



SECTION 1
OVERVIEW OF THE STUDY



1. OVERVIEW OF THE STUDY

1.1 INTRODUCTION

In this overview of the research, the background to the research problem will be illustrated, followed by a discussion of the problem. The research questions follow, as well as the purpose, with objectives, which give direction to the research. The researcher will state her paradigmatic perspective and explain the research design and research method that were used in this study. The measures to ensure rigour and the ethical considerations will be described. The significance of the study will be highlighted by including a short literature review and lastly an outline of the dissertation, which is reported in article format, will be given.

1.2 BACKGROUND AND RATIONALE FOR THE STUDY

The steady increase in the older population (Velkoff & Kowal, 2007:3) and the alarming shortage of qualified and experienced nurses to care for them (Jackson *et al.*, 2003:45) require urgent attention.

The population is ageing in numerous countries all over the world (Velkoff & Kowal, 2007:3; National Institute on Aging (NIA), 2007:3). Meeting the needs of this growing number of older persons provides challenges to governments, families as well as to the business and healthcare sectors (Velkoff & Kowal, 2007:3). This is confirmed by (NIA, 2007:3), that states that although worldwide ageing can be seen as a victory over disease owing to the progress made in the medical, social and financial fields, it also provides great challenges regarding social indemnity, pension schemes, social support models, as well as its effect on financial growth, trade, relocation, incidence and patterns of disease and basic beliefs about growing older (NIA, 2007:3). According to NIA (2007:7), it is estimated that in 2030, thirteen per cent of the total world population will be aged 65 and older, an estimated total of one billion older persons worldwide. This indicates that one in every eight people on earth will be aged 65 and older by 2030 (NIA, 2007:2). The South African population is also ageing. It is projected that by the year 2030 more than twelve per cent of the South African population will be aged 60 and older (Velkoff & Kowal, 2007:11). These projections estimate that there will be about 4.8 million older persons in South Africa by the year 2030 (Velkoff & Kowal, 2007:22). Statistics South Africa conducted a countrywide census in 2011 and according to the results of this census, the population aged 65 and older increased from 4.8% in 1996 to 5.3% in 2011, amounting to a total number of 2 765 992 older persons in 2011 (StatsSA, 2011:1).

Because of this steady increase in the older population, more nurses (including professional nurses, enrolled nurses and auxiliary nurses) are needed to provide in their needs. Although we need more nurses to care for the growing numbers of older persons, Oulton (2006:34S) states that an unparalleled worldwide shortage of nurses is experienced because of both supply and demand factors. The diminished supply cannot meet the enhanced demand (Oulton, 2006:34S). An enhanced demand for nurses is experienced because of hospital patients needing more acute care, a movement from hospital to home-based and community care, infectious diseases, for example Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), tuberculosis and malaria, an increasing older population, globalization, the growth in the private sector and the trust the community places in nurses (Oulton, 2006:35S). On the other hand we find that the diminished supply of nurses is caused by the nursing workforce that is growing older, less candidates applying for nursing training, adverse working conditions including extreme workloads, insufficient support personnel, violence, stress, burnout, salary disputes and limited participation in making decisions as well as variation in the way human resources are managed (Oulton, 2006:35S).

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

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

of professional nurses, enrolled nurses and auxiliary nurses willing to care for older persons, is evident.

The dearth of nurses caring for older persons can be attributed to the same work-related problems other nurses encounter but additional problems were highlighted in the literature studied. According to Jackson *et al.* (2003:43-44), the low status of caring for older persons, the physical demands rendering care to older persons place on nurses together with the risk of an injury on duty, exposure to workplace violence and low job satisfaction experienced by nurses are all contributing factors. This is supported by Schneekloth and Wahl (2007) (cited by Schmidt *et al.*, 2012:3135) who assert that symptoms of depression, aggression (especially in older persons suffering from dementia) and irritability is “challenging behaviour” that occurs often in nursing homes. This is confirmed by Isaksson *et al.* (2008:551), who state that violence towards caregivers in nursing homes happens often and numerous aspects may contribute including “maternal rejection” and “burnout” affecting the communication between the caregiver and the older person, leading to more aggression, although the personality characteristics of the caregivers do not seem to have an influence. This argument is supported by Sharipova *et al.* (2010:332, 338-339) who claim that workplace violence caused by older persons towards caregivers occurs extensively and the lower the age and seniority of the staff member, the more the risk of exposure to violence increases.

Additional factors that increase the risk of exposure to violence include shiftwork, especially night shift, work that is physically and emotionally challenging as well as low leadership, low involvement and conflicting roles (Sharipova *et al.*, 2010:332, 338). This argument was supported by Testad *et al.* (2010:796) who assert that caregivers providing care to older persons with dementia perceived that the organisation and leadership provided in the nursing homes was causing them the most stress. More than two-thirds of the personnel caring for older persons with dementia were exhausted emotionally and displayed moderate levels of burnout (Duffy *et al.*, 2008:43). Less job satisfaction and higher burnout were experienced by nurses providing mental health care services to older persons in comparison to other mental health experts (Spear, 2004:58). This is supported by Josefsson *et al.* (2007:72), who contend that all registered nurses providing care to older persons experience high levels of “time-pressure” irrespective of the diagnosis of the older person although providing care to older persons with dementia require more knowledge and place increased emotional and unpredictable demands on the nurses. Schmidt *et al.* (2012:3134) assert that this “challenging behaviour” of the older persons is stressful for nurses and it has an apparent influence on their health, work capacity and burnout risk. Nurses that experience burnout display a high turnover

rate, a grave problem taking into account the current nursing shortage (Schmidt *et al.*, 2012:3134).

According to Oulton (2006:39S) possible solutions for the global nursing shortage include preserving nurses currently practising, enrolling prospective nurses and creating a safe and secure work environment that is fair and appealing to nurses currently practising as well as to prospective nurses. Oosthuizen and Ehlers (2007:14) recommend the following to persuade South African nurses to stay and not to emigrate: higher salaries, improved work circumstances by providing sufficient materials and apparatus, lessening the workload by hiring more nurses, providing prospects for professional development and improvement of safety and security. Testad *et al.* (2010:789) assert that the health and well-being of caregivers caring for older persons with dementia will be improved and staff turnover rates will be lower if more attention is given to leadership and organisational factors in nursing homes.

Regardless of the shortages and high turnover rates, we still find nurses who choose to remain in nursing and manage to cope and survive and even flourish under the often difficult workplace conditions experienced (Koen, Van Eeden & Wissing, 2011:1; Jackson *et al.*, 2007:1), which implies that there must be something that keeps them there. One of the factors that might play a role in retaining nurses in care of the aged may be the resilience of these nurses. According to Edward and Hercelinskyj (2007:240), knowledge of resilient behaviour can empower nurses to handle workplace stress and prevent burnout. According to the Concise Oxford English Dictionary (2011:1224) a resilient person is “able to withstand or recover quickly from difficult conditions”. Resilient people can “bounce back” from hardship and continue with their lives (Dyer & McGuinness, 1996:276). Reich *et al.* (2010:4), confirm that resilience means that a person can successfully adjust to hardship. Fredrickson *et al.* (2003:373) assert that a series of psychological advantages for everyday life as well as in coping with crisis situations are connected to resilience. These definitions indicate that higher levels of resilience might empower nurses caring for older persons to cope and survive.

It is evident that there is a demand for more nurses to care for our increasing older population. It seems that resilience might contribute to their ability to remain in the nursing profession and be willing to care for older persons. This leads to the question: What is the level of resilience in nurses? Research relating to resilience in nurses has been done using different measuring instruments (Gillespie, Chaboyer & Wallis, 2007:130-132), and in a variety of settings (Hart *et al.*, 2012:6-7). Benchmark research was done on the resilience of professional nurses working in public and private hospitals as well as in primary health care clinics in South Africa. Koen, Van Eeden and Wissing (2011:3) established the “prevalence” of resilience in professional

nurses; Koen, Van Eeden, Wissing and Du Plessis (2011:106) explored how resilient professional nurses manage to stay resilient and what prevented the less resilient professional nurses from being resilient and Koen, Van Eeden, Wissing and Koen (2011:643) formulated guidelines to develop resilience in professional nurses. Although these research findings provide a strong foundation regarding resilience in professional nurses in this setting, these authors recommended further research regarding the resilience of professional nurses working in other healthcare settings (Koen, Van Eeden & Wissing, 2011:10).

It is important to note that the research that was conducted by (Koen, Van Eeden & Wissing, 2011; Koen, Van Eeden, Wissing & Du Plessis, 2011; Koen, Van Eeden, Wissing & Koen, 2011), included professional nurses only and not enrolled nurses and auxiliary nurses. The setting in which the research was conducted was public and private hospitals and primary healthcare clinics and not facilities caring for the older person. The guidelines that were formulated to strengthen resilience in professional nurses can be used fruitfully by all professional nurses but they are not focused enough on the practicalities that nurses caring for older persons have to deal with.

While these valuable research findings regarding resilience in professional nurses can be considered, there still seems to be a scarcity of research regarding the resilience of nurses caring for older persons globally as well as in South Africa. The only article that was found during the literature search on resilience in nurses caring for older persons, was an article by Cameron and Brownie (2010:66) regarding how the resilience in registered nurses caring for the aged can be enhanced. According to Cameron and Brownie (2010:66), the maintenance of important relationships with the older persons, the support of fellow nurses and the use of humour all contributed to strengthening the resilience of these nurses.

Although the research that was conducted by Cameron and Brownie (2010) regarding enhancing resilience in registered nurses caring for older persons in high-care residential aged care facilities provided valuable information on how resilience is enhanced by these nurses, this research included only registered nurses and not enrolled nurses and auxiliary nurses. They also did not investigate the level of resilience in these nurses. Even though important information was provided on how resilience is enhanced by these nurses, no recommendations were formulated on how to strengthen resilience in nurses caring for older persons.

1.3 STATEMENT OF RESEARCH PROBLEM

According to the RISE study (Strengthening the resilience of health caregivers and risk groups) (Koen & du Plessis, 2011:3), health caregivers, including professional nurses, experience difficult workplace circumstances that place their mental health and well-being at risk. Despite these difficult working conditions they experience, some of the nurses manage to remain in nursing and even flourish while they still provide healthcare of high quality to their patients (Koen & du Plessis, 2011:4). The RISE study acknowledges that there is a shortage of research regarding the concept of resilience and the strengths and coping abilities that enable health caregivers to stay loyal to the nursing profession and handle the workplace difficulties experienced (Koen & du Plessis, 2011:4). Koen and Du Plessis (2011:4) recommend further investigation into the resilience of health caregivers and risk groups. Such research might explore how the resilience of health caregivers and risk groups can be strengthened by means of a “comprehensive, multi-faceted approach” (Koen & du Plessis, 2011:4).

In this sub-study within the RISE study, the background discussion, as well as my personal experience as a junior lecturer in community nursing accompanying student nurses in old age homes and in the community, indicate that a further, very specific research problem could be identified. This is that there is a steady increase in older persons worldwide as well as in South-Africa (Velkoff & Kowal, 2007:3, 10-11), who need nursing care. At the same time there is a shortage of nurses in the world and in South Africa (Oulton, 2006:34S; SANC, 2013b). This limits the number of nurses available to provide care of the older person. Jackson *et al.* (2003:42) confirm that the nursing shortage is also prevalent in care for older persons. A shortage of nurses is also experienced by the facilities providing care to older persons in this urban setting within the eastern portion of the North West Province where the research study was conducted. This shortage can personally be confirmed by the researcher that worked as a manager of a retirement village in this setting for five years. Available literature indicates that the resilience of nurses might play a critical role in their decision to stay in nursing and, especially in this instance, in the care of older persons. Nurses caring for older persons might use a variety of strategies to develop resilience in response to workplace difficulties experienced (Cameron & Brownie, 2010:70). However, currently the level of resilience of nurses caring for older persons is unknown and we do not know what strengths and coping abilities they use while caring for older persons.

This paucity of research regarding the resilience of nurses caring for older persons confirms the need to explore the resilience of these nurses and how their resilience can be strengthened. Jackson *et al.* (2007:1) furthermore confirm that when nurses actively take part in the

improvement and enhancement of their own personal resilience to minimise their susceptibility to workplace difficulties, they can contribute to improve the general healthcare situation.

The statement of the problem led the researcher to ask the research questions as stated under 1.4.

1.4 RESEARCH QUESTIONS

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

1.5 PURPOSE OF THE RESEARCH

The purpose of this research was to investigate the level of resilience in nurses caring for older persons. The intention was further to explore and describe their strengths and coping abilities in order to formulate recommendations from the findings to strengthen resilience in nurses caring for older persons. An explorative, descriptive design with multiple phases was used to reach this purpose. The study was conducted in an urban setting within the eastern portion of the North West Province, as a sub-study within the RISE study. The purpose of this research is in line with the purpose of the RISE study which aims to strengthen the resilience of health caregivers and risk groups by developing a “comprehensive multi-faceted approach” (Koen & du Plessis, 2011:5).

1.6 RESEARCH OBJECTIVES

Table 1 provides an outline of the objectives of the study as well as an indication of the method (discussed in more detail in Section 1: 1.8.2) to reach these objectives.

Table 1: Outline of the objectives and indication of the methods of the study.

OBJECTIVE	METHOD TO REACH OBJECTIVE
1. To investigate the level of resilience in nurses caring for older persons.	Demographic information forms and the Resilience Scales.
2. To explore and describe the strengths and coping abilities of nurses caring for older persons.	Narratives and focus group interviews.
3. To formulate recommendations from the findings to strengthen resilience in nurses caring for older persons.	Conclusions and results of the demographic information forms, Resilience Scales, themes identified from narratives and focus group interviews, as well as relevant literature, were brought into relation with one another, integrated, and used to formulate recommendations.

1.7 PARADIGMATIC PERSPECTIVE

The paradigmatic perspective refers to the assumptions that the researcher has internalised which might have an influence on the research process. It is therefore good scientific practice for the researcher to declare his or her assumptions. The meta-theoretical assumptions, theoretical assumptions as well as the methodological assumptions are integrated in the paradigmatic perspective (Botma *et al.*, 2010:187).

1.7.1 Meta-theoretical assumptions

1.7.1.1 Judaeo-Christian philosophy

The researcher believes that God has created man to reign over creation and to inhabit the earth to honour His name. Inherent in this belief is that God loves mankind and therefore gave His only son, Jesus Christ, to die for the sins of humanity so that whoever believes in Him, might be saved and have eternal life with Him. The researcher believes that the purpose of man's life on earth is to fulfil this plan that God has for their lives and to love Him, above all, and their neighbours as themselves. The researcher accepts the Bible as the Word of God wherein these principles are stipulated.

The Theory of Nursing for the Whole Person is based on the Judaeo-Christian philosophy (Randse Afrikaanse Universiteit (RAU), 1992:2), and the researcher acknowledges and uses this theory to formulate her assumptions regarding the person, environment, health and nursing. The following is adjusted from the Theory of Nursing for the Whole Person, Oral Roberts University (ORU), Anna Vaughn School of Nursing, Student Handbook (ORU, 1990:6-8).

1.7.1.1.1 Person

According to the Theory of Nursing for the Whole Person, the body, mind and spirit all form part of the whole person (ORU, 1990:6). The body represents the physiological part, the mind represents the emotions, will and intellect, and the spirit is that part of the person that is in relationship with God (ORU, 1990:6). The body of the person is created by God and the real person, the spirit, lives inside the body (ORU, 1990:6). The spirit is created in the image of God (ORU, 1990:6). The mind inexplicably causes integration between body and spirit (ORU, 1990:6). A person is a spiritual individual that functions in an incorporated “bio-psychosocial” way to accomplish wholeness or health (ORU, 1990:6, 8). In this study the **person** refers to the nurse caring for the older person. The nurse is a spiritual individual that functions in an incorporated “bio-psychosocial” way to reach her pursuit for wholeness (ORU, 1990:6, 8). The nurse is a unique human being but she is also an important member of her family and her community (ORU, 1990:8).

1.7.1.1.2 Environment

The concept of environment includes an internal environment as well as an external environment (RAU, 1992:7). The internal environment includes the body, mind and spirit and the external environment includes the physical, social and spiritual environment (RAU, 1992:7). The interaction between the internal environment and the external environment determines the health status (RAU, 1992:7). In this study the environment is the internal and external environment of the nurse caring for the older person. The internal environment of the nurse includes her body, mind and spirit (RAU, 1992:7). The external environment of the nurse includes her physical, social and spiritual environment (RAU, 1992:7). In this study the environment in which the older person is being cared for namely the working environment of the nurse, forms part of the external environment. It includes the older persons’ home, old age homes, retirement villages as well as other facilities caring for older persons in the community. The internal and external environments of the nurse are in interaction with one another and have an influence on the health or wholeness of the nurse (ORU, 1990:8; RAU, 1992:7). The

nurse caring for the older person interacts with her internal and external environments as a holistic person and this interaction will determine her health (ORU, 1990:8; RAU, 1992:7).

1.7.1.1.3 Health

To heal means the restoration of wholeness or health (ORU, 1990:6). Wholeness or health is influenced by the condition of the body, mind and spirit (ORU, 1990:6). Health is a condition in which the body, mind and spirit are whole or healthy (ORU, 1990:8). The health condition of the person is influenced by the way he or she deals with their internal and external environments (ORU, 1990:8). Health can be explained as being on a continuum from maximum health to minimum health (ORU, 1990:8). Even if someone is healthy, there is always the possibility that they may become ill (ORU, 1990:8). In this study **health** refers to the physical, emotional, spiritual and social health of the nurse caring for the older person. The manner in which the nurse caring for older persons engages with her internal and external environments, will determine her health (ORU, 1990:8). The health of the nurse can be anywhere on a continuum from maximum health to minimum health (ORU, 1990:8). Even a healthy nurse has the potential for illness (ORU, 1990:8). The resilience of the nurse caring for older persons forms part of her emotional health. The resilience of the nurse may be on a continuum ranging from a very low level of resilience to a high level of resilience. The physical, emotional, spiritual and social health of the nurse, including the resilience of the nurse, must be strengthened to enable her to render quality care to the older person.

1.7.1.1.4 Nursing

Nursing is a purposeful service that promotes, maintains and restores the health of the individual person, the family and / or the community (ORU, 1990:8). In this study nursing is the care rendered to the older person. Nursing is a purposeful service that helps the older person to maintain, promote and restore health (ORU, 1990:8). The health of the older person is maintained by the nurse providing nursing care that will maintain or conserve his / her health (ORU, 1990:8). Nursing care that will contribute to a greater degree of wholeness for the older person, will promote his / her health (ORU, 1990:8). Restoration of health is the nursing care that will enable the older person to return to former levels of health (ORU, 1990:8). Nursing is provided to the older person as a whole person that includes his / her body, mind and spirit (ORU, 1990:6). According to the Nursing Act (33 of 2005), nursing is a caring profession practised by a person registered with the South African Nursing Council that supports, cares and treats a patient to sustain health or, if not possible, cares for the patient by providing comfort and dignity until death (South Africa, 2005). Nursing is a calling and each nurse has the responsibility to care for each patient as they would like to be cared for themselves.

1.7.2 Theoretical assumptions

The theoretical assumptions in this study include the central theoretical argument and the conceptual definitions.

1.7.2.1 Central theoretical argument

The focus of this study is on investigating the level of resilience in nurses caring for older persons. By identifying their resilience, as well as by learning from the strengths and coping abilities of nurses caring for older persons, recommendations can be formulated on how to strengthen the resilience of these nurses. These intended recommendations can be used to empower nurses to be resilient and continue providing quality care to the older person.

1.7.2.2 Conceptual definitions

For the purpose of this study, the following concepts are explained as applied in the study.

1.7.2.2.1 Resilience

Resilience is the human ability to deal with, rise above, be strengthened by, and even be changed by experiences of hardship, including natural disasters as well as those caused by man (Grotberg, 2001:76). Individual resilience refers to the amount of pressure that a person can tolerate without a vital change in the ability to follow aims that give meaning to life (Reich *et al.*, 2010:6). Resilient communities tend “to see the silver lining”; they recover and even strengthen their adaptive qualities (Reich *et al.*, 2010:4). In this study resilience refers to the ability of nurses caring for older persons to cope and even flourish under adverse working conditions in order to provide quality care to older persons.

1.7.2.2.2 Nurse

According to the Nursing Act (33 of 2005), a nurse is a person registered with the South African Nursing Council in order to practice nursing or midwifery (South Africa, 2005). Different categories of nurses are registered with the South African Nursing Council. According to section 30 of the Nursing Act (33 of 2005), an auxiliary nurse is trained to provide elementary nursing care according to the prescribed level; a staff nurse is trained to perform basic nursing according to the manner and level prescribed and a professional nurse is qualified and skilled to autonomously practise comprehensive nursing in the manner and to the level prescribed and who is able to assume responsibility and liability for such practice (South Africa, 2005). In practice as well as in literature a professional nurse is also referred to as a registered nurse

and a staff nurse is also called an enrolled nurse and an auxiliary nurse is also called an assistant nurse. In this study all these categories of nurses provide care to the older person.

1.7.2.2.3 Older person

According to the Older Persons Act (13 of 2006), an older person is seen as a person that is 65 years old or older when referring to a male person and 60 years of age or older when referring to a female person (South Africa, 2006). In this study the older person is any person older than 60 years of age that is being cared for by a nurse.

1.7.2.3 Theoretical framework

Although a comprehensive literature study was conducted, the resilience of nurses caring for older persons was explored with no specific theoretical framework guiding the study. The research was predominantly qualitative in nature and the researcher decided to explore the resilience of nurses caring for older persons without being influenced by a specific theoretical framework. After the qualitative data was analysed, the researcher conducted a thorough literature control of the themes and sub-themes that have emerged from the content analysis of the data to ground the findings in literature. This literature control provided the researcher with a theoretical framework, namely the model provided by Carr (2004:302-304) that explains how strengths can be used to handle opportunities and challenges. This theoretical framework was used as a vehicle to explain, discuss and interpret the qualitative findings. The framework provided by Carr will be discussed in detail in (Section 3: 2.1.3).

1.7.3 Methodological assumptions

According to Botma *et al.* (2010:188), the methodological assumptions clarify the researcher's viewpoint of high-quality science practice. The research methodology the researcher uses influences the quality of the research findings and needs to be recorded thoroughly. The researcher describes her methodological assumptions according to the Botes model (1995) as explained by Botma *et al.* (2010:188-189).

The practice of the nursing discipline is the first order of activity and concerns the phenomenon that is being explored and described in the area of practice by the researcher (Botma *et al.*, 2010:188). This study explored the resilience of nurses caring for older persons in an urban setting within the eastern portion of the North West Province.

The second order entails the research methodology that is used in the study (Botma *et al.*, 2010:189). An explorative, descriptive design with multiple phases was used. The study was conducted in three phases. The level of resilience in nurses caring for older persons was identified and the strengths and coping abilities of these nurses were explored. The results were used in combination with literature to formulate recommendations to strengthen resilience in nurses caring for older persons.

According to Botma *et al.* (2010:189), the third order includes “meta-theoretical assumptions”, “theoretical assumptions” and “methodological statements”. The meta-theoretical assumptions portray the philosophy of the researcher (Botma *et al.*, 2010:189). The theoretical assumptions include applicable knowledge, models and theories (Botma *et al.*, 2010:189). The methodological statements are established in the chosen research model (Botma *et al.*, 2010:189). The meta-theoretical assumptions of the researcher are based on a Judaeo-Christian philosophy and the Theory of Nursing for the Whole Person. The researcher formulated her perspectives of the person, environment, health, and nursing accordingly. The theoretical assumptions were stated as the central theoretical argument and the conceptual definitions. The researcher’s methodological assumptions guided her to use an explorative, descriptive design with multiple phases.

1.8 RESEARCH DESIGN AND METHODS

1.8.1 Research design

Within the RISE project, it is recommended that a variety of study designs, including quantitative, qualitative and mixed method research designs, are followed in order to explore and describe a “comprehensive multi-faceted approach” to strengthen the resilience of health caregivers and risk groups (Koen & du Plessis, 2011:5, 9). Almedon and Glandon (2007:127), confirm that resilience is a “multidimensional construct” that requires a “multimethod and multilevel study design” combining qualitative as well as quantitative techniques to study it adequately.

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

During quantitative research variables are measured with instruments and data in number format is analysed using statistical procedures whilst in qualitative research the meaning

individuals or groups of people give to social or human problems are explored and understood (Creswell, 2009:4). When little is known about a phenomenon, exploratory studies are often used in qualitative research in order to develop a preliminary appreciation of the phenomenon with the purpose to explore and describe it (Botma *et al.*, 2010:50). The attributes of the population or phenomenon are measured and reported accurately during descriptive studies (Botma *et al.*, 2010:50-51).

Figure 1 outlines the explorative, descriptive design with multiple phases that was followed in the study.

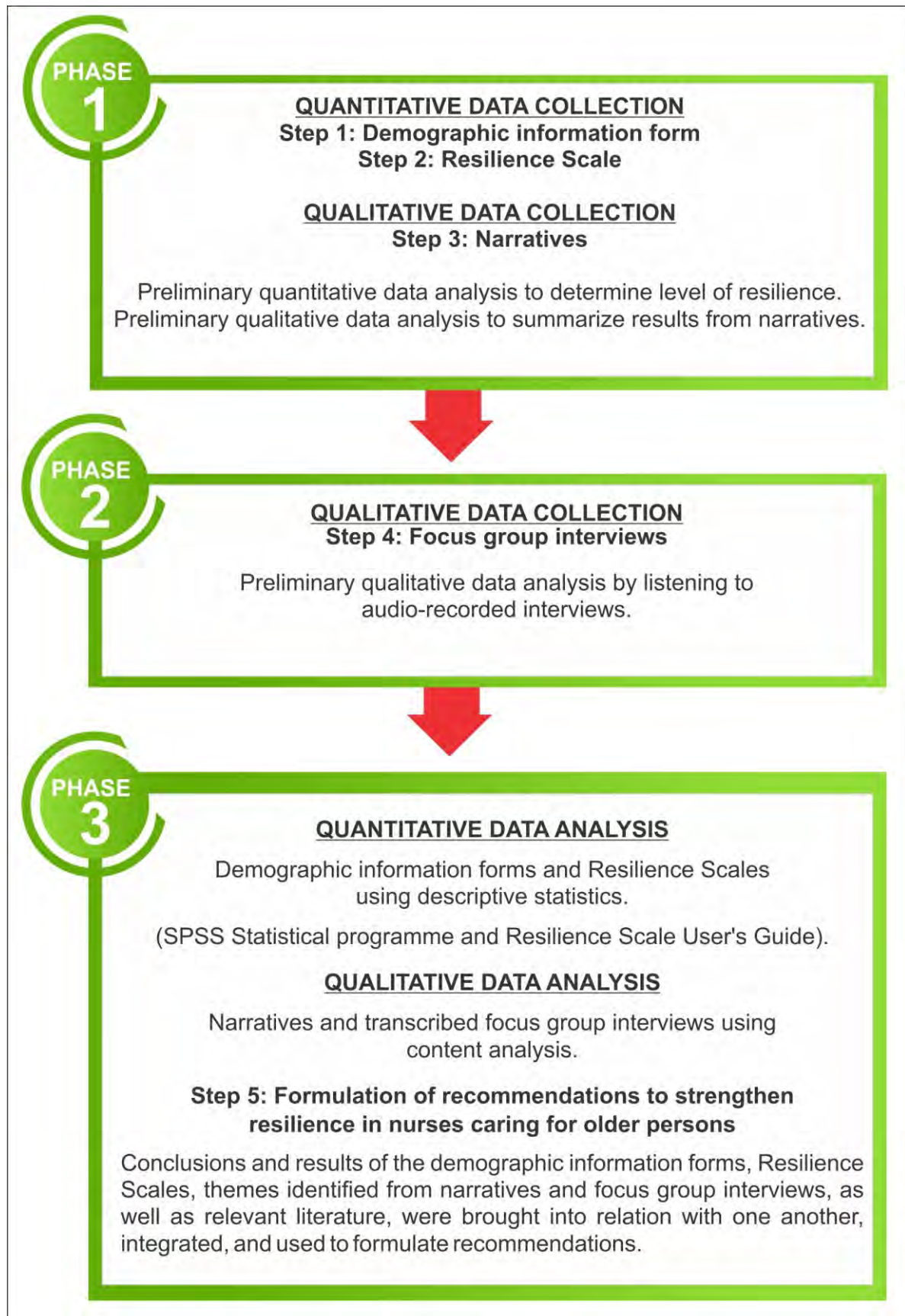


Figure 1: Outline of the explorative, descriptive design with multiple phases.

1.8.2 Research method

The research method included the steps, the procedures followed and the strategies used to collect and analyse the data in the study (Polit & Beck, 2012:73).

Table 2 outlines the research method in each phase, linked with the objectives. The research method includes the population and sample, data collection and data analysis.

Following Table 2 an overview of the sampling plan including the population, the sampling method, sample size and setting will be given. The trial run that was conducted to test the data collection instruments and to prepare the researcher for data collection, will then be discussed in detail. The methods that were used to collect data will follow and then a detailed discussion will be given on how data collection was implemented for this study clearly indicating the role of the researcher in the data collection process. The data analysis will then be discussed by starting with the quantitative data analysis, followed by the qualitative data analysis. The results of the quantitative data analysis as well as the findings of the qualitative data analysis will be reported in the results section of the article (see Section 2: Quantitative results and discussion; Qualitative findings, discussion and literature control).

Table 2: Outline of the phases, objectives, steps, population and sample, data collection and data analysis.

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

1.8.2.1 Sampling plan

1.8.2.1.1 Population

The population included all categories of nurses, namely professional nurses, enrolled nurses and auxiliary nurses that were caring for older persons in facilities or in the community, in an urban setting within the eastern portion of the North West Province.

1.8.2.1.2 Sampling method

The researcher contacted all the managers at the facilities to obtain permission that their nurses may participate in the research. An all-inclusive sample was used. Unfortunately not all the facilities gave written consent. In the facilities where management did give written consent that their nurses may participate in the research, the chief professional nurse or the manager of the facility that acted as the “gatekeeper”, invited all the nurses (all-inclusive sample), to participate in the research.

Initially the researcher formulated certain inclusion criteria that were indicated on the documents to the nurses and management. During data-collection the researcher realised that an all-inclusive sample of nurses could be used because all the nurses caring for older persons had a contribution to make to the research and that no inclusion or exclusion criteria were needed to reach the research objectives.

The nurses that participated in the study had the following characteristics:

- They were professional nurses or enrolled nurses or auxiliary nurses.
- They had at least six months" practical experience in caring for older persons. Experience gained during training as caregivers and auxiliary nurses was also taken into account.
- They were willing to participate in the study on a voluntary basis.
- They were able to communicate in Afrikaans or English.

From the discussion above it is clear that an all-inclusive, voluntary sample of all categories of nurses, namely professional nurses, enrolled nurses and auxiliary nurses, that were caring for older persons in facilities or in the community, in an urban setting within the eastern portion of the North West Province, participated in the research.

1.8.2.1.3 Sample size

At the time the research was conducted, 49 nurses (including part-time workers at some facilities), were working in the seven facilities that gave written consent to participate in the research. The sample size in phase one was 43 (n=43). Although all the nurses were invited, not all the nurses participated due to the different shifts they work and leave arrangements. The sample size in phase two was 17 (n=17). Although all the nurses that participated in phase one of the research, were invited to participate in phase two, the focus group interviews, only a few nurses participated in phase two due to the different shifts they work and lack of transport when they are off duty. Fortunately this was not a problem because data saturation determined the sample size and fewer participants were needed.

1.8.2.1.4 Setting

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

1.8.2.2 Trial run

The researcher conducted a trial run of the proposed research before starting data collection. A trial run was conducted for phases one and two of the research.

The trial run for phase one entailed the completion of the demographic information form, the Resilience Scale and the writing of the narratives. This was done to ensure that the nurses understood the instructions on how to complete the demographic information form and the Resilience Scale as well as to confirm if the request to write the narratives was formulated clearly. The trial run also gave the researcher an opportunity to do the data analysis on a small scale.

Eight professional nurses and one enrolled nurse working fulltime or part-time at the North-West University (NWU) School of Nursing Science were invited by email to participate in the research. The eight professional nurses were selected because of their experience, knowledge or involvement in the care of the older person. The enrolled nurse worked in an administrative post at the time of the research and her elderly father lived with her. The researcher decided to

include her because the sample included professional nurses, enrolled nurses as well as auxiliary nurses. Six professional nurses and one enrolled nurse gave informed voluntary consent to participate in the trial run.

The researcher arranged to see all the nurses at the School of Nursing Science. The letter obtaining permission from the nurses to conduct research was given to them. The purpose and objectives of the research were explained and they got the opportunity to give informed voluntary consent. After they gave consent, they each selected a file with the following included: an information letter; Section A: Demographic information form; Section B: Resilience Scale; and Section C: Writing of narrative. The request to write the narrative was provided in both English and in Afrikaans. They were asked to put the completed data collection instruments back into the envelope provided and to seal it. The data-collection instruments were marked T01, T02 and so forth.

One of the aims of the trial run was to decide on the best format to request the writing of the narratives. The possible questions were divided into an option one and an option two that will be discussed in detail in the paragraph that reports the valuable information that the writing of the narratives during the trial run provided. The researcher included the option one in one half of the envelopes and the option two in the other half. The nurses were given the opportunity to complete the data-collection instruments in their own time and put it in the researcher's post-box at the School of Nursing Science. Five completed data-collection instruments were received back, which was equal to ten per cent of the preliminary estimated sample of 50 participants that was established during January 2013, and were thus enough to help the researcher to prepare for the data-collection that was to commence on the next week.

The trial run of phase one served its purpose by alerting the researcher to possible problems that could be encountered during data collection during phase one. This gave the researcher the opportunity to make the necessary changes before data collection started.

Herewith a short account of what was learned from the trial run of phase one:

One nurse did not hand back the demographic information form. The researcher decided to include a section on the envelope to indicate that all the data collection instruments were included. The demographic information forms were completed correctly with an X although one nurse forgot to indicate her years of experience. The Resilience Scale was understood correctly and completed correctly by three nurses that made a circle around the number that best indicated their feelings about the statement. Two nurses marked their selection with an X instead of making a circle around their choice as requested. The researcher realised that this

will make the scoring more difficult. The researcher learned from this that she had to explain to the nurses to make a circle in order for the researcher to see the number clearly.

The completion of the narratives during the trial run provided valuable information to the researcher. Option one: two nurses received the request to write a story on each of the following questions: “How do you manage to cope while caring for older persons?” and “What makes it worthwhile to care for older persons?” They answered the questions satisfactorily although one nurse forgot to answer the second question. The first question was printed on page one and the second question was printed on page 4. Option two: the other three nurses received the request to write a letter to another nurse caring for older persons and to answer the following questions in their letter to her: “What gives you emotional strength while caring for older persons?” “What helps you to cope while caring for older persons?” “What makes it worthwhile caring for older persons?” “What recommendations can you give her to cope and be resilient while caring for older persons?” These nurses answered quite satisfactorily but the researcher realised that it was difficult to answer all four the questions and to turn back to the questions all the time. Some of the nurses also provided a lot of detail about elderly care and not about their coping and strengths, for instance. After reading and re-reading the narratives and after consultation with the supervisors, the researcher decided to change the request to write the narratives for the research study (see Section 1: 1.8.2.3.2).

All the nurses that participated in the trial run for phase one, were invited to participate in the trial run for phase two, namely the focus group interview. Only three nurses were able to participate. A suitable time and place was arranged. The reason for conducting the focus group interview during the trial run was to ensure that the researcher was well prepared for conducting the focus group interviews and to get the professional opinion of the participants regarding the focus group interview questions.

The focus group interview for the trial run was held in the researcher’s office at the School of Nursing Science and the door was closed to provide privacy. The researcher started with small talk by asking the nurses how they experienced participation in the first phase of the research in order to relax them (Botma *et al.*, 2010:212). They verbalised that they have experienced it positively although the writing of the narratives was a bit challenging for some of them because not all of them had a lot of experience in caring for older persons.

The researcher used a voice recorder to record the focus group interview. Each nurse was given a copy of the interview schedule for the trial run. The following procedure was followed during the trial run focus group interview. The researcher asked the nurses if they preferred to speak in Afrikaans or English. They preferred Afrikaans. The researcher welcomed the nurses,

thanked them for their willingness to participate in the research and asked them to make themselves comfortable. The researcher reminded them of the purpose of the research, namely to investigate the level of resilience in nurses caring for older persons with the intention to explore their strengths and coping abilities in order to formulate recommendations from the findings to strengthen resilience in nurses caring for older persons. The researcher confirmed that all the nurses did give written consent to participate in the focus group and reminded them that their participation is voluntary and that they may decide to withdraw at any time. The researcher reminded them that the focus group interview will be voice recorded and that the recordings will be analysed and transcribed. The researcher assured them that there are no wrong answers and that all contributions are valuable. The researcher reminded them that everything said in the group is confidential and that they must also keep it confidential. The researcher explained to them that the questions will be asked one by one and that each one of them will get an opportunity to participate in the discussion. They were asked to relax and to feel free to participate.

The following questions were asked. The questions were presented in Afrikaans and in English.

1. What are your personal strengths that enable you to care for older persons?
2. How do you manage to cope while caring for older persons?
3. What makes it worthwhile for you to care for older persons?
4. Give your own definition of resilience.
5. Do you think nurses caring for older persons need to be resilient? Please explain.
6. How do you manage to be resilient while caring for older persons?
7. What recommendations can you make to other nurses caring for older persons to be resilient?

After reading the questions, the researcher asked one question at a time and gave all the nurses an opportunity to participate. The nurses participated very well and there was very good interaction and positive group dynamics. The researcher used communication techniques including reflection and summarizing during the focus group interview. All the questions were discussed and at the end the researcher gave a short summary of the answers to all the questions. The researcher realised that it is important to make short notes regarding the answers because it is not always possible to remember everything for the summary. At the end

the researcher asked the nurses if anything was missed. A few comments were made. The researcher thanked the nurses for their participation and assured them that their contributions were held in high regard. Afterwards the researcher asked the nurses if they had any recommendations regarding the interview questions. One of the nurses mentioned that a question needs to be included regarding recommendations to management to strengthen resilience in nurses. A question to management could not be included because management did not form part of the sample but the results of the research were used to include recommendations to management on how to strengthen resilience in nurses caring for older persons.

The researcher noticed that she was emotionally exhausted after the focus group interview and realised that not too many focus group interviews must be conducted on one day. The researcher also realised that she was afraid that the voice recorder would malfunction in some way or other and that the data would be lost. The researcher decided to use the voice recorder as well as her cell phone during all the focus group interviews that would be conducted to audio record the interviews.

The voice recorder with the “trial run” focus group interview was given to the supervisor to listen for comments. The supervisor gave feedback that the focus group interview was conducted satisfactorily but recommended that the researcher needed to use more communication techniques, for example reflection, listening and summarizing. The supervisor made the researcher attentive of the fact that the researcher must not react too positively on comments because it may influence the participants to give answers the researcher prefers and the same must be taken into account for negative responses. The supervisor advised the researcher to rather be neutral when making comments.

After receiving feedback from the study leader, the researcher listened to the voice recording of the trial run “focus group interview” and realised all the areas for improvement the supervisor pointed out. The researcher also realised that she used the diminutive form of some words. She realised that she did react too positively on some comments and did talk about her own experience with an older person and realised that she had to refrain from sharing her own experiences on the topics discussed, or at least restrict them.

Although the researcher did not take formal field notes, she did write a few notes afterwards to remind her of how the trial run was conducted. The researcher learned from this as well as from previous research studies and literature that she must take extensive field notes before, during and after the focus group interviews.

The feedback received from the supervisor as well as the researcher's own reflection on the focus group interview, prepared the researcher well for the focus group interviews. The researcher discussed the questions that need to be asked during the focus group interview with her supervisors. It was decided that the researcher will give a summary of the answers received in the narratives from each question and provide opportunities for the participants to add more information if needed. Then the new questions will be asked. The aim of the focus group interviews will firstly be to verify the answers received from the narratives and give opportunities for new comments, secondly to explore the reasons why nurses caring for older persons need to be resilient and thirdly what advice these nurses can give other nurses caring for older persons on how to strengthen their resilience while caring for older persons.

1.8.2.3 Data collection

The data collection will be discussed by giving a short overview of the data collection method, followed by a detailed discussion of the process of data collection and the role of the researcher.

1.8.2.3.1 Data collection method

During phase one, three types of data were collected.

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

During step two, the level of resilience in nurses caring for older persons was investigated using a reliable and validated self-report instrument, the Resilience Scale, Annexure I, (Wagnild & Young, 1993:165; Wagnild, 2011:22), with permission from these authors (Annexure C). The Resilience Scale consists of 25 items (Ahern *et al.*, 2006:111) that measures the construct resilience. A seven point (1-7) Likert scale (Ahern *et al.*, 2006:112) is used where 1 indicates "Strongly Disagree" and 7 "Strongly Agree" (Wagnild & Young, 1993:168; Wagnild, 2011:122). All the items are formulated in a positive manner and represent the words that the participants used in the original study (Wagnild & Young, 1993:168). The scoring of the Resilience Scale will be discussed during quantitative data analysis, (see Section 1: 1.8.2.4.1), whilst the

reliability and validity of the Resilience Scale will be discussed under measures to ensure rigour, (see Section 1: 1.9).

During step three, the strengths and coping abilities of the nurses were explored by asking them to write narratives. According to Polit and Beck (2012:735), a narrative is a qualitative approach where the centre of attention is on stories as the object of the investigation. The decision to use narratives was made because, when individuals write stories, they are able to make sense of their world and they convey these meanings by building and rebuilding the stories (Polit & Beck, 2012:504). The writing of the narratives will be discussed in detail in (Section 1: 1.8.2.3.2).

During the second phase, step 4, focus group interviews were conducted with all the nurses that were willing to participate. The conducting of the focus group interviews and the questions asked will also be discussed in detail in (Section 1: 1.8.2.3.2).

1.8.2.3.2 Process of data collection and role of the researcher

The researcher completed an application letter to obtain ethical approval from the NWU under the RISE study, Annexure A, and submitted the research proposal to the Research Ethics Committee of the NWU for ethical approval.

The researcher then consulted with the statistical consultant regarding the demographic information form and the Resilience Scale. The consultation was in order to ensure that all the necessary aspects were included in the demographic information form to be able to determine after data collection and data analysis whether associations between the resilience of the nurses and their demographic information existed.

The researcher also obtained permission from the authors of the Resilience Scale to use the Resilience Scale and bought a license pack for students. The following were included in the license pack for students: The Resilience Scale User's Guide; Versions of the 25 item as well as the 14 item Resilience Scales that may be copied as well as the scoring sheets for both versions; unlimited quantity, one year licences for the use of both scales and limited email support. The licence agreement and personal note from Dr. G. Wagnild are included as (Annexure C).

While writing the research proposal, the researcher contacted the facilities to inform them of the proposed research and to obtain an estimation of the sample size. At that stage the researcher communicated mainly with the chief professional nurses or in some instances with the managers. The preliminary sample size was estimated at 50 during January 2013.

The data was collected during August 2013. Before the commencement of data collection, the researcher gained entry to the facilities (Botma *et al.*, 2010:203) by contacting the managers and / or chief professional nurses of the different facilities and made appointments with the managers and chief professional nurses. During the appointments the purpose and objectives as well as the benefits of the research were explained. The researcher also showed them the data collection instruments that would be used. The written consent of the managers or chief professional nurses was obtained. The document to obtain permission from management is included as Annexure D “Requesting permission from management to conduct research”. Most managers preferred to use the document provided by the researcher to indicate their permission and completed their details and made the permission official with the official stamp of the facility. Only one facility did give permission on an official letterhead as recommended in the letter. The researcher identified a “go-between” at each facility to connect the researcher with the nurses at the facility (Botma *et al.*, 2010: 203). This person was the manager or chief professional nurse that arranged with the nurses of each shift to be available at the date, time and venue as arranged in order for the researcher to explain the research to the nurses, obtain their permission and to collect the data.

The manager or chief professional nurses had ensured that comfortable, private venues were selected at each facility for data collection during phase one, where no interruption took place (Botma *et al.*, 2010:203). Conference rooms, sitting rooms or an office were used. The researcher welcomed the nurses and thanked the manager or chief professional nurse for the arrangements. The document “Requesting permission from nurses to participate in research”, Annexure E, was handed out to all the nurses and was explained in detail by the researcher. The researcher read the document in English and translated it into Afrikaans when requested by the nurses. The purpose and objectives of the research and the fact that participation is voluntary were explained to the nurses. The nurses were given a few minutes to decide if they wanted to participate in the research. If they decided to participate, the researcher gave them each a consent form. The researcher read the consent form to them and each nurse that was willing to participate, completed the “Informed consent to participate in research”, Annexure F, in the presence of a witness that also signed as witness. The researcher ensured that the nurses understood exactly what they consented to by explaining the consent form in Afrikaans and English as needed.

The nurses that were willing to participate were given an opportunity to select a NWU file containing the following:

1. An information page explaining the purpose and objectives of the research, (Annexure G).
2. Section A: Demographic information form, (Annexure H).
3. Section B: The Resilience Scale, (Annexure I).
4. Section C: Writing of narrative (story), (Annexure J).
5. An envelope with a checklist printed on top, to ensure that the nurses hand in all the data collection instruments.

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

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

Dear nurse,

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

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

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

Examples of narratives written by the nurses are included as (Annexure J).

The nurses were given enough time to complete the documents and hand them back to the researcher. The researcher collected all the envelopes containing the data collection instruments and kept them safely for data analysis. Some of the nurses on night duty requested to write the narratives during the night and in those instances the researcher collected the envelopes the following day or as soon as possible.

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

Practical arrangements such as the date, time and a private, comfortable venue where there would be no interruptions and where the door could be closed, were made well in advance and appointments were arranged with the help of the manager or chief professional nurse (Botma *et al.*, 2010:203). Two of the focus group interviews were conducted in offices, one in a conference room / activity room and one in a private hall. The researcher prepared an interview schedule for the focus group interviews, Annexure L, and made preparations for voice recording (Botma *et al.*, 2010:212). The researcher gave each nurse a copy of the interview schedule containing the rules as well as the interview questions and read the interview schedule to the nurses before the focus group interview started (Botma *et al.*, 2010:212). It was explained in English as well as in Afrikaans as needed. The following information was written on the interview schedule: the purpose of the research, the participants and what was expected of them, the fact that they voluntarily participated, a reminder that they will receive no money for participating, the fact that the focus group interview will be voice recorded, a reminder that they might withdraw at any time and the provision of emotional support if needed (Botma *et al.*, 2010:212). All the nurses were also reminded to ensure that they had signed informed voluntary consent forms before participation in the focus group interview.

A summary of the answers received from the questions that were asked in the narratives, included as Annexure K, was read to the nurses and they were asked to verify the answers and given the opportunity to add any new information. Thereafter two new questions were asked.

Questions asked in narratives:

1. My personal strengths that enable me to care for older persons are ...
2. This is how I manage to cope while caring for older persons...

3. The following makes it worthwhile for me to care for older persons ...
4. This is how I manage to be resilient while caring for older persons ...

Two new questions asked during the focus group interviews:

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

All the focus group interviews were conducted consistently according to the interview schedule (Botma *et al.*, 2010:212). Field notes were taken by the researcher during and after each focus group interview (Botma *et al.*, 2010:212). An example of the field notes taken by the researcher is included as Annexure M, and an example of a transcribed focus group interview as (Annexure O).

The researcher was open and friendly and facilitated group discussion (Botma *et al.*, 2010:212). The focus group interviews were voice recorded (Botma *et al.*, 2010:212). The choice to use focus group interviews was made to further explore the strengths and coping abilities of nurses caring for older persons as well as to explore the reasons why nurses caring for older persons need to be resilient. The nurses were also given the opportunity to verbalise advice to other nurses caring for older persons to help them to be resilient. During the focus group interviews the researcher explored the thoughts, feelings and conduct of the nurses and new information came to light and the words used by the nurses were recorded (Botma *et al.*, 2010:210-211). The questions were asked in a conversational manner and communication techniques, such as exploring, clarifying, reflecting, focusing, validating and summarizing, as described by Kreigh and Perko (1983:250-254), were utilized.

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

The researcher informed the nurses during both phases of the research that they might withdraw at any stage of the research without any consequences and that the data collected during phase one was anonymous and for phase two, the focus group interviews, their identities would be kept confidential (Botma *et al.*, 2010:204). The researcher explained that benefits might be gained when the researcher provide feedback concerning the results of the

research on how to strengthen the resilience of nurses caring for older persons. This might empower the nurses to be more resilient and even flourish while providing care to the older person. It would benefit the facility if the nurses were more resilient and better able to cope with their valuable work. The researcher also explained that no risks were foreseen for the nurses or the facilities. An invitation for emotional support was provided (Botma *et al.*, 2010:204) on the document “Requesting permission from nurses to participate in research” (Annexure E).

1.8.2.4 Data analysis

1.8.2.4.1 Quantitative data analysis

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

The level of resilience of each nurse was determined with the Resilience Scale, Annexure I, in order to identify the different levels of resilience in nurses caring for older persons. According to Ahern *et al.* (2006:112), the scores of all the items are counted together. The scores that are possible range from 25 to 175, with higher scores indicating higher resilience (Wagnild & Young, 1993:168; Ahern *et al.*, 2006:112; Wagnild, 2011:72).

Table 3 provides an outline of the scoring of the Resilience Scale indicating the different levels of resilience according to Wagnild (2011:72).

Table 3: Outline of the scoring of the Resilience Scale.

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

(Wagnild, 2011:72)

The ranges of moderate (131-145) and moderately high (146-160) were personally confirmed by email with Dr. Gail Wagnild (Annexure T).

Frequencies were calculated and associations were determined between the resilience of the nurses and their employment status, marital status, gender, language, education, nursing title

and years of service. The results of the quantitative data analysis will be reported and discussed in the results section of the article (see Section 2: Quantitative results and discussion). The researcher was able to calculate the level of resilience of the nurses by hand as well and was able to compare the results with the results from the statistical consultation service as recommended in the “Resilience Scale User’s Guide” (Wagnild, 2011:73).

1.8.2.4.2 Qualitative data analysis

Content analysis was used to analyse the qualitative data obtained from the narratives written by the nurses and the transcriptions of the focus group interviews that were conducted with them because it produces an orderly and complete outline of all the data (Botma *et al.*, 2010:213). The findings of the qualitative data analysis were reported in the results section of the article (see Section 2: Qualitative findings, discussion and literature control).

Before the narratives were analysed, the researcher sorted the narratives according to the level of resilience of each nurse. The resilience of one nurse was very low, two were on the low end, eight were moderate, sixteen were moderately high and sixteen were high. The researcher started by reading the narrative of the nurse with the very low resilience. The researcher could determine from the narrative that this nurse was not able to express herself clearly in writing although she did mention the fact that you need to have patience when working with older persons and that you need to know where to get “strength”, referring to God. The narratives of the two nurses with resilience scores that were on the low end were read and both of them gave good answers although the answers provided by one nurse were quite short. The researcher also read five of the narratives that were scored moderate, five that were scored moderately high and five that were scored with high resilience. All of these nurses gave answers that ranged from relatively good, good to very good. The researcher decided to use the narratives of all the nurses as recommended by the Research Ethics Committee of the NWU because it seemed evident that something could be learned from the strengths and coping abilities of all of these nurses irrespective of their level of resilience. This decision was further confirmed by the results received from the quantitative data analysis as reported in the article (see Section 2: Quantitative results and discussion) that indicated that the majority of the nurses had a moderately high to high level of resilience, with an average of a moderately high level of resilience.

The narratives were analysed using content analysis to learn from all the nurses about their personal strengths, how they manage to cope, what makes it worthwhile and how they manage to be resilient while caring for older persons. This was done in order to determine how the resilience of nurses caring for older persons could be strengthened and to formulate

recommendations from the findings to strengthen the resilience of nurses caring for older persons. The transcriptions of the focus group interviews were also analysed using content analysis in order to determine why these nurses need to be resilient and also to contribute to the formulation of the recommendations to strengthen the resilience of nurses caring for older persons. The group dynamics and the interaction between the nurses in the group all formed part of the analysis and it was recorded in the field notes (Greeff, cited by Botma *et al.*, 2010:213). Themes and patterns materialized from the similarities and differences in the data (Greeff, cited by Botma *et al.*, 2010:213).

An experienced co-coder was asked to analyse all the qualitative data independently of the researcher. A protocol for data analysis of the narratives and transcriptions of the focus group interviews was developed, Annexure P, and given to the co-coder.

The data was analysed for themes or viewpoints and a few themes were reported (Creswell, 2009:184). The following basic steps, as explained by Creswell (2009:185-190) were followed as guidelines during data analysis.

Step 1: Organising and preparing the data (Creswell, 2009:185).

The data was organized and prepared for analysis by sorting the narratives from one to forty three. The different sections were sorted together, for example personal strengths, how they managed to cope, what made it worthwhile and how they managed to stay resilient. The field notes were typed and the focus group interviews were transcribed. The field notes and transcriptions of focus group interviews were placed together. The researcher had a quick look at all the data (Creswell, 2009:185).

Step 2: Reading the data (Creswell, 2009:185).

The researcher read all the data to get a “general sense” of the information and to think about the general meaning of the data (Creswell, 2009:185). Notes were made in the borders and common thoughts were written down (Creswell, 2009:185).

Step 3: Comprehensively analysing the data by using a coding process (Creswell, 2009:186).

According to Rossman and Rallis (cited by Creswell, 2009:186), coding is the process where the text is arranged into sections and then sense is made out of the information. During data analysis, the data was coded by organising the data into sections of text before meaning was attached to the information (Creswell, 2009:186). Portions of the text were arranged into

categories and these categories were labelled with a term often based on the original words used by the nurse (Creswell, 2009:186).

A combination of predetermined codes and emerging codes was used (Creswell, 2009:187). Initially the six questions were used as the main themes and the subthemes emerged using the coding process (Tesch, 1990).

According to Tesch (1990) (cited by Creswell, 2009:186), there are eight steps in the coding process. The researcher used them as a guideline to code the data. The narratives were analysed first and then the transcriptions of the focus group interviews. The same steps were followed for both.

1. The researcher obtained a feeling for the complete data set by first reading through all the data and by writing down thoughts and facts as they emerged (Creswell, 2009:186).
2. The researcher selected one paper and after going through it, tried to determine its fundamental meaning and wrote ideas that came to mind in the border (Creswell, 2009:186).
3. This was done for a number of papers and then the researcher made a list of all the topics, while similar topics were grouped together. These topics were now fashioned into columns and arranged as main topics, exceptional topics and excess topics (Creswell, 2009:186).
4. This list was then taken back to the data where the topics were shortened as codes, and the codes were written in the sections of the text where they fitted. This initial organising system was used to see if new categories and codes materialized (Creswell, 2009:186).
5. The topics were described by the most eloquent words and then turned into categories. Topics that related to one another were grouped together in order to reduce the total list of categories. Lines were drawn between categories to illustrate relationships (Creswell, 2009:186).
6. A final decision was made regarding the acronym for each category and the codes were arranged in logical order although according to Creswell (2009:186), they can be arranged in alphabetical order. The data that fitted into each category was gathered in one place and an initial analysis was performed (Creswell, 2009:186).
7. The existing data were recorded as needed (Creswell, 2009:186).

Step 4: Describing the setting or people and identifying themes (Creswell, 2009:189).

A description of the site, individuals, categories or themes for analysis was produced by the coding process (Creswell, 2009:189). A small number of themes were generated by using the coding process while referring to the most important findings. These themes were used to create the headings when the results were reported (Creswell, 2009:189).

After data analysis, the researcher and the co-coder scheduled a meeting to discuss the results of the qualitative data analysis and to reach consensus regarding the main themes and the subthemes that emerged from the data.

After an in-depth literature control of these themes and subthemes was conducted, the theoretical model provided by Carr (2004:302-304), (see Section 3: 2.1.3) that explains how strengths can be used to handle opportunities and challenges, spontaneously lead to a further clustering and organisation of the themes and sub-themes. Consensus was reached between the researcher, co-coder and supervisors with regard to the final organisation of the themes and sub-themes that were used to report, discuss and interpret the qualitative findings of the study. This final organisation of the themes and subthemes is included in the article (see Section 2: Table 9).

Step 5: Representing the findings (Creswell, 2009:189).

The findings were represented by means of a comprehensive discussion of all the themes and subthemes, illustrated by citations from the narratives and focus group interviews (Creswell, 2009:189). The findings were grounded in literature, (see Section 2: Qualitative findings, discussion and literature control).

Step 6: Interpreting the data (Creswell, 2009:189).

The meaning of the data was interpreted as the “lessons learned” (Creswell, 2009:189). The researcher interpreted the data based on practical experience in caring for older persons in combination with relevant literature (Creswell, 2009:189).

1.9 MEASURES TO ENSURE RIGOUR

The rigour of the quantitative data was guaranteed by using a validated and reliable self-report instrument, namely the Resilience Scale. The authors of the Resilience Scale, Wagnild and Young (1993:165), conducted a psychometric assessment of the Resilience Scale and the

findings of their study maintained the “internal consistency reliability and concurrent validity of the Resilience Scale as an instrument to measure resilience”. Wagnild (2009:105) reviewed twelve particular studies conducted since 1999, that have used the Resilience Scale, and reported that the “Cronbach alpha coefficients ranged from .72 to .94 supporting the internal consistency reliability of the Resilience scale”. The construct validity of the Resilience Scale was also confirmed by these studies (Wagnild, 2009:105). The Resilience Scale was also used in South Africa by Koen, Van Eeden and Wissing (2011:4) with 312 professional nurses employed in public and private hospitals and primary healthcare clinics and a Cronbach alpha coefficient of 0.95 was obtained confirming the reliability and internal consistency of the Resilience Scale.

The statistical consultation service of the NWU determined the Cronbach alpha, also referred to as the coefficient alpha that is a trustworthy guide that assesses the internal consistency of the instrument (Polit & Beck, 2012: 724), for this study. The reliability of the Resilience Scale will be determined by the Cronbach alpha (Wagnild, 2011:34) and this will be reported in (Section 2: Quantitative results and discussion; and in Section 2: Table 3).

The Resilience Scale was originally tested with adults but later a number of studies have validated that the scale has performed well when used on participants of all ages and from different racial groups (Ahern *et al.*, 2006:121). The Resilience Scale was used in numerous studies including amongst others Russian immigrants, adolescent mothers, Irish immigrants, resilience and older women, Alzheimer family caregivers, Mexican women and depression, sheltered battered women, adolescents, mothers, and so on (Ahern *et al.*, 2006:116-118). Wagnild (2009:105) confirmed that the Resilience Scale has proved to be a dependable and legitimate instrument to measure resilience and has been used with a wide variety of studied populations.

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

According to Morse and Field (cited by Botma *et al.*, 2010:292) **truth value** (creditability) is ensured when the researcher reports the viewpoints of the participants as understandable as possible. Truth value was ensured by the researcher by reporting the nurse’s viewpoints portrayed in the narratives and focus group interviews as clearly and honestly as possible by inserting quotes from the narratives and focus group interviews. The researcher spent a lot of time in the practical facilities while collecting the data and was able to observe the nurses in

their work environment (Klopper, cited by Botma *et al.*, 2010:292). Data triangulation (Creswell, 2009:191; Klopper, cited by Botma *et al.*, 2010:292), was used by asking the nurses to write narratives regarding their personal strengths, how they managed to cope, what makes it worthwhile and how they managed to stay resilient as well as by conducting focus group interviews with the nurses to further explore their strengths and coping abilities while caring for older persons. During the focus group interviews member-checking (Creswell, 2009:191; Klopper, cited by Botma *et al.*, 2010:292), was done by asking the nurses to validate the results obtained from the narratives. During the focus group interviews, the researcher also explored the reasons why nurses caring for older persons need to be resilient and what advice can be given to nurses caring for older persons to be resilient. This advice included the same kind of information as that obtained from the narratives.

According to Moule and Goodman (cited by Botma *et al.*, 2010:292), **applicability** (transferability) refers to the degree to which the research results can be transmitted from one setting to another by providing a rich description of the data and by describing the sample and the research design. Applicability was improved in this study by providing a rich, in-depth description of the narratives written by the nurses and the focus-group interviews conducted with them as well as by describing the all-inclusive sample and the explorative descriptive design with multiple phases that was used.

According to Botma *et al.* (2010:292), **consistency** (dependability) is a course of action to establish the quality of data and it refers to the strength of the data over time and circumstances. The consistency of the qualitative data was improved by using an experienced co-coder and by the triangulation of the data as advised by Polit & Beck (cited by Botma *et al.* 2010:292).

According to (Botma *et al.*, 2010:292), **neutrality** (confirmability) refers to the impartiality or objectivity of the data. Neutrality was improved when the researcher used bracketing, the researcher wrote a narrative during the trial run as well as before data collection and an independent person was used as a co-coder and this confirmed the truth, significance and importance of the data as described by (Botma *et al.*, 2010:292).

1.10 ETHICAL CONSIDERATIONS

The research was conducted under the ethical approval of the RISE project (Annexures A and B). In this research, the resilience of nurses caring for older persons was explored and described, this brought the research in line with the RISE objective – “To explore and describe the resilience of health caregivers and risk groups” (Koen & du Plessis, 2011:6). Narratives

written by, and focus group interviews conducted with the nurses, were used to explore how resilience in nurses caring for older persons could be strengthened in order to formulate recommendations to strengthen their resilience. This was in accordance with the RISE objective “To implement and validate strategies developed by Koen, Van Eeden and Wissing to strengthen resilience of professional nurses and other health caregivers and risk groups” (Koen & du Plessis, 2011:6).

The ethical considerations of the research were in line with the ethical considerations of the RISE project. This included the general aspects to ensure that the research was conducted ethically, submitting it to the Research Ethics Committee of the NWU and by ensuring that the team had the necessary expertise to conduct the research (Koen & du Plessis, 2011:10). The research proposal as well as the application letter to conduct the research under the RISE project was submitted to the Research Ethics Committee of the NWU. The researcher worked closely with the supervisors to ensure that the necessary expertise was used to conduct the research.

According to Koen and du Plessis (2011:10), the institutional association of the researcher must also be made known. In the research conducted, the researcher had informed the nurses and the managers of the facilities of her position as a junior lecturer at the North-West University School of Nursing Science by stating it on the letters to obtain permission to conduct the research.

Koen and Du Plessis (2011:11) stated that admission to participants will be obtained by using gate-keepers such as ministers of religion or nurse managers. In the research conducted, the researcher used the managers or nursing services managers as gate-keepers to obtain admission to the nurses.

As mentioned earlier, the research was conducted in three phases. During phase one, the nurses were asked to complete a demographic information form and the Resilience Scale, as well as to write a narrative. During phase two the nurses were invited to participate in focus group interviews. The recommendations to strengthen resilience in nurses caring for older persons were formulated in phase three. All the ethical principles that will be discussed, were taken into account during all three phases of the research.

According to Koen and du Plessis (2011:10), the ethical principles of respect, justice and beneficence of all the participants must be obeyed by acknowledging that they are autonomous and by providing enough information regarding the purpose and objectives of the research as well as possible benefits and risks involved. In the research conducted, the basic principles of

respect for all people, beneficence and justice were honoured at all times as advised by (Botma *et al.*, 2010:277).

The researcher aimed to conduct the research ethically by taking the following human rights into account as described by Burns and Grove (2009:189) “the right to self-determination, the right to privacy, the right to anonymity and confidentiality, the right to fair treatment, and the right to protection from discomfort and harm”.

1.10.1 Right to self-determination

According to Burns and Grove (2009:189) the ethical **principle of respect for persons** is the basis of the right to self-determination. The nurses were treated autonomously by acknowledging their right to make their own decisions regarding participation in the research. Respect for people was demonstrated by conducting the research under the ethical approval of the RISE project, Annexures A and B; by obtaining permission from the managers of the facilities caring for older persons, Annexure D, in this urban setting in the eastern portion of the North-West Province; by informing the nurses of the proposed research and by allowing them to choose to participate voluntarily in the research (Botma *et al.*, 2010:277). According to Koen and du Plessis (2011:10), the participants must be given the chance to participate on a voluntary basis, refrain or withdraw at any time without punishment and give informed consent. According to Koen and du Plessis (2011:11), voluntary informed consent will be ensured if all participants are able to reason with the researcher, be able to ask questions regarding the research, clarify any uncertainties and communicate his / her decision to consent. In the research conducted, the nurses were informed about the study by giving them a document that explained the purpose, objectives and what was expected of them and by asking them to give written, voluntary, informed consent for participating in the research (Annexure F). The nurses were informed that their participation was voluntary and that they may withdraw at any time. The researcher had ensured that all the nurses were able to reason with the researcher, were given the opportunity to ask questions regarding the research, were able to clarify any uncertainties and communicate their consent to the researcher. The researcher explained everything in Afrikaans and in English as requested by the nurses.

1.10.2 Right to privacy

According to Burns and Grove (2009:194), privacy is the right the participant has to decide under which circumstances, to what degree and for what timeframe personal information may be shared with other people. The right to privacy was respected by conducting the data

collection at each facility in a private venue and by closing the door of the venue during data collection. The researcher also explained to the nurses that the results of the research may be published but that their names and the names of the facilities will be treated as confidential.

1.10.3 Right to anonymity and confidentiality

According to Burns and Grove (2009:196), the participant has the right to expect that the data will be kept confidential. When the participant cannot be connected to his / her data, not even by the researcher, anonymity is ensured (Burns & Grove, 2009:196). Confidentiality refers to the way the researcher manages private information shared by participants and means that the researcher may only share information with others if permission was obtained by the participant (Burns & Grove, 2009:196). According to Koen and Du Plessis (2011:10), the names of the participants must be kept confidential and the research data must be anonymous. The research data obtained during phase one was anonymous because no form of identification was provided on the demographic information form, the Resilience Scale, or the narrative. The same number was on each set of data collection instruments in order to link the demographic information form, Resilience Scale and narrative of the same nurse with one another but no identification was required. The data was also reported anonymously. Confidentiality was maintained during the focus-group interviews by stating on the focus-group interview schedule that everything that is said in the group is confidential and that the participants must not use the name of the facility or the names of their colleagues during the discussion. Confidentiality was further maintained by keeping the names used unintentionally by the nurses in the narratives and focus-group interviews confidential. All the data were protected by storing it safely for data analysis. The confidentiality of the research data was also ensured by requesting the person that transcribed the focus group interviews to sign a confidentiality declaration (Annexure N). The person that acted as co-coder for the narratives and focus group interviews also signed a confidentiality declaration (Annexure Q).

1.10.4 Right to fair treatment

Burns and Grove (2009:198) state that the ethical **principle of justice** forms the basis of the right to fair treatment. Each participant must be treated fairly by means of fair selection and treatment during the research (Burns & Grove, 2009:198). Fair selection and treatment were ensured by an all-inclusive voluntary sample and by treating the nurses fairly and respectfully during the research. The researcher adhered to the conditions and data collection procedures that the nurses agreed on and gave written consent to. All the nurses were invited to participate in phase one and in phase two of the research and all the narratives and focus group interviews

were analysed and the data used to formulate recommendations to strengthen resilience in nurses caring for older persons.

1.10.5 Right to protection from discomfort and harm

The ethical **principle of beneficence** forms the basis of the right to protection from discomfort and harm (Burns & Grove, 2009:198). According to Burns and Grove (2009:198), the ethical principle of beneficence means that doing good must be strived for and doing harm must be avoided at all costs. There was no foreseen risk to the nurses or the facilities (Botma *et al.*, 2010:277). Benefits might be gained when the researcher provides feedback concerning the results of the research on how to strengthen the resilience of nurses caring for older persons. This could empower the nurses to be more resilient and even flourish while providing care to the older person. It could also benefit the facility if the nurses were more resilient and better able to cope with their valuable work. According to Koen and du Plessis (2011:11), participants will be given feedback regarding the outcomes of the research. The researcher promised to provide feedback to the nurses as well as to their management regarding the results of the research on how to strengthen the resilience of nurses caring for older persons as soon as the results of the research have been examined.

The researcher declared that the research was her own work and that plagiarism had been avoided by paraphrasing the words of the authors cited as far as possible and by giving due credit to all the authors and sources cited. Scientific honesty was ensured because the researcher reported the results of the research as honestly and clearly as possible (Botma *et al.*, 2010:26).

1.11 LITERATURE REVIEW

1.11.1 Introduction

In line with the North-West University's guidelines for the article format of the dissertation (NWU, 2013:15), a literature review was conducted. This literature review briefly sketches the background to the study and explores the theoretical basis of resilience by giving a brief overview of the definition of resilience, the concept of resilience and theories relating to resilience. Some of the instruments that measure resilience are mentioned briefly. The literature review also focused on giving a review of previous research studies regarding resilience in nurses and served to indicate the gap in the knowledge base regarding resilience in nurses caring for older persons.

The following NWU Databases of the Ferdinand Postma library were searched: EbscoHost including: Academic Search Premier, CINAHL, Health Source: Nursing / Academic Edition, Medline, PsycArticles, PsycInfo and SocIndex; ScienceDirect; SAEpublications; ProQuest; Sabinet and Google Scholar. The library assistant was asked to search Nexus.

The following keywords were used initially:

Resilien* or coping or strength* or “well-being” AND nurs* or caregiver* AND old* or elder* or ageing or aging or geriatr* or frail or gerontol*

The searches were followed up by other searches on EbscoHost, Google Scholar, ProQuest and ScienceDirect using different keywords including:

Resilien* AND nurs*

And searches on Google Scholar using the following keywords:

Resilien* AND “aged care” AND nurs*

Specific information was searched on Google Scholar regarding the shortage of nurses, the increase in the older population and so forth, as needed.

1.11.2 Background

The background to the study portrays the worldwide increase in the older population (Velkoff & Kowal, 2007:3; NIA, 2007:3) while there is also a global shortage of nurses (Oulton, 2006:34S), including a shortage of nurses caring for older persons (Jackson *et al.*, 2003:42). South Africa also experiences an increase in the older population (Velkoff & Kowal, 2007:11, 22; StatsSA, 2011:1) and at the same time a shortage of nurses (SANC, 2013b). Although information is scarce on the shortage of nurses caring for older persons in South Africa, the shortage can be confirmed by the practical experience of the researcher.

The reasons for the global nursing shortage and shortage in South Africa are quite similar, including difficult working conditions, extreme workloads, workplace violence, stress, burnout, low salaries, limited career prospects and the way human resources are managed (Oulton, 2006:35S; Oosthuizen & Ehlers, 2007:14). Emigration of nurses is an additional factor that contributes to the nursing shortage in South Africa (Oosthuizen & Ehlers, 2007:14). Additional reasons for the shortage of nurses caring for older persons include the low status of caring for older persons, the physical demands caring for older persons place on the nurses, the risk of

injury on duty (Jackson *et al.*, 2003:43), workplace violence (Jackson *et al.*, 2003:43; Isaksson *et al.*, 2008:551) “challenging behaviour” of the older persons (Schmidt *et al.*, 2012:3134-3135), low job satisfaction (Jackson *et al.*, 2003:43-44; Spear, 2004:58), emotional exhaustion (Duffy *et al.*, 2008:43) and burnout (Spear, 2004:58; Duffy *et al.*, 2008:43, Schmidt *et al.*, 2012:3140; Issakson *et al.*, 2008:551).

Possible solutions for the nursing shortage include making the workplace safe and attractive for practising as well as prospective nurses, increasing salaries, providing career opportunities and employing more nurses to share the workload (Oulton, 2006:39S; Oosthuizen & Ehlers, 2007:14). Despite the difficult workplace circumstances, it was observed that some nurses manage to cope and survive and even flourish under the often difficult workplace conditions (Koen, Van Eeden & Wissing, 2011:1; Jackson *et al.*, 2007:1). One of the possible reasons for this phenomenon was that the resilience of these nurses may empower them to handle the workplace difficulties experienced. It is argued that knowledge of resilient behaviour may empower nurses to handle workplace stress and prevent burnout (Edward & Hercelinskyj, 2007:240).

1.11.3 Resilience definitions

Different definitions of resilience can be found in the literature including “a personality characteristic that moderates the negative effects of stress and promotes adaptation” (Wagnild & Young, 1993:165); “Resilience embodies the personal qualities that enable one to thrive in the face of adversity” (Connor & Davidson, 2003:76); “Resilience refers to a person’s ability to adapt successfully to acute stress, trauma, or more chronic forms of adversity” Rutter (2006) (cited by Wagnild, 2011:12); “an outcome of successful adaptation to adversity” (Reich *et al.*, 2010:4).

According to Fletcher and Sarkar (2013:12, 14) “adversity” and “positive adaptation” form the basis of most definitions of resilience and that resilience is needed to handle different difficulties ranging from problems encountered daily, to big, life changing events and that the positive adjustment must be in accordance with the difficulty experienced. This is confirmed by Jackson *et al.* (2007:1) stating that “Resilience is the ability of an individual to positively adjust to adversity” and Herrman *et al.* (2011:258) that resilience refers to “positive adaptation” or to be able to sustain or resume mental health although “adversity” is experienced. Earvolino-Ramirez (2007:76) adds that the quality of “bouncing back” and going forward in life after difficulties is evident in resilience. Adversity differentiates resilience from other personality characteristics or social organizational practices, and successful coping, control and “positive adaptation” are

important results of resilience (Earvolino-Ramirez, 2007:78). Tugade and Fredrikson (2004:331) contend that individuals with high levels of resilience experience positive emotions during stressful situations.

Pooley and Cohen (2010:34) formulated a new definition of resilience: “the potential to exhibit resourcefulness by using available internal and external resources in response to different contextual and developmental challenges”.

1.11.4 Concept of resilience

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

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

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

According to Fletcher and Sarkar (2013:15), researchers distinguish between protective and promotive factors and they explain that protective factors protect the individual from the possible negative consequences of an experience whereas a promotive factor may produce benefits. Resilience as a trait is recognised as a protective factor (Fletcher & Sarkar, 2013:15). Resilience as a trait acknowledges that people may be born resilient (Jacelon, 1997:128), but Gillespie, Chaboyer and Wallis (2007:124) disagree and state that resilience appears to be a process that can be developed at any age and it is not an inborn personality characteristic. According to Jacelon (1997:128) resilience has been acknowledged as a collection of “traits” as well as a “process” whereby people react to incentives from the environment. This is confirmed

by Fletcher and Sarkar (2013:15) who state that resilience has been considered to be a personality characteristic as well as being perceived to be a process.

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

1.11.5 Resilience theory

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

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

According to Fletcher and Sarkar (2013:17), the resilience model is one of the main contributions of Richardson (2002) and Richardson, Neiger, Jensen & Kumphier (1990). According to the resilience model, the resilience process starts with a state of physical, mental and spiritual equilibrium also referred to as “bio-psycho spiritual homeostasis” or “comfort zone” (Fletcher & Sarkar, 2013:17; Richardson, 2002:310-311). If a person has inadequate resources (protective factors) to safeguard him against stressors, hardship or life experiences, disruption

from this state of equilibrium occurs but after a while a person that experienced disruption will adjust and the reintegration process will begin (Fletcher & Sarkar, 2013:17). One of four outcomes may follow this process: “resilient reintegration” (additional protective factors are obtained from the disruption and an advanced level of homeostasis is obtained), “homeostatic reintegration” (the disruption caused the persons to just stay in their “comfort zones” and “just get past” the disruption), “reintegration with loss” (the disruption caused a loss of protective factors and a lower level of equilibrium or homeostasis); and “dysfunctional reintegration” (the disruption caused the people to turn to destructive activities, for example drug abuse) (Fletcher & Sarkar, 2013:17).

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

1.11.6 Instruments measuring resilience

According to Gillespie, Chaboyer and Wallis (2007:130) different reasons make it challenging to measure resilience, including the various definitions as influenced by the applicable health discipline, the variety of settings and age groups studied, as well as the fact that mainly qualitative methods were used to study resilience, causing a scarcity of quantitative measures.

Research relating to resilience has been done using different measuring instruments. Gillespie, Chaboyer and Wallis (2007:131-132), refer to five different instruments that have been used to measure resilience in different contexts and populations: the “Resiliency Attitudes Scale” that measures seven components of resilience; “the Ego-Resilience Scale” that assesses resilience in people living nearby warfare regions; the “Connor and Davidson Resilience Scale” that measures resilience across various community samples of grown-ups; the “Brief Resilient Coping Scale” that measures a predisposition towards coping and adaptation and lastly the “Resilience Scale” that identifies the degree of individual resilience that improves adjustment.

According to Ahern *et al.* (2006: 103) the Resilience Scale is the best instrument to use when studying resilience in adolescents because of the psychometric assets of the instrument and the fact that it can be used for various age groups.

1.11.7 Resilience research in nursing

Research relating to resilience has been done in a variety of settings, with different populations and with different age groups. Research regarding resilience in nurses is gaining momentum and a few studies conducted with nurses in different settings will be discussed shortly.

Ablett and Jones (2007:733-734) performed a qualitative study by conducting semi-structured interviews with ten palliative care nurses working at a hospice. Their intention was to describe their work experiences and understand the aspects that enhanced their resilience and lessen the effect of occupational stress (Ablett & Jones, 2007:734). They also aimed to explore the processes utilized to persist with working in palliative care and maintain a sense of happiness (Ablett & Jones, 2007:734). The interviews were audio recorded, transcribed and analysed using interpretative phenomenological analysis and ten themes emerged from the analysis that could be linked to the personality constructs of “hardiness” and “sense of coherence” (Ablett & Jones, 2007:735-737).

Although the nurses responded differently to change, it corresponded to the “sense of coherence” that need stability, and “hardiness” that view changes as exciting and as an opportunity to grow; “hardiness” explained some of the nurses’ resilience and “sense of coherence” the others (Ablett & Jones, 2007:738). The findings can be used to enhance resilience during training, especially “hardiness” and a strong “sense of coherence” and by introducing change gradually and sensitively because resilient staff might react differently to change (Ablett & Jones, 2007:739).

According to Ablett and Jones (2007:739) reflective practice can benefit the staff by helping them to cope with the emotional aspects of the work and their own mortality issues and it is to be expected that resilient nurses that sustain a sense of happiness will continue working in palliative care and be committed to provide good care to their families and patients.

Gillespie, Chaboyer, Wallis and Grimbeek (2007:427) used a correlational cross-sectional survey design, with a systematic random sample of 1430 operating room nurses. The nurses completed a questionnaire and demographic information to examine the relation of the following variables: perceived competence, collaboration, control, self-efficacy, hope, coping, age, experience, education and years of employment to resilience in operating room nurses

(Gillespie, Chaboyer, Wallis & Grimbeek, 2007:427). This was done because little is known about how resilience can contribute to the ability to handle workplace stress in the operating room and nursing context (Gillespie, Chaboyer, Wallis & Grimbeek, 2007:427). Resilience was explained by the following five variables at statistically significant levels: hope, self-efficacy, coping, control and competence indicating that hope, self-efficacy and coping were the strongest, but no statistical significance was shown with regard to nursing experience, education and years of employment (Gillespie, Chaboyer, Wallis & Grimbeek, 2007:427, 435). Strategies that enhance resilience can be formulated taking these variables into account and in the process contribute to the retention of operating room nurses (Gillespie, Chaboyer, Wallis & Grimbeek, 2007:427).

This research was supported by Gillespie *et al.* (2009:968) that used a predictive survey design to identify the level of resilience in a random sample of 1430 operating room nurses in Australia. The Connor-Davidson Resilience Scale was used to determine if age, experience and education had an influence on the level of resilience (Gillespie *et al.*, 2009:968). Demographic questions were completed in order to investigate if these personal characteristics made a contribution to resilience in the workplace (Gillespie *et al.*, 2009: 968). The results of the study indicated that age, experience and education seemed not to be responsible for resilience in operating room nurses and that younger nurses that receive enough support may flourish in the operating room (Gillespie *et al.*, 2009:968).

Literature and practice indicate that professional nurses are emotionally exhausted, experience low job satisfaction and leave the nursing profession although there are those that decide to stay in nursing and survive and even flourish despite difficult workplace circumstances (Koen, Van Eeden & Wissing, 2011:1). Koen, Van Eeden and Wissing (2011:1, 3-4) followed a quantitative, cross-sectional survey design to identify the level of resilience in a group of professional nurses in South Africa to determine if the levels of resilience differ in the group of nurses working in the private hospitals from those working in the public hospitals. Seven measuring instruments and a biographical questionnaire were used to collect data from 312 professional nurses working in private and public hospitals as well as in primary healthcare clinics and the data was analysed using SPSS (Koen, Van Eeden & Wissing, 2011:4). The results indicated that ten per cent of the professional nurses showed low resilience, 47% moderate resilience, 43% high resilience and the resilience of the nurses working in the private healthcare facilities was notably higher than the resilience of the nurses working in public healthcare facilities (Koen, Van Eeden & Wissing, 2011:1).

Following an explorative descriptive qualitative research design, Koen, Van Eeden, Wissing and Du Plessis (2011:105-106) asked 35 resilient professional nurses to write about the enabling aspects of their profession and ten less resilient nurses to write about the hindering aspects in the profession. Thematic content analysis with open coding was used to analyse the narratives and to identify the themes (Koen, Van Eeden, Wissing & Du Plessis, 2011:106-107). Their findings indicate that professional nurses demonstrate strengths that make it possible for them to be resilient in adverse working conditions and that these strengths are the result of resources in their personal or professional surroundings that enhance resilience (Koen, Van Eeden, Wissing & Du Plessis, 2011:114). Less resilient nurses were unmotivated and disappointed. This impaired their obligation to care and be considerate (Koen, Van Eeden, Wissing & Du Plessis, 2011:114). The vital finding of this study was that resilience is “crucial” in the profession of nursing (Koen, Van Eeden, Wissing & Du Plessis, 2011:114).

Koen, Van Eeden, Wissing and Koen (2011:643-652) formulated guidelines with strategies to enhance resilience and psycho-social well-being in professional nurses based on previous qualitative research on resilience in professional nurses that worked in private and public health care facilities in South-Africa.

Intensive Care Unit (ICU) nurses experience frequent exposure to work-related stress that gives rise to post-traumatic stress and burnout (Mealer, Jones, Newman, McFann, Rothbaum & Moss, 2012:292). Acknowledging that resilience can be learned and enable a person to flourish in the face of difficulty, the study aimed to determine if resilience was connected to improved emotional health in ICU nurses (Mealer, Jones, Newman, McFann, Rothbaum & Moss, 2012:292). A survey design was used and 744 ICU nurses completed a set of four measuring instruments including demographic questions (Mealer, Jones, Newman, McFann, Rothbaum & Moss, 2012:292). The results indicated that 22% were highly resilient and these highly resilient nurses showed a lower incidence of post-traumatic stress disorder, anxiety, depression and burnout and managed not to permit their work situation to interfere with their private life (Mealer, Jones, Newman, McFann, Rothbaum & Moss, 2012:292; 297-298).

Hart *et al.* (2012:1) conducted an integrative review on the resilience in nurses that provides important information to nurse managers regarding the concept resilience inside the work situation. Knowledge regarding the factors that contributes to the need for resilience, intrapersonal traits that enhance resilience and resilience building strategies, can benefit the recruitment and retention of nurses in the work situation (Hart *et al.*, 2012:12). Nursing managers need to know why some of the nurses are resilient and others not in order to render

support, develop a positive workplace environment and help with the development of programmes to empower nurses to become and stay resilient (Hart *et al.*, 2012:12-13).

According to Zander *et al.* (2013:17-18) resilience has been proposed as an essential coping strategy for nurses that work in challenging contexts, for example paediatric oncology and they aimed to explore the concept of resilience in paediatric oncology nurses and the processes they follow to develop resilience by doing a qualitative case study. Five paediatric oncology nurses were interviewed, the interviews were transcribed and analysed using thematic analysis and the themes that emerged were grouped to understand how these nurses develop resilience (Zander *et al.*, 2013:18-20). Strategies were developed from the findings to enhance resilience that included how to cope with working shifts, a well planned programme for orientation, improved support, employing a clinical support nurse, providing support to the friends and families of the nurses and by making more time to reflect on the work (Zander *et al.*, 2013:23-24).

In a literature review conducted by Grafton *et al.* (2010:698) in order to understand resilience and determine its potential to manage the work stress that oncology nurses experience, they concluded that resilience can be improved by the use of information for self-care, education as well as a supportive environment to lessen the effects of workplace stress. The complex and stressful character of oncology and other nursing specialities cause a lot of stress that is draining and may cause compassion fatigue and lead to burnout (Grafton *et al.*, 2010:698). Understanding resilience as an inherent resource in response to stress, emphasizes the need for processes to support the development of resilience as well as including strategies to manage stress on organizational and personal level as part of nursing education (Grafton *et al.*, 2010: 698). This was supported by McAllister and McKinnon (2009:371), who recommend that resilience training should form part of the theoretical and practical training of healthcare students. The resilience of healthcare professionals can be enhanced by providing education and training and by changing the culture of the workplace (McAllister & McKinnon, 2009:371).

Research specifically focusing on the resilience of nurses caring for older persons is scarce. Only one article was as yet found regarding enhancing resilience in registered (professional) aged care nurses (Cameron & Brownie, 2010:66). Cameron and Brownie (2010:66-67) did a qualitative study by conducting interviews with nine female registered nurses working in residential aged care facilities in Queensland, Australia, after they had time to reflect on the statement "Resilience is the ability to rebound from adversity and overcome difficult circumstances in one's life." The purpose of the study was to identify characteristics that contribute to resilience and the individual strategies used by skilled registered nurses to handle

stress experienced in residential aged care facilities (Cameron & Brownie, 2010:67). The intention was further to ensure that the necessary support is given to registered nurses to empower them to render effective, high quality, rewarding care to older persons (Cameron & Brownie, 2010:67).

During the interviews the nurses were asked “How do you experience and personally manage workplace stressors and demands in your role as an aged care nurse?” (Cameron & Brownie, 2010:67). The data was analysed using phenomenology and the results indicated that nurses caring for older persons experience and enhance resilience through clinical knowledge, skills and expertise; providing knowledgeable, competent, holistic care; making a positive difference; physical and psychological support from colleagues including sharing experiences, chance for self-reflection, debriefing and relief of stress through humour; being optimistic; ensuring a work-life balance by giving attention to exercise, rest, personal interests and networks for social support and lastly the long-term relationships with older persons and their families enhanced their resilience (Cameron & Brownie, 2010: 66-70).

Although this valuable research can be taken into account, there is still a scarcity of research regarding the resilience of nurses caring for older persons and a need for recommendations to strengthen their resilience.

1.11.8 Conclusion

During the review of the literature the background to the study was sketched, resilience was explored with regard to the definition of resilience, the concept of resilience and theories relating to resilience. Instruments to measure resilience were briefly explained and research regarding resilience in nurses was described indicating the “gap” in the knowledge base regarding the resilience of nurses caring for older persons as well as the need for recommendations to strengthen resilience in nurses caring for older persons.

1.12 SIGNIFICANCE OF THE STUDY

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

1.13 REPORT OUTLINE

The report was written according to the article model of the NWU. The Magister Curationis (MCur) student, Ms P Benadé, conducted the research and wrote the manuscript. Dr E du Plessis acted as supervisor and Prof MP Koen as co-supervisor. The manuscript was written and will be submitted according to the criteria for *Health SA Gesondheid*.

The research report followed the following structure:

Section 1:

- Overview of the study.

Section 2:

- Manuscript: “Exploring resilience in nurses caring for older persons”, to be submitted to *Health SA Gesondheid*. The researcher followed the instructions for authors as far as possible. However, for the purposes of the dissertation, the word count was not taken into account in order to describe the research process and the research results thoroughly. The quantitative results as well as the qualitative findings are reported in full in the results section of the article (see Section 2: Quantitative results and discussion; Qualitative findings, discussion and literature control) and will be shortened before the article is submitted for publication. The researcher also referred to the applicable annexures to explain the research process and results clearly. The tables and figures were inserted as part of the text to ensure a logical discussion of the results and findings. The researcher will insert the tables and figures according to the instructions for authors when the article is submitted for publication. The researcher also undertakes to adhere to the word count before submitting the article for publication. The researcher adhered to the publisher house style for authors as far as possible but undertakes to ensure that the shortened article submitted to *Health SA Gesondheid*, adheres to all the technical requirements.

Section 3:

- Conclusions, limitations and recommendations of the study.