research on professional nurses' lived experience of practising caring presence in the private healthcare sector in South Africa.
- Research on how intention-setting techniques and the practice of mindfulness can enhance the practice of caring presence in South African healthcare facilities.
- The impact of nursing service managers practising caring presence on patient outcomes.

4.6 Limitations of the research

Acknowledging the limitations of this research can help the reader understand the context in this specific selected rural public hospital; a natural setting in a real-life environment (Forister & Blessing, 2016:179). The following limitations for this study are identified:

- Since this was a qualitative study, the research findings cannot be generalized to all professional nurses in the South African healthcare sector. However, the information captured the nuances of this lived experience of these professional nurses practising caring presence in the context of a specific rural public hospital.
- The study was conducted at only one rural public health facility in the North West province, South Africa, thus limiting this study's findings to these specific setting and to only professional

nurses. However, the information can be extrapolated to other nursing categories and settings by making minor adjustments.

- The study reflected the lived experiences of only ten (n=10) participants identified by the mediator, who volunteered to participate in the study. However, data saturation was reached.
- Eight of the ten participants were female.
- Due to the high workloads of the participants, the researcher observed the urge among the participants to finish the interview as soon as possible in order to return to their units.

4.7 Summary

This chapter offered the conclusions and an evaluation of the study, followed by recommendations for nursing education, nursing practice and nursing research. Thereafter, the researcher described the limitations of the study.

The intention of this research study has been reached, namely to explore and describe the lived experiences of professional nurses in the context of a rural public hospital in the North West province, South Africa. Furthermore, the findings of this qualitative descriptive phenomenological design based on Husserl's philosophy may be used to expand and support existing literature regarding the practice of caring presence. In addition, the rich information and insight gained from the lived experiences of these professional nurses add to nursing's body of knowledge, specifically regarding the understanding of the concept "caring presence" nursing's body of knowledge, specifically regarding the understanding of the concept "caring presence" from a South African viewpoint.

LIST OF SOURCES

Acts **see** South Africa

Aiken, I., Sloane, D.M. Bruyneel, L., Van den Heede, K. & Sermeus, W. 2013. Nurses' report of working conditions and hospital quality of care in 12 countries in Europe. *International journal of nursing studies*, 50(2):143-153.

Alderson, P. & Marrow, V. 2011. The ethics of research with children and young people: a practical handbook. London, England: Sage.

Allison, J. & Gediman, D. 2006. This I believe: the personal philosophies of remarkable men and women. New York: Holt Paperbacks, Henry Holt.

Alperovitch, A., Dreifuss-Netter, F., Dickele, A.M., Gaudray, P., LeCoz, P., Rouvillois, P., Roux, M. & Waquet, P. 2009. Ethical issues raised by a possible influenza pandemic, National Consultative Ethics Committee for Health and Life Sciences. <http://www.ccne-ethique.fr/sites/default/files/publications/avis-106-anglaid.pdf>

Andrus, V. 2013. Caring presence: the key to improving the patient experience. *Advance for nurses*, 15(9):14-15.

Atkins, I. & Wallace, S. 2012. Qualitative research in education. Thousand Oaks, CA: Sage.

Backes, D.S., Erdmann, A.L. & Büscher, A. 2009. Demonstrating nursing care as a social practice: a grounded theory. *Latino-American Enfermagem*, 17(6):10-25.

Beauchamp, T. & Childress, J. 2009. Principles of Biomedical Ethics. 6th ed. New York: Oxford University Press.

Beck, C.T. 1993. Qualitative research: the evaluation of its credibility, fittingness and auditability. *Western journal of nursing research*, 15(2):263-266.

Beck, C.T. 2013. Routledge international handbook of qualitative nursing. New York: Routledge.

Begley, A.M. 2010. On being a good nurse: reflections on the past and preparing for the future. *International journal of nursing practice*, 16(6):525-532.

Bergin, M. 2011. NVivo 8 and consistency in data analysis: reflecting on the use of qualitative data analysis program. *Nurse researcher*, 18(3).

- Bergmann, T.J., Lester, S.W., DeMeuse, K.P. & Grahn, J.L. 2011. Integrating the three domains of employee commitment: an exploratory study. *Journal of applied bussiness research*, 16:15-26.
- Bevan, M.T. 2014. A method of phenomenological interviewing. *Qualitative health research*, 24(1):136-144.
- Bigby, E.S. 2015. Building a framework for professional nursing practice across the continuum of care. Doctoral dissertation, project 66. Theses, dissertations, capstones, and projects. University of San Francisco. <http://repository.usfca.edu/dup66>
- Boeck, P.R. 2014. Presence: a concept analysis. *SAGE Open*, 4:1-6.
- Borbasi, S. & Jackson, D. 2012. Navigating the maze of research. Chatswood, Sydney: Mosby Elsevier.
- Botma, Y., Greef, M. Mulaudzi, F.M. & Wright, S.C.D. 2010. Research in health sciences. Cape Town: Pearson.
- Bouchard, C. 2016. The virtuous nurse. *Health progress*, Jan-Feb: 81-83.
- Brady, M. 2013. The nature of health and social care partnerships. *Nursing management*, 19(9):30-35.
- Bridges, J., Nicholson, C., Maben, J., Pope, C., Flatley, M., Wilkinson, C. & Tziggili, M. 2013. Capacity for care: meta-ethnography of acute care nurses, experiences of the nurse-patient relationship. *Journal of advanced nursing*, 69(4):760-772.
- Bright, A, L. 2012. Presence in nursing practice: a critical hermeneutic analysis. San Francisco, CA: University of San Francisco. (Dissertation–PhD).
- Brink, H., van der Walt, C. & van Rensburg, G. 2012. Fundamentals of research methodology for healthcare professionals. 3rd ed. Cape Town: Juta.
- Brown, C.J., Bishop, M. & Bar, B.B. 2013. Creating and sustaining peace within for the journey of nursing leadership. *Nursing administration quarterly*, 37(4):E1-E7.
- Bullington, J. & Fagerberg, I. 2013. The fuzzy concept of “holistic care”: a critical examination. *Scandinavian journal for caring sciences*, 27:493-494.
- Burns, N. & Grove, S.K. 2009. The practice of nursing research: appraisal, synthesis and generation of evidence. 6th ed. St Louis, MO: Saunders.

- Burns, N. & Grove, S.K. 2011. *Understanding nursing research*. 5th ed. Philadelphia: Saunders.
- Burns, N., Grove, S.K. & Gray, J.R. 2013. *The practice of nursing research: appraisal, synthesis, and generation of evidence*. 7th ed. St Louis: Elsevier Saunders.
- Butts, J.B. & Rich, K.L. 2008. *Nursing ethics across the curriculum and into practice*. 2nd ed. Sunbury, MA: Jones and Bartlett.
- Byrne, B. 2012. Qualitative interviewing. (*In* Seale, C. *Researching society and culture*. 2nd ed. Thousand Oaks, CA: Sage.)
- Campbell, M. 2011. Bearing witness in relation to modern nursing practice. www.wtamu/webres/file/Academics/graduate%20Schol Date of access: 23 Feb. 2015.
- Cantrell, M. & Matula, C. 2009. The meaning of comfort for paediatric patients with cancer. *Oncology nursing forum*, 36:E303-E309.
- Chan, Z.C.Y., Fung, Y. & Chien, W. 2013. Bracketing in phenomenology: only undertaken in the data collection and analysis process? *The qualitative report*, 18(59):1-9.
- Chang, H.Y., Shuy, Y.L., Wong, M., Friesner, D., Chu, T.I. & Teng, C.I. 2015. Which aspects of professional commitment can effectively retain nurses in the nursing profession? *Journal of nursing scholarship*, 47(5):468-476.
- Clancy, C. 2014. The importance of emotional intelligence. *Nursing management*, 21(8):15.
- Cole, C., Wellard, S. & Mummery, J. 2014. Problematizing autonomy and advocacy in nursing. *Nurse ethics*, 21(5):576-582.
- Colaizzi, P. 1978. Psychological research as the phenomenologist views it. (*In* R. Valle & King eds. *Existential phenomenological alternatives for psychology*. 1st ed. New York: Oxford University Press. p. 48-71).
- College of Registered Nurses of Nova Scotia. CRNNS. 2012. *Professional presence*. Halifax, N.S.
- Converse, M. 2012. Philosophy of phenomenology: how understanding aids research. *Nurse research*, 20(1):28-32.
- Corbin Dwyer, S. & Buckle, J.L. 2009. The space between: on being an outsider in qualitative research. *International journal of qualitative methods*, 8(1):54-63.

- Covington, H. 2003. Caring presence: delineation of a concept for holistic nursing. *Journal of holistic nursing*, 21(3):301-317.
- Covington, H. 2005. Caring presence: providing a safe space for patients. *Holistic nursing practice*, 19(4):169-172.
- Crane-Okada, R. 2012. The concept of presence in group psychotherapy: an operational definition. *Perspectives in psychiatric care*, 48:156-164.
- Creswell, J.W. 2014. Research design: qualitative, quantitative, and mixed methods approaches. 4th ed. Thousand Oaks, CA: Sage.
- Cullity, G. 2007. "Beneficence". (In Ashcroft, R.E., Dawson, A., Draper, H. & McMillan, J.R. eds. Principles of health care ethics. 2nd ed. Chichester, West Sussex, UK; Hoboken, NJ: John Wiley and Sons). p. 19-26.
- Curtis, M.P. & Jensen, A.A. 2010. A descriptive study of learning through confluent education: an opportunity to enhance nursing students' caring, empathy, and presence with clients from different cultures. *International journal human caring*, 14(3):49-53.
- D'Antonio, P., Beeber, L., Sills, G. & Naegele, M. 2014. The future in the past: Hildegard Peplau and interpersonal relations in nursing. *Nursing inquiry*, 2(4):311-317.
- Da Silva Borges, M. & Soares dos Santos, D. 2013. Caring field: a quantum and transpersonal approach to nursing care. *Ciencia, Cuidado e Saude*, 12(3):608-613.
- Davidson, A., Ray, M. & Turkel, M. 2011. Nursing, caring, and complexity science: for human environment well-being. New York: Springer.
- De Vos, A.S., Strydom, H., Fouche, C.B. & Delport, C.S.L. 2011. Research at grassroots. 4th ed. Pretoria: Van Schaik.
- DeCuir-Gunby, J.T., Marshall, P.L. & McCulloch, A. W. 2011. Developing and using a codebook for the analysis of interview data: an example from professional development research project. *Field methods*, 23(2):136-155.
- Deloach, R. & Monroe, J. 2004. Job satisfaction among hospice workers. *The healthcare manager*, 3:209-219.
- Dempsey, P.A. & Dempsey, A.D. 2000. Using nursing research: process, critical evaluation and utilization. 5th ed. Philadelphia: Lippincott.

Deschaux- Beaume, D. 2012. Investigating the military field: qualitative research strategy and interviewing. *Current sociology*, 60(1):101-117.

Dochterman, J. & Bulechek, G. 2004. Nursing interventions classification. St. Louis, MO: Mosby.

DOH **see** Department of Health

Dossey, D.M. & Keegen, L. 2016. Holistic nursing. A handbook for practice. 7th ed. Burlington: Jones & Bartlett Learning.

Du Plessis, E. 2015. Caring presence narratives: cultivating an appreciative discourse in nursing. Oral presentation at The South African International Caritas Consortium – Ubuntu: I am because we are, co-hosted by the Watson caring science Institute, USA and the University of South Africa, Pretoria, SA in collaboration with the University of Johannesburg, SA, and the International Association in Human Caring, from 16-18 September 2015, at Monte Casino, Johannesburg South Africa.

Du Plessis, E. 2016. Presence: a step closer to spiritual care in nursing. *Holistic nursing practice*, 30(1):47-50.

Du Preez, M. 2014. Finding hope beyond the screaming headlines. <http://www.facebook.com/max.dupreez.3/posts/745829782147007> Date of access: 18 March 2016.

Eagar, D., Cooke, R., Levin, J. & Wolmarans, M. 2015. South African health review. Durban: Health Systems Trust.

Easter, A. 2000. Construct analysis of four modes of being present. *Journal of holistic nursing*, 18:362-377.

Eckroth-Bucher, M. 2010. Self- awareness: a review and analysis of a basic nursing concept. *Advanced nursing science*, 33(4):297-309.

Edward, K. 2006. A theoretical discussion about the clinical value of phenomenology for nurses. *Holistic nursing practice*, 20(5):235-238.

Edward, K. & Welsch, T. 2011. The extension of Colaizzi' s method of phenomenological enquiry. *Contemporary nurse*, 39(2):163-171.

Egan, G. 2010. The skilled helper: a problem-management and opportunity-development approach to helping. 9th ed. Belmont, CA: Brooks/Cole.

- Eisler, R. & Potter, T. 2014. Transforming inter-professional partnership: a new framework for nursing and partnership-based health care. Indianapolis, IN: Sigma Theta Tau International.
- Eley, D., Eley, R., Bertello, M. & Rogers-Clark, C. 2012. Why did I become a nurse? Personality traits and reasons for entering nursing. *Journal of advanced nursing*, 68:1546-1555.
- Elmir, R., Schmied, V., Jackson, D. Wilkes, Lo. 2011. Interviewing people about potential sensitive topics. *Nurse research*, 19(2):12-26.
- Englander, M. 2012. The interview: data collection in descriptive phenomenological human scientific research. *Journal of phenomenological psychology*, 43:13-35.
- Ferguson-Parè, M. 2012. Perspectives on leadership: moving out of the corner of our room. *Health science quarterly*, 24(4): 393-396.
- Finfgeld-Connet, D. 2006. Meta-synthesis of presence in nursing. *Journal in advanced nursing*, 55(6):708-714.
- Finfgeld-Connet, D. 2008. Qualitative convergence of three nursing concepts: art of nursing, presence and caring. *Journal of advanced nursing*, 63(5):527-534.
- Flood, C.M. & Gross, A. 2014. The right to health at the public/private divide: a global comparative study. New York: Cambridge University Press.
<http://books.google.co.za/books?isbn=1107038308> Date of access: 24 Feb. 2016.
- Forister, J.G. & Blessing, D. 2016. Introduction to research and medical literature for health professionals. 4th ed. Burlington, MA: Jones & Bartlett.
- Fraenkel, J.R., Wallen, N.E. & Huyn, H.H. 2012. How to design and evaluate research in education. 8th ed. New York: McGraw-Hill Higher Education.
- Gerrish, K. & Lacey, A. 2010. The research process in nursing. Oxford: Blackwell.
- Gerrish, K. & Lathlean, J. 2015. The research process in nursing. 7th ed. West Sussex: Wiley-Blackwell.
- GHWA & WHO **see** Global Health Workforce Alliance and World Health Organization.
- Giorgi, A. 1986. Theoretical justification for the use of descriptions in psychological research. (In Ashworth, P., Giorgi, A. & de Koning, A.J.J., eds. Qualitative research in psychology. Proceedings of the International Association for qualitative research. Pittsburgh, PA: Duquesne University Press).

- Giorgi, A. 2008. Concerning a serious misunderstanding of the essence of the phenomenological method in psychology. *Journal of phenomenological psychology*, 39:33-58.
- Giorgi, A. 2009. The descriptive phenomenological method in psychology: a modified Husserlian approach. Pittsburgh, PA: Duquesne University Press.
- Global Health Workforce Alliance & World Health Organization. 2013. A universal truth: no health without a workforce. Geneva: World Health Organization.
- Gokenbach, V. 2010. Improve professionalism in nursing: personal branding. <http://nursetogether.com/improve-professionalism-in-nursing-personal-branding> Date of access: 27 May 2015.
- Godkin, J., Godkin, L. & Austin, P. 2002. Nursing presence, patient satisfaction and the bottom line. *Journal of hospital marketing and public relations*, 14(1):15-33.
- Granick, J.L. 2011. Transpersonal aspects of therapists' presence: What do clients experience? (Order No.3495276, Institute of transpersonal psychology). ProQuest Dissertations and theses.
- Grove, S.K., Burns, N. & Gray, J.R. 2013. The practice of nursing research. 7th ed. St Louis, Missouri: Elsevier Saunders.
- Guba, E. & Lincoln, Y. 1994. Competing paradigms in qualitative research. (In N. Denzin and X.Y. Lincoln eds. Handbook of qualitative research. Thousand Oaks, CA: Sage. p. 105-117).
- Halifax, J. 2014. G.R.A.C.E. for nurses: cultivating compassion in nurse/patient interactions. *Journal of nurse educators and practitioners*, 4:121-128.
- Hammil, C. & Sinclair, H. 2010. Bracketing – practical considerations in Husserlian phenomenological research. *Nurse researcher*, 17(2):16-24.
- Hammond, M. Wellington, J. 2013. Research methods: the key concepts. New York, NY: Routledge.
- Hansbrough, W. 2011. Examining nursing presence in the acute care setting as an indicator of patient satisfaction with nursing care. San Diego, CA: University of San Diego. (Dissertation–PhD).
- Harding, J. 2013. Qualitative data analysis from start to finish. Thousand Oaks, CA: Sage.

- Hawley, P. 2009. The nursing moment. Phenomenologyonline.
<http://www.phenomenologyonline.com/sources/textorium/hawley-patricia-the-nursing-moment/>
Date of access: 21 Nov 2015.
- Hebert, K., Moore, H. & Rooney, J. 2011. The nurse advocate in end-of-life care. *Ochner journal*, 11(4):325-329.
- Herselman, G., Le Roux, E. & Opperman, M. 2015. Conscious caring. Paper presented at the South African International Caritas Consortium, Johannesburg, 16-18 Sept. 2015.
- Hill, C.E. & Nutt Williams, E. 2012. The sample. (*In Hill, C.E., ed. Consensual qualitative research: a practical resource for investigating social science phenomena. Washington, DC: American Psychological Association.*)
- Hobbs, J.L. 2009. A dimensional analysis of patient-centered care. *Nursing research*, 58(1):52-56.
- Holt, R. 2012. Ethical research practice. (*In Symon, G. & Cassel, N. eds. Qualitative organizational research: core methods and current challenges. Thousand Oaks, CA: Sage. p. 90-108*).
- Hooper, V.D. 2013. The caring presence of nursing: a qualitative focus. *Journal of Perianesth nurses*, 28:255-256.
- Huy, Q.N. 2012. Improving the odds of publishing inductive qualitative research in premier academic journals. *Journal of applied behavioural science*, 48(2):282-287.
doi:10.1177/0021886312438864
- Iseminger, K., Levitt, F. & Kirk, L. 2009. Healing during existential moments: the “art” of nursing presence. *Nursing clinics of North America*, 44(4):447-459.
- Istomina, N., Suominen, T., Razbadauskas, A., Martinkenas, A., Meretoja, R. & Leino-Kilpi, H. 2011. Competence of nurses and factors associated with it. *Medicina (Kaaunus)*, 47: 230-237.
- Jafaragae, F., Parvizy, S., Mehrdad, N. & Rafi, F. 2012. Concept analysis of professional commitment in Iranian nurses. *Iranian journal for nursing and midwifery research*, 17(7):472-479.
- Jansen, M.P. & Blair, K.A. 2015. Core concepts for professional role development. *Advanced practice nursing*. 5th ed. New York: Springer.

- Jooste, K. & Jasper, M. 2012. A South African perspective: current position and challenges in health care service management and education in nursing. *Journal of nursing management*, 20:56-64.
- Jooste, K., ed. 2010. The principles and practice, management, staff development, and research. Pretoria: Van Schaik.
- Josse-Eklund, A., Jossebo, M., Sandin-Bojo, A.K., Wilde-Larsson, B. & Petzall, K. 2014. Swedish nurses' perceptions of influencers on patient advocacy. *Nursing ethics*, 21(6): 673-683.
- Kenny, N.P., Mann, K.V. & Macleod, H. 2003. Role modeling in physicians' professional formation: reconsidering an essential but untapped educational strategy. *Academic Medicine*, 78:1203.
- Ketchem, S. 2016. Nurses' professional caring presence and the power to affect change. *Nursing for women's health*, 20(2):125-128.
- Kim, H.S. & Kollack, I. 2005. Nursing theories: conceptual and philosophical foundations. New York, NY: Springer.
- Kisiel, T. & Sheehan, T. 2015. The new yearbook for Phenomenology and phenomenological philosophy. Vol. 9. <https://books.google.co.za/books/isbn=1317548159> Date of access: 28 Feb. 2016.
- Klaver, K. & Baart, A. 2011. Attentive care in a hospital: towards an empirical ethics of care. *Medische antropologie*, 23(2):309-324.
- Klopper, H. & Knobloch, S. 2010. Validity, reliability and trustworthiness. (In Jooste, K., ed. The principles and practice of nursing and health care: ethos and professional practice, management, staff development, and research. Pretoria: Van Schaik) p. 317-334.
- Koerner, J. G. 2011. Healing presence. The essence of nursing. 2nd ed. New York: Springer.
- Kostovich, C.T. 2012. Development and psychometric assessment of the presence of nursing scale. *Nursing science quarterly*, 25(2):167-175.
- Kostovich, C.T. & Clementi, P.S. 2014. Nursing presence. *Journal for nurses in professional development*, 30(2):70.
- Lachman, V.D. 2010. Strategies necessary for moral courage. *Online Journal of Issues in Nursing*, 15(3): manuscript 3.

- Lanzara, S. 2014. A phenomenological study exploring Baccalaureate nursing students' experiences in simulation. Doctoral thesis. 888. Pennsylvania: Indiana University of Pennsylvania.
- Latham, J.R. 2013. A framework for leading the transformation to performance excellence part 1: CEO perspectives on forces, facilitations, and strategic leadership systems. *Qualitative management journal*, 20(2):22.
- Leebov, W. 2009. Nursing communication- how to make sure patients feel our caring. *Ezine articles*, 2(4). <http://ezinearticles.com/?Nursing-Communication-How-to-Make-Sure-Patients-Feel-Our-Caring&id=2105625> Date of access: 06 Feb. 2016.
- Leedy, P.D. & Ormrod, J.E. 2010. Practical research: planning and design. 9th ed. Boston: Pearson Education.
- Leedy, P.D. & Ormrod, J.E. 2013. Practical research: planning and design. 10th ed. Upper Saddle River, NJ: Pearson.
- Lewis, M. & Staehler, T. 2010. Phenomenology: an introduction. Routledge: New York.
- Lincoln, Y. & Guba, E. Gt. 1985. Naturalistic enquiry. Beverley Hills. California: Sage.
- Linehan, J. 2014. Nurses' perceptions of nursing presence and the relationship between nursing presence and moral sensitivity in nurses working with people with dementia in residential areas. University College Cork. (Thesis–PhD).
- LoBiondo-Wood, Gt. & Haber, J. 2010. Nursing research: methods, critical appraisal and utilisation. St. Louis: P Mosby.
- Mackinnon, K, McIntyre, M. & Quance, M. 2005. The meaning of the nurse's presence during childbirth. *Journal of obstetric, gynecologic, and neonatal nursing*, 34(1):28-36.
- Mahon, K. 2011. The impressions we leave... *Dynamics*, 22(3):5-6.
- Marais, C. & Van Wyk, C. de W. 2014. Methodological reflection on the co-construction of meaning within the South African domestic worker sector: challenging the notion of "voicelessness". *Mediterranean journal of social sciences*, 5(20):726-738.
- Marshall, C. & Rossman, G.B. 2011. Designing qualitative research 5th ed. Thousand Oaks, CA: Sage.

- McCaffrey, R. 2012. Doctor of nursing practice: enhancing professional development. Philadelphia: F.A. Davis.
- McCollum, E.E. & Gehart, D.R. 2010. Using mindfulness to teach beginning therapists therapeutic presence: a qualitative study. *Journal of marital family therapy*, 36(3):347-360.
- McDonough-Means, S.I., Kreitzer, M.J. & Bell, I.R. 2004. Fostering a healing presence and investigating its mediators. *Journal of alternative and complementary medicine*, 10(1):S25-S41.
- McGuire, A.L. & Beskow, L.M. 2010. Informed consent in genomics and genetic research. *Annual review of genomics and human genetics*, 11:361-381.
- McKivergin, M. 2005. The nurse as an instrument for healing. In B.M. Dossey., L. Keegan, & C.E. Guzzetta (eds). *A holistic nursing practice*. 4th ed. Sudbury, MA: Jones and Bartlett. p. 233-254.
- McKivergin, M. & Daubenmire, M. 1994. The healing process of presence. *Journal of holistic nursing*, 12(1):65-81.
- McMahon, M.A. & Christopher, K.A. 2011. Toward a mid-range theory of nursing presence. *Nursing forum*, 46:71-82.
- Medical Research Council. 2007. Guidelines on ethics for medical research. <http://www.mrc.ac.za/ethics/ethicsbook1.pdf> Date of access: 23 Nov. 2016.
- Melnechenko, K. 2003. To make a difference: nursing presence. *Nursing forum*, 38(2):18-24.
- Merriam, S.B. & Tisdell, E.J. 2016. Qualitative research. A guide to design and implementation. 4th ed. San Francisco: Jossey-Bass.
- Merril, A.S., Hayes, J.H., Luryclukey, D. & Curtis, D. 2012. Do they really care? How trauma patients perceive nurses' caring behaviours. *Journal of trauma nursing*, 19(1):33-37.
- Mohammadipour, F., Atashzadeh-Shoorideh, F.A., Parvizy, S. & Hosseini, M. 2017. Concept development of "nursing presence": application of Schwartz-Barcott and Kim's Hybrid Model. *Asian nursing research*, 11:19-29.
- Monareng, L.V. 2012. Spiritual nursing care: a concept analysis. *Curationis*, 35(1), Art.28. <http://dx.doi.org/10.4102/curationis.v35i.28> Date of access: 20 March 2016.
- Monareng, L.V. 2013. An exploration of how spiritual nursing care is applied in clinical nursing practice. *Health SA gesondheid*, 18(1), Art #635, 8p.

Morgan, S. & Yoder, L.H. 2012. A concept analysis of person-centered care. *Journal of Holistic Nursing*, 30(1):6-15.

Morse, J.M. & Field, P.A. 1995. *Qualitative research methods for health professionals*. 2nd ed. Thousand Oaks, CA: Sage

Mortari, L. & Tarozzi, M. 2010. Phenomenology as philosophy research: an introductory essay. (In Tarozzi, M. & Mortari, L., eds. *Phenomenology of human science today*. Bucharest: Zetabooks).

Moustakas, C. 1990. *Heuristic research: design, methodology, and applications*. Newbury Park, CA: Sage.

MRC **see** Medical Research Council.

NANB **see** Nurses Association of New Brunswick

National Planning Commission **see** South Africa. National Planning Commission.

NDOH **see** South Africa. National Department of Health.

Nelms, T.P. 1996. Living a caring presence in nursing: a Heideggerian hermeneutical analysis. *Journal of advanced nursing*, 24:368-374.

Newman, M. 2008. *Transforming presence: the difference that nursing makes*. Philadelphia, PA: FA. Davis.

Numminen, O, Leino-Kilpi, H., Isoaho, H. & Meretoja, R. 2015. Newly graduated nurses' occupational commitment and its association with professional competence and work-related stress. *Journal of clinical nursing*, 25(1):117-126.

Nurses Association of New Brunswick. 2012. *Standards of practice for registered nurses*. Fredericton N. B. (author). www.nanb.nb.ca/media/...NANB-Standardsofpractice-RegisteredNurses-2012-E.pdf Date of access: 23 Nov. 2016.

Nursing Act **see** South Africa.

North-West University. 2016. *Manual for master's and doctoral studies*. Potchefstroom: NWU.

NWU **see** North-West University.

Oosthuizen, M.J. 2012. The portrayal of nursing in South African newspapers: a qualitative content analysis. *African journal of nursing and midwifery*, 14(1):49-62.

Osterman, P & Schwartz-Barcott, D. 1996. Presence: four ways of being there. *Nursing forum*, 31(2):23-30.

Oxford Advanced Learners' Dictionary. 2016.

www.oxforddictionaries.com/definition/english/presence Date of access: 27 Feb. 2016.

Palmiery, C. 2014. Being a caring "presence": caring for the care experience. *Encyclopaideia*, XVIII (39):64-73.

Palmiery, G. & Kittleley, C. 2012. The gift of true presence: nursing story where theory and practice meet. *Canada oncology nursing journal*, 22(4):282-286.

<http://www.pubfacts.com/detail/23362661/the-gift-of-true-presence:-a-nursing-story-> Date of access: 23 Feb. 2015.

Papastavrou, E., Efstathiou, G., Tsangari, H., Suhonen, R., Leino-Kilpi, H., Patiraki, E., Karlou, C., Balogh, Z., Palese, A., Tomietto, M., Jarosova, D. & Merkouris, A. 2012. A cross-cultural study of the concept of caring through behaviours: patients' and nurses' perspectives in six different EU countries. *Journal of advanced nursing*, 68(5):1026-1037.

Parahoo, K. 2014. Nursing research principles, process and issues. 3rd ed. Basingstoke: Palgrave Macmillan.

Parè, J. 2015. Understanding the lived experiences of nurses working in critical access hospitals. *American research journal of nursing*, 1(5):1-5).

Parse, R.R. 2011. The art of humanbecoming in practice. *Discovery international publications*. Discoveryinternationalonline.com/wp11/2011-HBT-IN-ractice.pdf/ Date of access: 6 March 2015.

Paterson, J.G. & Zderad, L.T. 1988. Humanistic nursing. New York: National League for Nursing.

Patton, M.Q. 2015. Qualitative research and evaluation methods. 4th ed. Thousand Oaks, CA: Sage.

Peterson, I., Lund, C., Bhana. & Flisher, A.J. 2011. A task shifting approach to primary mental health care for adults in South Africa: human resource requirements and costs for rural settings. *Health and policy planning*, 24(4):318-323.

Polit, F.P. & Beck, C.T. 2012. Nursing research. Generating and assessing evidence for nursing practice. 9th ed. Philadelphia: Lippincott Williams & Wilkins.

- Polit, D.F. & Beck, C.T. 2014. Essentials of nursing research: appraising evidence for nursing practice. 8th ed. Philadelphia: Lippincott Williams & Wilkins.
- Polit, D.F., Beck, C.T. & Hungler, B.P.C. 2006. Essentials of nursing research: methods, appraisal, and utilization. 6th ed. Philadelphia: Lippincott.
- Potter, P.J. & Frisch, N. 2007. Holistic assessment and care: presence in the process. *Nursing clinics of North America*, 42:213-228.
- Praissman, S. 2008. Mindfulness-based stress reduction: a literature review and clinicians guide. *Journal of the American Academy of Nurse Practitioners*, 20(4):212-216.
- Pratt, B. & Loff, B. 2011. Justice in international clinical research. *Devison of world bioethics*, 11(2):75-81. doi: 10.1111/j.1471-8847.2010.00296.x
- Priest, S. 2012. Professional presence: an internal compass to guide you in nursing presence. *Info nursing*, 43(3):16-19.
- Quinlan, C. 2011. Business research methods. Hampshire, England: Cengage.
- Rahimaghaee, F., Dehghan Naiery, N. & Mohammadi, E. 2010. Iranian nurses' perception of their professional growth and development. *Online Journal for Issues in Nursing*, 9:10.
- Ray, M. & Turkel, M. 2015. Marilyn Ray's theory of bureaucratic caring. In M. Smith & M. Parker, eds. *Nursing Theories and nursing practice*. 4th ed. Philadelphia: F.A. Davic Company. p. 461-482.
- Rego, A., Godinho, L., McQueen, A. & Cunha, M.P. 2010. Emotional intelligence and caring behaviours in nursing. *The service industries journal*, 30(9):1419-1437.
- Reiners, G.M. 2012. Understanding the difference between Husserl's (descriptive) and Heidegger's (interpretive) phenomenological research. *Journal of nursing care*, 1(5):119.
- Reis, M., Rempel, G., Scott, S., Brady-Fryer, B. & Aerde, J. 2010. Developing nurse/patient relationships in the NICU through negotiated partnership. *Journal of obstetric, gynaecologic, & neonatal nursing*, 39:675-683.
- Renpenning, K., Taylor, S.G. & Pickens, J.M. 2016. Foundations of professional nursing: care of self and others. New York, NY: Springer.
- Rice, P.L. & Ezzy, D. 1999. Qualitative research methods: a health focus. Oxford: Oxford University Press.

Richards, L & Morse, J.M. 2013. Read me first for a user's guide to qualitative methods. 3rd ed. Thousand Oaks, CA: Sage.

Rispel, L.C. & Barron, P. 2012. Valuing human resources: key to the success of a national health insurance system. *Development Southern Africa.*, 29(5):616-635.

Rispel, L.C. & Bruce, J. 2015. A profession in peril? Revitalising nursing in South Africa. (In Padarath, A., & English, R., eds. South African Health review 2014/2015. Durban: Health Systems Trust). <http://www.hst.org.za/publications/south-african-health-review-2015> Date of access: 20 Feb. 2016.

Rivas, C. 2012. Coding and analysing qualitative data. (In Seale, C., ed. Researching society and culture. 3rd ed. p. 368-382.

Robertson, C.A. 2016. Nursing today: a new graduate's perspective. *Nurse leader*, 14(5):330-332.

Robinson, K. 2003. Technology can't replace compassion in health care. *Journal of emergency nursing*, 29(3):199-200.

Rosetto, K.R. 2014. Qualitative research interviews assessing the therapeutic value and challenges. *Journal of social and personal relationships*, 31(4):482-489).

Rowe, J. & Kellam, C. 2013. The provider's role in promoting hope for patients in clinical encounters. *Home health care management & practice*, 25(4):135-140.

Rubin, H.J. & Rubin, I. 2012. Qualitative interviewing: the art of hearing data. 3rd ed. Thousand Oaks, CA: Sage.

Rutherford, M. 2012. Nursing is the room rate. *Nursing economics*, 30:193-200.

SANC **see** South African Nursing Council.

Satoh, M., Watanabe, I. & Asakuro, K. 2016. Occupational commitment and job satisfaction mediate effort-reward imbalance and the intention to continue nursing. *Japan journal of nursing science*, 14(1):49-60.

Secretan, L. 1999. Inspirational leadership; destiny, calling and cause. Toronto, Ontario: MacMillan Canada.

Sellman, D. 2011. Professional values. *Medical health philosophies*, 14(2):203-208.

Shearer, N. & Crawford, B. 2011. Creating a nursing intervention out of passion for theory and practice.

Shosha, G. A. 2012. Employment of Colaizzi's strategy in descriptive phenomenology: a reflection of a researcher. *European scientific journal*, 8(27):31-43.

Smith K.V. & Godfrey, G. 2002. Being a good nurse and doing the right thing: a qualitative study. *Nursing ethics*, 9(3):301-312.

Sofhauser, C. 2016. Intention in nursing practice. *Nursing science quarterly*, 29(1):31-34.

Sokolowski, R. 2000. Introduction to phenomenology. New York, NY: Cambridge University Press.

South Africa. 1996. Constitution of the Republic of South Africa.

<http://www.gov.za/documents/constitution/1996/a108-96.pdf> Date of access: 23 Nov. 2016.

South Africa. 2005. Nursing Act 33 of 2005.

South Africa. National Department of Health (NDOH). 2011a. National core standards for health establishments in South Africa. <http://www.doh.gov.za> Date of access: 20 May 2015.

South Africa. National Department of Health (NDOH). 2011b. Human resources for health South Africa: HRH Strategy for the Health Sector: 2012/13-2016/17. Pretoria.

South Africa. National Department of Health (NDOH). 2013. Strategic Plan for Nursing Education, training and Practice 2012/13-2016/17. Pretoria.

South Africa. National Department of Health (NDOH). 2015a. Ethics in health research: principles, processes and structures. 2nd ed. <http://www.goc.za/documents/ethics/2015.pdf> Date of access: 24 Nov. 2016.

South Africa. National Department of Health (NDOH). 2015b. National health insurance for South Africa. Towards universal health coverage. Pretoria.

South Africa. National Planning Commission. 2011. National Development Plan: vision 2030. Pretoria.

South African International Caritas Consortium. 2015. Johannesburg.

South African Nursing Council. 2015. Statistics (online). Pretoria: Department of Health. <http://www.sanc.org.za/stats/stat2015/> Date of access: 21 Feb. 2016.

- Spitzer, R. 2012. Professionals first! *Nurse leader*, 10(2):8-11.
- Statistics South Africa. 2015. Mid-year population estimates, 2015. <https://www.statssa.gov.za/publications/P0302/P03022015.pdf> Date of access: 12 Nov. 2016.
- Speziale H.S. & Carpenter, D.R., editors. 2007. Qualitative research in nursing: advancing the humanistic imperative. 4th ed. Philadelphia, PA: Lippincott Williams & Wilkins.
- Streubert, H.J. & Carpenter, D.R. 2011. Qualitative research in nursing: advancing the humanistic imperative. New York: Lippincott Williams & Wilkins
- Tavernier, S. 2006. An evidence-based conceptual analysis of presence. *Holistic nursing practice*, 20(3):152-156.
- Taylor-Haslip, V. 2013. The lived experience of caring presence for nursing faculty and nursing students. New York, NY: The City University of New York. (Dissertation– PhD).
- Thompson Adams, L. & O' Neil, E.H. 2008. Nurse executive. The four principles of management. New York: Springer Publishing Company.
- Tjale, A.A. & Bruce, J. 2007. A concept analysis of holistic nursing care in paediatric nursing. *Curationis*, 30(4):45-52.
- Tokpah, M.M. & Middleton, M. 2013. Psychiatric nurses' understanding of the spiritual dimension of holistic psychiatric nursing practice in South Africa. *Africa journal of nursing and midwifery*, 15(10):81.
- Tong, A., Sainsbury, P. & Craig, J. 2007. Consolidated criteria for reporting qualitative research (COREQ); a 32-item checklist for interview and focus groups. *International journal for quality in health care*, 19(6):349-357. doi:10.1093/intqhc/mzm042
- Trout, L.A. 2013. Nursing presence from the perspective of hospice nurses. Widener University. (Dissertation–PhD).
- Turpin, R. 2014. State of the science of nursing presence revisited: knowledge for preserving nursing presence capability. *International journal for human caring*, 18(4):14-29.
- Vaillot, M.C. 1962. Existentialism: A philosophy of commitment to nursing. *American journal for nursing*, 66:500-505.
- Valentine, N.M. 2013. Communicating nursing's excellence and value: on the way to Magnet. *Nursing economics*, 31(1):35.

- Van den Heever, A.E., Poggenpoel, M. & Myburgh, C.P.H. 2013. Nurses and care workers' perceptions of their nurse-patient therapeutic relationship in private general hospitals, Gauteng, South Africa. *Health SA Gesondheid*, 18(1):7, Art. #727.
- Van Graan, A.C., Williams, M.J.S. & Koen, M.P. 2016. Professional nurses' understanding of critical judgement: a contextual inquiry. *Health SA Gesondheid*, 21:280-293.
- Van Kraam, A. 1966. Existential foundations for psychology. New York: Appelton Century Crofts.
- Van Manen, M., Higgins, I. & van der Riet, P. 2016. A conversation with Max van Manen on phenomenology in its original sense. *Nursing and health sciences*, 18:4-7.
- Vaughan, P. 2017. My passion others' development. *Nursing standard*, 31(32):35.
- Vythilingum, B. 2009. Anxiety disorders in pregnancy and the postnatal period. *Continuing medical education*, 27(10):450-452.
- Wadsworth, P., Colorafi, K. & Shearer, N. 2017. Using narratives to enhance nursing practice and leadership: what makes a good nurse? *Teaching and learning in nursing*, 12(1): 28-31. <https://doi.org/10.1016/j.teln.2016.08.001>
- Walliman, N. 2006. Social research methods. London: SAGE.
- Walsh, K.M. 2009. Disciplined silence: a focused ethnography of exemplary emergency nursing practice. University of Connecticut. (Dissertation–PhD). UMI Number:3367468.
- Wang, C.C. 2017. Conversation with presence: a narrative inquiry. *Chinese nursing research*, 4(1): 43-50.
- Webb, M. S. Passmore, D. Cline, G. & Maguire, D. 2014. Ethical issues related to caring for low birth weight infants. *Nursing ethics*, 21(6):731-741.
- Welch, S. 2015. Lived experience of nursing faculty who received caring from nursing students. *International journal for human caring*, 19(2): 29-34.
- Welsh, D. & Wellard, S. 2005. The phenomenon of presence within contemporary nursing practice: a literature review. *The Australian journal of holistic nursing*, 12(1):1.
- Wertz, F.J. 2005. Phenomenological research methods for counselling psychology. *Journal of counselling psychology*, 52(2):167-177.
- WHO **see** World Health Organization.

Williams, A. Pienaar, C., Toye, C., Joske, D. & Lester, L. 2011. Further psychometric testing of an instrument to measure emotional care in hospital. *Journal of clinical nursing*, 20:3472-3482.

Wojnar, D. & Swanson, K. 2007. Phenomenology: an exploration. *Journal of holistic nursing*, 25(3):172-180.

World Health Organization. 1978. Definition of health.

<http://www.who.int/about/definition/en/print.html> Date of access: 23 Feb. 2015.

World Health Organization. 2014. Service Delivery and Safety (SDS) Health Systems and Innovation (HIS). <http://www.who.int/servicedeliverysafety/about/en/> Date of access: 23 Feb. 2015.

Wright, S. & Neuberger, J. 2012. Why spirituality is essential for nurses. *Nursing standard*, 26(40):19-21.

Yesilot, S.B. & Oz, F. 2016. Validity and reliability of the presence of nursing scale in patients with cancer in the Turkish language. *International journal of caring sciences*, 9(2):443-451.

Zahavi, D. 2003. Husserl's phenomenology. Stanford, CA: Stanford University Press.

Zikorus, P. 2007. The importance of a nurse's presence. A personal story of holistic caring. *Holistic nurse practitioner*, 208-210.

Zyblock, D. 2010. Nursing presence in contemporary nursing practice. *Nursing forum*, 45(2):120-124.

ANNEXURE A: REQUEST FOR PERMISSION TO CONDUCT RESEARCH FROM THE NORTH WEST DEPARTMENT OF HEALTH



Private Bag X6001, Potchefstroom
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Dr F Reichel

Director: Policy, Planning, Research, Monitoring and
Evaluation

Dear Dr Reichel

PERMISSION TO CONDUCT RESEARCH

Herewith permission to conduct research at a hospital in the **North West Province** is kindly requested.

The research is entitled: **Professional nurses' lived experience of practising caring presence in a rural public hospital**. The purpose of the research is to explore and describe professional nurses' lived experience of practising caring presence in the context of a rural public hospital in the North West province. This study will be conducted on the premises of the hospital and will involve individual, semi-structured interviews done by the researcher trained in research interview skills and knowledgeable about practising caring presence. This research study aims to make known the significance and transformative potential of caring presence in the nursing profession, for future use in the practice, education and research field and to enhance professionalism among nurses.

This research has been approved by the Health Research Ethics Committee (HREC) of the Faculty of Health Sciences, NWU (NWU-00331-16-A1).

A **descriptive phenomenological design** with a qualitative approach will be used. In short the research method will be as follows:

Population:

Professional Nurses of [REDACTED] Hospital.

Sample: Purposive sampling will be used to recruit participants. The researcher aims to include 12-14 participants in the study. Data will be collected until repetitive information is generated and no new information is added.

Data collection: Individual semi-structured interviews with professional nurses who fit the inclusion criteria, will be used to collect data. The interviews will last between 45-60 minutes and for the

convenience of the participants and to ensure that are no financial costs involved, will take place in an office or boardroom at the hospital, during working hours.

Data analysis: Data will be organised and prepared for analysis and coding and identification of themes will be done. The researcher will request an independent coder who is an expert and has experience in qualitative data analysis to co-code the data. The co-coder who signed a confidentiality agreement with the researcher, will be involved to strengthen the trustworthiness of the research.

Dissemination of results: Results will be shared with participants and hospital management in the form of a research report. At a later stage, the researcher is willing to conduct a Power-Point presentation of the results to management and invite professional nurses, including the participants to this presentation. Strategies and recommendations to implement and enhance the practice of caring presence among nurses will also be shared during this presentation.

Unit managers at the hospital will be invited to act as mediators to inform potential participants about the research, to invite them to participate and to obtain informed consent.

Attached please find the research proposal and the ethics certificate.

I hope this request will be approved, and I am looking forward to your response.

Yours sincerely

.....

P. S. HOBBS.

ANNEXURE B: REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT A RURAL PUBLIC HOSPITAL



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Management team

Dear Dr and Management team

PERMISSION TO CONDUCT RESEARCH ON PROFESSIONAL NURSES' LIVED EXPERIENCE OF PRACTISING CARING PRESENCE

Herewith permission to conduct research at [redacted] hospital is kindly requested.

The research is entitled: **Professional nurses' lived experience of practising caring presence in a rural public hospital.**

The purpose of the research is to explore and describe Professional nurses' lived experience of practising caring presence in the context of a rural public hospital in the North West province South Africa. This study will be conducted on the premises of the hospital and will involve individual, semi-structured, interviews done by the researcher trained in research interview skills and knowledgeable about practising caring presence. This research study aims to make known the significance and transformative potential of caring presence in the nursing profession, for future use in the practice, education and research field and to enhance professionalism among nurses.

I furthermore kindly request that nursing service managers are identified to act as mediators to inform potential participants about the research, to invite them to participate and to obtain informed consent. It will be convenient to the participants if the semi-structured interviews are conducted in an office or boardroom at the hospital, during working hours. The researcher will arrange with the nursing managers to keep disruption of their work-schedule to a minimum. Your permission will be appreciated.

This research has been approved by the Health Research Ethics Committee (HREC) of the Faculty of Health Sciences, NWU (NWU- 00331-16-A1), and by the North West Provincial Department of Health (please see accompanying documents).

In short: A **descriptive phenomenological design** with a qualitative approach will be used. The research method will be as follows:

Population:

Professional nurses working at [REDACTED]

Sample: Purposive sampling, will be used to identify participants. The researcher aims to include 12-14 participants in the study. Data will be collected until repetitive information is generated and no new information is added.

Data collection: Individual semi-structured interviews with professional nurses, who fit the inclusion criteria, will be used to collect data. The interviews will last between 45-60 minutes and for the convenience of the participants and to ensure that no financial costs are involved, conducted during working hours in a boardroom or office at the hospital.

Data analysis: Data will be organised and prepared for analysis and coding and identification of themes will be done. A co-coder who signed a confidentiality agreement with the researcher, will be involved to strengthen the trustworthiness of the research.

Dissemination of results: The research report will be handed to the hospital's management. In addition, the researcher is willing to conduct a Power-Point presentation of the results to management and invite professional nurses, including the participants to this presentation. Strategies and recommendations to implement and enhance the practice of caring presence among nurses will also be shared during this presentation.

I hope this request will be approved, and I am looking forward to your response.

Yours sincerely

.....
Mrs P. S. Hobbs

ANNEXURE C: CONFIDENTIALITY AGREEMENT BETWEEN THE RESEARCHER AND MEDIATORS



NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

CONFIDENTIALITY UNDERTAKING

between the researcher and the mediators

I, the undersigned

Prof / Dr / Mr / Ms / Mrs _____

Identity Number: _____

Address:

Hereby undertake in favor of the **NORTH-WEST UNIVERSITY**, a public higher education institution established in terms of the Higher Education Act No. 101 of 1997

Address: Office of the Institutional Registrar, Building C1, 53 Borchard Street, Potchefstroom, 2520

(Hereinafter the "NWU")

1 Interpretation and definitions

1.1 In this undertaking, unless inconsistent with, or otherwise indicated by the context:

1.1.1 "Confidential Information" shall include all information that is confidential in its nature or marked as confidential and shall include any existing and new information obtained by me after the Commencement Date, including but not be limited in its interpretation to, research data, information concerning research participants, all secret knowledge, technical information and specifications, manufacturing techniques, designs, diagrams, instruction manuals, blueprints, electronic artwork, samples, devices, demonstrations, formulae, know-how, intellectual property, information concerning materials, marketing and business information generally, financial information that may include remuneration detail, pay slips, information

relating to human capital and employment contract, employment conditions, ledgers, income and expenditures and other materials of whatever description in which the NWU has an interest in being kept confidential; and

1.1.2 "Commencement Date" means the date of signature of this undertaking by me.

1.2 The headings of clauses are intended for convenience only and shall not affect the interpretation of this undertaking.

2 Preamble

2.1 In performing certain duties requested by the NWU, I will have access to certain Confidential Information provided by the NWU in order to perform the said duties and I agree that it must be kept confidential.

2.2 The NWU has agreed to disclose certain of this Confidential Information and other information to me subject to me agreeing to the terms of confidentiality set out herein.

3 Title to the Confidential Information

I hereby acknowledge that all right, title and interest in and to the Confidential Information vests in the NWU and that I will have no claim of any nature in and to the Confidential Information.

4 Period of confidentiality

The provisions of this undertaking shall begin on the Commencement Date and remain in force indefinitely.

5 Non-disclosure and undertakings

I undertake:

5.1 to maintain the confidentiality of any Confidential Information to which I shall be allowed access by the NWU, whether before or after the Commencement Date of this undertaking. I will not divulge or permit to be divulged to any person any aspect of such Confidential Information otherwise than may be allowed in terms of this undertaking;

5.2 to take all such steps as may be necessary to prevent the Confidential Information falling into the hands of an unauthorised third party;

5.3 not to make use of any of the Confidential Information in the development, manufacture, marketing and/or sale of any goods;

5.4 not to use any research data for publication purposes;

5.5 not to use or disclose or attempt to use or disclose the Confidential Information for any purpose other than performing research purposes only and includes questionnaires, interviews with participants, data gathering, data analysis and personal information of participants/research subjects;

5.6 not to use or attempt to use the Confidential Information in any manner which will cause or be likely to cause injury or loss to a research participant or the NWU; and

5.7 that all documentation furnished to me by the NWU pursuant to this undertaking will remain the property of the NWU and upon the request of the NWU will be returned to the NWU. I shall not make copies of any such documentation without the prior written consent of the NWU.

6 Exceptions

The above undertakings by me shall not apply to Confidential Information which I am compelled to disclose in terms of a court order.

7 Jurisdictions

This undertaking shall be governed by South African law be subject to the jurisdiction of South African courts in respect of any dispute flowing from this undertaking.

8 Whole agreements

8.1 This document constitutes the whole of this undertaking to the exclusion of all else.

8.2 No amendment, alteration, addition, variation or consensual cancellation of this undertaking will be valid unless in writing and signed by me and the NWU.

Dated at Potchefstroom this _____ 20____

Witnesses:

1

2

.....

(Signatures of witnesses)

(Signature)

ANNEXURE D: INVITATION TO PARTICIPATE IN RESEARCH

YOU ARE INVITED to participate in RESEARCH on :

Professional nurses' lived experience of practising *caring presence in a rural public hospital*

“True presence or being with another person, carries with it a silent power” (Allison & Gediman, 2006. This I Believe: The Personal Philosophies of Remarkable Men and Women).



A mediator will contact you and explain the details of the research, and what will be expected of participants, namely sharing your lived experience as professional nurse, of practising **caring presence** in individual semi-structured interviews. The **contact details** for your convenience:

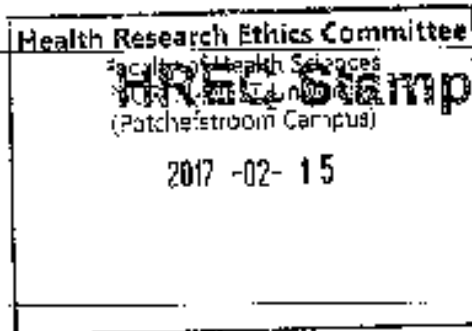
Tel:
Office:
E-mail

An informed consent document will be provided to you with more detail of the research process. Participation is **voluntary** and you may withdraw at any time without penalty. **Confidentiality and privacy** will be ensured, so that you can feel at ease to share your experience. If you are interested in participating, please inform the mediator.

ANNEXURE E: INFORMED CONSENT



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONGI-DI-BOFI IR MA
NDORWES-UNIVERSITOT
POTCHEFSTROOM CAMPUS



INFORMED CONSENT DOCUMENTATION FOR PROFESSIONAL NURSES

TITLE OF THE RESEARCH STUDY:

Professional nurses' lived experience of practising caring presence in a rural public hospital

ETHICS REFERENCE NUMBERS: NWU-00331-16-A1

PRINCIPAL INVESTIGATOR:

Prof. E. du Plessis.

POST GRADUATE STUDENT:

Mrs. P.S. Hobbs

CONTACT NUMBER: 0827868614

You are being invited to take part in a **research study** that forms part of a Magister degree in Professional nursing at the NWU Potchefstroom campus. **Please** take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no 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 now.

This study has been approved by the Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00331-16-A1) and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DOH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

What is this research study all about?

- This study will be conducted on the premises of the hospital and will involve individual, semi-structured interviews done by the researcher trained in research interview skills and knowledgeable about practising caring presence.
- The purpose of this research is to explore and describe professional nurses' lived experience of practising caring presence in the context of a rural public hospital in the North West province, South Africa.
- This research study aims to make known the significance and transformative potential of caring presence in the nursing profession, for future use in the practice, education and research field and to enhance professionalism among nurses.

Why have you been invited to participate?

- You have been invited to be part of this research because you are employed at a rural public hospital in the North West province, South Africa and it is believed that you will be able to inform the researcher with rich data information
- You have also complied with the following inclusion criteria:
- Professional nurse working for at least one year, full-time in a rural public hospital in the North West province, South Africa.
- You are willing to have interviews recorded on an audio recorder
- You are prepared to give voluntarily written consent to participate in the study after being informed about the purpose and procedures of the research
- You are identified by a mediator (or a previous participant) as a professional nurse who practices caring presence, as evidenced by behaviour such as not treating their patients as "a body in a bed" but as a holistic person, who checks regularly on patients, comforts patients, responds to the needs of patients, make eye-contact and portray true interest and genuine caring in the nursing profession.
- You will be excluded if:
- You are not a professional nurse and part-time employed and not able to communicate in English as medium of communication
- Working less than one year as a professional nurse at a rural public hospital

What will be expected of you?

- You will be expected to participate in a semi-structured interview which will be conducted by the researcher.

- You will be asked focus questions, namely to describe a situation where you practised caring presence as a professional nurse, and to share your experience of practising caring presence. You will be given the opportunity to ask questions before the interview starts.
- The individual interview will be audio-recorded for data analysis purposes. This study will be conducted under the supervision of experienced health researchers at the NWU trained in qualitative research in Nursing Sciences.
- The duration of the interview is expected to be between 45 and 60 minutes. The researcher aims to include 12-14 participants in this study. The interviews will be conducted during working hours for your convenience, in an office or boardroom at the hospital. These locations have sufficient light and air conditioning and are comfortable.
- The researcher will also need to contact you via a telephone call in order to discuss and validate the study findings to make sure it reflect your own experiences.

Will you gain anything from taking part in this research?

- There are no direct benefits for you as participant.
- The indirect benefits will be that the participants will be assisting the researcher to gain a better understanding of their lived experience of practising caring presence.
- The information generated in this research will be used for future formulation of recommendations to develop proper interventions and strategies to implement and enhance the implementation of the crucial nursing intervention of practising caring presence among nurses.
- The benefits for society at large are the possibility that these research findings may be used to improve and enhance the quality of patient-centred nursing care.
- By illuminating the practise of caring presence, professionalism among nurses may be enhanced

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

- The risks in this study are limited, yet emotional discomfort, because of participating in an individual semi-structured interview might be experienced. This discomfort is not expected to exceed discomfort experienced in daily life. Should this happen the participants will be referred for debriefing or counselling on the premises, free of charge.
- The benefits outweigh the risk.

How will we protect your confidentiality and who will see your findings?

- Anonymity will be safeguarded by the researcher throughout the research process. Confidentiality will be ensured by omitting the use of names and places. Participants will not be identified by their names, instead numbers will be allocated and these will not be linked to the names or place of work. Reporting of the findings will be anonymous by blinding the name of the hospital and any aspect that could be linked to the participants.

- Consequently, there will be no way to link your feedback to your identity. All data will be kept safe and secure by locking hard copies in locked cupboards in the researcher's office and electronic data will be password protected. Only the researcher and supervisors will have access to the raw data. A co-coder will be involved in the data analysis, but this role player will sign a confidentiality agreement to keep all information private. As soon as data has been transcribed, it will be deleted from the audio recorders.

What will happen with the findings?

- The findings of this study will only be used for this study and the data will be analysed and disseminated through a research report. Data will be kept safe and secure by locking hard copies in locked cupboards in the INSINQ research focus area's office and for electronic data, it will be password protected on the researcher's computer. (As soon as data has been transcribed it will be deleted from the recorders.) Data will be stored for at least 5 years.

How will you know about the results of this research?

- The research report will be handed to the hospital's management. In addition, the researcher is willing to conduct a Power-Point presentation of the results to management and invite professional nurses, including the participants to this presentation.

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

- You will not be paid to take part in this study but refreshments will be served after the interview in the form of cold drinks only. There will be no costs involved for you if you do take part, because the interview will be held during working hours and the location will be an office or boardroom in the hospital.

This study is funded by a bursary that the researcher received from the NWU and the researcher herself.

Is there anything else that you should know or do?

- You can contact Ronèl Hobbs at 0827868614 if you have any further questions or encounter any problems.
- You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes and records.

Declaration by participant

By signing below, I agree to take part in the research study titled: Professional nurses' lived experience of practising caring presence.

I declare that

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been 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 handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

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

Signature of participant

Signature of witness

Declaration by person obtaining consent

I (*name*) declare that:

- I clearly and in detail explained the information in this document to

.....

- I did not use an interpreter.
- 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 gave him/her time to discuss it with others if he/she wished to do so.

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

Signature of person obtaining consent

Signature of witness

Declaration by researcher

I (*name*) declare that:

The informed consent was obtained by an independent person.

- I am satisfied that the independent person adequately understands all aspects of the research, as described above.
- I am satisfied that the independent person explained all the information in this document of informed consent clearly and in detail to the signed participant.
- The independent person did not use an interpreter.

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

Signature of researcher

Signature of witness

ANNEXURE F: INTERVIEW SCHEDULE

Interviewer: Mrs. R. Hobbs. Interviewee: Participant A.
<p>I am presently studying for a Master's Degree at the School of Nursing Science at the North-West University (Potchefstroom Campus). The purpose of the study is to explore and describe professional nurses' lived experience of practising caring presence in a rural public hospital in the North West province, South Africa. The interview will be audio-recorded as discussed with you when you gave informed consent to be part of this research project. I want to emphasise that participation is totally voluntarily and you are free to terminate your participation at any stage without any consequences to you. It will however be appreciated if you participate for the duration of the study. Data will be kept in a safe place for confidentiality, only the researcher and co-coder has access to the raw data. Only an expert on qualitative research and I will share the transcribed recorded material. I undertake to safeguard your anonymity by omitting the use of names during the interview. This means there will be no link or clues to your identity. You will receive no remuneration for participation in this study. The benefit to your participation is that your experiences will be used for the future formulation of recommendations to develop proper interventions and strategies to promote and enhance the practising of caring presence among nurses. In order to validate the study findings, there will be a need for a second contact with you via a telephone call to make sure the findings reflect your own experiences. I am willing to conduct a Power-Point presentation at the hospital to share the final results with all nursing personnel. Should you wish to contact me for any enquiries feel free to do so at any time, using the contact details on the consent form.</p>
<p>I am going to ask you questions regarding your lived experience of practising caring presence. You may ask for clarification if you don't understand any question. The interview will last for about 45 minutes to one hour and if you are comfortable, we can start the interview now.</p>
<p>Focus questions: "Can you please describe a situation where you practised caring presence as a professional nurse?"</p> <p>"How do you experience practising caring presence?"</p>

Probing Questions:

1. Could you tell me more about that?
2. Could you give me some examples?
3. You just told me..... Can you also tell me more about.....?
4. Tell me about the experience you mentioned when you felt ...
5. Can you elaborate more, and describe..... in more detail..?
6. Could you tell me if I summarise your experience correctly, if I state that you verbalised.....?

Follow up questions, if needed for clarification, will be guided by the participants' responses to the initial questions.

Thank you for your time to be part of this research study.

ANNEXURE G: CONFIDENTIALITY AGREEMENT BETWEEN THE RESEARCHER AND CO-CODER



NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

CONFIDENTIALITY UNDERTAKING

between the researcher and the co-coder.

I, the undersigned

Prof / Dr / Mr / Ms / Mrs _____

Identity Number: _____

Address:

Hereby undertake in favor of the **NORTH-WEST UNIVERSITY**, a public higher education institution established in terms of the Higher Education Act No. 101 of 1997

Address: Office of the Institutional Registrar, Building C1, 53 Borchard Street, Potchefstroom, 2520

(Hereinafter the "NWU")

1 Interpretation and definitions

1.1 In this undertaking, unless inconsistent with, or otherwise indicated by the context:

1.1.1 "Confidential Information" shall include all information that is confidential in its nature or marked as confidential and shall include any existing and new information obtained by me after the Commencement Date, including but not be limited in its interpretation to, research data, information concerning research participants, all secret knowledge, technical information and specifications, manufacturing techniques, designs, diagrams, instruction manuals, blueprints, electronic artwork, samples, devices, demonstrations, formulae, know-how, intellectual property, information concerning materials, marketing and business information

generally, financial information that may include remuneration detail, pay slips, information relating to human capital and employment contract, employment conditions, ledgers, income and expenditures and other materials of whatever description in which the NWU has an interest in being kept confidential; and

1.1.2 "Commencement Date" means the date of signature of this undertaking by me.

1.2 The headings of clauses are intended for convenience only and shall not affect the interpretation of this undertaking.

2 Preamble

2.1 In performing certain duties requested by the NWU, I will have access to certain Confidential Information provided by the NWU in order to perform the said duties and I agree that it must be kept confidential.

2.2 The NWU has agreed to disclose certain of this Confidential Information and other information to me subject to me agreeing to the terms of confidentiality set out herein.

3 Title to the Confidential Information

I hereby acknowledge that all right, title and interest in and to the Confidential Information vests in the NWU and that I will have no claim of any nature in and to the Confidential Information.

4 Period of confidentiality

The provisions of this undertaking shall begin on the Commencement Date and remain in force indefinitely.

5 Non-disclosure and undertakings

I undertake:

5.1 to maintain the confidentiality of any Confidential Information to which I shall be allowed access by the NWU, whether before or after the Commencement Date of this undertaking. I will not divulge or permit to be divulged to any person any aspect of such Confidential Information otherwise than may be allowed in terms of this undertaking;

5.2 to take all such steps as may be necessary to prevent the Confidential Information falling into the hands of an unauthorised third party;

5.3 not to make use of any of the Confidential Information in the development, manufacture, marketing and/or sale of any goods;

5.4 not to use any research data for publication purposes;

5.5 not to use or disclose or attempt to use or disclose the Confidential Information for any purpose other than performing research purposes only and includes questionnaires, interviews with participants, data gathering, data analysis and personal information of participants/research subjects;

5.6 not to use or attempt to use the Confidential Information in any manner which will cause or be likely to cause injury or loss to a research participant or the NWU; and

5.7 that all documentation furnished to me by the NWU pursuant to this undertaking will remain the property of the NWU and upon the request of the NWU will be returned to the NWU. I shall not make copies of any such documentation without the prior written consent of the NWU.

6 Exceptions

The above undertakings by me shall not apply to Confidential Information which I am compelled to disclose in terms of a court order.

7 Jurisdictions

This undertaking shall be governed by South African law be subject to the jurisdiction of South African courts in respect of any dispute flowing from this undertaking.

8 Whole agreements

8.1 This document constitutes the whole of this undertaking to the exclusion of all else.

8.2 No amendment, alteration, addition, variation or consensual cancellation of this undertaking will be valid unless in writing and signed by me and the NWU.

Dated at Potchefstroom this _____ 20____

Witnesses:

1

2

(Signatures of witnesses)

.....

(Signature)

ANNEXURE H: ETHICAL APPROVAL HREC

Private Bag X6001, Potchefstroom,
South Africa, 2520

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

**Institutional Research Ethics
Regulatory Committee**

Tel: +27 18 299 4849

ETHICS APPROVAL CERTIFICATE OF STUDY

Email : Ethics@nwu.ac.za

Based on approval by **Health Research Ethics Committee (HREC)** on **14/02/2017** after being reviewed at the meeting held on **15/09/2016**, the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby **conditionally approves** your study as indicated below. This implies that the NWU-IRERC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: Professional nurses' lived experience of practising caring presence in a rural public hospital.

Study Leader/Supervisor: Prof E du Plessis

Student: PS Hobbs

Ethics number:

N	W	U	-	0	0	3	3	1	-	1	6	-	A	1
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Application Type: Single study

Commencement date: 2017-02-14

Risk:

Medium

Continuation of the study is dependent on receipt of the annual (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation up to a maximum period of three years.

Special conditions of the approval (if applicable): x Please submit the signed copies of the confidentiality agreements with the co-coder and the mediators once they become available.

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:

x The study leader (principle investigator) must report in the prescribed format to the NWU-IRERC via HREC:

- annually (or as otherwise requested) on the monitoring of the study, and upon completion of the study
- without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.

x Annually a number of studies may be randomly selected for an external audit. x The approval applies strictly to the proposal as stipulated in the application form. Would any changes to the proposal be deemed necessary during the course of the study, the study leader must apply for approval of these amendments at the HREC, prior to implementation. Would there be deviated from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.

x The date of approval indicates the first date that the study may be started.

x In the interest of ethical responsibility the NWU-IRERC and HREC retains the right to:

- request access to any information or data at any time during the course or after completion of the study;
- to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.

- withdraw or postpone approval if:
 - any unethical principles or practices of the study are revealed or suspected,
 - it becomes apparent that any relevant information was withheld from the HREC or that information has been false or misrepresented,
 - the required amendments, annual (or otherwise stipulated) report and reporting of adverse events or incidents was not done in a timely manner and accurately,
 - new institutional rules, national legislation or international conventions deem it necessary.

x HREC can be contacted for further information or any report templates via Ethics-HRECApplies@nwu.ac.za or 018 299 1206.

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

Yours sincerely

Digitally signed by

Prof LA

Du Plessis

Prof LA Du Plessis

Date: 2017.02.21

15:46:04 +02'00'

Prof Linda du Plessis

Chair NWU Institutional Research Ethics Regulatory Committee (IRERC)

ANNEXURE I: PERMISSION TO CONDUCT RESEARCH FROM DEPARTMENT OF HEALTH NORTH WEST PROVINCE



POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

Name of researcher : Ms. P.S. Hobbs
North West University

Physical Address Molopoweg 67
(Work/ Institution) Vryburg
8601

Subject : Research Approval Letter – Professional nurse's lived experience of practicing caring presence in a rural public hospital.

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

Mr. L.P. Moaisi
Acting Director: PPRM&E



03 March 2017
Date

[Signature]
Researcher

8/03/17
Date

ANNEXURE J: PERMISSION TO CONDUCT RESEARCH FROM THE RURAL PUBLIC HOSPITAL



OFFICE OF THE CEO

23 January 2017

Prof. Du Plessis
Nursing
NWU

Att: PS Hobbs

Re: GOODWILL PERMISSION

We hereby grant conditional goodwill permission for your intended study, Ethics number NWU-00331-16S1.
This permission is subject to a final approval by the North West Department of Health Policy, Planning, Research, Monitoring and Evaluation Unit.

Thank you,

CEO


Healthy Living for All

ANNEXURE K: AN EXCERPT FROM THE FIELD NOTES

Descriptive/ observational notes

This participant appeared calm and showed signs of a willingness to partake in the interview. She was dressed professionally in her uniform and maintained eye contact throughout the interview.

The scheduled semi-structured interviews were conducted during working hours in a private office at the rural public hospital. The office was furnished with two comfortable chairs and a desk. Furthermore, this office was well-ventilated and a 'do not disturb' board was placed on the door in order to avoid any form of disturbances. An electricity point was available to plug in the audio recorder.

Methodological notes

As I realised that I am the research instrument in this qualitative study, I kept on reminding myself to use open-ended questions to encourage the participant to fully describe her experience and to avoid leading the participant in a certain direction. In addition, I made a mental note to clarify the personal statements by repeating what she just shared. Therefore, I tried to use minimal verbal responses, nodded occasionally and responded with a questioning yes? Therefore, I encouraged her to reach into her own perspective and express her thoughts and feelings in more detail.

Theoretical notes

In an effort to attach meaning to my observations, while conducting this interview, I utilized the paraphrasing technique in order to test whether I understood what the participant attempted to share with me. I tried to reflect my interpretations verbally in an attempt to grasp the real meaning of the descriptions and experiences. This assisted me to verify if the statements shared by this participant, are observed correctly. During this specific interview, I observed enthusiastic passion towards the nursing profession, and a desire to truly reveal her experiences to me.

Personal notes

Although I have been waiting for this patient nearly half an hour, I realise that all the nursing personnel are rushing around to finish their work. I am confident that this interview will provide me with valuable information, and I reminded myself once more to avoid my own perceptions and judgements, and to be open to this individual persons' feelings and experiences regarding the research questions.

Demographic information

This semi-structured interview was conducted on 14 June 2017 at 11h00 in the office offered to me by the CEO of this rural public hospital. This participant is a black female, 58 years of age. She has 23 years of nursing experience and is currently working in the neonatal unit. This office provided a quiet and private environment which facilitated the conducting of an effective interview. There was no disturbance or interference during the interview.

ANNEXURE L: REQUEST TO ACT AS CO-CODER



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOM CAMPUS

Private Bag X6001, Potchefstroom
South Africa 2520

Tel 018 299 1111/2222

INSINQ Research focus area

School of Nursing Science

Tel 2991876

Fax 2991827

Email: emmerentia.duplessis@nwu.ac.za

petro.benadè@nwu.ac.za

ronelhobbs12@gmail.com

Dear [REDACTED]

REQUEST TO ACT AS CO-CODER

I am presently studying for a Master's Degree at the School of Nursing Science at the North-West University (Potchefstroom Campus). Your assistance to act as co-coder of the research study is kindly requested.

The research is entitled: **Professional nurses' lived experience of practising caring presence in a rural public hospital**. The purpose of the research is to explore and describe professional nurses' lived experience of practising caring presence in the context of a rural public hospital in the North West province. This study will be conducted on the premises of the hospital and will involve individual, semi-structured interviews done by the researcher trained in research interview skills and knowledgeable about practising caring presence. This research study aims to make known the significance and transformative potential of caring presence in the nursing profession, for future use in the practice, education and research field and to enhance professionalism among nurses.

This research has been approved by the Health Research Ethics Committee (HREC) of the Faculty of Health Sciences, NWU (NWU-00331-16-A1).

A **descriptive phenomenological design** with a qualitative approach will be used. In short the research method will be as follows:

Population:

Professional Nurses of [REDACTED] Hospital.

Sample: Purposive sampling will be used to recruit participants. The researcher aims to include 12-14 participants in the study. Data will be collected until repetitive information is generated and no new information is added.

Data collection: Individual semi-structured interviews with professional nurses who fit the inclusion criteria, will be used to collect data. The interviews will last between 45-60 minutes and for the convenience of the participants and to ensure that are no financial costs involved, will take place in an office or boardroom at the hospital, during working hours.

Data analysis: Data will be organised and prepared for analysis and coding and identification of themes will be done. The researcher will request an independent coder who is an expert and has experience in

qualitative data analysis to co-code the data. The 7-step method of Collaizzi will be utilised to analyse and code the data.

Your consent to sign a confidentiality agreement with the researcher are kindly requested as your assistance will enhance and strengthen the trustworthiness of this research.

Dissemination of results: Results will be shared with participants and hospital management in the form of a research report. At a later stage, the researcher is willing to conduct a Power-Point presentation of the results to management and invite professional nurses, including the participants to this presentation. Strategies and recommendations to implement and enhance the practice of caring presence among nurses will also be shared during this presentation.

Unit managers at the hospital will be invited to act as mediators to inform potential participants about the research, to invite them to participate and to obtain informed consent.

Attached please find the research proposal and the ethics certificate.

I hope this request will be approved, and I am looking forward to your response.

Yours sincerely

.....

P. S. HOBBS.

ANNEXURE M: THOUGHTS RECORDED IN THE REFLEXIVE JOURNAL

Before the interview began, I realized that I had started to think about what I knew so far on the concept of practising caring presence. In my mind, I went through a mental list and wrote down my own preconceived thoughts and impressions. I feel this has been helpful in bracketing or setting those thoughts and ideas aside. Furthermore, I purposefully postponed the literature review for this research and avoided some of the results or findings sections related to the practice of caring presence in the nursing profession, knowing that I wanted to keep my mind clear and my perspective fresh when conducting the interviews.

This morning, I conducted my first interview. I noticed that there were a couple of times during the interview, where phrases were used that reminded me of similar phrases that I read in literature. Reflecting on this experience, prompted me to remember that I will have to be very careful about not letting previous acquired knowledge influence my current research.

I finished the seventh interview today, and as I ponder on this experience, I realize that I am certainly affected by these interviews and the special situations and moments the professional nurses are sharing. I gained respect for the fact that despite many challenges and difficulties, they revealed such passion for nursing and commitment towards their patients.

Today, I almost felt I was gaining access to personal stories from a diary, or experiences another person wouldn't normally know about. These are really personal experiences to the participants. I discovered that my field notes became more and more detailed as my interviews progressed. I noted that my field notes were solely focused on the specific interviews and could be an excellent source for guiding data analysis.

As I mentioned a while ago, I must guard my thoughts to focus on the thoughts and feelings shared by the participants and that I must be careful to set aside my own thoughts, judgements and experiences from the actual information shared by them.

ANNEXURE N: AN EXAMPLE AN INTERVIEW WITH A PARTICIPANT

Professional Nurses' lived experience of practising caring presence.

TRANSCRIPTION of interview

Researcher: R Participant: P Line: L

R: Welcomes the participant and explain the informed consent documentation (Annexure **B**) in detail, as well as the interview schedule (Annexure **A**).

R: The first focus question is: "Can you please describe a situation where you practised caring presence as a professional nurse? and

"How do you experience practising caring presence?"

L1 P: Uhm..my experience when I compare this years we are in now, caring for the patients
L2 are not the same now. To my assessment caring has gone down.

L3 R: Yes?

L4 P: We are no more taking care of patients like when I started training.

L5 R: Yes.

L6 P: And then at the same time I think it is ee..it is a shortage of staff.

L7 R: Yes that is definitely playing a role in caring.

L8 P: When I started training we were so many students from different colleges and

L9 universities and they were helping a lot. We have students who were coming from different

L10 places and when they are here we can see a difference, at least there is a difference in

L11 nursing the patients. With the very same students...some of them are not eager to learn,

L12 it seems that they are only here for....sorry to say..they are only here for gaining

L13 something....,,maybe money..some of them they cannot come even to you and say sister

L14 I don't understand this. Some of them, you must run after them and say: "do this" "do this"

L16 and according to me is not how it has been before, it has gone down. I am so worried

L17 because I am old now.

L18 R: Uh huh.

L19 P: Nursing is going down the drain.

L20 R: I understand yes.

L21 P: Yes, and what will happen to our patients.

L22 R: But will you say that caring is a very important part....

L23 P: Yes, caring is a very important part of nursing. You can compare it to nursing at home

L24 your very own mother and you take care of her in **totality..**

L25 R: Yes..... ?

L26 P: **And if you don't do it.. I mean total caring..(silence) it is something, it keeps us**

L27 alive..(scratch head) I don't know how to say it./But like I said caring has gone down..

L28 R: Ja? It seems that it is worrying you.

L29 P: It is worrying me seriously.

L30 R: ja,.. ja. But how will you describe to a novice nurse maybe what is caring, practising

L31 caring presence for a nurse? If a nurse comes to you and say you are a more

L32 experienced professional nurse, I want to know, how would you describe practising

L33 caring presence to her?

L34 P: **Caring, ee...it does not mean just doing a patient's wound. It is sympathy, empathy,**

L35 communication...(silence) it includes so many things./

L36 R: Many things? Can you describe it a bit more in detail?

L37 P **More specific in nursing, caring goes with passion../**

L38 R: Passion.. ?

L39 P: If you don't have passion for nursing..(silence) for patients.../

L40 R: Yes..I agree with you.

L41 P: If you don't have passion, you will only give medication and then you will leave./

L42 (Kuri). You don't see if this patient is bathed, if he has he ate or is he suffering from pain,

L43 or what-ever. You don't even ask.. or if you hear a patient screaming.. you just come:

L44 "Hey man! Sjarrap!" Or whatever. You don't go in detail why is this patient screaming? /

L45 R: Uh huh..

L46 P: So passion plays a role (silence)

L47 R: So without passion?

L48 P Yes without passion I could not do it.. Passion goes for everything..if you have passion
L49 for education, you will see someone doing this.. if you were working in Shoprite.. you do
L50 it 100%..(silence) everything comes with passion.. /

L51 R: Yes, yes. I agree with you, can you maybe describe a specific situation where you L52
experienced passion, and you felt passionate?

L53 P: Umhmmm.mm.. its on daily basis neh, usually I am happy when I go home, seeing a
L54 patient from 7 o'clock in the morning up to 7 o'clock in the evening. I go home seeing a
L55 difference in the patient's condition.

L56 R: Yes?

L57 P: Or did something like, when you were struggling with a drip, or you were struggling
L58 with something along. I feel happy when I go home. Done this! Because when I failed, the
L59 patient will not get any medication during the night. And they will try, if I failed and maybe
L60 10 o'clock he get only medication...but if I go home, I feel pride and I know I did 1,2,3..for
L61 the patient, knowing I did it. I feel bad if I did not do something and when I am home and
L62 went sleeping I think....I did not put up the drip, and I did not ask anyone for help, or
L63 whatever. Or I feel bad when I did not do something that was supposed to be done for the
L64 patient.

L65 R: I hear what you say, so being competent is also for you being a caring presence for
L66 your patients?

L67 P: Yes then I feel so competent and I feel I did 1,2,3..

L68 R: Yes?

L69 P: Uhm uh uh..

L70 R: I hear what you are saying. Would you say passion is also part of being competent

L71 or..?

L72 P: No, I think passion in general is having a connection with whatever you are doing. For
L73 instance, we, as nurses we focus on the patient. If you do have a connection with the
patient..(silence) that is passion..(silence) and if L76 sometimes you don't know this thing is
my passion, people will tell you... like when I did L77 my practical, I think it was when I did
practical in bridging.. I think it was in (name of place L78 removed) orthopaedic ward. I came
in early because I don't want to be late because you L79 must hand- over by this patient 1,2,3.
I was the first one in the ward but I could not take L80 report because I was new in the ward.

L81 R: Yes?

L82 P: And secondly I was a student. So the staff of that ward came, I did not know who was
L83 the manager, and that manager came but I did not know her. So I took the report. After

L84 taking report I went for delegation and I had to do dressings. So I do dressings, I went for
L85 tea, and then at three o' clock the manager calls me.

L86 R: Yes?

L87 P: She wants to have tea with me. I was so shocked. I was thinking: "Why? The manager,
L88 the first day? Tea with me?" A white person!

L89 R: Uh huh?

L89 P: She said that I must come with her. I was not happy at all. I was not free. And then she
L90 started asking me to tell her about myself. About myself? Is this the procedure in this

L91 ward? I was asking myself...Then I started 1,2,3.. and what, what... I come from Taung
L92 and what, what..(silence) and then she asked what food I prefer, pap en vleis, stamp and
L93 whatever and then: “don’t you want some tea?” and I asked: Why those questions?

L94 R: Yes?

L95 P: Then she replied that first thing in the morning when I came in the ward, I saw the way
you were standing, the way your wear your uniform..(silence) I saw.... this is a nurse.

L96 R: Can you believe it?

L97 P: Yes can you believe it? .. Then she said that she went after me the whole day and she
L98 saw this is a nurse. You know that manager made my day! So I see if she can see this a
L99 nurse, I must start to work hard now, I became motivated. I did not came to nursing by
L100 mistake.

L103 R: Uh huh.

L104 P: Then there was a sister from (name of place removed) and she said:” sister are you
L105 a manager or what?” and I said no I am just a professional nurse. She said that she was
L106 so surprised. You are Really this is my passion, because I was a clerk before and I did
not want to be L102 a clerk. I was putting pressure to become a nurse. So some will
see...working like a manager, you are taking care of patients, its paper L107 work...You
know what... Our manager in (place removed), she sits with phone.., and L108 from there it
will be tea...I said to her: “no, no, no, I am not here for paper-work, I am L109 here for the
patients”. You see that’s why I am saying that passion plays a role.

L110 R: Yes, I can understand and what I heard is that you said: “being there, not only with
L111 the papers but being there on the floor with the patients is showing your passion and
L112 living out your passion as a nurse”.

L113 P: Uh hu. Yes without passion nurses cannot care

L114 R: I can hear your heart, and it is nice to hear that there are still nurses with passion for
L115 their profession.

L116 P: Yes.

L117 R: Like you started the interview with the word: “caring is going down”. That is also why
L118 we are doing this research to enhance practising caring presence. Is that also how you
L119 would describe caring presence... or can you elaborate more or give me something

L120 more, how you will say, what does caring presence mean to you. Can you tell me more,
L121 add something more?

L122 P: Uh..uhmm (silence)?

L123 R: Like you said caring presence is having a passion for what you are doing...like being
L124 competent... like being recognised...like you said that manager said she saw the way
L125 you are, that "you are a nurse"...

L126 P: You know, when it comes to competence, there are nurses who are competent neh,
L127 but at times they do not care. Kuri, they don't practice this competency. They think this
L128 one is doing this, why should I dig deeper into the patient? And at the same time it is
L129 not nice to work with nurses who don't care. Every time, you must tell them to do this or
L130 do that. It is not nice. I wish all nurses, you know... others agree that all competence
L131 come with a skill..., education. You cannot expect a nursing assistant to maybe put up
L132 the drips, to do whatever. To see that everything is 100% neh...

L133 R: Yes...?

L134 P: But if that person has passion, or he cares. He will be after you and say: "I want to
L135 see myself one day, doing what you are doing now." I want to be specialised... You see
L136 some... but they are not many. You see... (silence)

L137 R: I hear what you say. So do you think role-modelling is also important for you.

L138 P: Role-modelling is so important for me. Like the very same sister saying she never
L139 saw a manager like me. She said you are the manager but you go up and down. I told
L140 that sister, yes you can't say you are a manger and you sit down and everything will be
L141 done. You must check and be an example. If you come late... who is taking the report?

L142 R: Yes...?

L143 P: So you must be a role-model. Yes, sometimes you will come late, but it must not be
L144 a habit.

L145 R: So being punctual... not being late for work, not taking an hour for tea....

L146 P: Uhhh... agree?... with nursing... after taking the report, its prayer, after prayer... its
L147 dusting...then you cabolize....do whatever... so you know what? Nowadays, after taking
L148 the report...some don't check whether the equipment are working..., they don't check
L149 emergency trolley...

L150 R: Yes...?

L151 P: What they are doing is, they sit with their phone, (silent)... is it whatsapp?...or

L152 Facebook? (silence) or(silence) I don't know these things..?

L153 R: Yes...?

L154 P: And when the doctors come the doctors-trolley is "deurmekaar".

L155 R: Uh huh..

L156 P: It is not prepared... that is what they are doing now... You reprimand... (silence)...,
L157 the person.

L158 R: Yes...

L159 P: She goes and says: "I don't want to work with that sister now". Change me from that
L160 ward now.

L161 R: Ja, ja that is...

L162 P: It is so frustrating... and the minute you get those who will be eager to do what-ever..
L163 (silence). You know they don't pray nowadays, after the report... they are sitting with
L164 their phones...

L165 R: Agg! It's a shame...

L166 P: We are still praying, we are still praying, fortunately, in peads, we are dealing with
L167 babies. We must pray for this babies (silence) they cannot talk.. they cannot pray for
L168 themselves...with adult, agree, she can just go in the bed: "my god..what,
L169 what..".(holding her hands together, eyes closed).

L170 R: Yes? Do you think spirituality is important in practising caring presence?

L171 P: E.ee (silence) Yes, at least fortunately, some of us pray. I pray that I can get strength
L172 (silence) to do nursing, and I pray on behalf of babies, they cannot pray (silence).

L173 And now the problem comes...when you want to keep them in the ward... The good
L174 nurses, that is another story... That is the problem that we are facing.

L175 R: Yes I can hear..

L176 P: You see. You want to keep the nurse that is doing things right, taking care and that.

1177 R: Yes, and she is doing it with compassion?

L178 P: And when you say you don't want this nurse to be taken out of this ward, it is a fight
L179 again. You call it favouritism.

L180 R: Yes, so? (participant is eager to talk again)

L181 P: Unfortunately, those who still have passion, they are few from those who don't have
L182 passion.

L183 R: Don't you think there is too few role-models who is really caring? That the role-models
L184 also don't care and that they are also on their phones... and they are also not there for
L185 their patients (silence) do you think that it is causing....

L186 P: Yes the problem is that its causing that others will say to you that they want to go to
L187 that ward because the manager does not say anything. Even you can go for a lunch for
L188 three hours...(silence)

L189 R: Sjoel

L190 P: Because the same manager goes for hours! And when she comes back, she just sits
L191 in the office.

L192 R: Oh!

L193 P: So you see it is a problem. If you do this, they will follow you. If you don't care, they
L194 also won't care.

L195 R: Yes. I hear what you are saying.

L196 P: That is why I am saying you must be strict. But when you are strict they will want to
L197 go out of your ward. And you cannot work alone in the ward.

L198 R: I hear what you are saying. Will you agree that being strict and wanting things to be
L199 done right, is also part of being caring and being there for your patients?

L200 P: That strictness, not to be too strict. You must do the things that they can see you do
L201 it right. Take this paper and put it there, she will know this paper must be there. If you

L202 start in the morning dusting or giving treatment, you say to someone to do the delegation.

L203 You know, today delegation is not done. If delegation is done, you can go and check if

L204 things are done. They don't do delegation. And if it is not done, you reprimand.

L205 R: Yes.

L206 P: To be a manager it is sometimes not nice. When you do PMDS you must write 100%.

L207 R: Is that PMDS professional development?

L208 P: Yes. If they don't get money, (silence) they will call you names (silence).

L209 R: Yes and you won't be popular and ja, ja....

L209 P Uh uh. It is not nice to give 100%, 100% if she is not doing that. That is corruption,

L210 you are saying she can continue to do nothing, at the same time, she will get money. It

L211 is not right. E,ee I must be honest (silence).

L212 R: So being honest is also difficult. Having integrity, doing things right?

L213 P: By doing things right, you show caring, but you become a culprit, with patients who

L214 are sick, it's different. You are not talking of someone who is in the street, being not sick.

L215 R: Ja, being vulnerable?

L216 P: Yes, when the sick comes here, she is expecting that she will be healed and she can

L217 go home. But if you start to say 1,2,3, it won't do good to the patient.

L218 R: Yes? So being caring is also being good to your patient so that they can get better

L219 and healed?

L220 P: When you sympathise too much they will get tight. In Peads things can get tight In

L221 this ward malnutrition is a problem. So at times nurses will not give formulas according

L222 to protocol, the mothers will complain. It is difficult. But others comply. Sometimes the

L223 mothers fight with us, sometimes even physically.

L224 R: Yes, shoe!. It is really difficult circumstances.

L225 P: Yes, yes to be still caring and being there for your patients.

L226 R: I think we can summarise. I got a picture of how you experience practising caring

L227 presence within the context of a rural public hospital. I am really happy and I thank you

L228 for your time. I also want to confirm that I can contact you telephonically when the data
L229 was analysed to check whether you agree with the findings.

L230 P: I don't have a problem. Its fine.

L231 R: Thank you for your passion in the nursing profession. Anything you can add?

L232 P: You know what, I tell my husband it is so sad that nursing has gone so down. It is so
L233 sad that patients are being send from pillar to post for a little thing.... When somebody
L234 did not do this, why can't you do it?

L235 R: Yes. I hear what you are saying.

L236 P: I remember last year I was so hurt...(silence).

L237 R: Yes? What happened?

L238 P: I was standing at the Help desk and I saw a white man coming. He was wandering,
L239 wandering. Something that comes to my mind, is that I wondered if this is a psychiatric
L240 patient? Because, when I looked at him, he was shivering... The first thing that I did,
L241 was: "father, just come and sit down". He was so confused, man, and then fortunately
L242 he sat down. But he was still (shaking her hands).

L243 R: Trembling?

L244 P: Trembling. I thought maybe he had bad news, that someone passed away.

L245 R: Yes?

L246 P: I went to the phone and called casualty and asked the doctor to come and assist me.
L247 I told him that there was a middle-aged man-65 years old. That I don't know what is
L248 wrong. The doctor said no, to bring the patient to casualty. I felt so hurt, so sorry(silence)

L249 R: Uh,huh? What did you do?

L250 P: I saw that man cannot go to casualty on his own, so I took him there. Fortunately, he
L251 calmed a little bit and I asked him what the problem is. He told me in a shaking voice
L252 that he looked for his file in OPD and those people tossed him around, and then he
L253 started to cry! I took his hand and say you will be ok, I take care of you.

L254 R: Ag shame.

L255 P: At casualty we put him on the bed and I stayed near him. We took vital signs. His
L256 blood pressure was high. The doctor came and said that we should keep him for a while.

L257 For a simple thing they send him from pillar to post. Apparently they could not find his
L258 file, and then send him from the one place to another on his own, that he became

L259 confused and lost his way.

L260 R: So they tossed him around and did not took care of him?

L261 P: Yes. Fortunately, I found him. So, if you can't find a file, why can't you take this old
L262 man and go with him to help him find his file? And come to a conclusion, that we can't
L263 found the file and open a new one, just to help him? It is uncaring. We must care (silence)

L264 R: I hear what you are saying.

L265 P: The clerks are also here because of our patients. They cannot care. It is not right.

L266 R: I agree. Can I wrap up the conversation and thank you again for sharing the useful
L267 information. I really do appreciate your participation.

L268 P: It is fine, thank you.

(Demographic information was also collected from the participant after the interview was conducted).

ANNEXURE O: THE PROCESS OF EXTRACTING SIGNIFICANT STATEMENTS

Significant statements	Formulated meanings (Fm)
<p>1.</p> <p>"Yes, caring is a very important part of nursing. You can compare it to nursing at home your very own mother...". T1, P1, L23-24</p>	<p>Caring is compared with giving nursing care for our own mother at home. Fm 1</p>
<p>2.</p> <p>... and you take care of her in totality T1, P1, L24</p>	<p>Practising caring presence is grounded in a holistic nursing approach. Fm 2</p>
<p>3.</p> <p>And if you don't do it. I mean total caring..(silence) it is something..it keeps us alive". I don't know how to say it".T1, P1, L26-27</p>	<p>Commitment to total care is seen as an essential element in nursing. Fm 3</p>
<p>4.</p> <p>Caring, eee, it does not mean just doing a patients' wound. It is sympathy, empathy, communication (silence) it includes so many things".T1, P2, L34-35</p>	<p>Caring does not only include procedures, but it includes sympathy, empathy, communication(silence) it includes so many things. Fm 4</p>
<p>5.</p> <p>"More specific in nursing, caring goes with passion. If you don't have passion, you will only give medication and then you leave.T1, P2, 37-41</p>	<p>Passion is fundamental to the nursing profession, in order to care and to build meaningful relationships with patients. Fm 5</p>
<p>6.</p> <p>"You don't see if the is bathed, if he has ate or he is suffering from pain, or whatever. You don't even ask...or if you hear a patient screaming...you just come: "Hey man! Sjarrap!. Or whatever. You don't go in detail why is this patient screaming.T1, P2, L42-44</p>	<p>Neglecting the basic physical needs of the patient, and being rude to patients is described as <i>not</i> practising caring presence. Fm 6</p>

<p>7.</p> <p>Yes, without passion I could not do it... passions goes for everything.... You do it 100% (silence) everything comes with passion..."T1, P2, L48-50</p>	<p>Whith-out passion for the nursing profession, it is not possible to render quality nursing care, and 100% dedication and commitment is emphasised. Fm7</p>
<p>8.</p> <p>Its on daily basis, neh, usually I am happy when I go home.. I go home seeing a difference in the patients' condition".T1, P2, L53-55</p> <p>9.</p> <p>"or did something like, when you were struggling with a drip, or you were struggling with something along, I feel happy when I go home. Done this!"....T1, P2, L57-58</p> <p>10.</p> <p>"But if I go home, I feel pride and I know I did 123..for the patient, knowing I did it".T1, P2, 60-61</p>	<p>Happiness and professional fulfilment is experienced when the difference in the patients' condition is observed. Fm 8</p> <p>Although challenging, personal and competent caring presence, are experienced as very rewarding. Fm 9</p> <p>Feelings of professional satisfaction and pride are experienced by professional nurses, at the end of a work-shift. Fm 10</p>
<p>11.</p> <p>"Or I feel bad when I did not do something that was supposed to be done for the patient" T1,P2, L63-64</p>	<p>Feeling disappointed when some tasks were not done. Fm 11</p>
<p>12.</p> <p>"Yes, then I feel so competent and I feel I did 123..."T1, P3, L67</p>	<p>Feeling satisfied when nursing tasks were competently done. Fm 12</p>
<p>13.</p> <p>".. I think passion in general is having a connection with whatever you are doing. For instance, we, as nurses focus on the patient".T1, P3, L72-73</p> <p>If you do have a connection with the patient..(silence) that is passion..(silence)".T1, P3, L75-76</p>	<p>Passion requires an intersubjective human connecting with whatever you are doing, as well as focusing on a meaningful relationship with patients. Fm 13</p>

<p>14.</p> <p>"Then she replied that first thing in the morning when I came in in the ward, I saw the way you were standing, the way you wear your uniform.. (silence) I saw...this is a nurse".T1, P3, L95-96</p> <hr/> <p>15.</p> <p>"Then she said that she went after me the whole day and she saw this is a nurse. You know that manager made my day! ... I became motivated. I did not come to nursing by mistake".T1, P3, L97-100</p>	<p>The manager comments at the physical presence and personal confidence of the nurse. Fm 14</p> <hr/> <p>The nurse indicates that the positive comment of the manager, motivated her and confirms her career choice. Fm 15</p>
<p>16.</p> <p>"Really this is my passion...".T1, P3, L100</p> <p>17.</p> <p>"...I said to her, no, no, no, I am not here for paper-work, I am here for the patients. You see that is why I am saying that passion plays a role".</p> <p>" yes without passion nurses cannot care".T1, P4, L126-130</p>	<p>Emphasise her passion for the nursing profession. Fm 16</p> <p>Points out that the patients are her priority and not the administrative tasks. Fm 17</p> <p>Importance of passion and commitment to care is illuminated. Fm 17</p>
<p>18.</p> <p>"You know, when it comes to competence, there are nurses who are competent neh, but at times they do not care"</p> <p>"They think this one is doing this, why should I dig deeper into the patient?"</p> <p>"And at the same time it is not nice to work with nurses who don't care. Every time, you must tell them to do this or do that. It is not nice".T1, P4, L126-130</p>	<p>Confronts the fact that competence does not guarantee a caring attitude and genuine interest in patients and working with such nurses is challenging. Fm 18</p>

<p>19.</p> <p>“But if that person has passion, or he cares. He will be after you and say, I want to see myself one day, doing what you are doing now. I want to be specialised...You see some... but they are not many. You see(silence)”. T1, P4, L134-136</p>	<p>A level of passion is required to become a specialised nurse. Fm 19</p>
<p>20.</p> <p>“Role-modelling is so important for me. T1, P4, L138-141</p> <p>“You must check and be an example”. If you come late, who is taking the report?”.</p> <p>So you must be a role-model. Yes, sometimes you will come late, but it must not be a habit”.T1, P4, L143-144</p>	<p>Being a role-model is necessary in the nursing profession, therefore, being an example requires that the professional nurse portrays professionalism at all times. Fm 20</p>
<p>21.</p> <p>“Nowadays, after taking the report...some don't check whether the equipment is working...they don't check emergency trolley”.</p> <p>“What they are doing is, they sit with their phone, (silence) it is whatsapp? (silence) or Facebook? (silence)or (silence) I don't know these things..?”T1, P5, L147-149</p> <p>“And when the doctors come, the doctors-trolley is deurmekaar”.T1, P5, L151-152</p>	<p>It is currently a trend amongst nurses not to check emergency-trolleys and spending lots of time on their phones during working hours. Fm 21</p>
<p>22.</p> <p>“We are still praying, we are still praying, fortunately, in peads, we are dealing with babies. We must pray for the babies (silence) they cannot talk... they cannot pray for themselves... with adult, agree, she can just go in the bed: “my God, what, what”. (holding her hands together, eyes closed).</p>	<p>Spiritual presence is fundamental to nursing babies and the professional nurse regain inner strength when she prays. Fm 22</p>

<p>"I pray that I can get strength (silence) to do nursing, and I pray on behalf of babies, they cannot pray (silence)" T1, P5, L166-169</p> <p>23.</p> <p>"And now the problem come ...when you want to eep them in the ward...the good nurses, that is a another story....That is the problem that we are facing". T1, P5, L173-174</p>	<p>Frustration is experienced by the professional nurses when they want to allocate nurses with a caring attitude in their wards. Fm 23</p>
<p>24.</p> <p>"You see you want to keep this nurses that is doing things right, taking care and that". T1, P5, L176</p>	<p>Expresses a desire to keep caring personnel in her ward. Fm 24</p>
<p>25.</p> <p>"And when you say you don't want this nurse to be taken out of this ward, it is a fight again. You call it favouritism".</p> <p>T1, P5, L178-179</p>	<p>Frustration is experienced when the professional nurse struggles to recruit specific nurses for her nursing team. Fm 25</p>
<p>26.</p> <p>"Unfortunately, those who still have passion, they are few from those who don't have passion". T1, P6, L181-182</p>	<p>Having feelings of disappointment because the majority of nurses are not passionate anymore. Fm 26</p>
<p>27.</p> <p>That the role-models also don't care and that they are also on their phones...and they are also not there for their patients (silence)" ..Even you can go for a lunch for three hours (silence). Because the same manager goes for hours! And when she comes back, she just sits in the office." T1, P6, L183-191</p> <p>"So you see it is a problem. If you do this, they will follow you. If you don't care, they also won't care". T1, P6, L193-19</p>	<p>Grounding the reality that professional nurses display unprofessional conduct by being on their sell-phones, taking lunch for three hours and reflecting un-caring behaviour towards patients. Fm 27</p>

<p>28.</p> <p>“That is why I am saying you must be strict. But when you are strict they will want to go out of your ward. And you cannot work alone in the ward” T1, P6, L196-197</p> <p>“That strictness, not to be too strict. You must do the things that they can see you do it right...”. T1, P6, L200-210</p> <p>“Uh hu. It is not nice to give 100%, 100% if she is not doing that. That is corruption, you are saying she can continue doing nothing....E,ee I must be honest”. T1, P6, L209-211</p> <p>29.</p> <p>“By doing things right, you show caring...”. T1, P6, L213</p> <p>30.</p> <p>“When you sympathise too much they will get tight. In Peads things can get tight”. T1, P6, L213</p> <p>31.</p> <p>“In this ward malnutrition is a problem. So at times nurses will not give formulas according to protocol, the mothers will complain. It is difficult... Sometimes the mothers fight us, sometimes physically. T1, P7, L220-223</p>	<p>Difficulty to remain strict and at times firm with nursing staff and frustration towards corruption and absence of integrity, during personnel evaluations. Fm 28</p> <p>Commitment to do everything ethically correct, is a crucial element within a caring attitude. Fm 29</p> <p>Professional nurses should be able to detach and separate from the emotions of patients. Fm 30</p> <p>The need to remain committed to correct procedures and protocol in order to achieve the goal of quality nursing care. Fm 31</p>
<p>32.</p> <p>Yes, yes to be still caring and being there for your patients”. T1, P7, L225</p>	<p>Implies difficulty to stay committed, caring and present for patients. Fm 32</p>
<p>33.</p> <p>“You know what, I tell my husband it is so sad that nursing has gone so down. It is so sad that patients</p>	<p>Frustration and disappointment are experienced towards the fact that</p>

<p>are being send from pillar to post for a little thing... When somebody did not do this, why can't you do it?" T1, P7, L232-234</p> <p>34.</p> <p>"I remember, last year I was so hurt..(silence).I was standing at the Help desk and I saw a white man coming. He was wandering, wandering. Something that comes to my mind, is that I wondered if this is a psychiatric patient? Because when I looked at him, he was shivering... The first thing that I did, was "father, just come and sit down. He was so confused, man, and then fortunately he sat down. But he was still (shaking her hands). T1, P7, L236-242</p>	<p>professionalism and a caring attitude within the nursing profession, is decreasing. Fm 33</p> <p>Showing compassion towards the helpless and confused patient and offers to be emotionally present. Fm 34</p>
<p>35.</p> <p>"I went to the phone and called casualty and asked the doctor to come and assist me. I told him that there was a middle-aged man 65-years old. That I don't know what is wrong. The doctor said no, to bring the patient to casualty". T1, P7, L246-248</p>	<p>Staying focused and advocate for the patient. Fm 35</p>
<p>36.</p> <p>"I felt so hurt, so sorry (silence). T1, P7, L248</p> <p>37.</p> <p>"I saw that man cannot go to casualty on his own, so I took him there</p> <p>Fortunately, he calmed a little bit and I asked him what the problem is. He told me in a shaking voice that he looked for his file in OPD and those people tossed him around, and then he started to cry". T1, P7, L250-253</p>	<p>Experiencing feelings of hurt and compassion. Fm 36</p> <p>Participant connected with the patient by means of verbal communication. Fm 37</p>

<p>38.</p> <p>"I took his hand and say you will be ok, I take care of you".At casualty we put him on the bed and I stayed near him. We took vital signs".T1, P7, L253-255</p>	<p>The professional nurse took the hand of the patient, reassured him and remained at his side. Fm 38</p>
<p>39.</p> <p>"For a simple thing they send him from pillar to post. Apparently they could not find his file, and then send him from one place to another on his own, that he became confused and lost his way".T1, P8, L257-259</p>	<p>Frustration is experienced when the patient is send "from pillar to post" and his needs is not attended to. Fm 39</p>
<p>40.</p> <p>"Fortunately, I found him. So , If we can't find a file, why can't we take this old man and go with him to help him find his file? And come to a conclusion, that we can't find the file and open a new one, just to help him? It is uncaring (silence). We must care".T1, P8, L261-263</p>	<p>Problem-solving skills and a caring attitude is emphasised as essential characteristics in caring presence. Fm 40</p>

Significant statements extracted and coded from transcription (interview No.2).

Significant statements	
<p>41.</p> <p>"when I got here I realised, go reh, I was told this people of here, this people are rude and blah, blah T2, P9, L16-17</p>	<p>Realised that people tend to judge the population of certain demographic areas and display a negative attitude towards them. Fm 41</p>
<p>42.</p> <p>"I came here as a nurse neh. I met the patients, I realised one thing that I must treat the patients as an individual" T2, P9, L17-18</p>	<p>Treating and valuing patients as unique individuals is an important ethical principal. Fm 42</p>

<p>43.</p> <p>I used my own, what can I call it? My (silence) my, how can I put it? The way I am"...I then started nursing patients like that." T2, P9, L22-24</p>	<p>Reflects on her own uniqueness as a person and confirms that self-awareness, as an important antecedent in the nursing profession. Fm 43</p>
<p>44.</p> <p>I remember there was this patient neh. This patient was, I could tell this patient was from a poor socio-economic standard neh".T2, P9, L29-30</p> <p>45.</p> <p>I could see just by entering (silence). But to her, eeee, I became a nurse. The person that I am".T2, P9, L29-30</p>	<p>Identifies that the patient experiences social problems that may need attention. Fm 44</p> <p>Explains when she entered the room, she displayed her genuine character and experienced that she was valued as a person. Fm 45</p>
<p>46.</p> <p>I didn't become just a professional nurse, I didn't use my professional skill to her. I treated her with, (silence) love, uhh, I opened my heart (silence). She shared her problems with me".T2, P10, L33-34</p>	<p>Compassion, commitment and willingness to give of herself in order to gain an understanding of the patient. Fm 46</p>
<p>47.</p> <p>"...I also shared some of my experiences, just to easy her. But I was doing that out of love, go reh,..."</p> <p>" and just by talking to her, go reh, she told me, you know what, you should have been a social worker T2, P10, L38-44</p>	<p>Utilising own personal experiences to assist the patient, (which indicates professional maturity) and connected with the patient through responsive communication. Fm 47</p>
<p>48.</p> <p>" I told her, one thing, when you are a nurse, you become everything.T2, P10, L46</p>	<p>Explains her passion for the nursing profession, in becoming everything for her patients, and displays a willingness to give of herself. Fm 48</p>
<p>49.</p> <p>"..a social worker, everything.T2, P10, L48</p>	<p>Confirms the social needs of patients. Fm 49</p>

<p>50.</p> <p>So she started opening up. Every time I come, she will talk to me, even relationship stuff".T2, P10, L48-49</p>	<p>Reveals an openness to connect with the patient unconditionally. Fm 50</p>
<p>51.</p> <p>"She will talk to me about it. I will give her advice on what to do, what to be careful for.."T2, P10, L51-52</p>	<p>Shares a willingness to advise and educate her patients. Fm 51</p>
<p>52.</p> <p>"I remember the other one, she was telling me she could not talk to the doctors. Because she was afraid".T2, P10, L52-53</p>	<p>Reveals the fact that patients are afraid to communicate with doctors regarding their problems. Fm 52</p>
<p>53.</p> <p>"She started telling me, you know, I am having this problem".</p> <p>T2, P10, L55</p>	<p>Staying focused on the patient, invited the patient do connect emotionally with the nurse. Fm 53</p>
<p>54.</p> <p>I will tell her no, no don't do that, you are inviting germs and infection into your body. Then I sit down and I talked to her. You must not do this or that. She even tell me then, now you are not a social worker now, now, you are even a teacher" T2, P10, L55-58</p>	<p>Responsive communication and spending time with patients, are fundamental elements in creating meaningful relationships with patients. Fm 54</p>
<p>55.</p> <p>"The other thing that I realised here neh, while I am working here. It is important for me as a nurse, to pray for my patients. If I fail therapeutically, agree,to pray for the patient is very important".T2, P10, L60-64</p>	<p>Denotes her spiritual connectedness, by praying for her patient. Fm 55</p>

<p>56.</p> <p>"Yes, when a patient go through something bad, I will pray for them that they can get healed....Then we will pray together".</p> <p>Once praying neh, eee, something will change. I will do my thing differently (silence)".T2, P11, L66-72</p>	<p>During difficult times, the professional nurse pray for and together with her patients, for their healing. Fm56</p>
<p>57.</p> <p>"Not that I will prescribe something, I will talk to the doctors. Why can't you prescribe and see how it works T2, P11, L73-74</p> <p>...Sometimes I really helped the patients, by communicating with the doctors.</p> <p>Yes I made suggestions on their behalf and advocate, yes. So being everything as a nurse, is very important".T2, P11, L78-79</p>	<p>Requires advocacy for patients by communicating with doctors regarding the wellbeing of the patient. Fm 57</p>
<p>58.</p> <p>"Taking your profession very seriously, is so very important. T2, P11, L82</p> <p>59.</p> <p>You must feel that you are fully there for them, being everything for them(silence)"...."You must put yourself in the patients' shoes".Feel what they feel, if it was me, having this problem, what was I going to do?"So always when a patient is suffering (silence). Sometimes I even cry".Because I will put myself in that patients' shoes. Or eh, this patient is experiencing this and that".T2, P11, L82-91</p>	<p>Passion and commitment to the nursing profession. Fm 58</p> <p>Illustrates her commitment to the deep level of connecting with her patient and willingness to share this intimate interaction, by describing this experience as: "you must feel that you are <i>fully there</i> for them, <i>being everything</i> for them" (silence)....you must put yourself in the patient's shoes...feel what they feel..." Fm 59</p>
<p>60.</p> <p>Then the nurses came in, I followed their routine very well. They came in the morning, they will greet</p>	<p>The necessity of a positive attitude and effective communication is highlighted. Fm 60</p>

<p>us and they will be (silence) only few of them had a positive attitude....</p> <p>Ok, here in nursing, it is important to communicate, you pass the message of the day to the next staff. Failing to do so, we will put the patient at risk".T2, P12, L112-113</p>	
<p>61.</p> <p>" I liked the way how they communicated with patients, and care for them". , P12, L113-114</p>	<p>Describes that she was impressed by the way the nurse communicated and cared for others. Fm 61</p>
<p>62.</p> <p>"And then I loved nursing.....my calling is nursing, I want to do nursing".T2, P12, L113-114</p> <p>Yes that is why it is not my work, it is my passion. Without passion I cannot be a nurse..".T2, P12, L127-128</p>	<p>Passion for the nursing profession is described, by denoting that nursing is a calling for her, and not only a work. Fm 62</p>
<p>63.</p> <p>"who is caring and present for my patients".T2, P12, L128</p>	<p>Identifying the importance of connecting emotionally, in order to display a caring attitude. Fm 63</p>
<p>64.</p> <p>"I told myself that I will correct this things, I will pay for their mistakes. T2, P12, L134</p>	<p>Willingness to correct the mistakes that other nurses made. Fm 64</p>
<p>65.</p> <p>"The other thing neh, is that you cannot nurse in a rural village, with a broken heart or with anger, it is so (silence) wrong".T2, P12, L135-136</p>	<p>Confronting the reality that self-awareness is important, therefore, nurses cannot take care of rural people with a broken heart or with anger. Fm 65</p>

<p>66.</p> <p>"I am not saying in a rural area, you cannot get rich people. But most people in a rural village, have poor social-economic status".T2, P13, L139-140</p> <p>67.</p> <p>So if you treat them bad, you are adding to their problems. So you must always try to be good to them, to your patients".T2, P13, L140-142</p>	<p>Confronting the reality that people from rural areas experience poor social economic status. Fm 66</p> <p>Treating them bad, add to their problems, therefore, nurses should be morally sensitive. Fm 67</p>
<p>68.</p> <p>"Before you come to work, you must focus to be present for your patients. You must talk to yourself, you know what, today I am going to work for my patient, I am going to treat that patient that need me, because I am a nurse.</p> <p>You just come with that attitude then everything will just fall into place. If you just treat them their physical, their emotions, their spirit (silence). If their mind is ok, their body follows. It becomes ok. So it is important for us nurses to just be there".T2, P13, L144-149,</p>	<p>Participant reveals the practice of connecting and intention setting technique, by focusing her energy on the <i>holistic needs</i> of her patients, to <i>be there</i>, and <i>connect</i> not only in the physical sense but also in the psychological, emotional and spiritual realms. Fm 68</p>
<p>69.</p> <p>"You must first check the emotion of the patient, how the patient is feeling and focus on that first.T2, P13, L151-152</p>	<p>Indicates the importance of focusing on the emotional needs of the patient. Fm 69</p>
<p>70.</p> <p>This way you can write even on your notes, this patient is stable holistically....you nurse the patient in totality. You take care of all his needs..You will not only look at the physical part and leave the emotional and spiritual part".T2, P13, L152-155</p>	<p>Explains the importance of a holistic, patient-centred approach in the nursing profession. Fm 70</p>

<p>71.</p> <p>"So it is very important for us to do. That is what I do (silence). I nurse the patient from head to toe." T2, P13, L157-158</p>	<p>Emphasise that nursing the patient "from head to toe" is an essential characteristic of healing presence. Fm 71</p>
<p>72.</p> <p>"I access the spirit, when I ask how are you doing I want to know if I can pray for you too" T2, P13, L158-159</p>	<p>Accessing the spirit of a patient may reveal the need to pray for him/her (spiritual need). Fm 72</p>
<p>73.</p> <p>"Uhhh, you can't just greet the patient and leave".T2, P13, L159</p>	<p>Shares that neglecting the holistic needs of a patient, is what caring presence is not. Fm 73</p>
<p>74.</p> <p>"Sometimes, the patient wants to open up, wants to talk, then how are you going to know if you don't ask?"</p> <p>Also to read faces.. You approach the patient and ask how are you doing? Are you ok?" T2, P13, L161-165</p>	<p>Showing genuine interest in a patient is necessary to connect with a patient therapeutically. Fm 74</p>
<p>75.</p> <p>"Then you through the file, you check the history Why is this patient here?..." T2, P13, L165-168</p>	<p>Utilising cognitive skills is a fundamental dimension of caring presence. Fm 75</p>
<p>76.</p> <p>"So you sit down at the patient, you comfort her. By doing that you started to understand the patient better. Look at the face and non-verbal communication. Feel the sadness and realise that the patient needs to understand why this is happening...." T2, P13, L168-171</p>	<p>Reveals the intimate interaction of sharing in the subjective world of the other. Fm 76</p>

<p>77.</p> <p>You advise her, not toSometimes they lack knowledge, like most patients, they do not know".T2, P13, L171-173</p>	<p>Giving advice to patients who lack knowledge. Fm 77</p>
<p>78.</p> <p>"I don't know if it is coincidence but the area that made me love nursing is Gine, and I am working here long".T2, P13, L171-175</p>	<p>Shares her passion for the Gine-ward. Fm 78</p>
<p>79.</p> <p>"Because I experienced the same problems and I was from a rural village also. I was from the very same situation and I got healed".T2, P13, L175-176</p>	<p>Self-disclosure is utilised to facilitate healing, when the participant shares her own problems with her patients Fm 79</p>
<p>80.</p> <p>"I want them also to get healed, that is why I am a nurse. I am proud to say that I give education to make them understand their situation better".T2, P13, L176-178</p>	<p>Feelings of pride and <i>personal</i> satisfaction is experienced. Fm 80</p>
<p>81.</p> <p>"Yes, I even share with them that....</p> <p>I also had two miscarriages. In the Batho-Pele principles, transparency is important, and communication. It is very important to communicate honestly with our patients". T2, P13-14, L181-183</p>	<p>Sharing reality, honesty and transparency as important principles to facilitate the practice of emotional caring presence. Fm 81</p>
<p>82.</p> <p>"Because most of all they lack information. They don't have access to information. So you must share your knowledge with them". " I advise my patients to read".T2, P14, L185-188</p>	<p>Sharing knowledge, and giving appropriate advice, assist patients who don't have access to information. Fm 82</p>

<p>83.</p> <p>"You must make time for your patients, you must connect with your patients(silence). T2, P14, L192</p>	<p>The need to spend sufficient time with patients is emphasised to facilitate a connectedness and meaningful relationship with patients. Fm 83</p>
<p>84.</p> <p>"So, my experience with patients here in the rural area, caring for them, it is tough (silence). Short staff, but if you are loving, you love your profession, then everything becomes so smooth. Because I am doing nursing from the bottom of my heart. I do understand what nursing want from me, I understand what I have to do for my profession. What I should not do".T2, P14, L193-196</p>	<p>Experiencing nursing within a rural area, as challenging, but shares that compassion for patients and passion for the nursing profession, enable her to cope. Fm 84</p>
<p>85.</p> <p>But I put my humanity, like, I put it up-front. Whenever the patient is different or not, you must understand why is this patient is so difficult. So you can get to the bottom of the problem".T2, P14, L198-200</p>	<p>The humanness of the interaction and accepting the patient as unique human beings are illuminated. Fm 85</p>
<p>86.</p> <p>"Ok, on that issue of Batho-Pele principles, agree, the principles are there. They help us (silence) to reach good quality continues nursing care. You put the patient first, people first".</p> <p>They even help us to give our best. It tells us what the patient expects from us, and what we expect from them.T2, P14, L207-212</p>	<p>Implementing the Batho-Pele principles enables the professional nurse to reach good quality, patient-centred nursing care. Fm 86</p>

<p>87.</p> <p>So, if you take this example, the one of openness and transparency...when you focus on the patient and are open to him, he will open up to you....you must give him honest treatment....you must ask relevant questions and not judge him, then he will be honest and open up. It is not that you are leading the patient”.</p> <p>Then the nurse will be able to render good quality nursing care”.T2, P14, L222-223</p>	<p>Openness, transparency and honesty are essential antecedents for the practice of good quality patient care. Fm 87</p>
<p>88.</p> <p>“Even the one of communication, neh, eee, when you communicate well, they say communication is the key, agree? To resolve an issue”.“ Like you have to communicate each and every thing you are going to do for the patient, ...can I have your hand?. T2, P15, L225-232</p>	<p>Effective communication and treating patients with kindness are the keys to resolve problems. Fm 88</p>
<p>89.</p> <p>“You respect the patient and treat them with respect. That is the principles”.T2, P15, L235</p>	<p>Respect as core ethical principle is pointed out. Fm 89</p>
<p>90.</p> <p>“So when I see a patient who is struggling, I advise them to pray, Because I believe in God and I know what He did for me”. Spirituality is important in caring presence, you must tell them to pray. Even the Lord’s prayer, that is the big prayer.“If a person belief in prayer, the miracle will happen. I always, like mostly I will pray for the patient, or pray with them, if they like”.T2, P15, L242-250</p>	<p>Praying for and with patients, are identified as core characteristics of connecting spiritually with patients. Fm 90</p>
<p>91.</p> <p>“Yes, I will do everything, give everything for them to heal.....”.T2, P15, L251</p>	

	Doing everything to, and being everything for patients to facilitate their healing, are illuminated. Fm 91
<p>92.</p> <p>I will give medication, I will attend to their needs. I will do blah, blah, blah until that patient get all the things that he needs. T2, P15, L253-255</p>	Attending to the physical needs of the patients is emphasised. Fm 92
<p>93.</p> <p>" I will also tell them, let me consult with God, then I will consult with God. I will talk to God and then wait....For me, I pray for patients. When you are sick, your mind does not work properly, you will forget to pray....and then the difference will be there." T2, P15, L255-263</p>	Being spiritual connected herself, assists the professional nurse to facilitate spiritual presence for her patients. Fm 93
<p>94.</p> <p>"Yeah, that is why I said that you must be there. Be there to comfort hurting stories, be the comforter of that patient too. But that only happens when you are approachable" T2, P15, L267-269</p>	Being approachable facilitates the process for patients to connect emotionally with nurses. Fm 94
<p>95.</p> <p>"I even take my chair and sit with them that they can talk T2, P16, L271</p> <p>96.</p> <p>"I remember in my free time I also came to give education T2, P16, L271-272</p>	<p>To sit down with patients, shows physical availability to establish meaningful relationship. Fm 95</p> <p>Willingness to take care of the educational needs of the patient. Fm 96</p>
<p>97.</p> <p>We even talk about finances. One girl gave all her money to a boyfriend and he left" T2, P16, L272-274</p>	Reveals willingness to attend to the social needs of the patient. Fm 97

<p>98.</p> <p>"I make time for my patients."T2, P16, L278</p>	<p>Spending sufficient time with patients is illuminated as antecedent to facilitate caring presence. Fm 98</p>
<p>99.</p> <p>"..and educate them. That is good care in nursing. Then the patients are happy, they feel they learned something".T2, P16, L278-279</p>	<p>Willingness to share information with the patient, enhance their wellbeing . Fm 99</p>
<p>100.</p> <p>You must be your patients, everything. T2, P16, L280</p>	<p>Commitment to be everything for patients, facilitates the level of full presence for patients Fm 10.</p>
<p>101.</p> <p>"What is the role of the nurse? To give medication? No, it is not. You cannot give medication to an emotional problem. You must give your patient an ear to listen. Emotional problem needs talking, ventilating (silence). When you listen, you may save the patient from this mental illness thing".T2, P16, L280-284</p>	<p>Questioning the role of the nurse, by confronting the reality that patients have emotional needs to attend to. Fm 101</p>

Significant statements extracted from transcript and coded from interview No.3

Significant statements	
<p>102.</p> <p>"...there was nobody to suction her in the ward and she was having a nappy....So, we have to change her nappy and position-changing every now and then and also suction her because she was feeding with the NG tube".T3, P17, 16-18</p>	<p>Sharing her willingness to attend to the physical needs of the patient, by changing nappies, do position-changing and suctioning her. Fm 102</p>
<p>103.</p> <p>"So I had to always comfort her and tell her the situation is not that bad. She will be ok. So we helped her a lot... was there for her".</p> <p>Mmm. I decided to be there for her.T3, P17, L19-26</p>	<p>Willingness and desire to connect with the patient and to be there for her patient. Fm 103</p>
<p>104.</p>	

<p>“Mmmm, it was hard for me, because if we are in the hospital and there is nobody to care for the patients, especially the patient who cannot feed themselves, who cannot go to the toilet. So I felt I must always be there for this patient and help her”. T3, P17, L29-30</p>	<p>Confronts the challenge of staff-shortages and willingness to be there to take care of the physical needs of patients. Fm 104</p>
<p>105.</p> <p>“I think as a nurse, you made a vow that you will always care for your patients. So you must always be there for them, and practice caring for them.</p> <p>It is important that you make a point that you always care for and that you are always there for your patient if they need anything from you”. T3, P18, L37-40</p>	<p>Commitment to the nursing profession as well as commitment to practice caring presence. Fm 105</p>
<p>106.</p> <p>“Caring is being there for the patient...being empathic with the patient. Sympathise with her and help her” T3, P18, L42-43</p>	<p>Empathy and sympathy is emphasised as important attributes of caring presence. Fm 106</p>
<p>107.</p> <p>You promised to put the patient first (silence) yes”.</p> <p>So it is very important to be always there and help them and be dedicated. So that they can help themselves, next time”.</p> <p>You have to care for the patient holistically”. T3, P18, L43-46</p>	<p>Dedication to take care of the patient holistically and thereby assisting the patient to function independently. Fm 107</p>
<p>108.</p> <p>Mmm. Always relieves their anxiety, comfort them, make them comfortable where ever they are in hospital”. T3, P18, L48</p>	<p>Willingness to relieves anxiety and to comfort patients. Fm 108</p>
<p>109.</p> <p>“take care of their needs in total”. T3, P18, L48</p>	<p>Attending to all the needs of the patient. Fm 109</p>
<p>110.</p> <p>“It means like understanding the situation of the patient that they are in.</p> <p>“Yes, and then put yourself in the same shoes as the patient”.</p>	<p>Explains the importance of understanding the situation of patients and being empathic, genuine and sincere. Fm 110</p>

<p>"It means just being there, feel as they feel".T3, P18, L50-55</p>	
<p>111.</p> <p>"Explain the condition to them and explain it further and help them with their treatment".T3, P18, L55-56</p>	<p>By sharing knowledge, the patient is empowered to assist in his/her healing process. Fm 111</p>
<p>112</p> <p>"So when you do counselling, the patient can be stronger and hope that they will heal".T3, P19, L67-68</p>	<p>Counselling facilitates spiritual presence and hope for healing is instilled. Fm 112</p>
<p>113.</p> <p>"The patient will be hopeless and you will explain to her that things will get better and they must believe in God".</p> <p>"Yes, that they can get better and heal and go home in a better condition".</p> <p>Yes, if you are a Christian you will explain that they must pray every day, and believe God will also help them to heal".T3, P19, L70-74</p>	<p>A spiritual connectedness is illuminated to enhance healing. Fm 113</p>
<p>114.</p> <p>Agree, most of the time it is cold in theatre. So me make patients feel nice and comfortable so that they are not cold. We use the warmer, the "bed-hugger" to warm the patients in theatre".T3, P19, L79-82</p>	<p>Ensuring physical comfort in theatre. Fm 114</p>
<p>115.</p> <p>"..and to explain the procedures to the patients so that they understand what the doctor will do. He gives you this injection, after this one you will sleep and you will not feel any pain during the procedure".</p> <p>"So we make sure we explain the procedure to them so that they can be as comfortable as possible...".</p> <p>"Yes, because some of them they become very anxious. Maybe they have this myth that it is very scary in the theatre. They will make you die and then you come back, so..we try our best to explain to them".T3, P19, L79-93</p>	<p>The process of the professional nurse's method of connecting with patient cognitively, is explained. Fm 115</p>

<p>116..</p> <p>"I think that it is to make sure that their needs is taking care of, that they are happy".T3, P19, L99</p>	<p>Willingness to ensure the best nursing care and wellbeing of the patient. Fm 116</p>
<p>117.</p> <p>"Agree, the patient has needs? He must be bathed, he must eat and then he must get medication".T3, P19, L103-104</p>	<p>Attending to the basic physical needs of the patient. Fm 117</p>
<p>118.</p> <p>" Yeah, we talked about taking care of the patient holistically...I must ensure that all the needs are taken care of. When you take care of the needs of the patient, he will feel free and happy".T3, P19, L106-108</p>	<p>Confirming a willingness to ensure that the patient is holistically cared for and the patient is satisfied with the care received. Fm 118</p>

Significant statements extracted from transcript and coded from interview No. 4.

Significant statements	
<p>119.</p> <p>"Most of specialities like ophthalmology is non-existing. This hospital did not have eye care services.</p> <p>Yes, I saw it as a need because most of the patients who are suffering from eye conditions were neglected.</p> <p>"I was starting something from nowhere T4, P21, L14-21</p>	<p>Confronting the challenges in the rural area, and shares a personal responsibility to attend to the specialised eye-needs of patients. Fm 119</p>
<p>120.</p> <p>But because I wanted this to exist, to assist the clients here in (place name removed), then I started with a small area in out-patients. To start examining patients, promoting eye health, prevent needless blindness".</p> <p>T4, P21, L26-28</p>	<p>Professional commitment and dedication to promote eye-health in a rural area. Fm 120.</p>
<p>121.</p> <p>"I done that with the assistance of an ophthalmologist and nurses (place name removed)...They were behind me. So I had to</p>	<p>Confronting the challenge of limited resources, but reveals a personal commitment to deliver a much needed service. Fm 121</p>

<p>gather instruments, everything, when you want to deliver a service to the eye patients....It was not easy". T4, P21-22, L30-35</p> <p>122.</p> <p>"I decided to do something extra for patients" T4, P22, L37</p>	<p>Reveals a personal responsibility to do something extra for patients. Fm 122</p>
<p>123.</p> <p>"So I can say I feel fulfilled, because I have started it from nowhere". T4, P22, L39</p>	<p>Shares personal feelings of fulfilment when she started a service on her own. Fm 123</p>
<p>124.</p> <p>Our hospital is a regional hospital. So our nearest hospitals, they are referring to me. I was able to make a difference.. So what make me happy is that patients who could not see a thing, can see now. They will say: "Sister, I have been hearing your voice, but now I can see you".</p> <p>"That makes nursing so worth-while!" T4, P22, L41-44</p>	<p>Confronting the reality of challenges in the remote rural area, and shares commitment and feelings of personal satisfaction, when patients who was nearly blind, can see again. Fm 124</p>
<p>125.</p> <p>"Most of them are the aged. So most of their blood-sugars are not controlled. So we find that most of them are being cancelled because:" Your blood-sugar is high, mama, your blood sugar is high". So we are not able to do it. So there are this patients who I see that have been several times cancelled. Then I had to advocate for them".</p> <p>"I beg them to give them a chance". T4, P22, L52-60</p>	<p>Safeguarding the best interest of the patients, by attending to the needs of the elder patients and advocating for them. Fm 125</p>
<p>126.</p> <p>"I am able to do post op, even if the doctors are not around, I can prevent complications". T4, P22, L66-67</p>	<p>By being physical available for the patients, post-operative complications are prevented. Fm 126</p>
<p>127.</p> <p>"I do follow ups and listen to their problems" T4, P22, L67-68</p>	<p>Physical and emotional presence is illustrated, by rendering follow-up services and resolving problems. Fm 127</p>

<p>128.</p> <p>“Yes, I am willing to walk an extra mile. To make a difference”.....</p> <p>So I recalled my practical lessons, of do this do that. So I was able to deliver the baby..”</p> <p>I was so fulfilled because I could save a life and was competent and was there for the mother and the baby”...</p> <p>So I went extra mile for those patients, I gave everything”.T4, P23-72-91</p>	<p>Willingness to walk an extra mile and a commitment to be fully present for patients are described. Fm 128</p>
<p>129</p> <p>“In nursing, advocacy role is part of being, having a close contact with our patients”.T4, P24, L97</p>	<p>Advocacy is described as part of having a personal and close connectedness with patients. Fm 129</p>
<p>130.</p> <p>“To listen to the problems of the patients, to have a listening ear. So as a nurse you should be there for your patients, listening carefully and have sympathy. And then do something”.T4, P23, L99-101</p>	<p>The importance of responsive listening is emphasised. Fm 130</p>
<p>131.</p> <p>“..I want to be there and even in the evenings it will haunt me if I did not do 1,2,3. For them. They even have my contact number, I want to take care of whatever the situation is”.T4, P24, L104-106</p> <p>132.</p> <p>Or advocate if it is beyond my scope of practice or control”.T4, P24, L106-107</p>	<p>Professional commitment and personal dedication is illustrated by the professional nurse. Fm 131</p> <p>Utilising the advocacy-role to safeguard the best interest of patients. Fm 132</p>
<p>133.</p> <p>Yes, my conscience plays a role. I must do my part, to the best of ability”.T4, P24, L110</p>	<p>Confronts the reality that her conscience motivates her to give her best as professional nurse. Fm 133</p>
<p>134.</p> <p>You know this is a call...You should have passion for caring, and patience...that is point number one to care for people who are in need.</p>	<p>Confirms her passion for the nursing profession and professional commitment and dedication to care for patients with</p>

<p>“Secondly, you must have the very conscience we are talking about to treat this person as a human being”.</p> <p>“As I would like my mother, myself, my child to be treated”.</p> <p>You must treat patients as your family. That one will make you do right every time. T4, P24, L112-118</p>	<p>compassion, as if they are her own family. Fm 134</p>
<p>135.</p> <p>“To do your best, go extra mile, not to leave any stone unattended, you will try to treat in totality”.</p> <p>You will feel happy that you have done that the patient was here for”.T4, P24, L118-120</p>	<p>Personal responsibility to render holistic care, by doing your best, go an extra mile, and not to leave any stone unattended. Fm 135</p>
<p>136.</p> <p>Yes, to see the patient with physical, spiritual and emotional needs”.</p> <p>Not only a body, but a person with more needs. Like I say to help the patient to heal”.T4, P24, L124-125</p>	<p>Confronting the reality that patients need holistic nursing care to heal. Fm 136</p>
<p>137.</p> <p>“Yes, that they can get better and happy and that makes me feel fulfilled”.T4, P24, L128</p>	<p>Reveals a willingness to assist the patient in his/her healing process and shares personal satisfaction, when this goal is achieved. Fm 137</p>
<p>138.</p> <p>Eee, healing means that not only the body is better, but that the person is healthy in totality. Body, mind and eee, emotionally they are better”.T4, P24, L130-131</p>	<p>Explains that healing for her, means being healthy in totality. Fm 138</p>

Significant statements extracted from transcripts and coded from interview No.5

Significant statements	
<p>139.</p> <p>Also you must advocate for the patients. Because we are here to advocate for them”.T5, P27, L42-43</p>	<p>Regards advocating for patients as important. Fm 139</p>

<p>140.</p> <p>“Then you must show love, show patience to them. Not just treat them as an object, you see?”.T5, P27, L43-44</p>	<p>Showing love and having patience with patients, and treating them as human beings and not objects is highlighted. Fm 140</p>
<p>141</p> <p>You see when the patient cannot express himself, maybe he must go for the operation, and has to sign a consent form. Or maybe, he has to get blood, and he does not understand”.T5, P27, L48-50</p>	<p>Explains the importance of safeguarding the best interests of the patient and empowering the patient with knowledge. Fm 141</p>
<p>142.</p> <p>Let’s talk about when the patient must go for an operation.“Some patients don’t understand so you must advocate and explain so that the patient feels free and understand what is happening. What is going to be done to him.”.T5, P27, L52-55</p>	<p>By sharing knowledge, the patient is empowered to understand his treatment better. Fm 142</p>
<p>143.</p> <p>So as a sister it is necessary to explain that the patient get the correct procedure....that there is not complications.T5, P27-58</p>	<p>Necessity of empowering the patient with knowledge is emphasised. Fm 143</p>
<p>144.</p> <p>You do explain...everything will be fine for you”.T5, P27, L63-65</p>	<p>Explaining to the patient his treatment is part of caring presence, and may reduce anxiety. Fm 144</p>
<p>145.</p> <p>“By showing love to your patients you must always be friendly, you must smile at the patient. Don’t be always in a hurry. Show that you care that you are here for him”.T5, P27, L68-69</p>	<p>Showing love, kindness and humanity to patients, indicates that the professional nurse is there for them. Fm 145</p>
<p>146.</p> <p>“Agree, some patients are coming from far, they don’t have family who come to visit them.T5, P28, L72-77</p>	<p>Because of the remoteness of rural areas, patients don’t get visitors often. Fm 147</p>
<p>147.</p> <p>“I tell them I am here for you, don’t worry if your family cannot come visit you”. You must not feel lonely and lost’.</p>	<p>The intimacy of the relationship is reflected by being personally available for the patient. Fm 147</p>

<p>"Yes, I am here for you, I am here."</p> <p>You must talk to them. You must not work with patient as if he is object. He is not an object".T5, P28, L72-77</p>	
<p>148.</p> <p>"You know sometimes, you must touch them (she bent and touch my arm).T5, P28, L75</p>	<p>The power of therapeutic touch is illustrated. Fm 148</p>
<p>149.</p> <p>"Then you must sit with them, you must show that he is not an object".T5, P28, L82</p>	<p>Communication on the patients' level, and valuing the patient as a human being, is important. Fm 149</p>
<p>150.</p> <p>"Not just passing, hey, take this tablets".T5, P28, L83-84</p>	<p>Necessity of spending sufficient time with patients, and being kind to them, is highlighted. Fm 150</p>
<p>151.</p> <p>"No, no. You must say, here is the tablet, can you drink this one, then you give water. Then you look that he takes the tablets and you ask, are you fine? Wa bon?".T5, P28, L83-85</p>	<p>Valuing the patient as a person and establishing a meaningful relationship with the patient. Fm 151</p>
<p>152.</p> <p>"You must not call the patient by his diagnosis. You must say, Mr So and so and Mrs So and so. Whoever the name, but not by the diagnosis.".</p> <p>T5, P28, L87-88</p>	<p>Importance of treating a patient as a human being, not a case, is recognised. Fm 152</p>
<p>153.</p> <p>"If you call them the laparotomy-patient they don't feel all-right. It is not fair to the patient".T5, P28, L91-92</p>	<p>Un-ethical approach and unfairness of de-personalising of patients is highlighted. Fm 153</p>
<p>154.</p> <p>"You show respect and love that you have time for them".T5, P28, L95</p>	<p>Showing love and respect for patients is emphasised. Fm 154</p>

<p>155.</p> <p>“You don't throw the tablets next to the patient (slap her hand on the table). You explain what, what, this is an antibiotic and it helps for what, what...”</p> <p>“Then please explain”. T5, P28, L96-98</p>	<p>Importance of informing and educating patients is illustrated. Fm 155</p>
<p>156.</p> <p>“Then you have to advocate for the patient and explain to the doctor that the patient said this tablet don't help. Please can you do something else for him? So advocacy is very important”. T5, P28, L98-101</p>	<p>Value of being an intercessor between the doctor and patient is described. Fm 156</p>
<p>157.</p> <p>“You know that sometimes we are in a hurry. We must pause and care for the patients. We must spend sufficient time with them. T5, P29, 111-112</p>	<p>Reflects on the value of pausing and focusing on the needs of patients. Fm 157</p>
<p>158.</p> <p>Yes, just stop at the patient, and show your love”</p> <p>T5, P29, L114</p>	<p>Checking in frequently, with patients, facilitates caring presence. Fm 158</p>
<p>159.</p> <p>“They usually appreciate that I explain and I must encourage them..” T5, P29, L123-124</p>	<p>The role of motivating and encouraging colleagues, is fundamental in strengthening relationships. Fm 159</p>

Significant statements extracted from interview No.6

Significant statements	
<p>160.</p> <p>“Each and every day I would come to the ward, was and feed the patients. Then I notice that this one patient go to this specific spot and he will pat on his head. I went to the sister and ask why is this patient doing this?”</p> <p>“Just be with him”. So I went there. I took time with him”. He just not want to be alone. So I went there, I took time with him. Just be with him...” T6, P30, L18-25</p>	<p>Attending to the basic needs of patients, as well as recognising the need for personal attention is fundamental in the practise of caring presence. Fm 160</p>

<p>161.</p> <p>"At that time I felt that I have done something and I become so attached to him." T6, P30, L31-32</p>	<p>Feeling appreciated for making a difference. Fm 161</p>
<p>162.</p> <p>"... and I become so attached to him." T6, P30, L32</p>	<p>The intimacy of the experience is described. Fm 162</p>
<p>163.</p> <p>"I realised that I must spend time with patients to mean something to them." T6, P30-31, L32-33</p>	<p>Realising that spending sufficient time is important factor to facilitate a meaningful relationship. Fm 163</p>
<p>164.</p> <p>"I felt that I contributed to his well-being. When I was near him, he would smile, and that made me feel so good". T6, P31, P31, L33-34</p>	<p>Feelings of personal satisfactions and fulfilment is experienced. Fm 164</p>
<p>165.</p> <p>For me that experience taught me that sometimes we look at the patients and we think that one is not nice, but I learned that I should engage with the patient to understand him better". T6, P31, P37-39</p>	<p>Realising that being non-judgmental towards patients and valuing the uniqueness of each person, are important in creating meaningful relationships. Fm 165</p>
<p>166.</p> <p>"For me it is to spent time and try to understand the patient". T6, P31, L41</p>	<p>Indicates that spending sufficient time with patients is a fundamental element in gaining an understanding of their unique situation. Fm 167</p>
<p>167.</p> <p>"...and the doctor was discussing with other nurses this patient and they thought that she did not understand.."</p> <p>T6, P31, L46-47</p>	<p>Feelings of frustration is experienced when colleagues discuss patients in an unkind manner. Fm 167</p>
<p>168.</p> <p>"I was so hurt for her".</p> <p>"I felt the pain in here (touch her heart).</p>	<p>The intimacy and humanness of the experience and the deep level of</p>

<p>"I went to this patient and I ask her how are you feeling?" "I was so emotional, and I wanted to make everything better for her..".T6, P31, L50-57</p>	<p>connectedness with the patient is described. Fm 168</p>
<p>169.</p> <p>"I was so happy that she was content and she said that "I made it better for her, because I was at her side".T6, P31, L57-58</p>	<p>Sense of professional pride and feelings of self-worth, are gained from the experience. Fm169</p>
<p>170.</p> <p>"She started crying and asked: "Did they remove my uterus?". I said no, the doctor removed the tube because the baby was in the tube and not in the uterus.because the baby was getting too large and the tube burst. Because she would not understand me if I said raptured".T6, P32, L73-77</p> <p>171.</p> <p>"Yes, she thanked me so much because she did not know what to tell her husband that her uterus in no longer there".T6, P32, L80-81</p>	<p>Indicating the importance of support, genuine concern and therapeutic communication with patients. Fm 170</p> <p>Feeling professionally appreciated. Fm 171</p>
<p>172.</p> <p>"I asked her, when you signed the consent did you not know what the doctor explained to you?...."T6, P32, L81-82</p>	<p>Safeguarding the best interest of patients. Fm 172</p>
<p>173.</p> <p>"I even made a sketch to explain, to let understand that her uterus is still fine.....".T6, P32, L85-87</p>	<p>Dedication to share knowledge and support the patient. Fm 173</p>
<p>174.</p> <p>"When she was discharged, she came to the theatre to thank me...."</p> <p>...I was so happy for her, that I could help her understand her situation better. That I assisted her. She told me sister, ...you have enlightened me".T6, P32, L87-91</p>	<p>Assisting a patient on cognitive level is valued and appreciated. Fm 174</p>
<p>175.</p> <p>"From then on I make sure that I educate the patients so that they can understand their condition".T6, P32, L91</p>	<p>Assuring cognitive understanding of their unique situation. Fm 175</p>

<p>176.</p> <p>"Yes, I calmed them and showed them that they understand better they can help themselves".T6, P32, L96-97</p>	<p>Empowering patients by sharing knowledge with them. facilitates independent functioning. Fm 176</p>
<p>177.</p> <p>"So I think that in that way it is my way of showing my caring and showing (silence)". Sometimes I will ask , and most cases I will just listen (silence) just listen (silence) T6, P32, L97-98</p>	<p>Importance of effective communication and responsive listening are highlighted. Fm 177</p>
<p>178.</p> <p>".and then educate them, guide them. I will encourage them to ask and then I will start to explain".T6, P32, L98-99</p>	<p>Guidance and encouragement of patients are emphasised. Fm 178</p>
<p>179.</p> <p>"I don't know how to explain it further, but if you see this patient has a problem, other than the illness. Because sometimes they are ill,..".T6, P32-33, L106-107</p>	<p>Identifying holistic needs of the patient. Fm 179</p>
<p>180.</p> <p>".but they also have social or what, what problems..T6, P33, L109</p>	<p>Social needs are identified. Fm 180</p>
<p>181.</p> <p>For example, the patient will say, sister I am in pain, you go there and explain the routine of pain management...".T6, P33, L113-114</p>	<p>Connecting cognitively assist patient with pain management. Fm 181</p>
<p>182.</p> <p>"You listen and you try to make him understand. But in the meantime you listened to him, and explain. The patient feels that you care, she did not ignore me and swear at me".T6, P33, L116-118</p>	<p>Responsive listening and "tuning in" with the patient are highlighted as a core element of caring presence.</p> <p>Fm 182</p>
<p>183.</p> <p>"He see that you are busy, but you were there by his side to spend time".T6, P33, L118</p>	<p>Being available at the side of the patient, is recognised as a caring attitude. Fm 183</p>

<p>184.</p> <p>“At least he will sister, and then you come and with patience explain. Then you reassured her that you know of her pain”.T6, P33, L123-124</p>	<p>Importance of reassurance is highlighted. Fm 184</p>
<p>185.</p> <p>“If I want to reassure her, I will just go with her through everything...”.T6, P33, L133-135</p>	<p>Indicates that reassuring the maternity-patient, involves sharing knowledge and guiding her through the phases of the delivery process. Fm 185</p>
<p>186.</p> <p>“That is how I reassure her and I will rub her back, I will just be there, if the ward is not that busy”.T6, P33, L139-140</p>	<p>Reveals being physically there for her patient and performing a simple action, such as rubbing her back to sooth the pain. Fm 186</p>
<p>187.</p> <p>“Yes, I will say I will help you and even if the doctor comes I am still here.”.T6, P33, L142</p>	<p>Reassuring the patient that she will remain at her side, even when the doctor arrives. Fm 187</p>
<p>188.</p> <p>“In the ward, with 30-40 patients, I have to give medication, I have to do vitals, I have to assist the patients. In the mean-time I needed with resuscitation. How are we able to cope? We are very much under pressure. We cannot focus, and we cannot care enough. Then the patients feel that we don't care. At least if we have adequate staff, the workload is less and we can give more quality care”.T6, P34, L151-156</p>	<p>Feelings of frustration arose from the lack of resources within the health environment, such as staff shortages and difficult circumstances within a rural public hospital. This results in a decrease of the quality of nursing care, rendered to patients. Fm 188</p>

Significant statements extracted from interview No.7

Significant statements	
<p>189.</p> <p>“Because we could not leave the patient like that, we stayed with him, we started with oxygen, we inserted the short-drip, we started with TNT, because the pain was radiating from the chest, to the back, to his left side”.</p> <p>Yes, I was at his side”.T7, P36, L32-34</p>	<p>Being physically with the patient, combined with safe, effective and prompt nursing interventions are described. Fm 189</p>

<p>190.</p> <p>Yes, because we got the telephonic order while the doctor is still not there, we will not leave the patient like that. No. We must take care of him, we started giving oxygen, we started giving TNT, we started giving Aspirin”.</p> <p>The patient was still sweating and after the medication was given, we were still monitoring and the patient recovered. Then the patient was stabilised”.T7, P36, L37-55</p>	<p>Professional competence and effective teamwork are indicated. Fm 190</p>
<p>191.</p> <p>“Yes, the wife of the patient was so happy, they are staying around here in (place name removed for confidentiality reasons).Then he said to us, you know what? I feel like you were doing more than a doctor. The doctor was not even there. He said you take care of me. So, after two hours the patient was standing and was saying you helped me so much”.</p> <p>T7, P36, L57-61</p>	<p>Gratitude towards the professional nurse is indicated. Fm 191</p>
<p>192.</p> <p>“So we saved the patient even though we did not have eee. (silence). The team as a whole, because the doctor was a bit far. We were given the information, we communicated.The patient is still alive today, because of (silence).T7, P37, L70-74</p>	<p>Reveals professional commitment of the nursing team. Fm 192</p>
<p>193.</p> <p>“And they appreciated the way. They even come to us, they even went to the CEO, and they said you know what? We thank your nurses. If they were not there, we did not know what was going to happen (silence). That was one of the experiences I have, which was very brilliant”.T7, P37, L74-77</p>	<p>Professional nurse experiences feelings of professional satisfaction and fulfilment. Fm 193</p>
<p>194.</p> <p>Yes, yes, that is my way to show my caring presence. I did not wait for the doctor, I acted and used the protocol that are available” T7, P37, L80-81</p> <p>195.</p> <p>“My way is staying at the side of the patient and acting, acting, acting”.T7, P37, L86196.</p>	<p>Safe and effective nursing interventions are factors that facilitate caring presence. Fm 194</p> <p>Attending to the physical needs of the patient, by means of safe effective nursing interventions. Fm 195</p>

<p>I said doctor, even if you put this patient on oxygen, there is nothing, the saturation is not improving".T7, P37, L98-99</p>	<p>The importance of moral sensitivity as well as advocating for the patient. Fm 196</p>
<p>197.</p> <p>"He was bad. I wanted so much to help him. I did not leave him (silence).T7, P38, L106-107</p>	<p>Professional dedication to attend to the needs of the patient. Fm 197</p>
<p>198.</p> <p>"Yes!. I acted and advocated for him, he was helpless and was not improving. He was still sweating and bleeding.I said to the doctor, then we must put in a IC drain. The doctor did not know" ..T7, P38, L118-121</p>	<p>Urging the doctor to assist the patient. Fm 198</p>
<p>199.</p> <p>"We have been putting it in. We inserted it by ourselves. The doctors on call are very busy. We cannot wait. We must act".T7, P38, L127-128</p>	<p>Professional competence to implement nursing interventions and perform life-saving procedures. Fm 199</p>
<p>200.</p> <p>"Yes, I know it is not our scope. But I said doctor, we need to insert an IC drain for my patient.</p> <p>Yes, I wanted him to act.....</p> <p>..the doctor was not comfortable (silence). He told me I am not comfortable in this procedure.</p> <p>Then I said, ok, the landmarks are very important doctor.</p> <p>Once you have localised it, and you see your margin between eee. The anterior nipple, mid-axilla, just go there (silence). Then he was able to go through with the procedure".T7, P39, L139-147</p> <p>201.</p> <p>"..the patient was able to be helped.</p> <p>The patient was saved. Immediately, I was so relieved.</p> <p>Yes, immediately when the drain was inserted, the patient was able to breath well and the saturation started to get ok, improved (silence).</p>	<p>Urging and guiding the medical practitioner to perform a life-saving procedure. Fm 200</p> <p>Experiencing personal satisfaction, when a life was saved. Fm 201</p>

<p>Yes, the doctor said, wow! I need to practice more. Thank you very much.</p> <p>So that was experiences that I will never forget". T7, P39, L147-159</p> <p>202.</p> <p>"Trying to call the doctor and say, doctor this patient is deteriorating.</p> <p>The doctor will say, No! This last stage patient. I still advocate (silence)". T7, P39, L167-169</p> <p>203.</p> <p>"But those patients, because of the nursing care we do, the position changing, the cleaning, the monitoring, the total care that we provide (silence). T7, P39, L173-174</p> <p>204.</p> <p>"Those patients showed us really, if you manage your patient correctly, in totality..take care of all his needs. Physical, emotional, spiritual. Psychological and what what. They will improve. They must get a chance. I tell the doctor that. T7, P39, L176-180</p> <p>205.</p> <p>" I begged the doctor to give them also a chance". T7, P39, L186-187</p> <p>206.</p> <p>"Yes, because we did not sit down in the nurses-bay, and say no, we have done our routine (silence). We can relax now. No, every minute, if we know we have a patient who is critically ill, we always went to him". T7, P39, L190-192</p>	<p>Persistence to advocate for the best interest of the patient. Fm 202</p> <p>Patient-centred, holistic nursing approach is the core of the healing process. Fm 203</p> <p>Safeguarding the best interest of the patient and fighting for his human rights. Fm 205</p> <p>Delivering effective and continuous nursing interventions. Fm 206</p>
<p>207.</p> <p>"..and every 15-20 minutes I must be at his side. I did not leave his side. I monitored him, stay near him". T7, P39, L192-194</p>	<p>Patient-centred and continuous care are rendered. Fm 207.</p>
<p>208.</p>	

<p>Yes. Those patients, they made a very huge improvement. I did not give up on them". T7, P40, L196-197</p>	<p>Healing is enhanced, because of personal attention and continuously attending to the needs of the patient. Fm 208</p>
<p>209.</p> <p>"Yes, then I tell the doctor, let us just give this patient chance. Just give this patient a chance". T7, P40, L203-204</p>	<p>Fighting for the patients' right to live. Fm 209</p>
<p>210.</p> <p>"The patient is confused, he is restless. I am gonna shift this patient. I am going to use insulin and glucose and all that (silence), according to the protocol. I must try to make an improvement". T7, P40, L210-212</p> <p>211.</p> <p>"Yes, I am passionate. Without passion, we cannot care for our patients. T7, P40, L223</p>	<p>Personal commitment and dedication to enhance healing. Fm 210</p> <p>Passion is the core characteristic that enables nurses to practise caring presence. Fm 211</p>
<p>212.</p> <p>"I was actually giving my all for this patient". That is caring presence for me. Saying, you know what? Our aim is to save lives, to advocate for our patients (silence). To give everything". T7, P41, L226-228</p>	<p>Willingness to give the gift of himself to facilitate caring presence. Fm 212</p>
<p>213.</p> <p>"But I am for this. I tend to say, never(silence). I know we must look for resources first. T7, P41, L245-247</p> <p>214.</p> <p>"She, this lady is 32 years old, she has two children. They are depending on her. The social economic status, it was a bit poor..... T7, P42, L249-250</p> <p>215.</p> <p>"These children were only depending on the grants and on her (silence). She stayed around for plus minus a month. We did not give up on her". T7, P42, L252-253</p>	<p>Indicates professional commitment and feelings of frustration because of the lack of resources. Fm 213</p> <p>Identifies the social need of the patient that needs attention. Fm 214</p> <p>A young patient with dependent children, is a motivational aspect towards recovery. Fm 215</p>
<p>216.</p>	

<p>“But if I know I am fighting for my patients, their right to life, to get a chance (silence). T7, P42, L261</p> <p>217.</p> <p>I feel motivated again”.T7, P42, L261</p>	<p>Acknowledging the ethical obligation to fight for the patients' rights. Fm 216</p> <p>Feeling motivated to continue with nursing career. Fm 217</p>
<p>218.</p> <p>“As a team leader, I always say to the assistant nurses, the staff-nurses, guys, we don't have to fake things, we have to, just have to be there, for our patients. That is your responsibility”.T7, P42, L264-266</p>	<p>Effective teamwork and integrity are highlighted. Fm 218</p>
<p>219.</p> <p>It means you must treat them with dignity, respect their rights T7, P42, L268</p> <p>220.</p> <p>“Do everything for them. That is why we must do vital signs. It is called vital signs because it is vital, if you can improve that, his lifespan will be increased”.T7, P42, L268-270</p> <p>221.</p> <p>We motivate our juniors to be honest”.“Yes, Honest in everything. In their vital signs, because they sometimes they don't check, they just write”.T7, P42, L272-275</p>	<p>Treating patients with dignity and respect is important ethical principles. Fm 219</p> <p>Attending to the physical needs of the patient. Fm 220</p> <p>Motivating and encouraging juniors to be honest and to display professional integrity. Fm 221</p>
<p>222.</p> <p>“Yes, at least these are the things that sometimes killed patients. We found that there is high mortality because nurses don't recognise the importance of small things (silence).T7, P42, L277-279</p>	<p>Neglecting to attend to the small things, like checking vital signs, can result in the death of a patient. Fm 222</p>
<p>223.</p> <p>“We found that these nurses who do mouth care, who do position changing, who do small things, they are more motivated. They change nappies, change soiled linen, put in draw sheets. Their morality is not lowT7, P42, L277-279</p> <p>224.</p> <p>“You find they are over-stressed, when they are so short-staffed. Remember they are working with two</p>	<p>Attending to the basic needs of the patient. Fm 223</p>

<p>staff or three staff. But they are still motivated” ...but they are still motivated” T7, P42, L281-283</p>	<p>Confronting the reality of over-stressed and over-worked, nursing personnel. Fm 224</p>
<p>225.</p> <p>“But the lack of appreciation by our managers, the public, even the community, the morality is low. These are the dynamics of nursing today. We need to be appreciated more. That is why our profession is going down”.T7, P43, L289-292</p>	<p>Lack of appreciation by management, the public and community, result in a decrease of personnel morality and professionalism. Fm 225</p>
<p>226.</p> <p>“But the moment we, as professional nurses motivate the staff, the absenteeism went down. Because even our juniors can say, now we enjoy nursing. We must motivate the staff to care and to be motivated”.T7, P43, L289-291</p>	<p>Motivating and encouraging the nursing personnel, results in a decrease in absenteeism and enhance professional satisfaction. Fm 226</p>
<p>227.</p> <p>“It is actually most important. Creating rapport with the patient. T7, P43, L297</p>	<p>Creating rapport with the patient facilitate the opportunity to connect with patient. Fm 227</p>
<p>228.</p> <p>“Remembering the nurses’ vow”.T7, P43, L297-298</p>	<p>Acknowledge the commitment and dedication to the nursing profession. Fm 228</p>
<p>229.</p> <p>“Then people will tend to say, no, he can go to the psychologist”.T7, P43, L304</p>	<p>Reveals the uncaring attitude of people within the health environment. Fm 229</p>
<p>230.</p> <p>“But after I did the routine for the patient. I took time and looked at this patient...the main aim is to sit with this patient, try to gain his trust”.T7, P43, L304-318</p>	<p>Identifies that spending time with patients, establish meaningful and trusting relationships. Fm 230</p>
<p>231.</p> <p>“The patient did not have any medication to stabilise him. To relax him, or anything. Then I said, doctor, how about you give this patient Amitrepilene? How about you give something to sleep to him? He will not sleep tonight..”.T7, P43, L320-321</p>	<p>Willingness to advocate for the patient to enhance healing. Fm 231.</p>

<p>232.</p> <p>Yes, then I approached the patient personally. Immediately when I sit down and share my own experience from where I come from, the patient opened up".T7, P43, L320-321</p>	<p>Genuine interest and openness between the professional nurse and the patient, facilitated the establishment of a meaningful relationship. Fm 232</p>
<p>233.</p> <p>"So, the interpersonal skills, they eye-contact, the touch (reaching out to touch my arm). That is very important. The therapeutic touch,"T7, P44, L323-324</p>	<p>Therapeutic connection and the humanness of the interaction. Fm 233</p>
<p>234.</p> <p>"...the patient ends up to say this and this is my problems (silence) can you help me? He said his aunt accused him of taking money, and that is why he tried to kill himself. Then the patient started to open up and shared his feelings".T7, P44, L324-327</p>	<p>Being present for the patient, created an opportunity for the patient to open up and share his feelings. Fm 234</p>
<p>235.</p> <p>"Yes, it starts with us, the nurses. So it is very important. The eye-contact is very important. Even at end stage patient who cannot talk."The eye contact say that we care. We are here.." T7, P44, L332-334</p>	<p>Making eye-contact, is a core characteristic of the practice of caring presence. Fm 235</p>
<p>236.</p> <p>We are responsible for the well-being of the patient. The total condition of the patient, not only physical".T7, P44, L334-335</p>	<p>Personal responsibility towards the holistic wellbeing of the patient. Fm 236</p>
<p>237.</p> <p>"That is when we reach out to the patient in a therapeutic way. Connecting with him (silence)".T7, P44, L337</p>	<p>The humanness of the connection and interaction between the nurse and patient is highlighted. Fm 237</p>
<p>238.</p> <p>"Yes, to connect emotionally. T7, P44, L340</p>	<p>The connection in the emotional dimension is emphasised. Fm 238</p>
<p>239.</p> <p>Make eye contact again ,".T7, P44, L340</p>	<p>Focusing on the patient, by making eye-contact. Fm 239</p>

<p>240.</p> <p>“..and focus on the needs of this patient and using the skills to resolve his problems” T7, P44, L340-341</p>	<p>Making use of therapeutic skills to connect with the patient and develop a meaningful relationship. Fm 240</p>
<p>241.</p> <p>“Maintaining the relationship and make sure he understands his treatment”. T7, P44, L341-342</p>	<p>Maintaining a meaningful relationship and showing a desire to assist the patient to gain a better understanding of his/her treatment. Fm 241</p>
<p>242.</p> <p>To not treat only the condition of the patient, but to care holistically” T7, P44, L342-343</p>	<p>Valuing the humanness of the interaction. Fm 242.</p>
<p>243.</p> <p>“It is most important that we as professional nurses check if the job that we delegated to the other categories, like the care-givers, we must check if they did the job correct. It is thoroughly done”. T7, P44, L349-351</p>	<p>Acknowledging the professional responsibility of professional nurses. Fm 243</p>
<p>245.</p> <p>“..and we must manage it immediately. And to refer these issues to the doctor maybe if it needs referral” T7, P44, L357-358</p> <p>246.</p> <p>“That is very important, but more important is to focus on not only on the condition of the patient, but focus on the wellbeing of the patient holistically. To focus physical, psychological, social, even cultural needs of the patient” T7, P44, L358-361</p>	<p>Importance of professional referral in the nursing profession. Fm 245</p> <p>The holistic wellbeing of the patient is illuminated. Fm 246</p>
<p>247.</p> <p>We must educate them that it is the traditional medicine that caused that condition of renal failure....the lack of knowledge leads to this actions”. T7, P45, L363-368</p>	<p>Acknowledging the fact that the lack of knowledge, leads to medical conditions that could be prevented. Fm 247</p>
<p>248.</p> <p>“It must be part of our care to give education on traditional beliefs”. T7, P45, L370-373</p>	<p>Sharing knowledge regarding traditional beliefs is regarded as part high quality nursing care. Fm 248</p>

<p>249.</p> <p>"We can also refer them to the dietician. So it is collaborative teamwork that we are aiming for. So as professional nurses, we need to advocate for our patients....".T7, P45, L376-377</p>	<p>Effective teamwork and collaboration is important. Fm 249</p>
<p>250.</p> <p>In rural areas, we have many social-economic problems. We must guide and assist the patients accordingly. It is very important, yes, it is very important".T7, P45, L380-381</p>	<p>The multitude of social-economic problems in rural areas is acknowledged. Fm 250</p>
<p>251.</p> <p>"So holistically, it is very important to care for the patient".T7, P45, L381-382</p>	<p>Holistic, patient-centred care is the fundamental driving force to the practice caring presence. Fm 251</p>
<p>252.</p> <p>I love my job very much". Yes, I am passionate about nursing".T7, P45, L389-392</p>	<p>Experiencing commitment and passion for the nursing profession. Fm 252</p>

Significant statements extracted from interview No.8

Significant statements	
<p>253.</p> <p>"I think this patient was not fully aware, the reason she was to be done a Ceasar. The doctors came to give the reasons, but the patient still refused to be done. Then I spoke to uhh, to the, patient. But even for me it was hard". T8, P47, L31-39</p>	<p>Acknowledging the challenge to safeguard the best interest of the patient and to ensure that the patient is adequately informed regarding the medical condition.. Fm 253</p>
<p>254.</p> <p>"We even call the Matron, even the clinical manager. They went to say this patient are to be returned to (name of the place removed), of which I clearly refused..."T8, P48, L39-42</p>	<p>Indicating the inner desire to protect the interests of the patient. Fm 254</p>
<p>255.</p> <p>"Then I stayed with the patient".T8, P47, L45</p>	<p>A willingness to be physically there for the patient. Fm 255</p>

<p>256.</p> <p>"I came closer to this patient, because I refused to leave her side...I knew what was going to happen if I leave her".T8, P47, L51-52</p>	<p>The intimacy of the interaction and unique bond are described. Fm 256</p>
<p>257.</p> <p>"Her family was back on the farm, so I asked the social worker to try and contact whoever.....so really the background was not good".</p> <p>Fortunately, the social worker managed to get the telephone number of the boyfriend, but he refuses to come to the hospital".T8, P47, L57-59</p>	<p>Social needs of the patient are identified. Fm 257</p>
<p>258.</p> <p>"Then I spoke to him, and begged him to come, because he must convince her to take the C-section. I advocated for the mother and the unborn baby".T8, P47, L64-66</p>	<p>Advocacy- role of the professional nurse. Fm 258</p>
<p>259.</p> <p>I spend time with her and it seems that she did not want to be pregnant, because of the background. She grow up in a difficult situation".T8, P47, L68-69</p>	<p>The need to spend sufficient time with the patient in order to establish a meaningful relationship. Fm 259</p>
<p>260.</p> <p>"Yes, I had this relationship with this patient, until the boyfriend came and we sit down and communicated". T8, P48, L75-76</p>	<p>Therapeutic communication is a core element of a meaningful relationship. Fm 260</p>
<p>261.</p> <p>"Ja, but eventually this patients' boyfriend went back home. It was that I went an extra mile, uhh, (silence). I brought some baby stuff to her and keep on trying to convince her to take C-section. T8, P48, L80-82</p>	<p>Commitment to go an extra mile for the patient, and persistence to act in her best interest. Fm 261.</p>
<p>262.</p> <p>"I told her I was there for her, no matter what, but that I wished that she will take the operation. Then late that afternoon, she said, sister, do this C-section for the sake of you, I will do it for the sake of you". T8, P48, L82-84</p>	<p>Confirming a willingness to be available for the patient and reveals genuine interest and a unique bond with the patient. Fm 262</p>

<p>263.</p> <p>“Ja, when I was on duty, I visited her, I keep on asking her to change her mind, until she agreed, I was so relieved”. T8, P48, L90-91</p>	<p>Being personally and professionally available and displaying a genuine and sincere interest in the patient. Fm 263</p>
<p>264.</p> <p>Uhh, even when I was at home, I was caring a lot. I wondered how can I convince her to be done C-section. That is why as a professional, I wanted to convince her T8, P48, L94-95</p>	<p>Being connected with the patient, even when she was off-duty, displays the close contact and unique bond between the nurse and patient. Fm 264</p>
<p>265.</p> <p>“I went an extra mile because I cared a lot”.</p>	<p>Reveals a personal responsibility and sincere interest in the patient. Fm 265</p>
<p>266.</p> <p>As if she was my relative, I could not turn a blind eye”. T8, P48, L96</p>	<p>Sharing commitment to care for the patient with dedication as if the patient is a family member. Fm 266</p>
<p>267.</p> <p>“It is not according to how you do things. Uhh, it is more your attitude, to persist and give everything, for the sake of the patient”.T8, P48, L99-100</p>	<p>Illustrates the importance of a caring attitude, persisting and to give everything, for the sake of the patient. Fm 267</p>
<p>268.</p> <p>“I want to educate the community to give more support during labour”. T8, P48, L105</p>	<p>Willingness to give health education to community members. Fm 268</p>
<p>269.</p> <p>“We must act on behalf of the patient”. T8, P49, L109-110</p>	<p>Willingness to safeguard the best interest of patients. Fm 269</p>
<p>270.</p> <p>“We must go in the community, especially the advanced midwives, then maybe this woman would understand that she had to get the sterilisation after three Caesars. Then all this drama was not happening. When we act, we give education and information and we make complications less. Then we act and advocate for the sake of their wellbeing”. T8, P49, L112-115</p>	<p>Importance and necessity of health education within the community, by specialised nurses. Fm 270</p>
<p>271.</p>	

<p>“Yes, I would say emotional support is very important in caring presence. Because, the emotional being of the patient is important”.</p> <p>T8, P49, L118-119</p>	<p>Attending to the emotional needs of patients is a fundamental element in caring presence. Fm 271</p>
<p>272.</p> <p>I try to become part of their family, or like a family member who cares genuinely”“I will go that far to come close to my patient”. T8, P49, L121-123</p>	<p>Commitment and dedication to render compassionate care, illustrates the genuine closeness of the relationship. Fm 272</p>
<p>273.</p> <p>“I will say just put yourself in the shoes of your patient” T8, P49, L126</p>	<p>Willingness to understand the patient as a unique human being. Fm 273</p>

<p>274.</p> <p>When you treat a patient, just think at the way you want to be treated”. T8, P49, L126-127</p>	<p>Valuing the patient as a unique human being. Fm 274</p>
<p>275.</p> <p>“You must think, this is my mom, this is my aunt. Just treat them that way, then you show that you care”. T8, P49, L129-131</p>	<p>Considers the commitment to take care of patients as if they are your own family. Fm 275</p>
<p>276.</p> <p>“You must give everything when you are really there for your patients”. T8, P49, L131-132</p>	<p>Willingness to give the gift of yourself, when practising caring presence. Fm 276</p>
<p>277.</p> <p>“Ja, just give the whole of yourself, emotionally, physically, everything” T8, P49, L134</p>	<p>Confirms the total commitment towards the holistic nursing approach. Fm 277</p>

Significant statements extracted from interview No.9

<p>Significant statements</p>	
<p>278.</p> <p>“Ons het ‘n pasient gehad sy was 10, nee, 16 jaar oud, sy was swanger en haar living conditions was nie so lekker nie...” T9, P50 L15-16</p>	<p>Confronting the social problems that needs attention. Fm 278</p>

<p>279.</p> <p>“..ons het ‘n ekstra mile gegaan.” T9, P50, L17</p>	<p>Confirms the willingness to go an extra mile. Fm 279</p>
<p>280.</p> <p>“Ek het tyd met haar deurgebring en by haar gesit en ook saam met haar gehuil”. T9, P50, L19-20</p>	<p>Spending sufficient time with the patient allowed the development of a close relationship with the patient. Fm 280</p>
<p>281.</p> <p>“Ons het gereel dat die social werker haar na “n place van safety te stuur”. T9, P50, L20-21</p>	<p>Ethical responsibility is recognised. Fm 281</p>

<p>282.</p> <p>“Ja, sy is ook geabuse deur haar antie, wat haar SASSA -kaart gevat het en die kinders se geld gevat het”. T9, P50, L28-29</p>	<p>Identifyng the social problems that needs attention. Fm 282</p>
<p>283.</p> <p>“Sy het niks gehad nie en sy was nie skoon nie, sy was onnet”.</p> <p>“Ek het vir haar seep gegee en ook vir die baba goedjies...”. T9, P50, L29-31</p>	<p>Attending to the physical needs of the patient. Fm 283</p>
<p>284.</p> <p>“Ek het gevoel ek het ‘n verskil gemaak” T9, P51, L32-33</p>	<p>Feeling satisfied because she made a difference in the life of the patient. Fm 284</p>
<p>285.</p> <p>“Ja ek het compassion gehad vir haar, saam met haar gevoel (stilte)”. T9, P51, L35</p>	<p>Sharing commitment and compassion for the patient. Fm 285</p>
<p>286.</p> <p>“Ja, sy moes spinal X-Rays kry, en ek wil nou nie so se nie, maar die dokter was bietjie lelik met haar..Ek het toe vir haar gese ek sal haar help, en het toe vir ‘n ander dokter gevra om haar te help...en het toe saam met haar gegaan X-rays toe en haar gehelp”. T9, P51, L37-42</p>	<p>Safeguarding the best interest of the patient, by treating her with dignity. Fm 286</p>
<p>287.</p>	

<p>"Ja ek moes intree vir haar". T9, P51, L45</p>	<p>Advocating for the patient. Fm 287</p>
<p>288.</p> <p>"...ek het vir haar gese sy moenie worry wat die dokter gese het nie, ek sal jou help. Ek weet nie hoe om te explain nie, dis wat ek voel dat ek daar vir my pasient". T9, P51, L45-47</p>	<p>Reassuring the patient and being there for the patient. Fm 288</p>
<p>289.</p> <p>"Ja jy moet 'n passie hê vir jou pasiënt". T9, P51, L50</p>	<p>Reveals a compassion for her patients. Fm 289</p>
<p>290.</p> <p>"Die pasient kan nie vir himself praat nie". T9, P51, L50.</p>	<p>Identifies the need to advocate for patients. Fm 290</p>

Significant statements extracted from interview No.10

Significant statements	
<p>291.</p> <p>"As you know we are surrounded here by more rural areas, more villages, with people who are so disadvantaged. We are surrounded by people who really need our help". T10, P52, L14-16</p>	<p>Recognising the social problems and social needs in rural areas. Fm 291</p>
<p>292.</p> <p>"I came across a patient who was very ill. The patient told me that the illness started with a small pimple on the lower leg..." "I felt so sorry for that patient". T10, P52, L21-25</p>	<p>Connecting with a patient and showing sympathy towards him. Fm 292</p>
<p>293.</p> <p>"I decided to stay with the patient a while to just settle with the diagnose". T10, P52, L25-26</p>	<p>Reveals his humanity and willingness to be available for the patient in difficult times. Fm 293</p>
<p>294.</p> <p>"I told him that I will assist him with care that he needed. I got the experience that the people from this rural area, they need our caring intervention as health professionals". T10, P52, L26-27</p>	<p>Reveals that people within this rural area needs the caring intervention of health professionals. Fm 294</p>

<p>295.</p> <p>"Yes, it means sister, that we must act on behalf of our patients". T10, P52, L29</p>	<p>Indicates the desire to act on behalf of patients. Fm 295</p>
<p>296.</p> <p>"When I probed into questioning this patient, I realised that he knew that he was not well".</p> <p>T10, P52, L31</p>	<p>Participant indicates therapeutic communication skills. Fm 296</p>
<p>297.</p> <p>"I decided to remain at his side". T10, P52-53, L33-34</p>	<p>Reveals a conscious decision to remain at the side of the patient. Fm297</p>
<p>298.</p> <p>"Because I knew that the doctor is going to tell him that he was going to amputate that leg. It was bad".</p> <p>T10, P53, L34-35</p>	<p>Realising the impact of being personally available for the patient. Fm 298</p>
<p>299.</p> <p>"Yes, sister, but I decided to be there for him and support him through this difficult time". T10, P53, L37</p>	<p>Necessity to support the patient as professional nurse. Fm 299</p>
<p>300.</p> <p>"After the operation, I made sure that I was there when he opened his eyes, and touched his arm and said to him that he was going to be ok". T10, P53, L38-39</p>	<p>Ensuring that he was actively present for the patient and utilising therapeutic skills to support him. Fm 300</p>
<p>301.</p> <p>"He managed to smile and thanked me and started to cry. I was so hurt for him". I felt his pain and his loss. He only had now one leg, but I told him he will manage". T10, P53, L39-41</p>	<p>Intimacy of the moment is shared, when participant experienced a deep level of connection with the patient. Fm 301</p>
<p>302.</p> <p>"I was working in theatre, but I visited him and encouraged him to stay positive". T10, P53, L41</p>	<p>Inner desire to move beyond the objective aspects of care to provide sincere, humanistic nursing care. Fm 302</p>
<p>303.</p> <p>"That was one experience, sister, where I experienced that I practised caring presence. Another experience was (silence) eee, when I</p>	

<p>further learned that nursing is a caring profession. When you nurse the patient in totality". T10, P53, L44-46</p>	<p>A meaningful relationship was experienced, during the discovery of nursing being a caring profession. Fm 303</p>
<p>304.</p> <p>"Yes, through that caring profession, your patient will start to trust you". Trust is very important and building rapport, in order to care for your patient". T10, P53, L48-49</p>	<p>The openness and trust of the relationship enabled both the professional nurse and patient to gain significant meaning from their interactions. Trust is an important antecedent for caring presence. Fm 304</p>
<p>305.</p> <p>"And communication, yes, to talk not only about work related matters, eee, yes (silence). T10, P53, L49-50</p>	<p>Sharing in the subjective world of the other. Fm 305</p>
<p>306.</p> <p>"Building trust sister, is to be honest". T10, P53, L52</p>	<p>Reflecting on the fact that having a trusting relationship requires honesty. Fm 306</p>
<p>307.</p> <p>Tell the truth but educate that it may get better, not to lose hope". T10, P53, L53</p>	<p>Importance of telling the truth, education and instilling hope. Fm 307</p>
<p>308.</p> <p>"You can share with the patient that maybe where there is life, there is hope".</p> <p>I also take care of the patients' spiritual needs. It is important to listen and if he needs to pray, let him pray and support him". T10, P53, L56-58</p>	<p>Connecting in the spiritual dimension leads to a deeper level of connectedness between the two persons. Fm 308</p>
<p>309.</p> <p>You can also ask the spiritual worker in the hospital to assist this patient". T10, P53, L58-59</p>	<p>Referring the patient for further assistance. Fm 309</p>
<p>310.</p> <p>"All patients, sister, do have physical, emotional and spiritual needs, ok?" T10, P53, L62</p>	<p>Acknowledging that patients have holistic needs. Fm 310</p>
<p>311.</p> <p>"So we take care, as professional nurses, of the patient holistically, sister. I take care of all the needs and is present for the patient holistically". T10, P53, L64-65</p>	<p>Active presence and participation by the professional nurse is required to be able to meet the holistic needs of patients. Fm 311</p>

<p>312.</p> <p>“Being present, sister, involves that you are there at the side of your patient (silence)”. T10, P53, L67</p>	<p>Being present at the side of the patient, is considered as practising caring presence. Fm 312</p>
<p>313.</p> <p>“Maybe like you will be there for your own family, eee, yes, treat him like you will treat your own father, your mother and sister”..with love and compassion..”....without love and compassion our profession is nothing”. T10, P53, L68-70</p>	<p>Expresses the holistic philosophy of highly individualised care and emphasise that love and compassion is the fundamental driving force to practice caring presence in the nursing profession. Fm 313</p>
<p>314.</p> <p>“We must be role-models to the younger nurses to show them that we really care for our patients, eee, (silence). T10, P53, L70-71</p>	<p>Importance of being a role-model to enhance the practice of caring presence. Fm 314</p>
<p>315.</p> <p>“In my nursing career, sister, I show love and compassion, eee, like to put myself in the shoes of that patient, and say, I feel what you feel (silence) I care and I am here, yes”. T10, P54, L73-74</p>	<p>Love, compassion, physical presence and empathy is core elements to establish a meaningful relationship. Fm 315</p>
<p>316.</p> <p>“In the theatre we work in a different context with patients, but during my post-op rounds, eee, I can show my passion for nursing” T10, P54, L76-77</p>	<p>Confronting the different context of working in theatre, but still being able to show passion towards patients. Fm 316</p>
<p>317</p> <p>and support my patient. T10, P54, L77</p>	<p>Importance of emotional support. Fm 317</p>
<p>318.</p> <p>I give education and encourage them to heal (silence) yes T10, P54, L77</p>	<p>Educating and encouraging to reach healing. Fm 318</p>
<p>319.</p> <p>“You see sister, without passion, we cannot be part of the caring profession of nursing, as I mentioned before (silence). “The experience of passion is when I give everything and do what I do, with my whole, eee, heart, with love and compassion..”. T10, P54, L53-55</p>	<p>Commitment and passion is the core driving force to practice caring presence. Fm 319</p>

ANNEXURE P: DEVELOPMENT OF FORMULATED MEANINGS, THEME CLUSTERS AND EMERGENT THEMES

Development of formulated meanings, theme clusters and emergent themes.

Formulated meanings (Fm)	Theme cluster	Emergent theme
<p>Passion is fundamental to the nursing profession, in order to care and to build meaningful relationships with patients. Fm 5</p> <p>With-out passion for the nursing profession, it is not possible to render quality nursing care, and 100% dedication and commitment is emphasised. Fm7</p> <p>Passion requires an intersubjective human connecting with whatever you are doing, as well as focusing on a meaningful relationship with patients. Fm 13</p> <p>Explains her passion for the nursing profession, in becoming everything for her patients, and displays a willingness to give of herself.</p> <p>Passion and commitment to the nursing profession.</p> <p>Passion for the nursing profession is described, by denoting that nursing is a calling for her, and not only a work.</p> <p>Emphasise her passion for the nursing profession. Fm 16</p> <p>Importance of passion and commitment to care is illuminated. Fm 17</p> <p>A level of passion is required to become a specialised nurse. Fm 19</p> <p>Explains her passion for the nursing profession, in becoming everything for her patients, and displays a willingness to give of herself. Fm 48</p> <p>Passion and commitment to the nursing profession. Fm 58</p> <p>Passion for the nursing profession is described, by denoting that nursing is a calling for her, and not only a work. Fm 62</p>	<p>Passion for the nursing profession, enacts professional caring presence</p>	<p>Professional caring presence</p>

<p>Shares her passion for the Gine-ward. Fm 78</p> <p>Experiencing nursing within a rural area, as challenging but shares that compassion for patients and passion for the nursing profession, enable her to cope. Fm 84</p> <p>Passion is the core characteristic that enables nurses to practise caring presence. Fm 211</p> <p>Feelings of professional satisfaction and pride are experienced by professional nurses, at the end of a work-shift. Fm 10</p> <p>Feelings of professional satisfaction and pride are experienced by professional nurses, at the end of a work-shift. Fm 10</p> <p>Sense of professional pride and feelings of self-worth, are gained from the experience. Fm169</p> <p>Feeling professionally appreciated. Fm 171</p> <p>Assisting a patient on cognitive level is valued and appreciated. Fm 174</p> <p>Professional nurse experiences feelings of professional satisfaction and fulfilment. Fm 193</p> <p>Gratitude towards the professional nurse is indicated. Fm 191</p> <p>Reflects on her own uniqueness as a person and confirms her self-awareness. Fm 43</p> <p>Confronting the reality that self-awareness is important, therefore, nurses cannot take care of rural people with a broken heart or with anger. Fm 65</p> <p>Points out that the patients are her priority and not he administrative tasks. Fm 17</p> <p>Utilising own personal experiences to assist the patient, (which indicates professional maturity) and connected with the patient through responsive communication. Fm 47</p> <p>Commitment to the nursing profession as well as commitment to practice caring presence. Fm 105</p> <p>Willingness to ensure the best nursing care and wellbeing of the patient. Fm 116</p>	<p>Professional satisfaction and pride</p> <p>Self- awareness</p>	
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<p>Professional commitment and dedication to promote eye-health in a rural area. Fm 120.</p> <p>Professional commitment and personal dedication is illustrated by the professional nurse. Fm 131</p> <p>Confronts the reality that her conscience motivates her to give her best as professional nurse. Fm 133</p> <p>Confirms her passion for the nursing profession and professional commitment and dedication to care for patients with compassion, as if they are her own family. Fm 134</p> <p>Professional competence and effective teamwork are indicated. Fm 190</p> <p>Reveals professional commitment of the nursing team. Fm 192</p> <p>Safe and effective nursing interventions are factors that facilitate caring presence. Fm 194</p> <p>Professional dedication to attend to the needs of the patient. Fm 197</p> <p>Professional competence to implement nursing interventions and perform life-saving procedures. Fm 199</p> <p>Indicates professional commitment and feelings of frustration because of the lack of resources. Fm 213</p> <p>Acknowledge the commitment and dedication to the nursing profession. Fm 228</p> <p>Personal responsibility towards the holistic wellbeing of the patient. Fm 236</p> <p>Making use of therapeutic skills to connect with the patient and develop a meaningful relationship. Fm 240</p> <p>Valuing the humanness of the interaction. Fm 242.</p> <p>Acknowledging the professional responsibility of professional nurses. Fm 243</p> <p>Professional competence to implement nursing interventions and perform life-saving procedures. Fm 199</p>	<p>Dedication and commitment</p>	
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<p>Indicates professional commitment and feelings of frustration because of the lack of resources. Fm 213</p> <p>Experiencing commitment and passion for the</p> <p>Reveals a compassion for her patients. Fm 289</p> <p>A young patient with dependent children, is a motivational aspect towards recovery. Fm 215</p> <p>Effective teamwork and integrity are highlighted. Fm 218</p> <p>Necessity to support the patient as professional nurse. Fm 299</p> <p>Being a role-model is necessary in the nursing profession, therefore, being an example requires that the professional nurse portrays professionalism at all times. Fm 20</p> <p>Expresses a desire to keep caring personnel in her ward. Fm 24</p> <p>Experiencing feelings of disappointment because the majority of nurses are not passionate anymore. Fm 26</p> <p>Difficulty to remain strict and at times firm with nursing staff and frustration towards corruption and absence of integrity, during personnel evaluations. Fm 28</p> <p>Implies difficulty to stay committed, caring and present for patients. Fm 32</p> <p>Problem-solving skills and a caring attitude is emphasised as essential characteristics in caring presence. Fm 40</p> <p>Explains when she entered the room, she displayed her genuine character and experienced that she was valued as a person. Fm 45</p> <p>The role of motivating and encouraging colleagues, is fundamental in strengthening relationships. Fm 159</p> <p>Motivating and encouraging juniors to be honest and to display professional integrity. Fm 221</p> <p>Confronting the reality of over-stressed and over-worked, nursing personnel. Fm 224</p>	<p>Being a role model</p>	
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<p>Willingness to safeguard the best interest of patients. Fm 269</p> <p>Ethical responsibility is recognised. Fm 281</p> <p>Safeguarding the best interest of the patient, by treating her with dignity. Fm 286</p> <p>Indicates the desire to act on behalf of patients. Fm 295</p> <p>Reflecting on the fact that having a trusting relationship requires honesty. Fm 306</p> <p>Staying focused and advocate for the patient. Fm 35</p> <p>Requires advocacy for patients by communicating with doctors regarding the wellbeing of the patient. Fm 57</p> <p>by attending to the needs of the elder patients and advocating for them. Fm 125</p> <p>Advocacy is described as part of having a personal and close connectedness with patients. Fm 129</p> <p>Utilising the advocacy-role to safeguard the best interest of patients. Fm 132</p> <p>Regards advocating for patients as important. Fm 139</p> <p>Value of being an intercessor between the doctor and patient is described. Fm 156</p> <p>Urging the doctor to assist the patient. Fm 198</p> <p>Urging and guiding the medical practitioner to perform a life-saving procedure. Fm 200</p> <p>Persistence to advocate for the best interest of the patient. Fm 202</p> <p>Willingness to advocate for the patient to enhance healing. Fm 231.</p> <p>Importance of professional referral in the nursing profession. Fm 245</p> <p>Effective teamwork, referral and collaboration is important. Fm 249</p>	<p>Advocacy</p> <p>Advocating</p>	
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<p>Advocacy- role of the professional nurse. Fm 258</p> <p>Advocating for the patient. Fm 287</p> <p>Identifies the need to advocate for patients. Fm 290</p> <p>Advocating for the patient. Fm 287</p> <p>Identifies the need to advocate for patients. Fm 290</p> <p>Referring the patient for further assistance. Fm 309</p> <p>Realised that people tend to judge the population of certain demographic areas and display a negative attitude towards them. Fm 41</p> <p>Explains the importance of safeguarding the best interests of the patient and empowering the patient with knowledge. Fm 141</p> <p>Importance of treating a patient as a human being, not a case, is recognised. Fm 152</p> <p>Realising that being non-judgmental towards patients and valuing the uniqueness of each person, are important in creating meaningful relationships Fm 165</p>	<p>Non-judgmental</p>	
<p>Although challenging, personal and competent caring presence, are experienced as very rewarding. Fm 9</p> <p>Feeling satisfied when nursing tasks were competently done. Fm 12</p> <p>The manager comments at the personal presence and personal confidence of the nurse. Fm 14</p> <p>The nurse indicates that the positive comment of the manager, motivated her personally and confirms her career choice. Fm 15</p> <p>Feelings of pride and <i>personal</i> satisfaction is experienced. Fm 80</p> <p>Shares personal feelings of fulfilment when she started a service on her own. Fm 123</p>	<p>Feeling appreciated</p> <p>Personal satisfaction/proud of care provided, establishes personal caring presence</p>	<p>Personal caring presence</p>

<p>Confronting the reality of challenges in the remote rural area, and shares commitment and feelings of personal satisfaction, when patients who was nearly blind, can see again. Fm 124</p> <p>Feelings of personal satisfactions and fulfilment is experienced. Fm 164</p> <p>Experiencing personal satisfaction, when a life was saved. Fm 201</p> <p>Feeling satisfied because she made a difference in the life of the patient</p> <p>Confronting the challenges in the rural area, and shares a personal responsibility to attend to the specialised eye-needs of patients. Fm 119</p> <p>Confronting the challenge of limited resources, but reveals a personal commitment to deliver a much needed service. Fm 121</p> <p>Reveals a personal responsibility to do something extra for patients. Fm 122</p> <p>Willingness to walk an extra mile and a commitment to be fully present for patients are described. Fm 128</p> <p>Personal responsibility to render holistic care, by doing your best, go an extra mile, and not to leave any stone unattended. Fm 135</p> <p>Reveals a willingness to assist the patient in his/her healing process and shares personal satisfaction, when this goal is achieved. Fm 137</p> <p>The intimacy of the relationship is reflected by being personally available for the patient. Fm 147</p> <p>Feeling appreciated for making a difference. Fm 161</p>	<p>Willingness to walk an extra mile</p>	
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<p>Delivering effective and continuous nursing interventions. Fm 206</p> <p>Personal commitment and dedication to enhance healing. Fm 210</p> <p>Feeling motivated to continue with nursing career. Fm 217</p> <p>Commitment to go an extra mile for the patient, and persistence to act in her best interest. Fm 261.</p> <p>Reveals a personal responsibility and sincere interest in the patient. Fm 265</p> <p>Illustrates the importance of a caring attitude, persisting and to give everything, for the sake of the patient. Fm 267</p> <p>Confirms the willingness to go an extra mile. Fm 279</p>		
<p>Practising caring presence is grounded in a holistic nursing approach. Fm 2</p> <p>Commitment to total care is seen as an essential element in nursing. Fm 3</p>	<p>Willingness to render holistic/ patient-centred care establishes a healing presence</p>	<p>Healing caring presence</p>
<p>Indicates the deep level of connecting with her patient and willingness to share this intimate interaction, by describing this experience as: “you must feel that you are <i>fully there</i> for them, <i>being everything</i> for them” (silence)....you must put yourself in the patient’s shoes...feel what they feel...” Fm 59</p> <p>Participant reveals the practice of connecting and intention setting technique, by focusing her energy on the <i>holistic needs</i> of her patients, to <i>be there</i>, and <i>connect</i> not only in the physical sense but also in the psychological, emotional and spiritual realms. Fm 68</p> <p>Explains the importance of a holistic, patient-centred approach in the nursing profession. Fm 70</p> <p>Emphasise that nursing the patient “from head to toe” is an essential characteristic of healing presence. Fm 71</p> <p>Doing everything to, and being everything for patients to facilitate their healing, are illuminated. Fm 91</p>	<p>Connecting to be “fully there”</p> <p>Connecting and intention setting technique</p>	

<p>Commitment to be everything for patients, facilitates the level of full presence for patients Fm 100.</p> <p>Dedication to take care of the patient holistically and thereby assisting the patient to function independently. Fm 107</p> <p>Attending to all the needs of the patient. Fm 109</p> <p>Confirming a willingness to ensure that the patient is holistically cared for and the patient is satisfied with the care received. Fm 118</p> <p>Confronting the reality that patients need holistic nursing care to heal. Fm 136</p> <p>Explains that healing for her, means being healthy in totality. Fm 138</p> <p>Identifying holistic needs of the patient. Fm 179</p> <p>Patient-centred, holistic nursing approach is the core of the healing process. Fm 203</p> <p>Indicates the importance of patient-centred care. Fm 204</p> <p>Patient-centred and continuous care are rendered. Fm 207.</p> <p>Healing is enhanced, because of personal attention and continuously attending to the needs of the patient. Fm 208</p> <p>Willingness to give the gift of himself to facilitate caring presence. Fm 212</p> <p>The holistic wellbeing of the patient is illuminated. Fm 246</p> <p>Holistic, patient-centred care is the fundamental driving force to the practice caring presence. Fm 251</p> <p>Willingness to give the gift of yourself, when practising caring presence. Fm 276</p> <p>Confirms the total commitment towards the holistic nursing approach. Fm 277</p> <p>A meaningful relationship was experienced, during discovery of nursing being a caring profession. Fm 303</p>	<p>Commitment to facilitate the level of full presence</p> <p>Offering the “gift of himself/herself”</p>	
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<p>Acknowledging that patients have holistic needs. Fm 310</p> <p>Active presence and participation by the professional nurse is required to be able to meet the holistic needs of patients. Fm 311</p>		
<p>Participant connected with the patient by means of verbal communication. Fm 37</p> <p>The professional nurse took the hand of the patient, reassured him and remained at his side. Fm 38</p> <p>The necessity of a positive attitude and effective communication is highlighted. Fm 60</p> <p>The need to spend sufficient time with patients is emphasised to facilitate a connectedness and meaningful relationship with patients. Fm 83</p> <p>Participant indicates therapeutic communication skills. Fm 296</p> <p>Physical and emotional presence is illustrated, by rendering follow-up services and resolving problems. Fm 127</p> <p>The importance of responsive listening is emphasised. Fm 130</p> <p>Attending to the physical needs of the patients is emphasised. Fm 92</p> <p>To sit down with patients, shows physical availability to establish meaningful relationship. Fm 95</p> <p>The need to spend sufficient time with patients is emphasised to facilitate a connectedness and meaningful relationship with patients. Fm 83</p>	<p>Willingness to be physical present</p> <p>Therapeutic touch</p> <p>Responsive communication</p> <p>“Tune in” with patient</p>	<p>Physical caring presence</p>

<p>Spending sufficient time with patients is illuminated as antecedent to facilitate caring presence. Fm 98</p> <p>Sharing her willingness to attend to the physical needs of the patient, by changing nappies, do position-changing and suctioning her. Fm 102</p> <p>Confronts the challenge of staff-shortages and willingness to be there to take care of the physical needs of patients. Fm 104</p> <p>Ensuring physical comfort in theatre. Fm 114</p> <p>Attending to the basic physical needs of the patient. Fm 117</p> <p>By being physical available for the patients, post-operative complications are prevented. Fm 126</p> <p>The power of therapeutic touch is illustrated. Fm 148</p> <p>Communication on the patients' level, and valuing the patient as a human being, is important. Fm 149</p> <p>Valuing the patient as a person and establishing a meaningful relationship with the patient. Fm 151</p> <p>Reflects on the value of pausing and focusing on the needs of patients. Fm 157</p> <p>Checking in frequently, with patients, facilitates caring presence. Fm 158</p> <p>Attending to the basic needs of patients, as well as recognising the need for personal attention is fundamental in the practise of caring presence. Fm 160</p> <p>Realising that spending sufficient time is important factor to facilitate a meaningful relationship. Fm 163</p> <p>Indicates that spending sufficient time with patients is a fundamental element in gaining an understanding of their unique situation. Fm 166</p> <p>Indicating the importance of support, genuine concern and therapeutic communication with patients. Fm 170</p>	<p>Willingness to attend to basic physical needs</p>	
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<p>Being available at the side of the patient, is recognised as a caring attitude. Fm 183</p> <p>Being available at the side of the patient, is recognised as a caring attitude. Fm 183</p> <p>Reveals being physically there for her patient and performing a simple action, such as rubbing her back to sooth the pain. Fm 186</p> <p>Being physically with the patient, combined with safe, effective and prompt nursing interventions are described. Fm 189</p> <p>Attending to the physical needs of the patient, by means of safe effective nursing interventions. Fm 195</p> <p>Attending to the physical needs of the patient. Fm 220</p> <p>Attending to the basic needs of the patient. Fm 223</p> <p>Therapeutic connection and the humanness of the interaction. Fm 233</p> <p>Making eye-contact, is a core characteristic of the practice of caring presence. Fm 235</p> <p>Focusing on the patient, by making eye-contact. Fm 239</p> <p>A willingness to be physically there for the patient. Fm 255</p> <p>The intimacy of the interaction and unique bond are described. Fm 256</p> <p>Attending to the physical needs of the patient. Fm 283</p> <p>Reveals his humanity and willingness to be available for the patient in difficult times. Fm 293</p> <p>Reveals a conscious decision to remain at the side of the patient. Fm297</p> <p>Ensuring that he was actively present for the patient and utilising therapeutic skills to support him. Fm 300</p> <p>Inner desire to move beyond the objective aspects of care to provide sincere, humanistic care. Fm 302</p>	<p>Eye-contact</p>	
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<p>Being present at the side of the patient, is considered as practising caring presence. Fm 312</p> <p>Importance of being a role-model to enhance the practice of caring presence. Fm 314</p> <p>Confronting the different context of working in theatre, but still being able to show passion towards patients. Fm 316</p> <p>Commitment and passion is the core driving force to practice caring presence. Fm 319</p>		
<p>Caring is compared with rendering nursing care for your own mother at home (shares the intimacy of the interaction). Fm 1</p> <p>Caring does not only include procedures, but it includes sympathy, empathy, communication (silence), it includes so many things. Fm 4</p> <p>Professional nurses should be able to detach and separate from the emotions of patients. Fm 30</p> <p>Showing compassion towards the helpless and confused patient and offers to be emotionally present. Fm 34</p> <p>Experiencing compassion. Fm 36</p> <p>Compassion, commitment and willingness to give of herself in order to gain an understanding of the patient. Fm 46</p> <p>Reveals an openness to connect with the patient unconditionally (technique used by the holist nurse to enact presence). Fm 50</p> <p>Staying focused on the patient, invited the patient do connect emotionally with the nurse. Fm 53</p> <p>Describes that she was impressed by the way the nurse communicated and cared for others. Fm 61</p> <p>Identifying the importance of connecting emotionally, in order to display a caring attitude. Fm 63</p> <p>Indicates the importance of focusing on the emotional needs of the patient. Fm 69</p>	<p>Willingness to be emotionally present, establishes emotional presence</p> <p>Sympathy, empathy</p> <p>Compassion</p> <p>Openness to connect emotionally</p> <p>Connecting emotionally</p>	<p>Emotional caring presence</p>

<p>Showing genuine interest in a patient is necessary to connect with a patient therapeutically. Fm 74</p> <p>Reveals the intimate interaction of sharing in the subjective world of the other. Fm 76</p> <p>Self-disclosure is utilised to facilitate healing, when the participant shares her own problems with her patients Fm 79</p> <p>Effective communication and treating patients with kindness are the keys to resolve problems. Fm 88</p> <p>Being approachable facilitates the process for patients to connect emotionally with nurses. Fm 94</p> <p>Questioning the role of the nurse, by confronting the reality that patients have emotional needs to attend to. Fm 101</p> <p>Willingness and desire to connect with the patient and to be there for her patient. Fm 103</p> <p>Empathy and sympathy is emphasised as important attributes of caring presence. Fm 106</p> <p>Willingness to relieves anxiety and to comfort patients. Fm 108</p> <p>Explains the importance of understanding the situation of patients and being empathic, genuine and sincere. Fm 110</p> <p>Showing love and having patience with patients, and treating them as human beings and not objects is highlighted. Fm 140</p> <p>Showing love, kindness and humanity to patients, indicates that the professional nurse is there for them. Fm 145</p> <p>Importance of treating a patient as a human being, not a case, is recognised. Fm 152</p> <p>The intimacy of the experience is described. Fm 162</p> <p>The intimacy and humanness of the experience and the deep level of connectedness with the patient is described. Fm 168</p>	<p>Love</p>	
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<p>Importance of effective communication and responsive listening are highlighted. Fm 177</p> <p>Responsive listening and “tuning in” with the patient are highlighted as a core element of caring presence. Fm 182</p> <p>Importance of reassurance is highlighted. Fm 184</p> <p>Reassuring the patient that she will remain at her side, even when the doctor arrives. Fm 187</p> <p>Creating rapport with the patient facilitate the opportunity to connect with patient. Fm 227</p> <p>Identifies that spending time with patients, establish meaningful and trusting relationships. Fm 230</p> <p>Genuine interest and openness between the professional nurse and the patient, facilitated the establishment of a meaningful relationship. Fm 232</p> <p>Being present for the patient, created an opportunity for the patient to open up and share his feelings. Fm 234</p> <p>The humanness of the connection and interaction between the nurse and patient is highlighted. Fm 237</p> <p>The connection in the emotional dimension is emphasised. Fm 238</p> <p>The need to spend sufficient time with the patient in order to establish a meaningful relationship. Fm 259</p> <p>Therapeutic communication is a core element of a meaningful relationship. Fm 260</p> <p>Confirming a willingness to be available for the patient and reveals genuine interest and a unique bond with the patient. Fm 262</p> <p>Being connected with the patient, even when she was off-duty, displays the close contact and unique bond between the nurse and patient. Fm 264</p> <p>Attending to the emotional needs of patients is a fundamental element in caring presence. Fm 271</p>	<p>Genuine interest</p> <p>Unique emotional bond</p> <p>Compassion</p> <p>Intimacy of interaction</p>	
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<p>Commitment and dedication to render compassionate care, illustrates the genuine closeness of the relationship. Fm 272</p> <p>Willingness to understand the patient as a unique human being. Fm 273</p> <p>Valuing the patient as a unique human being. Fm 274</p> <p>Considers the commitment to take care of patients as if they are your own family. Fm 275</p> <p>Spending sufficient time with the patient allowed the development of a close relationship with the patient. Fm 280</p> <p>Sharing the commitment and compassion for the patient. Fm 285</p> <p>Reassuring the patient and being there for the patient. Fm 288</p> <p>Connecting with a patient and showing sympathy towards him. Fm 292</p> <p>Reveals that people within this rural area needs the caring intervention of health professionals. Fm 294</p> <p>Realising the impact of being personally available for the patient. Fm 298</p> <p>Intimacy of the moment is shared, when participant experienced a deep level of connection with the patient. Fm 301</p> <p>The openness and trust of the relationship enabled both the professional nurse and patient to gain significant meaning from their interactions. Trust is an important antecedent for caring presence. Fm 304</p> <p>Sharing in the subjective world of the other. Fm 305</p> <p>Expresses the holistic philosophy of highly individualised care and emphasise that love and compassion is the fundamental driving force to practice caring presence in the nursing profession. Fm 313</p> <p>Love, compassion, physical presence and empathy is core elements to establish a meaningful relationship. Fm 315</p>	<p>Reassurance</p> <p>Creating rapport</p>	
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<p>Empowering patients by sharing knowledge with them. facilitates independent functioning. Fm 176</p> <p>Guidance and encouragement of patients are emphasised. Fm 178</p> <p>Connecting cognitively assist patient with pain management. Fm 181</p> <p>Indicates that reassuring the maternity- patient, involves sharing knowledge and guiding her through the phases of the delivery process. Fm 185</p> <p>Maintaining a meaningful relationship and showing a desire to assist the patient to gain a better understanding of his/her treatment. Fm 241</p> <p>Acknowledging the fact that the lack of knowledge, leads to medical conditions that could be prevented. Fm 247</p> <p>Sharing knowledge regarding traditional beliefs is regarded as part high quality nursing care. Fm 248</p> <p>Acknowledging the challenge to safeguard the best interest of the patient and to ensure that the patient is adequately informed regarding the medical condition. Fm 253</p> <p>Willingness to give health education to community members. Fm 268</p> <p>Importance and necessity of health education within the community, by specialised nurses. Fm 270</p> <p>Importance of telling the truth, education and instilling hope. Fm 307</p> <p>Educating and encouraging to reach healing. Fm 318</p>	<p>Patient empowerment</p>	
<p>Spiritual presence is fundamental to nursing babies and the professional nurse regain inner strength when she prays. Fm 22</p> <p>Denotes her spiritual connectedness, by praying for her patient. Fm 55</p>	<p>Willingness to connect spiritually</p>	<p>Spiritual presence</p>

<p>Social needs of the patient are identified. Fm 257</p> <p>Confronting the social problems that needs attention. Fm 278</p> <p>Identifying the social problems that needs attention. Fm 282</p> <p>Recognising the social problems and social needs in rural areas. Fm 291</p>		
<p>Neglecting the basic physical needs of the patient, and being rude to patients is described as <i>not</i> practising caring presence. Fm 6</p> <p>Feeling bad and disappointed when some tasks were not done. Fm 11</p> <p>Confronts the fact that competence does not guarantee a caring attitude and genuine interest in patients and working with such nurses is challenging. Fm 18</p> <p>Currently a trend amongst nurses not to check emergency-trolleys and spending lots of time on their phones during working hours. Fm 21</p> <p>Frustration is experienced by the professional nurses when they want to allocate nurses with a caring attitude in their wards. Fm 23</p> <p>Frustration is experienced when the professional nurse struggles to recruit specific nurses for her nursing team. Fm 25</p> <p>Grounding the reality that professional nurses display unprofessional conduct by being on their sell-phones, taking lunch for three hours and reflecting un-caring behaviour towards patients. Fm 27</p> <p>The need to remain committed to correct procedures and protocol in order to achieve the goal of quality nursing care. Fm 31</p> <p>Frustration and disappointment are experienced towards the fact that professionalism and a caring attitude within the nursing profession, is decreasing. Fm 33</p>	<p>Neglecting patients/ state of being uncared for, indicates what caring presence is not</p> <p>Unprofessional conduct</p>	<p>What caring presence is not</p>

<p>Frustration is experienced when the patient is sent “from pillar to post” and his needs is not attended to. Fm 39</p> <p>Reveals the fact that patients are afraid to communicate with doctors regarding their problems. Fm 52</p> <p>Willingness to correct the mistakes that other nurses made. Fm 64</p> <p>Shares that neglecting the holistic needs of a patient, is what caring presence is not. Fm 73</p> <p>Necessity of spending sufficient time with patients, and being kind to them. Fm 150</p> <p>Un-ethical approach and unfairness of de-personalising of patients is highlighted. Fm 153</p> <p>Feelings of frustration is experienced when colleagues discuss patients in an unkind manner. Fm 167</p> <p>Feelings of frustration arose from the lack of resources within the health environment, such as staff shortages and difficult circumstances within a rural public hospital. This results in a decrease of the quality of nursing care, rendered to patients. Fm 188</p> <p>Neglecting to attend to the small things, like checking vital signs, can result in the death of a patient. Fm 222</p> <p>Lack of appreciation by management, the public and community, result in a decrease of personnel morality and professionalism. Fm 225</p> <p>Reveals the uncaring attitude of people within the health environment. Fm 229</p>	<p>Uncaring attitude</p>	
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ANNEXURE Q: POWERPOINT PRESENTATION



Research TOPIC

Professional nurses' lived experience of practicing caring presence in a rural public hospital in the North West province, South Africa.



Caring moments....


**DO IT WITH
PASSION
OR NOT
AT ALL.**

I'll scream for you.....

- The state of *being present* with someone in need, characterizes the practice of **professional nursing**.
- A heart-touching example that *illustrates caring presence* can be found in the following moment of understanding as described by Patricia Hewley (2011:1)



- The goal of this study is to make known the significance and transformative potential of practicing caring presence in the nursing profession, for future use in the practice, education and research field.




A moment of understanding

- "I have a patient, Bob, a high school teacher and soccer coach. He is 29 years old and was admitted to our ICU with a broken neck. One day an independent, active man, whole and mobile. The next, he lies motionless, no longer able to speak, blinking became his only means of communication- one blink for yes, two for no.
- One day I sensed that Bob was having a rough time- I just knew. I could feel the tension. Just before leaving I bent over and said: "Bob, when I go for coffeeI'll scream for you".
- "I'll scream for you". What an odd thing to say. And yet how perfectly appropriate ...Later when Bob was breathing on his own, he told this nurse: "I have been waiting all this time to tell you how grateful I was for your willingness to scream for me". What the nurse did, was lend the patient her voice, her throat....

Background and rationale for the study

Nurses question, how their being with can make a difference to a patient's quality of health, they wonder if giving of themselves is an appropriate use of their time. Therefore, the phenomenon of caring presence in nursing, challenges the professional nurse, who acts as role model, mentor and patient's advocate, to explore what it means to practice caring presence.



Research on the state of nursing- (RESON) 4 year research programme, SA.

- Show that nursing is a profession in peril, which requires major attention and revitalization (Rispel et al, 2015) SA Health review.
- NDoH (2011) estimated a nursing shortage of 44780 in the public health sector and according to SANC (2015) patients to PN ratio is 402 patients to/ 1 Professional Nurse.
- Another challenge is an ageing workforce- SANC (2015) indicates that 43% of PNs are over 50 years of age.

WHO, 2014

- * Similarly, in order to improve the efficiency and effectiveness of health systems, (WHO) Programme Budget 2014-15 lauded SDS as a "center of excellence" within WHO.
- * Objective: help countries "re-think health care"
- * In this regard, Palmieri (2013) maintains that an attitude of "true being" and a gift of "true presence" enable the nurse to provide quality patient-centered care. Furthermore, the experience of practicing caring presence is positively associated with quality of care by the patient and family, as well as increased job satisfaction by the nurse (Fairfield-Cooper, 2006).

South African Health care

- The public sector has buckled under the impact of free services to the majority of the population.
- Resulting in overcrowded clinics and hospitals, putting an extra burden of unbearable workloads on the personnel.
- Furthermore, the extraordinary additional disease burden created by HIV/AIDS and decrease in training of nurses, result in – patient care outcomes and quality care.

South African International Caritas Consortium. (2015)

- * Recognizing this crucial need for practicing caring presence in SA healthcare as well, the SAICC addressed the importance of caring presence in nursing.
- * Also a private hospital group initiated "Presence Communication- 50 seconds to connect" with the aim to enhance caring presence in nursing practice...to build built up a mutual understanding with pts within seconds, to be present and really connect (Herselman et al, 2015).



Recognizing the depth of the challenges facing nursing, the South African Department of Health convened the National Nursing Summit in 2011.

Aim of the summit: "Reconstructing and re-vitalizing the nursing profession for a long and healthy life for all SA".

- One of the 7 themes highlighted was professional ethos and ethics in nursing.
- National call towards increased professionalism (NDoH) in the nursing profession.
- Therefore, to truly uphold professionalism in nursing, caring presence is a crucial approach for nurses to practice on a daily basis.

nursing



- As expounded in the information , it is clear that nurses in SA , are challenged by numerous factors that jeopardize their ability to practice caring presence.
- It is emphasized by du Plessis (2010:3) that the core of improving the quality of healthcare, is the caring attitude and values of the nurse.
- The implications of presence for nursing practice are according to Bright (2012:96) every bit as important as the skills and technologies nurses use to save lives.

Problem statement and research question



- The researcher experience in her own professional practice that nursing devoid from practicing caring presence will result in a profession with a catastrophic decrease in professionalism and inferior patient outcomes.
- Many studies conducted in both the public and private sector, describe the poor working environment and organizational climate (Rippe, 2015)
- A critical look at the image of the nursing profession in SA, portrays nurses in general as:

Knowledge gap

- There is a huge gap in SA literature on phenomenological studies exploring the lived experience of nurses regarding practicing caring presence in a SA context, especially in rural areas in the public health sector, because this is where PNs have to cope with very limited resources and a heavy workload.
- Clarifying the significance of practicing caring presence
- Invites the prospect of additional evidence –based research
- Addressing the deficiencies in this body of evidence may have -positive implications for nursing practice, education and research.



nursing



- "overworked, uncaring, lazy, ruthless, incompetent and suffering from burnout" (Dotholizen, 2012:53).
- However, reports of caring presence are often overlooked and/or not told (Max du Preez, 2014).

Enhance caring presence

- Consequently, this knowledge may assist policy-makers, educators, researchers, and health organizations to preserve and enhance the therapeutic nursing intervention of practicing caring presence,
- while ensuring that the art of nursing **not only is sustained, but flourishes.**



Focus

- Advancing the skill of "presence", will create breakthroughs in the patient experience and job satisfaction of the nurse.
- Parse (2011) states that true presence is a non-intrusive gentle glimpsing in reaching the other with dignity, it is a standing with, during a journey.....
- Du Plessis (2010:47) maintains that it is important to reflect on how presence can be cultivated and suggests further research to explore and describe the enactment of presence and mindfulness by nurses.

Research question

- The above discussion leads to the following research question:
- **How do professional nurses working in a rural public hospital in the North-West province, South Africa, experience practicing caring presence?**



Research purpose

- Aims to explore and describe the lived experience of PNs of practicing caring presence within a rural public hospital in the NW province, SA.
- The purpose is to illuminate how PNs, caring for large numbers of pts with a high acuity within a complex rural health care system, *experience practicing caring presence, despite difficulties and challenges within a rural public hospital.*
- The researcher thus departure from the stance that there are nurses in this context who do practice caring presence.

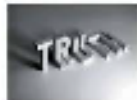
The paradigmatic perspective is discussed within this framework

- The assumptions of the researcher are based on a Christian philosophy that is based on the Bible as the source of truth.
- Assumptions regarding human beings, the environment, health and nursing are included.



Paradigmatic perspective

- The researcher presents the paradigmatic perspective that involves human sciences.
- Human science is guided by views of human care and caring- nurses want, and need to know what is most essential to their profession, patients and the community.



For the purpose of this study

- The term **human beings** refers to PNs, who are magnificent, unique, multi-dimensional beings created to the image of God.
- The **environment** is the sphere in which human beings can live and serve God- in this study, it refers to PNs workplace within a rural public hospital.
- **Nursing** is an art and science and include activities that promote, maintain and restore health, as well as care for the dying.

Paradigm offers to the researcher:

- A conception of reality -ontology
- An idea of scientific knowledge refers-epistemology
- Methodology involves the generating of specific procedures for research.
- The phenomenon of practicing caring essence is a truth that exists as an essence that can be described.



Central theoretical statement

- The exploration and description of the lived experience of the PN working in a rural public hospital will address the need for research on how PNs experience practicing *caring presence*.
- *Such research is needed to gain insight into the description of the moment of the now- not a generalization, but a description of a specific and unique moment of the experience (van Manen, 2016:5).*
- This research thus has the potential to contribute to the improvement of quality healthcare within the nursing profession.



Caring presence

- The researchers' definition of **caring presence** is "a connection to our own hearts to be felt by patients and is enacted in special moments of being there or being with another, in times of need. It portrays the art of nursing and is the gift of one's self" (Nelms, 1996:368).
- Phenomenologically, **lived experience** are intentional and presents to the individual what is true or real in his/her life (Kisiel & Sheehan, 2015).



Research design

- The aim of this **qualitative research** is, to describe accurately the lived experiences of people, **not** to generate theories or models.
- The **context** involves difficult and challenging factors that compromise PNs ability to truly connect with their patients.

Professional nurse (PN)

- A nurse who is registered with SANC under section 31 of the Nursing Act of 2005.
- A **rural public hospital** is defined as a hospital funded by the NDOH that renders free health services, or at a minimal fee according to income, in an area located outside of the metros and lacks "urban characteristics".

Research method

- **Descriptive phenomenology** will be used to inform this study, as descriptive phenomenology insists on the careful portrayal of ordinary experience of everyday life.



PRACTISING CARING PRESENCE



The research method is discussed as follows:

- **Non-probability, purposive sampling**, will be utilized to recruit participants (Polit & Beck, 2014:284).
- Participants will be selected on the basis that they know the most about the phenomenon (Brink et al, 2015:126).
- The criteria for **inclusion** in this study are that each participant must be a **PN**, permanently employed for at least one year, in a rural public hospital and have experienced practicing caring presence, or felt that they have connected with their patients).
- **Exclusion criteria** are: PNs who are part-time employed or less than one year permanently employed and non-English speaking, or employed within the private hospital sector or any other health sector, than a rural public hospital.

Data analysis.

- The term "lifeworld" or "lived experience" is used in phenomenology (Garrath & Lacey, 2010:280). Instead of the term **data** and individual experiences are the **starting point** for inquiry.
- This analysis involves the following 4 steps:
- **Bracketing**- to bracket out preconceived beliefs.
- **Intuiting**- remain open to participants meaning attributed.
- **Analyzing**- using Colaizzi's 7 step method
- (Polit & Beck, 2014:181).
- **Describing** the true essence (essential structure) of the experience.

Data collection

- The unit managers in the rural public hospital will be asked to act as mediators to recruit participants and to assist the researcher to obtain informed consent. The **mediator** will be a person who provides a **link** between the researcher and participants who suit the inclusion criteria (Brink et al, 2015:203). The mediator will be trained and informed about the aim of the study and how to share the information.
- Qualitative researchers are research instruments and attempts to get as close to the data as possible (Creswell, 2013:237).

Trustworthiness

- Refers to the rigor that involves the principle of truth value of the research outcome in qualitative research (Polit & Beck, 2013:184).
- Proposed by Lincoln and Guba (1985:178) as a substitute to reliability and validity.
- 5 criteria to determine trustworthiness will be used to ensure the truth value in this study:
- Credibility
- Dependability
- Conformability
- Transferability
- Authenticity
- **Strategies employed:** member checking, reflective journaling, prolonged engagement, peer debriefing, and audit trails.

Semi-structured face-to-face interviews will be used to collect data.

- Interviews will be audiotaped and the researcher will employ communication strategies to glean in-depth descriptions from participants, encouraging them to reach into their own perceptions and express their thoughts (de Vos et al, 2012:345)



Ethical considerations



**CODE
OF
ETHICS**

Involved with human participants

- Special concerns related to the protection of human rights.
- In this study, commonly accepted international ethical principles will be applied as outlined in the Helsinki Declaration, Belmont Report and Nuremberg Code (Burns & Grove, 2009:184-185).
- National level- adheres to the code of ethics as stipulated by HREC, Faculty of Health Sciences NWU and by the National Health Research Ethics Committee (NORH, 2015).



ANY QUESTIONS???????



**Nursing is
the gentle art of
caring.**

Ethical principles

(Burns & Grove, 2009:194)

- Autonomy will be respected- participants have the right to accept / decline or withdraw from the study.
- Principle of justice- Participants will be fairly selected and treated and informed consent will be obtained.
- Their well-being will be secured by protecting them from harm and discomfort.
- Anonymity, confidentiality and privacy will be assured-all data will be locked and stored safely.
- Scientific appropriate methods in conducting the study to ensure scientific integrity.

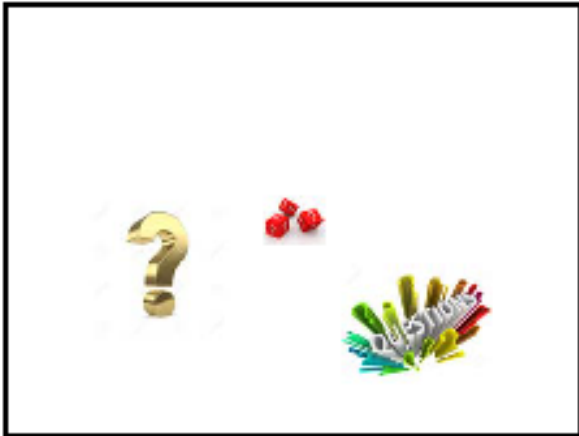


Acting honestly regarding findings and feedback.

- Results will not be masqueraded, made up or falsified and all participants and co-workers will be acknowledged.
- Policies regarding plagiarism and copyright as prescribed will be adhered to (NWU, 2011:26).
- Feedback about the findings will also be shared by means of a Power-point presentation at the rural public hospital, and in the form of a dissertation.



**Nursing is
the gentle art of
caring.**



Professional nursing

Caring presence.....

Three images illustrating caring presence. The top right image shows two hands cupping a glowing white heart. The middle image shows two hands holding a smaller, glowing white heart. The bottom left image shows a pair of hands gently holding a baby's hand.

ANNEXURE R: DECLARATION OF LANGUAGE EDITING



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DECLARATION OF LANGUAGE EDITING

I, Christina Maria Etrechia Terblanche, hereby declare that I edited the research study with the title:

Professional nurses' lived experience of practising a caring presence in a rural public hospital

for **PS Hobbs** for the purpose of submission as a research study for examination. Changes were suggested in track changes and implementation was left up to the author.

Regards,

CME Terblanche

Cum Laude Language Practitioners (CC)

SATI accreditation nr: 1001066

Full member of PEG