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PERCEPTIONS OF NURSING COMPETENCE

DISSERTATION SUBMITTED BY
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IN FULFILMENT OF REQUIREMENTS
FOR A M.Sc. (NURSING) DEGREE WITH
THE UNIVERSITY OF THE WITWATERSRAND

SUPERVISOR : PROFESSOR B. ROBERTSON

DECLARATION

I declare that this dissertation is my own unaided work. It is being submitted for the degree of Master of Science in Nursing at the University of the Witwatersrand, Johannesburg.

It has not been submitted before for any degree or examination at any other University.

Dated 21.09.93

ABSTRACT

A qualitative research study has been carried out in order to determine Perceptions of Nursing Competence. A critical incident technique was used to collect data from patients to determine the criteria used by them in judging whether a nurse is competent or not. This data was analysed by means of a content analysis, and the findings compared with the available literature and with the requirements of the South African Nursing Council. This study was done in order to determine whether a set of criteria can be developed from the perceptions of the patients with regard to nursing competence, with the long term aim of designing an evaluation tool based on these criteria. The study was carried out in a large teaching hospital in Johannesburg by means of interviewing in-patients in selected wards involved in student training. Five categories were developed from the data which were built up from recording units and themes. In comparing the findings of the study to the literature, consensus was found to exist between the patients criteria and those of nurse authors.

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CHAPTER ONE

BACKGROUND INFORMATION AND LITERATURE REVIEW OF KEY CONCEPTS AND METHODOLOGY

1.1. REASONS FOR ATTEMPTING THE STUDY

One of the most important tasks of any nurse educator is to determine whether a student nurse is "competent" to join the profession at the end of her training. The longer one attempts to carry out this task of evaluation, the more conscious one becomes that it is difficult, if not impossible, to do this adequately or meaningfully.

The evaluation of cognitive skills both in nursing and general education, has received a good deal of attention. Nurse educators are therefore in a better position to evaluate cognitive rather than psychomotor and affective skills. Even so, there is still much to be done to improve cognitive evaluation so that relevant, appropriate, meaningful evaluation is done.

It is the evaluation of the practica, which include the psychomotor and affective skills, where so many problems exist that we hardly dare pretend that we evaluate in a meaningful way.

1.1.1. Common Practices in the evaluation of Practica.

It is common practice in most nursing colleges to "evaluate" students' progress regarding practica, both during and at the end of each stage of their training. The method most commonly used is the so called "OSCE." method (Objective Structured Clinical Evaluation). This method was developed on the assumption that psychomotor and affective skills can be successfully tested in a simulated environment with a time limit for each "station". (Harden 1978)

There are problems, however. "Simulation" can be anything from a person acting the designated role of another to a part of a manikin lying on a table awaiting the student's ministrations, e.g. changing a dressing on an "arm". In many centres written stations are included in this "practical" examination. The latter practice occurs because of the lack of manpower to "man" all the stations. Another problem is that the stress caused the students by the time constraints and unnatural circumstances do not simulate a real live situation. Hence, the student's performance is not commensurate with her normal performance in the wards. As a result of these problems, OSCEs do not evaluate what they are supposed to evaluate - the student's ability to nurse a patient. What is meant by the term "nurse" will be discussed

in the next section, as it causes problems and has a direct influence on this study.
With all the problems above, perhaps the most serious is that OSCEs do not adequately test aspects that are important to the patient. If affective skills are important, we are in particular trouble, as simulated settings are notoriously bad for this purpose for the very reason that everyone is role playing, including the student who is being evaluated. If this were an evaluation for a drama school, this may be acceptable but in nursing it is not. Due to the tutors' recognition of the fact that it is well nigh impossible to evaluate affective skills in a simulated setting, OSCEs tend to concentrate on testing psychomotor skills, resulting in affective skills being neglected.

It is, therefore, quite feasible that a nurse who had passed her practica examinations and therefore deemed competent, is not able to communicate adequately, demonstrate empathy, make value judgements, behave in a professional manner, arrange management details, or teach patients adequately. Attempts are made to evaluate these aspects in the wards.They tend, however,to be subjective assessments by the ward sisters who are often not adequately trained for the purpose of evaluating students. These very sisters, in all probability, passed through the very system described above, thus casting doubt on the effectiveness of her own affective skills.

1.1.2. Perceptions of Criteria for Evaluation

Methods of evaluation certainly cause problems as outlined above, but the criteria used within evaluation instruments are also problematical.

Nurse educators have long been acutely aware of how difficult it is to select appropriate criteria, but have nevertheless done exactly that - the nurse educator decides what criteria to use, based solely on her own perception of what is appropriate.

The problem with this practice is that the educators are not usually the people who benefit or suffer as a result of the nurses' care, or lack of it. As a result, unless the educator has herself been a patient, the criteria selected are unlikely to reflect those considered important by the patient. Patients, or health care consumers, may well judge a nurse differently to how another nurse would judge her, and are likely to consider affective behaviours more important than either psychomotor or cognitive skills. As stated above, it is these very affective skills that are largely ignored in the present evaluation system.

The fact that it is the patient who pays for the nursing care received, and who benefits or suffers from that care, surely gives the patient a right to, at least partly, determine which students are ultimately deemed competent to practice. Nurses cannot assume that they can speak for the patient on this matter.

For these reasons, this study was undertaken to determine what criteria the patients use to determine whether the nurse is "good" or "competent" in their eyes and, at a later stage, to use this information to develop an appropriate evaluation tool.

1.2. PREVIOUS SIMILAR RESEARCH UNDERTAKEN

Studies have been undertaken to determine what is meant by the term "caring" or to identify "caring behaviours", (Chipman 1991, Cronin & Harrison 1988, Gorham 1962, Komorita & Doehring 1991, Leiniger 1988, Shields 1978) but relatively few, available to the researcher, involved patients in the studies.(Cronin & Harrison 1988, Gorham 1962) Studies on caring are best done using a phenomenological approach. The studies that looked at "competence" seemed to favour a critical incident technique of data collection, followed by either a content analysis, or quantitative analysis. (Gorham 1962, Shields 1978) Far more studies looked at "caring" than "competence", (Cronin & Harrison 1988, Leiniger 1988, Komorita & Doehring 1991) but, hopefully, in nursing, these concepts have much in common and an analysis of both types is useful.

Cronin and Harrison (1988) conducted a study, which, although employing quantitative research techniques, is highly relevant. In this study on "the importance of nurse caring behaviours as perceived by patients after a myocardial infarction," they discovered that the patients they studied believed that certain physical needs must be met, such as hygiene and feeding, before affective aspects such as empathy can be addressed.

In the study by Ray (1989), patients expressed the need for "human care" whereas physicians described care in terms of technical aspects.

Chipman (1991), conducted a study using student nurses and found that none of the respondents talked or wrote about technical competence as a caring nurse behaviour. All caring behaviours were described in humanistic terms.

Tagliacozzi and Mauksch (1972) found quite the opposite. The patients they interviewed considered personalized, supportive care as subordinate to physical care.

Shields (1978) found in her survey of labouring patients that "supportive measures" which included assisting with breathing, holding the patient's hand, staying with her, encouraging and reassuring her were the most helpful measures. Physical care and the administration of medications were not considered helpful.

The study by Comstock and Williams (1980) used a qualitative type of questionnaire to determine information regarding the competence of student nurses, which they attempted to elicit from patients. They had considerable difficulty, as patients were loathe to criticize their care givers and also, the patients were not always able to separate their feelings about the student from those about the rest of the medical team.

William Gorham (1962), used a critical incident technique to "develop an explicit definition of the current role of the general staff nurse." Less than 6% of his total sample were patients. No indication is given if the patients' perceptions differed from those of health personnel. His information was grouped into five major behavioural areas, viz. improving the patients' adjustment to hospitalization or illness, promoting patients' comfort and hygiene, contributing to medical treatment, arranging management details, and personal characteristics.

The findings and problems encountered by these researchers were of great assistance in planning a study on perceptions of Nursing Competence, and some will be referred to again in the next chapter. It is interesting to note the diverse nature of the findings which presumably indicate that the setting and methodology used for the study significantly affect findings.

1.3. THE CONCEPT "COMPETENCE"

Defining an abstract term such as "competence" is always difficult as it depends from whose perspective it is being looked at. A person who has never driven a car may believe another driver is competent, whereas an experienced driver may recognize that the person is taking undue risks and causing mechanical strain on the vehicle.

In the same way, defining competence in nursing is difficult as it depends on perspective. One of the reasons this study was attempted was to see how the patients view competence. Even within this group, individuals viewed the concept from different perspectives - an issue which will becom clear in later chapters.

Schneider (1984:1) defines competence as "the quality or state of having sufficient knowledge, judgement, skill or strength." The problem, Schneider points out, is how to evaluate whether a person is "functionally adequate" or has "sufficient" knowledge.

Synonyms given by Seaton (1990:107) for competence include "ability, adequacy, appropriateness, aptitude, capability, expertise, proficiency, skill." It can be seen that judgement is required to evaluate whether a person is competent. The act of judging, requires the "judge" to "compare ideas to elicit truth." (Davidson 1985:522). A person can only compare what he sees in relation to his own conception of the matter in hand.

The discussion needs to revert back to looking at what various people use as criteria for measuring whether a person, in this case a nurse, is competent or not, or, what she should do as a "competent" nurse, or, in fact, what a nurse does in order to earn this title.

Travelbee (1971:7), an oft quoted author on nursing, compounds the problem by defining nursing as "an interpersonal process whereby the professional nurse practitioner assists an individual, family or community to prevent or cope with, the experience of illness and suffering and, if necessary, to find meaning in these experiences." She does not tell us how the nurse assists or what she actually does in order to provide this assistance.

The South African Nursing Council's (SANC) definition of Nursing solves the problem to a limited extent. " Nursing is a caring profession which enables and supports the patient, ill or well, at all stages of life, to achieve and maintain health, or, where this is not possible, cares for the patient so that he lives in dignity until his death." (SANC 1992) If one could establish what is meant by "enabling", "supporting" and "caring", it would be possible to establish exactly what a nurse does. The SANC's definition of "Nurse Practitioner" does tell us that she is "a registered nurse who practises nursing independently within her scope of practice." The Scope of Practice document tells us that the nurse assists the patient to meet his needs: e.g. elimination needs, communication needs. This brings us closer to an understanding of what the nurse actually does.

As soon as one returns to the concepts "enabling", "supporting" and "caring" mentioned above, one walks into yet another minefield in the literature. The concept "caring has received much attention.

Komorita et al (1991:24) give an excellent synopsis of definitions of caring by various authors. They tell us that Gant (1983) defines caring as a process with components divided into a series of actions / identification of patient needs, selection and implementation of an action; and patient-defined criteria to measure success of outcome. Griffin (1980) is quoted as identifying two complementary elements: activities as well as the attitudes and feelings underlying them. Mayerhoff (1971) saw caring as a process with a goal- directed outcome to help others grow and self actualize. He identified the following characteristics of caring - knowing, patience, honesty, truth, trust, humility, hope, courage and alternating rhythms.

Komorita's own definition (1991:24) states that "caring involves deliberate, rational, and knowledgeable acts of assistance to another individual, as well as feeling tones conveyed to the patient." It is interesting that having given a non specific definition, these authors go on to comment that most definitions of caring lack specificity and are without operational definitions. They also say that the term eludes classification.

Leiniger would not agree with the last statement as she developed such a classification - a multilevel structural caring model i.e. individual, family, institutional, cultural, social and world systems. (Leiniger 1981). Leiniger's definitions, however, largely lack specificity. For example, "Care....refers to those assistive supportive or facilitative acts towards or for another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway." and "caring refers to the direct (or indirect) nurturant and skilful activities, processes, and decisions related to assisting people in such a manner that reflects behavioural attributes which are empathetic supportive, compassionate, protective, succorant, educational and others depending on the needs, problems, values and goals of the individual or group being assisted." (Leiniger 1988:4)

With this last definition, the point made at the beginning of this section regarding the abstract nature of competence (or caring) and its various perspectives is well made. All these concepts appear to defy definition. Even so, it is often the process rather than the result which is valuable, so one should not be deterred from examining these concepts through qualitative research.

1.4. QUALITATIVE RESEARCH

Nurses have, until fairly recently, tended to use quantitative methodologies for their research - not out of any belief that they were more appropriate or valid for their purposes, but rather because they preferred to stay in the mainstream of medical research. Nurses, lacking in self-esteem, conducted research in the way that would gain credibility with their medical colleagues who believe steadfastly in positivism. The purpose of research, according to the principles of positivism, is to generate scientific laws.(Moll,1986) Nursing, traditionally, deals with people -their feelings, attitudes, needs - i.e. subjective data -making it all the more strange that they have attempted to use quantitative methodologies rather than qualitative ones. It seems clear that the difficulty previously experienced to obtain funding to conduct qualitative research could have something to do with this phenomenon.

Bailey (1982:6) states that Weber believed that the use of the methods of natural science play a role in social research, but not an exclusive one. Scientific research methods alone are inadequate for studying social phenomena and should be used only when they seem appropriate and valuable.

Goodwin and Goodwin (1984:378) argue this point further, saying that qualitative and quantitative research methodologies are not mutually exclusive : "Although certain methods are usually linked to certain paradigms, the association between paradigm and method is far from exclusive. The choice of research procedures ... should match the research question, and be optimally efficient, powerful, valid and reliable. Sometimes the methods of choice will be qualitative, sometimes quantitative and sometimes they will be a combination of both procedures."

1.4.1. Defining Qualitative Research

Despite an abundance of literature on qualitative research, it is difficult to find an adequate definition of the term.

Schurink (1987:1) refers to a definition of social research given by Babbie as follows: " a particular style of research which is employed to describe, interpret, or reconstruct the subjectively meaningful worlds of people."

Mouton (1986:2) says that "the aim of (qualitative) research is not to explain human behaviour in terms of universally valid laws or generalizations, but rather to understand and interpret the meanings and intentions that underlie everyday

human action ... it concentrates on qualities of human behaviour."

Wilson (1989:454) defines qualitative analysis as "the non-numerical organization and interpretation of data in order to discover patterns, themes, forms, exemplars, and qualities found in field notes, interview transcripts, open-ended questionnaires, journals, diaries, documents, case studies and other texts."

Polit and Hungler (1991:652) define qualitative analysis as " The organization and interpretation of non numerical observations for the purpose of discovering important underlying dimensions and patterns of relationships."

It would appear from the above, that there are two ways of defining qualitative research, one being that it deals exclusively with human behaviour and the other that it does NOT deal with numerical data. A combination of these two viewpoints might bring about a better definition.

There are several reasons why it is difficult to define qualitative research. One is that there are so many different types of research all classed under the broad heading of qualitative research. A second is that " (some people) regard it as an outright misnomer or even a myth, pointing out that statistical operations such as factor analysis are frequently used to categorize nominal qualitative data." (Wilson 1989:453) A third reason is that this type of research appeared after quantitative research and acquired its name simply because it was different to the concept of "research" held up until qualitative research was developed. The "qualitative/quantitative" terminology was coined in order to separate out types of research considered "valid" due to the fact that they had been statistically proven and therefore acceptable to logical positivists and types that could not be validated in this way.

1.4.2. The Purposes of Qualitative Research

It is evident from the definitions above that the purpose of qualitative research is to study human behaviour. This can, however, be done in other ways, so does not answer the question as to why qualitative rather than quantitative methodology is used.

It is worthwhile, first of all to look at the reasons for doing research per se. Reasons given by Brink (1986:9) are: 1. to get results 2. to vivify the entire educational system 3. to foster intellectual curiosity.

Waterworth (1990:30) cites 5 reasons for doing research : 1. to obtain new knowledge 2. to solve a stated problem 3. to make a decision 4. to develop a programme, procedure or product 5. to evaluate a programme, procedure or product.

In order to understand why qualitative research is done, it is necessary to determine what type of results, products, programmes and new knowledge can only be obtained or developed in this way, and what particular value it has to education.

When looking specifically at the purposes of qualitative analysis, Wilson cites four reasons for doing it (1989:456) 1. Exploring and describing 2. accounting for and illustrating quantitative findings 3. Discovering and explaining 4. Extending a theory. Wilson seems to indicate that the role of qualitative research is to complement the role of quantitative research. She acknowledges, particularly in the examples she gives to illustrate her point, that one needs qualitative research to look deeply into human behaviour - into motivation and relationships, to interpret behaviour and use the information to improve the quality of people's lives, and then solve the "problems" referred to by Waterworth.

Hughes (1980:14) points out that the type of philosophical and social questions traditionally looked at in "people sciences" can arise in any discipline or activity and "far from being unconnected to its daily practice, or the remote concerns of a small coterie of scholars, their solutions are crucial to the future shape and character of that particular discipline." He also states that the method used to reach the conclusion and the evidence supporting the theory is at least as important as the theory or conclusion itself.(1980:12)

While discussing this very process of qualitative data collection, Schurink (1987:11) helps to answer the original question of why we do this type of research. He states that "qualitative researchers typically attempt to develop concepts and ultimately typologies, generalizations, models and/or theories that "stay close" to the events studied i.e. in qualitative analysis, the researcher takes the insider's concepts, definitions and interpretations of their situations and behaviours seriously."

The purpose then, of qualitative research is to find solutions for human problems that are intrinsic in nature. Any question requiring an understanding of how people feel and think falls into the domain of qualitative research.

Certainly human behaviour is studied, but behaviour is directed by the way people think and feel.

It would seem sensible, in the light of the above, to study nursing competence by means of a qualitative methodology. The critical incident technique provides an opportunity to collect data which can be subjected to a qualitative analysis, and was chosen as the method of choice for this study.

It is difficult to reach consensus on this relatively seldom-used methodology. Hence, a review follows on this technique, which explains how the technique was used in the study and the background to these decisions.

1.5. CRITICAL INCIDENT TECHNIQUE

1.5.1. History and Development

Although John C Flanagan is acknowledged to be the "father" of the Critical Incident Technique, he states that Sir Francis Galton had begun work on the technique 70 years prior to Flanagan. Flanagan worked on developing the technique between 1944 and 1954, much the same time as content analysis was receiving attention.

The Critical Incident technique grew mainly from the studies conducted as part of the Aviation Psychology Program of the United States Army Air Forces in 1941. (Flanagan,1954:328) An attempt was made to determine criteria for selecting and classifying aircrews. Initially factual reports of incidents observed by trained observers were used in an attempt to develop criteria. Later the pilots themselves were asked to describe incidents, as it was realized that the trained observers missed a great deal, however diligent they were, and by using the subjects themselves, some bias was removed.

By 1949 dentists had begun using the technique for selecting students. It is interesting to note that, in this particular study, four classes of criteria were developed, viz. demonstrating technical proficiency, handling of patient relationships, accepting professional responsibility and accepting personal responsibility. Several other occupation groups including industrial foremen, bookkeepers, life assurance agents and psychology students were subjected to testing using this technique in an attempt to better select candidates for the future.(Flanagan 1954:328).

1.5.2. Defining Critical Incident Technique

Flanagan (1954:327) says of the technique " it consists of a set of procedures for collecting direct observations of human behaviour in such a way as to facilitate their potential usefulness in solving practical problems and developing broad psychological principles. The critical incident technique outlines procedures for collecting observed incidents having special significance and meeting systematically defined criteria."

Polit and Hungler (1978:613) define the technique as " A method of obtaining data from study participants by in-depth exploration of specific incidents and behaviours related to the matter under investigation."

1.5.3. Using a Critical Incident Technique

The methodology of the original founder of the technique will be dealt with in some detail, and the views of two more recent authors will also be given.

1.5.3.1. John C. Flanagan

Flanagan (1954:335) states that the technique does not consist of a single rigid set of rules governing such data collection. Rather it should be seen as a flexible set of principles which must be modified and adapted to meet the specific situation at hand.

The "principles that Flanagan (1954:354) refers to are
1. The reporting of facts regarding behaviour is preferable to the collection of interpretations of ratings and opinions based on general impressions.
2. Reporting should be limited to those behaviours which, according to competent observers, make a significant contribution to the activity.

In other words, Flanagan believed that the reporting of specific incidences was more objective than collecting people's ideas and interpretations. Also, if the reports were collected from the people who were themselves involved in the incident, or witnessed the incident, the reporting would be more accurate and less biased.

Flanagan suggested five steps to his technique:

1. The determination of the general aim of the activity.
2. The development of plans and specifications for collecting factual incidents regarding the activity

3. The collection of the data
4. The analysis of the data
5. Interpretation and reporting

The type of analysis and interpretation used by Flanagan was a content analysis which has been developed into a more sophisticated form by other, more recent researchers, since 1954, and will be discussed in the next section.

Before leaving the work of Flanagan, it is important to understand what he meant by the word "critical" and "incident".

"Critical" means "...an incident must occur in a situation where the purpose or intent of the act seems fairly clear to the observer and where the consequences are sufficiently definite to leave little doubt concerning its effects."

"Incident" means (1954:327) "..any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act."

1.5.3.2. Polit and Hungler

Polit and Hungler (1983) do not even refer to Flanagan in their section on the Critical Incident Technique (CIT) and discuss the method in a section entitled "Other data collection procedures".

"Critical" means " the incident must have a discernible impact on some outcome - it must make some positive or negative contribution to the accomplishment of some activity of interest."

"Incident" is defined in their book (1983:348) as "an observable and integral episode of human behaviour."

In their view, data is typically collected by a self-report procedure such as an interview, but they do not rule out observation. The interviews are highly unstructured, but guided by the interviewer's probing questions.

1.5.3.3. Lucy McDaniel

Lucy McDaniel published an article only ten years after Flanagan had published his work. She clearly uses Flanagan's work as a basis and makes frequent references to it.

She describes CIT (McDaniel,1964:236) as "a method of collecting or organizing direct observations of significant acts. "

The steps she uses are to :
1. Gather observed incidents
2. Edit the incidents
3. Classify the incidents into like groups
4. Name the groups in action terms.

McDaniel's definitions of key terms are as follows:(1964:236)

"Critical" " A critical point is a turning point, in this case the turning point toward success or failure."

"Incident" "...is a unit of action - an event. Something which is done in a certain situation with a definite result."

For the purposes of the study, it was decided to define the term "critical incident" as " An observable and integral episode of human behaviour, which had a discernable impact on some outcome."

1.6. CONTENT ANALYSIS

1.6.1. History and Development

Content analysis has been used as a research methodology for literally hundreds of years. First references date back to 1744 when sophisticated analysis was made of religious texts and concepts. (Dovring,1965:9). The method is still widely used today by scholars and lay people alike to study the Bible in an attempt to better understand its meaning and use this information to influence their daily lives.

Studies first employing the technique in a scientific way were commenced at the beginning of the twentieth century, and were largely confined to analysing newspapers. (Carney,1972:27) In this form of content analysis, systematic, objective and quantified descriptions were made of newspaper reports. The method received yet more attention in the First World War when used to analyse propaganda material. During this time, inferences were made rather than the objective quantitative style of analysis used formerly. It is of interest to note that the Allies were able to predict bombing campaigns, planned by the Germans, three weeks prior to their scheduled date by analysing what was said, and not said, in the local German newspapers.

This new approach to Content Analysis attracted great inter-disciplinary interest in the method, and resulted in a

conference being held in 1955 to discuss the method and formulate approaches and policies.

Wilson (1989:469), refers to the above development of Content Analysis stating that it is one of the "earliest specific procedures for analysing unstructured qualitative data" and that the first studies using the method simply counted words or synonyms and later studies "coded for latent feeling tone". Wilson refers to the former method as "semantic content analysis" and the latter as "feeling tone, or inferred, content analysis "

During the 1960's inferred content analysis was in danger of being confined to a minor form of research methodology as the age of computers arrived. The early computers were best at "counting" words. Information such as the fifty most commonly used words was identified. The structure of language, rather than it's meaning received great attention. As computers became more sophisticated and programmers more innovative, computers began to be used for analysing clusters, or categories of things (Carney 1972:33) and hence became a useful ally to qualitative content analysts.

Looking for categories and clusters of things has been used with increasing frequency, particularly by nurse researchers. Various developments including phenomenology, grounded theory and ethnography use the same basis as content analysis.

1.6.2. Defining Content Analysis

The definitions of Content Analysis have changed as the method has developed. In 1952, Berelson defined the term as follows " a research technique for the objective, systematic and quantitative description of the manifest content of communication." (Carney,1972:23)

In Berelson's definition, the quest for findings that could be counted is obvious, implying that research is only valid if it is quantifiable. As referred to in the previous section, analysts had moved beyond this restrictive practice during World War One - long before Berelson coined this definition. In Berelson's defence, there was a tremendous upswing in the belief that valid research was quantifiable research, and Berelson appears to be trying to justify the use of content analysis to the mainstream researchers of the day.

Holsti (1969:5) points out that "a content analyst always aims to compare the data it extracts against some norm, standard or theory, so as to draw it's conclusions". This approach is compatible with the definition used by Linzey and

Aronson (1968:596), " Content Analysis is a technique for making inferences by objectively and systematically identifying specific characteristics of messages."

This definition makes important distinctions to that of Berelson. It does not identify "quantifying" as an integral part of the process. It also puts the emphasis on the making of inferences. There is no reference to Berelson's "manifest", thus implying that the analyst can look deeper into what has been written or said, in an attempt to elicit meaning.

Carney (1972:26) says of Content Analysis and analysts, " (It) is a general purpose analytical infrastructure, elaborated for a wide range of uses. It is intended for anyone who wishes to put questions to communications ... to get data that will enable him to reach certain conclusions. Some content analysts are more objective than others. All are more objective than impressionistic assessment of the same question and materials. None are perfectly objective, though some approach this goal remarkably closely."

Wilson (1989:469) defines Content Analysis as follows, " It is one way of categorizing verbal and behavioural data, and it (requires) ... analytical thinking and creativity in the researcher."

It can be seen that, although the thinking on the nature of Content Analysis changed markedly between 1952 and 1968, there has been little change between 1968 and 1989. None of the definitions given provide information on how to carry out a content analysis.

1.6.3. Conducting a Content Analysis

Two authors, namely Carney (1973) and Wilson (1989) explain the method of content analysis well. Interestingly, although there are similarities in their approaches, they are not identical. There is apparently no agreed upon way of doing a content analysis, but each of these author's views will be summarized and reviewed. It will be seen that the methodology used for the purposes of this study, as discussed in Chapter Two, employs a combination of the two approaches.

Carney (1973:284) cites four steps to carrying out a content analysis:

1. Question Posing
2. Unitizing and Categorizing
3. Developing Standards
4. Validating

Wilson (1989:470) has a different approach, suggesting three steps:
1. Deciding on a unit of Analysis
2. Borrowing or developing a set of categories
3. Developing the rationale and illustrations to guide coding of data into categories.

1.6.3.1. Carney's Methodology

1.6.3.1.1. Question Posing

Carney (1973:284) states that 80% of the success of the study comes from thinking up the initial question, 10% from collecting the information and 10% from the analysis. This is somewhat alarming in view of the fact that less than 10% of his book deals with question posing!

Content analysis cannot be used to "go fishing" among a mass of documents in the hope that a "bright idea" will be suggested by probing. The researcher will only get the answers to the question with which it is supplied. The question must be carefully directed, the text sufficiently ample and relevant to provide an answer. Superficial questions will provide superficial answers, so it is better to provide questions of comparatively deep significance although this significance is generally obtained at the cost of some validity, because qualitative analysis of latent meaning will inevitably be involved.

The question posed, therefore, should be specific, deep, and carefully constructed.

1.6.3.1.2. Unitizing and Categorizing

Carney uses the term "theme" in quite a broad context. He describes a theme (1973:159) as "a conceptual entity or an incident, thought process or viewpoint which can be seen as a coherent whole. (Themes) are not clear cut, self evident wholes as words (are). They can sometimes be quite fuzzy. Consequently there tend to be problems of reliability in coding them."

According to Carney (1973:39), context units are " the passages in which the recording units are set, the contexts which define the meaning of the recording unit."

Recording units are the smallest units identified which may be a word or a phrase or item which can be counted if necessary.

Categories are the classification, the pigeonholes... into which recording units are placed.

It is important first, having posed the question, to become familiar with the writing - to read and re-read the writing. Having done this, one should search the text for items. Once this has been done, items are placed in categories. There are no rules for doing this. Very few standardized categories exist which may be used in other studies. Categories can be formed by taking the text at its surface meaning or they can be formed by inference, by reading "between the lines". They can, therefore involve descriptive, factual classification of the subject matter or can involve assessments of more tangible things. (1973:40).

Once a tentative set of categories has been drawn up, each category should be taken one at a time, in order to make one judgement at a time i.e. to decide whether the units belong to the category or not.

This having been completed, the reliability of the assessment of items and categories should be checked by someone else who re-does the categorization independently.

1.6.3.1.3. Comparison with Existing data to set Standards

Carney (1973:40) suggests that the most successful content analysis occurs when the researcher has an informed awareness of related background matter to the study. In this way knowledge of existing theories will suggest categories to the researcher. He gives the example of questions being asked of a psychological nature, when an awareness of theories of personality will suggest categories based on outside, expert findings rather than on "subjective, off-the -top-of the-head feelings of the analyst." An informed background is therefore necessary if a study is to have adequate standards by which to assess its findings.

Content Analysis "directs attention to the fact that, without a norm against which to compare them, individual sets of data are meaningless. Data elicited by one person's analysis gain meaning only when set against some outside criterion." (Carney 1973:40)

Carney suggests that the analyst should spend a great deal of time stockpiling criteria so as to assess their worth and using them for comparison purposes to establish the reliability of the categories adopted.

The reason for relating the study to pre-existing theoretical frames of reference is to ensure that the analyst does not skew his findings in favour of a particular personal viewpoint, either unconsciously or surreptitiously.

1.6.3.1.4. Validation

Carney (1973:197) points out that there is no such thing as the content of a document - content that is independent of the person examining the document. "Content is produced by the interaction between reader and document. The reader is in a particular situation and frame of mind. He wishes to use the document for his own special purposes of enquiry. Consequently, any content analysis involves its own conception of the content of the documents on which it bears. "

Carney suggests several ways of off-setting this problem, but two are significant to studies where inferences have been made.

Firstly, Carney (1973:200) suggests using a panel test. With this method, a panel looks at the categorization of the themes and decides whether they are correctly done or not. Another variation of this method is to select out sufficient, significant data for the panel to work with if it is not feasible to work with all th documents. It obviously helps if the panel has the necessa "informed background" mentioned in the previous section.

Secondly, Carney (1973:56) suggests splitting the sample to be analysed in two at the outset, and redoing the investigation on the second half to see if similar findings result, as a means of valida.ion.

1.6.3.2. Wilson's Methodology

1.6.3.2.1. Deciding on a Unit of Analysis

Wilson (1989"470) explains that deciding on a unit of analysis means "deciding whether to use a whole response or to break down responses into separate words, phrases, or sentences."

Wilson does not discuss the advantages and disadvantages of selecting separate words, phrases or sentences, leaving the reader to make these decisions. It becomes clear when working with unstructured data that the smaller the unit, the more is lost from it's meaning as the context is lost.

1.6.3.2.2. Borrowing or developing a set of Categories.

If a study is based on an existing theory, one can use the categories described purely for comparative purposes i.e. code them according to the existing categories. However, if no such theory pre-exists, or if the data falls outside the existing categories, a set of categories must be developed. Wilson is quick to point out that developing a set of categories is a complex, time-consuming and difficult activity. She states "the set of categories must be sufficiently detailed and mutually exclusive to allow you to code all of the notes in your sample."

1.6.3.3.3. Developing the Rationale and Illustrations to guide coding of data into categories

Wilson (1989:470) explains that this means that the analyst is required to make a judgement on the right category for each unit of analysis. She says that it is important to define categories as fully and clearly as possible, using typical examples as illustrations of properties a response should have if it is to be coded into a particular category. Wilson also advocates using an independent judge to code the same data as a form of validation.

Wilson deals with Reliability and Validity of Content Analysis in a separate section from her "steps involved in a content analysis". It is useful information, which was used in designing the methodology for the study discussed in chapter two, and is therefore included here.

Wilson (1989:475) states that categories should meet the following criteria : homogeneity,inclusiveness, usefulness, mutual exclusiveness, clarity and specificity.

She also states (1989:476) that ultimate validity for content analysis relies on ability to develop rationale for categories, ability to define categories, ability to show how the categories are appropriate to the data, ability to illustrate the fit with which the data can be coded into the categories and ability to demonstrate relevance of categories to the research question.

All these points were taken into consideration during the study conducted on Perceptions of Caring, as will be explained in the following chapter on the methodology adopted for this particular study.

CHAPTER TWO

RESEARCH METHODS

2.1. THE RESEARCH PROCESS

The stages of the research process used as a basis for this study are :

- choosing the research problem and stating the hypothesis or constructing social explanations
- formulating the research design
- gathering the data
- coding and analysing the data
- interpreting the results

Each of these stages has been sub-divided into several subsections, most of which are suggested by Bailey (1982:9) and a few borrowed from other authors. As Bailey points out, research is a system of interdependent, related stages so that, although the following chapters are dealt with according to these headings, references will continually be made to other stages whilst demonstrating how this study was carried out.

2.2. CHOOSING THE RESEARCH PROBLEM

The problem which was identified and felt to be in need of research in order to solve the problem is as follows:

No valid, reliable evaluation instrument exists which is based on the criteria that patients use in evaluating whether a nurse is competent. The SANC provides guidelines as to what the profession considers are minimum standards, in the form of behavioural objectives, and not evaluation criteria.

As a result of the above, questions need to be asked viz.

- Can a set of criteria be developed from the perceptions that patients have of what constitutes nursing competence?

- Do patients and the SANC use common criteria when evaluating nursing competence?

The background information of why it was decided to carry out this study was explained in the previous chapter. It is evident from what was said there, that the problem is significant to the nursing profession, unless current evaluation of students is perfected, or at least significantly improved. In terms of reliability and validity, the nursing profession will continue to indiscriminately admit students into the profession.

This will lead to a progressive downward spiral of competence, as inappropriately trained nurses in turn evaluate successive generations of nurses. This study to determine patient criteria for assessing students is a step towards creating valid evaluation instruments.

Deciding on whether this problem was researchable, was more difficult. As seen in the literature review of previous attempts in Chapter 1, researchers have been singularly unsuccessful in determining criteria for measuring competence and caring in nursing. Results of these studies have been so varied that one wonders if it is possible to determine a set of criteria. However, Flanagan (1952) was successful in determining selection criteria for aviation schools, using the critical incident technique, that several other professions followed his lead in a quest to do likewise.

Certainly, this problem could not be researched using a quantitative approach as there are many variables involved, some of which are difficult, if not impossible to define or measure.

Qualitative research, however, very often concentrates on the process rather than the end product. Often, rather than starting with an hypothesis, it generates one. This can, at a later stage, then be subjected to testing.

In view of the above, it was considered feasible to research this problem in the full knowledge that further work will be required to improve evaluation in nursing. The results of this study, should be able to be used for this purpose, at a later stage.

Polit and Hungler (1991:79) point out that problems that are both significant and researchable may still be inappropriate if they are not feasible. The original idea was to collect relevant information and to use it in formulating an evaluation instrument. It was, however, realised that this was too wide for the scope of a Masters degree, and it was, therefore decided that it was more feasible to collect and categorize the information at this stage, and later to use the information to design an evaluation instrument.

The subjects for the research were patients in a large teaching hospital. There were always patients available to interview but they were mainly short stay patients and could therefore only be interviewed on the one occasion. This had to be born in mind when planning this study as it inevitably affected the testing of validity. The other point regarding the availability of patients was that many of the patients in

the hospital used were not fluent in the use of English. As this study's success hinged upon content analysis, this was a significant problem. It was decided that it was feasible to interview people who spoke English on a regular basis, and, therefore the study was planned to use these subjects and not to limit the study to subjects whose home language was English.

Another factor taken into consideration when deciding whether or not this was a feasible study was the expected co-operation or lack of co-operation of prospective subjects. It was realised that many of the patients in the hospital would not be able to participate due to the nature of their illness. This included patients in the Intensive Care Units who could not be subjected to the stress of an interview, patients whose consciousness was compromised, paediatric patients who were too young to co-operate, and some of the psychiatric patients whose contributions may not have been reliable. Nevertheless, it was decided that there were still sufficient patients available for the sample. As the interviews were to be conducted personally by the researcher who had ready access to the patients under normal circumstances, it was felt that both patients and ward staff were likely to co-operate, and not refuse access or withhold information.

The study was designed to be a relatively low-budget study with the researcher doing the data collection personally and having ready access to facilities and equipment in the normal course of her duties. Interviewing skills were already well developed which made gaining co-operation from subjects a relatively easy task.

2.3. ETHICAL CONSIDERATIONS

Ethical considerations, also had to be taken into account when deciding on the feasibility of the study. Matters such as confidentiality and anonymity were considered by numbering all the interviews rather than naming them. Although the Ethics Committee asked for written consent, the consent forms were kept separate to ensure that no one else would link the incident to a particular patient. As only positive incidents were to be requested, it was felt that patients would not disclose potentially damaging material from the hospital management's point of view. All patients were to be asked whether they wished to participate and assured that they were under no obligation to do so, and that their treatment would in no way be jeopardized by their decision. A copy of the consent form will be seen in annexure 3.

2.4. AIMS AND OBJECTIVES

The short term aim of the study was to determine the criteria used by patients to judge whether a nurse is competent or not. The long term aim is to improve student nurse teaching and evaluation

The objectives were as follows:

- to collect the criteria patients consider characteristic of a competent nurse.
- to categorize the criteria used by the patients
- to compare these criteria with those described in the guidelines and philosophy of the South African Nursing Council for basic nurse training, in order to develop a composite list of behaviours and attributes with which to evaluate student nurses.

2.5. FORMULATING THE RESEARCH DESIGN

The research took the form of a descriptive study, using qualitative methodology. A critical incident technique (as developed by Flahagan 1954) was used to determine what behaviours health care consumers consider characteristic of a "good" or competent nurse. The collected data were analysed using a content analysis technique.

2.5.1. Population

As indicated in the previous section, the population used in the study were patients in a large teaching hospital which included patients from all the Hospital-based disciplines used in training the four year comprehensive course student nurses. The patients from this hospital represent all major culture groups in the country, but it was decided to use only those patients who could communicate adequately in English, as a content analysis was to be done on the transcriptions of the incidents they related. This excluded a great number of patients and must, inevitably, limit the study as the interviews are only representative of the views of those patients conversant with the English language. Another important group of patients that had to be excluded were those who were unable to communicate because they were too ill. This group of people are particularly vulnerable and dependent on nurses to meet their needs, and hence their experiences would have been most valuable. It was not possible to overcome this problem using the methodology chosen, unless the researcher had been able to wait sufficiently long for them to recover. Even if this had

been possible, they may not necessarily have had sufficient recall of the time they were very ill.

For the purposes of the study, a "patient" was an in-patient at the hospital, i.e. someone who had spent at least one night in the hospital.

It is acknowledged that patients may have viewed the care they received differently depending on their state of health, and the number of days they had been in hospital. However, as patients were asked to relate an incident in specific terms, it was felt that their subjectivity would not influence the study. One should also remember that patients' feelings are, by their very nature, subjective and remain important. Nurses cannot afford to ignore them on this basis.

2.5.2 Site

The research was limited to one teaching hospital and included general, psychiatric and midwifery patients in the sample. If, however, an attempt is made to draw up a national evaluation instrument, it will be essential to include other institutions and communities in a larger study. The researcher confined her sample to those patients in the major teaching hospital where her students are placed.

It was decided to interview patients from medical, surgical, obstetric, gynaecology, orthopaedic and psychiatric wards that are used for student placement purposes. The wards where students are placed were used in the study.

2.5.3. Sample

In deciding on the size of the sample, other qualitative studies were consulted. (Beenhakker 1980, Gorham 1962, McDaniel 1964) Ultimately, it was not possible to decide on the number of interviews that would be necessary as the most important thing is to continue until no new categories are found in a batch of interview transcripts.

As a guide for planning purposes, other studies were taken into account. Crisham (1980) in her study on "Measuring Moral Judgment in Nursing Dilemmas" studied 130 staff nurses and 38 graduate nurses. Ray (in Leiniger 1988)in her attempt to develop a classification system of institutional caring, interviewed 92 participants. Gorham, (1962) in a study entitled "Staff nursing behaviours contributing to patient care and improvement" conducted group interviews, during which process he collected 2,065 incidents. Mangold (1991) used 60 participants in her study on Senior Nursing Students'

and Professional Nurses' Perceptions of Effective Caring Behaviours". Shields (1978) interviewed 80 patients in her study on Nursing Care in Labour and Patient Satisfaction.

It can be seen that samples vary in size. However, as each study was conducted differently from the other, these can only be used as a guide to planning rather than as a definite criteria for deciding on sample size. As stated above, the most important criteria is to reach a point at which categories are saturated. Numbers can only, therefore, be determined in retrospect.

Apart from the criteria that patients should be able to communicate in English and be able to participate without exacerbating their symtoms or causing distress, patients were selected as convenient. As it is impossible to judge language ability purely from external appearance, the researcher had to depend on the ward staff's (often inaccurate) perception of the patient's language ability, and on trial and error. Patients who appeared quite able to participate were sometimes not, due to their confusion, depression or disorientation. These interviews were not transcribed and constituted 6 interviews. They were however continued, where possible, to prevent hurting the patient's feelings.

92 interviews were recorded and transcribed, of which 9 were excluded. Reasons for exclusion included poor reporting as indicated above, insufficient or vague data given which made it impossible to analyse, and negative incidents. An example of a vague incident was, " All the nurses in this ward come in with a smile and a joke. It makes us feel much better." An example of a negative incident was, "The doctor came on his rounds and said that the nurses must do an irrigation. I didn't know what it meant...I thought it was the drip or something so I just kept quiet. Two days later he came and talked about it again and I realised the nurses were supposed to irrigate the wound...you know...wash it out. So I said to the Sister "when are you going to irrigate my wound? Then she came and did it...and all this vile smelling stuff came out. They have done it three times a day since then and now it is clean. They wasted all that time...I could have gone home but they ignored the doctor's instruction. There is no communication."

Of the 83 incidents remaining, 18 were related by Obstetric and Gynaecology patients, 19 by surgical patients, 27 by medical patients, 13 by orthopaedic patients and 6 by psychiatric patients. 59 of the patients were female and 24 were male. The ages of the patients ranged from 17 to 87. 47 of the patients use English as a home language.

2.5.4. Instrument

A focused interview was conducted with each patient after posing the same question to each. A copy of the information sheet given to each patient is included as annexure number 3.

The patients were asked to recall a specific incident that they had observed, or were part of, that, in their opinion, illustrated a competent and caring behaviour by the nurse concerned.

Although a great deal of time had been taken to refine and define the question, problems were encountered.

It was essential to ask the patients to be "participant observers" as it was their interpretations that were being researched. Participant observation is thought to be particularly valuable for its ability to "get inside" a particular situation and lead to a more complete understanding of its complexities. (Polit and Hungler, 1991:324) One problem that arose was that, when the patients chose to relate an incident they had observed rather than been part of, they superimposed their own feelings on the situation, which were not necessarily those of the patient involved in the actual incident. Some of the patients gave information about other patients that may or may not have been correct and left one wondering how the informant could have been informed about quite intimate and personal details. Patients are known to share more information in a hospital setting than elsewhere, but the researcher had no way of knowing whether information was based on surmise or fact. As many of the incidents were collected "third hand", that is from patient observers, information may easily have become distorted. This constitutes a limitation of the research and is discussed later (vide p 39). In retrospect, it would seem better to ask patients to confine themselves to relating incidents that they were personally involved in rather than ones which they had observed. Having said this, however, the researcher found that the patients were more reluctant to describe their personal experiences than those of others. Many could not recall incidents that had occurred to them but could recall incidents that had occurred to others.

Another problem which arose with the questionnaire was that only positive incidents were required. Several patients told the researcher that they could think of many incidents they had observed which illustrated incompetent or uncaring behaviour, but not the reverse. This was an extremely

worrying aspect, particularly as most of these comments were confined to one particular ward. Although these aspects could not be used in the research, an attempt was made to bring these matters to the attention of the relevant authorities. Negative incidents were not used both for ethical reasons and because it would have made classification more difficult.

The other problem encountered with the question posed was that the patients did not fully understand what was being asked, and required further explanation. This became a particular problem when patients asked for examples of what was required. The researcher avoided giving such examples as it was felt that this might bias the research, as it would invite a similar type of response. Nevertheless, explanations may have had a similar effect.

Despite the problems encountered, the interviews were useful, and the limitations of the method, and the instrument itself, were taken into consideration when analysing the information.

2.5.5. Collecting the Data

The first step in collecting data was to attempt to ensure co-operation from those involved. Permission had first to be sought from the Provincial authorities and the Superintendent and Matron of the hospital where the study was to be conducted.

It was also necessary to gain the co-operation of each of the nurses in charge of the wards which were used for the research. As there was such a rapid change over of staff, it proved to be most useful to speak to the Sister in charge of the particular shift when the interviews were conducted. Very few were interested in the explanations offered but all were quite ready to give permission for the interviews to be conducted. Some assisted by providing information on which of the patients were too ill, and which spoke adequate English to participate. Only one asked for feedback of patients' responses, but an attempt was made to give feedback to the others, despite their not asking, regarding patient responses and other pertinent information.

The researcher wore uniform as it assisted greatly in gaining co-operation from the staff, but did not necessarily have this effect on the patients.

Two patients refused to participate on the grounds that they thought they would be victimized by the ward staff if they were seen talking to the researcher who was dressed in

uniform also worn by matrons in the hospital.

The majority of patients were however, willing, if not necessarily able, to participate adequately. Many patients had difficulty responding immediately to the question, and, after some experience, it was found to assist greatly if the researcher spent a considerable amount of time talking to the patient about matters totally unrelated to the research before posing the question. Once the patients had got to know the researcher, they seemed to "hear" the question better and not be totally floored by it. It became very evident that the patients were not accustomed to nurses coming to talk to them and were immediately suspicious when this happened, until they became used to the researcher's presence.

As explained in the previous section, patients were asked to volunteer to participate and were also told prior to commencing the interview that the interview would be audio-taped. Few had a problem with this but several asked what would happen to the recording once it had been transcribed and needed to be assured that it would be erased. This problem appeared to be directly linked to their fear of being victimized should "someone" identify who the "informer" was; this, despite the fact that only positive incidents were being sought. This matter is of great concern, as one has to presume that victimization of some sort has occurred in the past for patients even to consider this a possibility.

Written consent was obtained from each patient, which in many instances seemed to worry them more than being taped, and they had to be assured there was no way to link a recording with the consent. For this reason, the numbers appearing on the consent form were not the numbers used in numbering the transcriptions of the interviews.

Information regarding the type of ward, (rather than the actual ward to prevent identification) sex, age and home language of the patient were kept for statistical purposes, as well as the type of illness.

The recordings presented other problems, in it was sometimes difficult to hear the patient adequately on the tape, particularly when they were speaking softly, and when a great deal of background noise was present. One became acutely aware that hospitals are not quiet places. A small recorder was used so that it was easily portable and was as unobtrusive as possible so as not to disturb patients during the recording.

Most of the patients needed prompting during the interviews

as they initially gave insufficient information to understand the importance of the incident to the patient. Many of them originally gave general information and had to be reminded that a specific incident was required. Many were immediately able to identify a nurse who, to them, was good but had more difficulty remembering specific incidents.

Batches of approximately 10 interviews were conducted at a time, and each recording was transcribed verbatim once the batch of interviews was complete. The only editing done was to remove unnecessary expletives and vacillations. Dots were inserted where words were omitted or there was a pause in the narration. In one memorable interview, the patient "dictated" his interview, complete with punctuation marks e.g. he said, "open brackets" and "fullstop" when he thought these should appear.

Initially, the researcher collected all the incidents personally. Half way through the process, however, she was transferred to another centre, necessitating the employment of a research assistant to collect the remaining incidents. The assistant was trained with regard to obtaining co-operation, obtaining consent, collecting the incidents, and transcribing the incidents. The research assistant was carefully chosen, being highly skilled in interviewing and managed the task most ably. It was gratifying to note during the validation process that no apparent differences existed between the incidents she collected and those of the researcher.

2.5.6. Organizing the Data

Initially the incidents were stored in a data base programme, as it was believed that it would be easy to recover them in this way. Several problems were encountered which led to the system being changed.

The particular programme being used, Filing Assistant, was most efficient at grouping and retrieving data according to language group, sex, age, etc but less efficient at grouping information within the incidents. The programme had no facility to search for words and word strings, thus making classifying difficult, as classification was done according to the information given rather than according to the informant. A word processing programme was therefore found to be more efficient for this purpose.

The other problem encountered was that the "files" on the programme were too small to hold the entire incident, with the exception of the short incidents. A facility did exist to enlarge the file, but having done this, the memory was too

small to hold all the incidents in one unit, making searching still more difficult, as the incidents could not be stored altogether on one disk.

During this time, the researcher was transferred, making it necessary to change to using a "laptop" computer with a smaller memory. It was decided at this stage to transfer all the data onto a word processing programme called "Kwikwrite" which took little of the computer's memory space and allowed all the incidents to be placed on disk. Although it was most frustrating to transcribe incidents a second time, it was a worthwhile procedure in the long term. Fortunately there were only 83 incidents in the sample making manual coding feasible.

As can be seen in the section comprising the incidents (Annexure 7), each interview was allocated a number. This was important as it made location of the incident easy when the incidents were being categorized. Incidental information such as age, sex, type of ward, home language and type of illness were recorded for statistical interest, as well as the verbatim transcription of the incident and space for recording the behaviours, the salient aspects from the interviewees viewpoint, the unit, the theme, the subcategory and the category were provided. A separate sheet was kept for each incident.

The reason why verbatim interviews were recorded was to ensure that the patients words were used in forming the categories. Had this not been done, a very real possibility would have existed that the researcher's interpretation of the patient's views would have been categorized rather than those of the patient himself.

Bailey (1982:319) emphasizes the importance of viewing the words of the interview in context, in order to understand the meaning of the words to be analysed. This is another reason why it was decided to record the interviews verbatim. Single words have little meaning, or may change in meaning depending on the context in which they appear. An example of this was the word "wash" which appeared in several incidents. On some occasions, the importance of the nurse assisting the patient to "wash" was that it helped the patient to be clean, but in others, the nurse had taken time to wash the patient in the way she preferred, indicating that the nurse cared for the patient's individual needs. The context of the statements obviously influences its categorization, thus making it essential to record all the information given.

2.5.7. Coding and Analysing the Data

Wilson (1989:470) says that the first step in doing a content analysis should be to decide on the unit of analysis, but this was found to be extremely difficult until becoming familiar with the material which had been collected.

The first step taken in this study, was to read the transcribed incidents and to highlight all the actions and behaviours that were mentioned by patients. The original intention had been to use each "behavioural" word as a unit of analysis, but it became obvious that the context of the statements would be lost in this way. Nevertheless, this was an important step, as the researcher was able to become familiar with the content and begin to develop concepts. More than one behaviour was frequently found in each incident, but each was highlighted and recorded.

The criteria for identifying behaviours are by no means clear. Even finding a definition of the word "behaviour" proved an impossible task Most sociology and psychology texts refer to behaviour, but none define it as such. Conventional dictionaries define it in terms of behaving oneself according to society's norms. Eventually, Chambers Thesaurus was consulted which gave the following synonyms for the word "behaviour" - action(s), bearing, conduct,dealings, demeanour, deportment, doings, functioning, habits, manners, operation, performance, reaction, response and ways.(Seaton,1990:57)

While most studies using a content analysis refer to behaviours, there is little agreement on its meaning. Gorham (1962:68) began his research project with the assumption that "the behaviour of general staff nurses in contributing to patient care and improvement can be studied in a scientific way" and says "the key word in this assumption is "behaviour. .....while it is variously referred to as "duties", "roles", "functions", "responsibilities", it is actual behaviours which contribute to patient improvement." This explanation still leaves it up to the researcher to identify "what" contributes to patient improvement, thus creating much room for interpretation.

Mc Daniel (1964:237) was more specific and viewed behaviours as actions. When discussing behaviours, she says "incidents with like actions were put into groups."

The decision was finally made to identify behaviours as "anything the nurse does that can be observed and reported upon." Initially, no notice was taken of what benefit the patient derived from these behaviours, if any. It had been

hoped that the behaviour could be used as a unit of analysis and the computer could the have searched for words which indicated behaviours e.g. wash, brought analgesia, gave liquids. It soon became evident that this was not possible, because of the loss of context as mentioned above, and demonstrated the concern expressed by Carney (1972:33) regarding the early use of computers to "count" words, thus losing important meanings contained in documents.

The definition of behaviour used in this study was useful, although the significance of the action was not identified, but could be used when searching for like behaviours or characteristics during the categorization phase of the research.

After the behaviours were identified, each incident was re-read and an attempt was made to understand it from the patient's point of view. This was done because of the restriction explained above, and in an attempt to understand the context of the incident. The heading on the index card "Salient aspects from the interviewees viewpoint was used. This step helped to distinguish important motives and meanings, e.g. three patients may have mentioned that the nurse had brought them analgesia. For one, what was most important was that her pain was relieved, for another the fact that the nurse had had to ask the doctor to prescribe analgesia before she brought it, and yet another that the nurse did not keep the patient waiting after he had asked for the analgesia. Great care was taken not to sever the connection of the meaning of the incident from the original description of the incident and to see it from the patient's viewpoint rather than that of the researcher.

When thirty interviews had been completed, transcribed, and "labelled" as indicated above, the sorting process began. It was decided at this point that phrases would be used as recording units. The phrases used were, as far as possible, those used by the patients themselves, to describe in as short a phrase as possible what had happened and why it was important. Sometimes, however, it was necessary to use phrases which conveyed the meaning intended by the patient but which had not, necessarily been stated by the patient.

These recording units were then grouped and named, thus creating a tentative set of categories. The grouping was done according to perceived similarities in the recording units.

This proved to be an extremely difficult task at this stage as insufficient incidents had been collected to draw up a complete classification system. In order to learn more about the process and to perfect the technique, it was decided to

"borrow" a set of categories developed by Gorham (1962) who had identified five categories in a study conducted in the United States of America. His categories were as follows:

1. Improving Patients' Adjustment to Hospitalization or Illness
2. Promoting Patients' Comfort and Hygiene
3. Contributing to Medical treatment of Patient
4. Arranging Management Details
5. Personal Characteristics

Although no incidents "fitted" into category 4, and very few into 3, this set of categories provided impetus and direction by stimulating thought, and, although this set of categories was quickly abandoned, was useful. After this the first set of tentative categories was developed for the study. These were:

1. Being with the Patient
2. Anticipating Needs
3. Communicating
4. Demonstrating Professional Knowledge and Skill
5. Promoting Basic Comfort needs

As more incidents were added, new recording units were added and sub-areas formed. Existing categories were redefined, and several became subcategories, as larger groups were developed. This process was continued until approximately half the incidents in the total sample were analysed.

It was decided to start the process from scratch with the second half of incidents for two reasons. One was that a research assistant had been employed to collect them, and the other reason, which admittedly was only realised in retrospect, was to test validity as explained by Carney (1972:56). His idea, as outlined in chapter one of this report, was to split the sample into two at the outset, and to redo the investigation on the second half to see if similar findings resulted.

Exactly the same procedure was followed as detailed above for the first half of the sample, and the following categories were formed:

1. Being with the patient
2. Communicating
   - 2.1. Verbal
   - 2.2. Non verbal
3. Demonstrating Knowledge
4. Providing Comfort
5. Nursing Skills

It can be seen that these were fairly similar, and indicated validity, although the similar themes that emerged in the second half of the sample, that had already emerged in the first half, were not always put into the same category. It was decided at this stage to combine the two halves of the sample and to work with them as a whole.

The index "cards" of the total sample were too many with which to work comfortably, so all the recording units, i.e. like word/s were separated out, retaining the interview number for easy identification, and placed on several sheets, with space inbetween for manual recordings.

The important word/s in each recording unit were highlighted, and like recording units were grouped, first by coding them on the paper, and then by separating out like recording units and placing them on a separate sheet. This was easily accomplished as the programme being used at this stage was a word processing package.

Themes were then identified, named, and placed, tentatively, into appropriate categories.

It was then decided that it was necessary to go back to the original incidents related by the patients as it was feared that the researcher's interpretations may not have been accurate. If this had been the case, the entire categorization system would have been formed from the researcher's perspective, rather than that of the patients. By transferring the themes and categories onto the original index cards, it was a relatively simple, if time-consuming task to check through each one, read the patient's description of the incident and decide whether it was correctly classified or not. Often, on re-reading the incident, additional behaviours emerged, or took on new meaning, necessitating changes being made. It helped greatly at this stage to be familiar with all the incidents and be able to recall them for comparison purposes.

Once certainty existed that the themes were representative of what the patients had said, they were used for the final development of categories.

The changes made at this stage were mainly to reorganize categories and subcategories as improved groupings emerged. Two were re-named after a literature search revealed more appropriate names for the categories. Where less than two like units existed, the theme developed for them was discarded, as it was considered to be insignificant.

Some of the final categories were much larger than others and were broken down into sub-categories. Other smaller groupings were left with a category but no sub-categories. It was found that if categories were broken down too far, they lost meaning.

The classification system was then subjected to a validation process which will be described below, and the necessary changes made.

The final task was to "tidy" up the wording of the categories, subcategories, themes and units, to ensure uniformity and meaningfulness. Although definitions of each are provided, it is important that each of these aspects is meaningful, without detail so that they can be useful, neutral and comprehensive. (McDaniel, 1964:238)

The final set of categories is as follows:

1. Assisting with patient needs
2. Demonstrating knowledge
3. Interpersonal abilities
4. Personal attributes of the nurse
5. Nurturance

2.5.8. Comparison with Documentation of the S.A.N.C.

In an attempt to meet the last objective for this research study, viz. to compare the themes developed with those described in the guidelines and philopsophy of the South African Nursing Council, a content analysis was done on the Scope of Practice of Registered Nurses document, and the Programme Objectives for the Four Year Course, leading to registration as a Nurse (General, Psychiatric, Community) and Midwife.

During this process, themes were identified and were placed in the most appropriate categories already formed, during the study, in an attempt to compare the data. Serious problems were encountered with this process, the single most problematical being the non-specificity of the programme objectives. As very few "behaviours" were present in the document, it became impossible to use the same units for classification purposes, rendering the exercise useless. An example of the problem encountered was with the objective :" (i) evinces an enquiring and scientific approach to the problems of practice and is prepared to initiate and/or accept change." (SANC 1988) No behaviours can be identified and thus it could not be classified using the same set of categories that had been specifically designed for

specific incidents of behaviour. An additional problem was that many of the programme objectives were broad and were categories within themselves rather than providing units for classification e.g. " (j) is able to manage a health service unit effectively " (SANC 1988) Obviously " unit management" could be a category in itself, but this was not identified by the patients in this particular study.

Much more success was obtained when the exercise was repeated using the Scope of Practice for registered Nurses (SANC, 1987) . This document is written in a different style as its purpose is to outline behaviours expected of the registered Nurse. Of the 22 behaviours identified in the document, 13 could be placed in existing categories. Other aspects had not been identified as important by the patients, and therefore fell outside the system of categories developed. (see annexure 4)

2.5.9. Validating the Research

As explained previously, the first form of validation occurred early in the research when the sample was divided into two and categorized separately.

The next, and probably most important form of validation, was that of the expert committee. This was done in line with Carney's suggestion of using a panel test (1972:200). The expert committee was used to look at the categorization of themes and to decide whether they were correctly done or not.

The committee of experts was chosen from experienced registered nurses who had not had a part in collecting the data, and who represented the three major disciplines of nursing included in the research, viz. general nursing, midwifery and psychiatric nursing.

The "general" nurse was unfortunately ill the day the committee was to meet, and an "extra" expert with general and recent psychiatric experience was invited to participate. The general nurse was consulted later, as will be explained.

The committee of three were each given copies of the categories and sub-categories which had been developed. The original transcript of each incident was then read to them, one by one. They did not know how the researcher had categorized each individual incident. As each was read, they were asked to place the incident with what they considered to be the most appropriate category. The rule applied was that consensus should be reached, with all three agreeing to the placement.

At the outset, the committee had a problem with the category, which, at that stage was named "Communication" and asked that it be named "Interpersonal Abilities" as they believed this was a wider, and therefore more appropriate category which could include sub-categories of verbal and non-verbal communication. This did not cause a major problem as it involved a name change rather than a change of concept.

The "Nurturance " category caused some difficulty, due mainly to the relative unfamiliarity of the term. The committee asked,after reviewing several incidents, that a new sub-category be added under this heading called "attentiveness" as they had difficulty placing several of the incidents, and, with this addition their problem was solved. Once this was done, the committee was able to place all the incidents, indicating that the set of categories was sufficiently comprehensive and inclusive. They did, however, remove a category entitled "meeting physical needs" stating that the meeting of the need was secondary in virtually all cases to the main benefit to the patient as they perceived it. The researcher was concerned about this and was aware that the expert general nurse was not present at the time.

55% of the units were placed identically to that of the researcher. The change of terminology, the addition of the one sub-category and the elimination of another category obviously influenced this figure. What was of more importance was that so few, and such relatively minor, changes (with the exception of the removal of the "needs" category) were made to the system of categories.

Although not planned, the late participation of the general nursing expert proved most useful in terms of validation. By the time she was consulted, the new set of categories, as agreed upon by the expert committee, had been fully developed. She was then asked to proceed with the exercise along identical lines to those followed by the expert committee. The only change made to the categories by this expert was to re-introduce the category on meeting needs. As she is an expert in this field, her opinion was accepted. Apart from this major departure, most of her classifications of the units were the same as those of the committee.

Wilson (1989:476) states that the ultimate validity for content analysis relies on the ability to develop rationale for categories, ability to define categories, ability to show how the categories are appropriate to the data, the ability to illustrate the fit with which the data can be coded into the categories and the ability to demonstrate the relevance of categories to the research question. Although this is acknowledged to be part of the validation process, these

aspects can only be demonstrated when describing the findings of the study, and will accordingly be dealt with in the next chapter.

2.5.10. Limitations and Delimitations

As competence and caring are abstract concepts, it is difficult, if not impossible to measure them in concrete terms, hence the decision to undertake a qualitative study. It is always more difficult when analysing results of qualitative research to decide whether the researcher has met his objectives, as there is no statistical evidence to "prove" or "disprove" a theory, and often, as in this case, no theory to prove in the first place, only a problem to solve.

The only way of evaluating results, is to go back to the research questions, aims and objectives for the study to see whether they have been met and to decide along the way whether the study is comprehensive, valid and free of bias.

The first objective was to collect criteria patients consider characteristic of a competent nurse.

A great deal of effort was made to ensure that the patients' views were recorded, and categorized rather than anyone else's interpretation of what the patients thought. A question still remains regarding whether they were describing a "competent" nurse. Although the research question, posed to each patient, mentioned only the words "competent" and "caring", the introductory paragraph also mentioned the word "good". It is possible that the use of all three terms could have elicited a more varied response than the use of one word. However, the words do appear to be used synonymously by patients and nurses, but further investigation into this possible problem is warranted. The word "caring" may indicate interpersonal aspects, whereas the word "competent" may indicate psychomotor aspects. In any event a good spread of both these aspects was obtained and indicates that this was not a significant problem.

Although patients were encouraged to recall more than one incident, very few did. As a result, most patients gave only one criterion which obviously does not describe the nurse "characteristically". As over 80 were eventually collected, this collective concept of a competent nurse may well be adequate. It is essential that, when using these criteria for future projects, they are used collectively.

The other obvious limitation stated before commencing this study is that only patients from one hospital and then only patients who use English regularly, who were relatively well, were interviewed. Clearly this is not representative of the patients that the students from the one college care for, let alone student nurses from other centres. For this reason, a wider study would be required before it could be assumed that the views of patients, in the wider sense, had been represented.

Another difficulty was that patients could only describe competent behaviours they had observed in the particular hospital. As a result, even if the patient believed that certain criteria were important, he was not given the opportunity of saying so. This resulted in important aspects being omitted. For example, if a patient believed that competent nurses use hot water to bedbath the patient, and all the bedbaths are done by orderlies, this would not have featured in the research. Unless this is born in mind when ultimately drawing up an evaluation instrument, such important aspects will vanish from nursing curriculae forever.

No community patients were included in the study, thus limiting the study to sick people in a hospital setting. As the emphasis on health care is moving very rapidly into the community, this study should be extended to include this important category of patients.

The next objective was to categorize the criteria used by patients.

As Carney (1972:40) says, there are no rules for forming categories, but that it assists the process if the researcher has an informed background. It is clear in viewing the final set of categories that well established terms were used, if from vastly differing sources. This certainly assists with the definition of the categories, which is one of Wilson's (1989:475) criteria for deciding on whether the set of categories is valid or not.

The most serious problem with the categorization, was that a decision was taken to stop collecting data when the categories were saturated, in other words when no new categories were being formed by incoming data. This occurred after about 70 incidents had been placed into the final set of categories. The difficulty came, in that, although the categories were "saturated", the sub-categories, and themes, were not. This may become a problem when attempting to use the set of categories for evaluation purposes, as the themes and sub-categories would be used as criteria for evaluation.

The third objective was to compare the criteria with those described in the guidelines and philosophy of the SANC for basic nurse training in order to develop a composite list of behaviours and attributes with which to evaluate the student nurse. Certainly, by combining the behaviours in the SANC documentation with those in the study, a much more comprehensive list exists. The list would still not be complete until a significant number of nurses have been interviewed to establish the importance of each of the behaviours in the documentation and to ensure that they were considered important by expert, practising nurses.

The short term aim of the study was to determine the criteria used by patients to judge whether a nurse is competent or not, which was done in the study. The long term aim to improve student nurse teaching and evaluation still has to be fulfilled, although, even during the process of conducting the research, the data has been used for teaching purposes.

With regard to the research questions asked, some answers have been obtained. The first research question was: can a set of criteria be developed from the perceptions that patients have of what constitutes nursing competence. The answer has to be a qualified "yes". Certainly the criteria can be used, but further interviews need to be conducted, notably with members of the profession, before a composite list of criteria can be developed.

The second research question was : do patients and the SANC use common criteria when evaluating nursing competence. The answer here is that some criteria are found in both, but equally many are not. This matter will be fully discussed in the chapter on research findings. With regard to methodology, the study would appear to have succeeded in the most important area, i.e. establishing criteria patients use in establishing competence, but further work is required before the objectives are fully met.

2.5.11. Interpreting the Results

As pointed out above, there were limitations and delimitations to the study, but the results demonstrate that the patients believe that psychomotor, affective and cognitive skill is important for a nurse. As the results were not quantified in any way, it is not possible to know which aspects are more important than others.
In order to interpret the results of this study adequately, the categories need to be compared to those from other studies, and to demonstrate similarities in the literature. This will be dealt with in the next chapter.

CHAPTER THREE

RESEARCH FINDINGS

3.1. OUTLINE OF FINDINGS

In this chapter, the findings of the study will be discussed, explaining what criteria were used for developing categories, defining and explaining each of the categories and smaller units, in an attempt to justify their development and to form the basis for the recommendations based on these findings. A summary of the findings of the study based on the research conducted, as outlined in the previous chapter, will be given first, in order to provide a composite view of the findings. Each category will then be dealt with separately and in detail.

There were five categories formed viz.

1. Assisting with patient Needs
2. Demonstrating Knowledge
3. Interpersonal Abilities
4. Personal Attributes of the nurse
5. Nurturance

Each of these categories was broken down into smaller units, or rather, the categories were built up from smaller units. In the larger categories, sub-categories were formed. All comprised themes which, in turn, were built up from units, grouped together according to similar meanings or content to form the theme. (see annexures 5 and 6)

It must be born in mind that these categories were formed from what the patients viewed as important in judging whether a nurse was competent or not. It is by no means a complete categorization of all the skills, qualities and knowledge that a professional nurse needs to possess in order to render patient care. This categorization, does, however indicate where emphasis should be placed in teaching students and caring for patients.

3.2. ASSISTING WITH PATIENT NEEDS

This category was formed from units and themes which indicated that the patient had either expressed a need, or it was an obvious need i.e. it did not require a great deal of experience or knowledge on the part of the nurse to identify the need. What was important in this category was that the nurse met the need, rather than identified it.

A need is taken to mean " want of something without which one cannot do without." (Davidson 1985:646) All the aspects included in this category are, therefore, essential for the maintenance or recovery of physical, social or psychological health, and therefore absolutely essential aspects of nursing care.

Four sub-categories were formed, viz. Physical needs, social needs, comfort needs, and safety needs. At one stage in the development of the categories, spiritual needs had been included in the categorization. However, only two incidents fell into this category, and had already been included elsewhere in the classification system. It was decided that there was insufficient scientific basis for it's creation and that it had rather been included due to the bias of the researcher. It was therefore excluded quite late in the process. If one subscribes to Maslow's (1954) hierarchy of needs, the reason why so few incidents related reflected spiritual needs, was that the patient's more basic needs needed to be satisfied before a need was felt for meeting "higher" needs. Presumably, as the patients were in hospital and their health was at risk, they were functioning at a relatively low level in terms of Maslow's hierarchy.

3.2.1. Physical Needs

The term "physical" needs refers to those needs that pertain to bodily functions as opposed to mental or social functions.

This sub-category was sub-divided into two themes, viz. Hygiene and Elimination and Exercise and Mobility.

Hygiene and Elimination were linked together as many of the patients related incidents which included both, i.e. washing the patient after they had used the bedpan, and were thus inseparable from one another.

As expected, most of these incidents came from medical and orthopaedic patients who were incapacitated to a significant degree by their illnesses or operations and were therefore largely confined to bed and dependent on nurses to fulfil these very basic needs. In all cases patients appeared almost apologetic that they had to rely on others for these basic, and what they often viewed as, unpleasant, needs. Once the ratio of men to women respondents was considered, as many men as women gave incidents expressing this need.

The units included under the theme of hygiene and elimination needs were:

- Helping the patient to wash
- Washing the patient after using the bedpan
- Helping the patient onto the bedpan
- Combing the patient's hair
- Giving tablets to stop diarrhoea

A concern that surfaced while reviewing not only these units, but others too, was, if these were incidents of "good" or competent nurses, what are the other nurses doing, or omitting to do? Surely all nurses should cater for these very basic needs, and what happens to patients where nurses do not do these things for them? It became evident during the research that relatives undertook some of the basic nursing care that was provided, particularly with regard to washing the patients. Relatives even brought in towels and clean linen in order to carry out this task for the patients as linen was apparently not available and nurses very often used this as an excuse for not being able to wash patients.

Incident number 83 illustrates this concern well. "The tall nurse, she is very nice. She is very understanding. When you can't wash yourself properly, she takes you and go and wash you in the bath. This is when you are not well enough. She hold my arm and put Savlon as well." By implication, the other nurses do not assist patients who are "not well enough" to wash properly.

Incident number 79 also acts as a good example of this problem. " I was involved in a plane crash on 11 June. I have lain here for 5 weeks ...it is difficult to move around. When we crashed, there was a lot of dirt and sand. The thing that really got me was that my hair was so dirty. I could feel it driving me insane and I mentioned it to Sister W. She was in charge and very busy, and she said, "don't worry, I'll make time. " She came and washed my hair ..." This particular patient had lain in hospital with a fractured spine for five weeks, and not one nurse had thought to wash his hair until he asked for it to be washed. This is quite alarming when most people, which includes nurses, usually wash their own hair regularly, and yet they do not consider this may be necessary for their patients.

Exercise and mobility were also linked as there is a very fine dividing line between the two, particularly when a patient is ill. Moving the limbs of a helpless patient is known as passive exercise and yet no healthy person would consider it in this light.

The units included under the theme of exercise and mobility needs were:

- Helped the patient to sit up
- Helped the patient to walk
- Persuaded the patient to sit up

It is interesting that all the respondents who related incidents in this theme were female. They were from all the different types of ward and of all age groups.

An example of a patient who recognized the importance of exercise and mobility related incident number 81. "That patient is tied to the chair. Nurse N helps him very well. She feeds him and walks him now and then. She is not afraid of him like the others."

Again, one is worried by the implication that the "others" do not care adequately for this patient and have possibly hindered his care by restraining him. As one does not know details of the patient's problem, it is difficult to judge this situation.

The above incident was one of the very few that related to "feeding" the patient. As there were so few, it was not thought justified to create a sub-category for food and fluids, although this was considered. One hopes that the reason for so few patients commenting on this aspect of meeting basic needs, was that patients are fed regularly and by all nurses, hence it is not considered to be "special" behaviour. During the research, however, it was observed that the very patients who were excluded from this research due to the fact that they were too ill or could not communicate adequately were often neglected at meal times. Meals were served by domestic workers. The only role played by the professional nurse in this regard being, to tell the domestic worker which tray to give to which patient. Meals were seen to be placed out of reach of the patient and collected half an hour later untouched, and also given to patients who were unable to open the containers. Some patients said they only ever ate the puddings and vegetables because the boxes containing the meat portions were too difficult to open. It is of great concern that nurses do not make it part of their routine to supervise meal times, and do not appear to understand the role of nutrition in the recovery process.

Oxygen needs and temperature regulatory needs were not mentioned by the patients. The former is not surprising as no patient with compromised oxygen needs was included in the

study. Temperature needs were referred to in terms of comfort and thus included in another category.

The physical needs in this category were relatively easy to identify as they involved specific behaviours on the part of the nurses in response to a patient's stated or observed need, and are all well described in the nursing literature.

3.2.2. Social Needs

This subcategory was subdivided into 2 themes :

- Recognition as an Individual
- Acceptance

The term "social" can be defined as " pertaining to life in an organized community." (Davidson 1985:946)

It was decided that it was justifiable to include both themes as social needs as they certainly referred to life in an organized community. In this context, a hospital ward was considered to be an organized community. Both recognition as an individual and acceptance are essential for humans, i.e. they are elements that they "cannot do without", thus fulfilling the criteria for a need.

With regard to Recognition as an Individual, there were two units identified viz.:

- Made patient feel valued
- Acted in a special way for this patient

Patients felt valued by being greeted, especially when by name, by having their ideas acknowledged, by the nurse coming to visit her after she had left the nurse's care, by understanding a personal problem, by sitting and talking to the patient, and by remembering a patient from a previous admission.

Incident number 80 illustrates this last aspect well:
" I was feeling very new in the ward. Previously when I had been here not only as a bi-polar disorder but also treated for alcohol abuse, I caused a lot of trouble. Since then I have sobered up in A.A. When Sister E came on duty, she recognized me and put her arms around me and gave me a big hug, and said how much better I looked. That evening I felt so much happier and it was nicer to be in the ward. She didn't hold anything against me."

One can see from this incident that the patient was made to feel "valued" and that because of it, she felt more comfortable within the social group, reflecting the meeting of a "social need." Because of this latter effect, it was also included in the theme "Acceptance".

Greeting a patient would seem to be such an automatic and natural thing to do and part and parcel of good manners, but several patients mentioned it, indicating that it is not always done, and certainly not done by all nurses. Incident number 15 reads : " My best nurse says, "good morning, how are you?" when I wake up in the morning. It makes me feel like a real person."

Acting in a special way for the patients involved meeting a specific individualized need. Patients felt these needs were different from other people's and hence were appreciative of the nurse meeting them as it was outside the routine. A good illustration of this unit is incident number 20:
" People seldom take notice of me. I think of myself as a poor white. Then all of a sudden, a black nurse came to me and saw that I am not so good dressed and she rubbed my back and combed my hair. I think that is good of her. It made me feel good."

Another incident which illustrates this unit is number 47:
" I can't stand being without ice water. It is very difficult to get ice in this hospital, but she brings it to me. She makes sure I am never without very cold water - there - you see it there."

With regard to acceptance, two units were identified:
- Acceptance despite being different or unpleasant
- Made patient feel part of the ward group

The first one refers to the nurse's acceptance of the patient despite problems. The second refers to the nurse's ability to ensure the patient is accepted by the ward group or able to adapt to and accept the ward situation, thus becoming part of the group.

An example of the former is found in incident number 32:
" ..... For two days - excuse my expression - I was a bitch. My attitude was too terrible. After two days I apologised and she accepted it. She said "I know you were very sick."

An example of the latter is found in incident number 69:
" ....The old people love her. She gets the old ladies eating and sitting." As soon as these "old ladies" began eating and

sitting, they were able to participate in ward activities or at least be acknowledged by other patients.

It was interesting to note that several patients who were asked to be interviewed, refused on the grounds that they had only been admitted that day or the previous day and were not able to think of any incidents of caring that they had observed. They must, in reality, have observed several, but it seems as though, until they are comfortable in the ward, they cannot assimilate what is happening there. There is no doubt that a hospital admission is traumatic, mainly because of the difficulty in mixing with a group of people previously unknown to one - both patients and nurses. One is therefore unsure what to expect from them, which is threatening.

Even once the ratio of men to women in the study was taken into account, far more women than men related incidents falling into the "Social Needs" category, but no other trends could be seen. It is difficult to know whether women have greater social needs than men or whether they are more ready to express their needs.

3.2.3. Comfort Needs

The term "comfort" was taken in it's broadest sense, i.e. not only the relief of pain, but also as Davidson defines it, " a subject of satisfaction, freedom from annoyance, whatever gives ease." (1985:192)

Three themes were identified viz:

- Elimination of Pain
- General Comfort
- Psychological Comfort

Patients seemed to indicate various levels of ability of the nurse to relieve or eliminate their pain, as indicated by the units identified. The "lowest" was the giving of analgesia when asked for it by the patient, the next was asking the patient if they needed analgesia and then giving it rather than waiting for the patient to have to ask. The next level was assisting the patient to take the analgesia, although this was only identified by one patient, followed by asking the doctor to prescribe analgesia as the nurse thought this was necessary, and finally assessing the reason for pain and taking appropriate steps to prevent or eliminate the pain. Added to these was a unit, identified by several patients, describing how the nurse conducted a procedure in such a way that it caused minimal pain.

An example of the latter unit is found in incident number 12 described by a patient in somewhat quaint English:
"This nurse - she treated me well, and when she pricked my finger for my sugar diabetes, she was kind - she didn't hurt me. She didn't do jumping and make you frightened. She has got the art of doing it - when she does it it doesn't hurt so much."

It would appear from the above incident that if the nurse is confident when she does the procedure, the patient relaxes and does not experience as much pain, showing that the nurse's attitude is as important as her skill.

An example of the nurse asking the doctor for analgesia is found in incident number 17:
" I'll tell you about one incident. I asked this nurse for a pain pill and she just said, " the doctor hasn't prescribed one for you." but this other one - the good one - she said it wasn't prescribed but she would go and ask the doctor - and she did. She came back with the pill. She mustn't just turn and walk away or say "oh well, same old story."

It is inconceivable that anyone could walk away from someone else in pain when she has the ability to help that person, and yet here is an example of a nurse - a supposedly caring person - doing exactly that. It would seem that it is now necessary to train nurses to do and be what was formerly considered common sense and an inherent kindness.

With regard to general comfort, units were included that dealt with physical comfort measures apart from the elimination of actual pain.

Units included, rubbing the patient's back, putting ointment on dry lips, giving the patient a hot cup of tea, warming the bedpan, rearranging pillows, tuning the radio perfectly to the station and washing and combing hair to prevent irritation. These are all tasks that have traditionally, over the years, been carried out by women caring for children and ill people, without any formal training. They seem to be part and parcel of the female role, and not specifically nursing skills, and yet are greatly valued.

It was interesting to note that, although rubbing of the back is no longer considered "good" nursing practice as it does not prevent the formation of bedsores, the patients still like it. It would seem as though the contact is still important and it is seen in the same light as therapeutic massage which is receiving much attention in the overseas nursing press at present.

The incident (number 9) regarding the administration of a hot cup of tea illustrates the point of this group of incidents being a collection of unskilled, but valued, actions quite well:
"I went to have one of those pipes put down my throat. When I came back, I asked the nurse to give me a hot cup of tea. She went straight away and made me a cup of tea. It wasn't tea time .....she did it specially. It helped me." One isn't sure whether the hot fluid was soothing for her sore throat, or whether the tea itself was equated with comfort in true British tradition where a cup of tea was served at times of adversity. Whatever the reason, it was a simple, but comforting action on the nurse's part. What would have been still more encouraging was if the nurse had offered it to the patient rather than the patient having to ask for it.

With regard to psychological comfort, the units included here included actions which saved the patient embarrassment. This seemed to be a mainly male domain, indicating that men find the procedures conducted in hospitals more embarrassing than women do. This could be due to the fact that the majority of nurses are women.

An example of such an incident is number 72:
" I asked for certain assistance (catheterization) and the nurse in question came without any problems at all and did it with a great big smile on her face. No problem at all and it was over and done in a jiffy. She was happy and I was happy."

3.2.4. Safety Needs

This sub-category included two themes viz. physical safety and emotional security. The term safety is therefore seen in a broad light, as defined by Davidson (1985:874), "free from danger, secure, certain, sure."

It was often difficult to know whether to classify an incident under physical safety or emotional security in the absence of any real physical danger. Many patients appreciated the nurse supporting them physically when they were not well, but in reality it was probably more out of psychological fear than physical fear, as it is unlikely they would have fallen. One such incident is number 3: "I decided to go for a shower and I was very weak. The nurse walked me all the way to the shower and sat in the shower cubicle with me to see that I was O.K. "

The decision was made to keep the sub-category for physical safety if only to emphasize the importance of preventing medico-legal hazards.

Units included under emotional security were as follows:
- Contact with patient made him feel safe
- Explanations made him feel secure
- Capable actions made him trust the nurse.

All of these units could have been included in other categories, but the important aspect was that the patients indicated that the action made them feel safe or secure e.g. incident number 67:
" P. is good and kind. She comes to check on me every now and then. This makes me feel great and makes me feel safe."

3.2.5. Summary of Category "Assisting with Patient needs"

A total of 77 recording units were identified as belonging to this category. 36.5 % of these were classified under the comfort subcategory, 26 % under social needs, 19.5 % under the physical needs, and 18 % under safety needs.

As stated at the beginning of this section, this listing is by no means a complete list of all patient needs that have to be catered for. All the incidents discussed above were cited as the patient thought these indicated that the particular nurse was good, and therefore, presumably that the rest of the nurses did not assist with these needs. Apart from being an indictment on nursing care at the institution in question, it is worrying to note that the patients felt it necessary to mention any of the above incidents as they involve very basic care, and in most cases could have been provided by a caring lay person. If the basic nursing care had been up to standard, one presumes that patients would have related incidents higher up on Maslow's hierarchy of needs. There did not appear to be any indication that the patients' needs were being better met in any one ward, or group of wards as the incidents came from patients in all the wards visited.

3.3. KNOWLEDGE

This category was formed from themes and units which indicated that the nurse in question possessed some knowledge not possessed by all people and that she was able to use this knowledge to the benefit of the patient. The category was subdivided into two sub-categories viz.:

- Theoretical knowledge
- Skills

3.3.1. Theoretical Knowledge

The meaning of "theory" in the context of theoretical knowledge used here, is derived from Davidson's definition of "theory" meaning, "an exposition of the abstract principles

of a science or art."(1985;1032) Incidents included in the sub-category of Theoretical knowledge included two units i.e.

- Able to give patient information
- Knowing the correct action to take

It is not surprising that patients value being given information as we know that they also like a nurse to talk to them, but the incidents included in this unit indicated that the actual information was important to the patient, usually because they believed that it helped them cope with a situation if they knew what to expect as illustrated by incident number 84:
" I flew back from England when I got the results. (of the amniocentesis) I was afraid and sad. The nurse was fabulous. She came in and sat down and explained what would happen, and what to expect. For me that is easier. If someone says "it is going to hurt like hell" it's fine as long as you know."

Another incident indicates that often nurses give generalized information rather than listening to the patient's needs and answering their specific questions. This was indicated by incident number 42, which was short but said a great deal:
" She told me all about family planning. She told me what I wanted to know."

With regard to knowing the correct action to take, patients often seemed surprised that the nurse did know what to do, or cited incidents of taking an action which they would not have expected her to take. Most often, the nurse was acting within her scope of practice, but patients seemed not to realize that nurses could take such action. Incident number 64 illustrates this point:
"I slipped and fell in the shower. I reported it to the Sister. Despite the fact that she was busy at the time, she took a statement, inspected the shower, did an examination, asked if I wanted to see the doctor immediately, and reported it to the day sister. On my return from a day out, the doctor was waiting to see me. Afterwards I enquired why she took this so seriously. She replied, proving that she is competent and has knowledge of policy and administration, that the hospital could be held liable, and the patient could enter into litigation..."

3.3.2. Skills

The subcategory on Skills was so large that it was further subdivided into
- Observational Skills
- Psychomotor Skills

The term "skill" was used to indicate some type of action or reaction to a situation rather than the exposition of abstract principles emphasized in the knowledge sub-category.

At one stage in the classification procedure, communication skills had been included in this sub-category, but it was decided that it was so large that it warranted a section of it's own, and also included more than pure "skill."

Observational skills contained two units, viz.
- notices if patient is in need
- assesses the situation (as opposed to the patient)

Incident number 6 is a rather lengthy example of the former and has been abbreviated here:
" When the nurse came to do my dressing - you know it is sore and I am nervous...she watches my face and can see when there is a change in my face that it is sore...and she says there is a certain thing (a drain) here that I have to take out - but there, it is finished now - you can cool down."

This is an example of the nurse using her skills of observation to assess the patient and take appropriate action. This same patient indicated that if you do not co-operate totally with some nurses, they will not treat you. She said, " She doesn't just say, " I am doing my job..I have to do this otherwise I am leaving you. You can just go rotten." This one, she talks to you nicely...she does things gently, gently like a baby."

An example of assessing the situation is seen in incident number 44:
" A woman went into labour and was pushing. Me and another lady was telling her not to push, but this Sister comes in, she quickly closes the curtain, and she says "oh no, the head." But she knew what to do immediately. She didn't panic or anything. She was laughing. She took the whole bed out in a hurry."

Although one would have to agree with the patient who related the incident that the Sister assessed the situation, some doubt seems to exist as to whether the said Sister took appropriate action, inspiring one to change the maxim "beauty is in the eye of the beholder" to "competence is in the eye of the beholder."

It is important to note that in all the incidents classified under observational skills, the nurse observed a need or situation rather than being told of it's existence as in the first category discussed. Alternatively, in the patient's eyes at least, the nurse was able to make this observation because of her knowledge - it was not obvious to everyone.

The term psychomotor skills is derived from Bloom's taxonomy of educational objectives and refers to muscle and motor skills and all kinds of activities. (Child 1981:360) Clearly much of the work nurses do falls into this classification, and is incorporated into what nurses refer to as "practica".

The theme on psychomotor skills was comprised of several units :
- Dressings done efficiently
- Painful procedures done with little pain
- Difficult tasks done well
- Generally displays dexterity

With regard to doing dressings efficiently, patients seemed to regard the task itself remarkable. One would expect them to comment on dressing technique if they, the patient, suffered little pain as a result of the nurse's technique, but only one patient mentioned this. It is possible that dressings have become such a ritualized procedure that patients hold anyone who can do them in awe. Incident number 48 reads as follows:
"This competent nurse - she does my dressings very well. She comes and takes off the old one and makes it nice." One hopes that the nurse did not put the old dressing back on the wound once it was "made nice."

The unit, painful procedures done with little pain was created despite the fact that all the incidents could be included in the comfort category, because it was obvious from what the patient said that it was the nurse's skill that had reduced the amount of pain experienced by the patient.

Incident number 27 illustrates this unit well:
" When I was admitted, I was in a lot of pain....I have arthritis you know... and this one nurse, she lifted me onto the bed so gently...she didn't hurt me at all. I just said, "thank you, thank you."

The unit of Difficult tasks done well obviously indicates that the patient considered that the tasks were difficult and that they were done well. They need not have been difficult from a nursing point of view, although circumstances often make the simplest of tasks difficult. An example of this point can be seen in incident number 71:
" There's one nurse that deals so beautifully with the patients. One patient is very far gone, and she is like his mother. She calms him so he doesn't jerk around. She can feed him when others can't keep him still." (The patient receiving this attention has Huntington's chorea)

The unit of generally displaying dexterity included all demonstrations of psychomotor skills that did not fit comfortably within the other units belonging to this sub-theme. It included giving a bedpan, assisting a patient to take medication, and a generalized statement that the nurse in question was not a butter fingers. Although these were difficult to classify, it seemed wrong to exclude them as they were presumably as important to patients as other units which were easier to classify.

3.3.3. Summary of Category " Knowledge"

Although 38.9% of all the female respondents and 33.3% of male respondents gave incidents falling into this category, the men seemed to favour incidents in the psychomotor skills category. Due to the small sample, however, it is uncertain whether this is statistically significant, but might warrant further investigation.

A total of 36 incidents was classified in the "Knowledge" category, compared to the 77 in the "Needs" category, indicating that fulfilment of basic needs is more important to patients than the knowledge of the nurse. However, it is again important to make the point that, should basic needs be better catered for in the hospital concerned, patients are more likely to start expecting more from the nurse.

3.4. INTERPERSONAL ABILITIES

Travelbee's concept of "interpersonal" which includes human-to-human relationships (1971:119) was used in forming this category. Whereas it is acknowledged that the term was wider to Travelbee than communication, and that the incidents used included mainly communication, it was felt advisable to use the term "interpersonal" if only to show a deficit that appears to exist.

The term interpersonal means, literally, "between people", but Travelbee includes human-to-human relationships in her concept of Interpersonal relationships, which, by definition means " an experience or set of experiences between a nurse and the recipient of her care. The relationship is purposefully established and maintained by the professional nurse practitioner. The relationship is significant and meaningful in that both nurse and recipient have needs met as a result of this experience." (1966:123)

The two themes identified in this category were :

- Verbal Communication
- Non-verbal communication

3.4.1 Verbal Communication

Units included in this theme all entailed verbal communication, or the use of words with the patient in order to send a message. It may be significant that all the units identified involved sending messages, and not one involved receiving a message or listening. This could be for two reasons. Either the patients did not observe listening occurring, which is disturbing, or patients do not believe it to be important, which seems unlikely.

Several units were identified, viz. explaining to the patient, reassuring the patient, greeting the patient, talking to the patient, enquiring after the patient (the closest anyone came to indicating that listening was to occur), and communicating despite communication difficulties.

None of the incidents was particularly profound, and communication appeared to take place at a very superficial level. In defence of the nurses it is fair to mention that the patients and the staff comprise such cosmopolitan groups that this impedes verbal communication. All the wards visited consisted of staff and patients of many cultural groups, and although English is the official language of the hospital, it is spoken very little in some of the wards. Many of the patients were not able to communicate adequately in English in any event.

References were made to the language difficulties, as seen in incident number 32 where in the last part of the interview, the patient says:
"...It is important that she speaks your own language and doesn't use hers as I can't understand hers."
This problem appears to be particularly noticeable in cases where the nurses are arrogant and refuse to use the "official" language of the hospital, even when addressing patients and students. It appears to be used as a weapon against students and patients in an attempt to show "who is boss". Certainly, the patient quoted above indicated that the nurse she was describing was the only nurse in the ward who routinely used English when speaking to white patients.

Several of the incidents that were included in the unit on "greeting the patient" and "enquiring after the patient" have been included in the category "Social Needs" as well as it involves the patient feeling respected as an individual if a nurse enquires after him. The importance of this act of communication is, however, illustrated by incident number 29:
" In my present situation, it is closely linked with the baby. She is not in this ward anymore, but the nurse popped into my room and asked "how is the baby?" That is important

to me. If someone is interested in my baby it makes me feel good and I think I will get better sooner if I feel good."

Explaining to the patient is important in order to make the patient feel more secure as well as needing the information per se. Doctors often believe they have explained an aspect of treatment to a patient, only for the patient to ask the nurse for an explanation as soon as the doctor has gone. This probably occurs because they are not used to communicating with doctors and do not "hear' them initially. An example of a nurse giving a better explanation than the doctor is found in incident number one:
"The patient in that bed has something wrong with her baby. (hydrocephalus) The doctor came to explain that the baby was not normal and that she would have to have a caesar to get it out. The nurse stayed with her after the doctor had gone and explained over and over again what was wrong with the baby and that the caesar would not save the baby's life, but that it was necessary to get it out. She carried on explaining and explaining until she was satisfied that the patient understood..."

One possible explanation for verbal communication being on such a superficial level, apart from the language problems mentioned above, is that the average stay of the patients in this particular hospital is very short, i.e. three days. It takes time to build up a good interpersonal relationship with a stranger, so this may well be a contributing factor.

3.4.2. Non Verbal Communication

The theme Non verbal communication was subdivided into
- Touch and
- Facial expression

With regard to touch, the aspects mentioned were holding the patient's hand, hugging the patient and stroking the patient. Of all the incidents described, there were only 7 that fell into this unit. This could again be explained by the cultural diversity in the hospital, but when one considers the number of distressed patients one encounters in a hospital, it seems strange that touch is not mentioned by more patients, as certainly holding a patient's hand is a common way of communicating empathy with a patient. One example of the value of holding the patient's hand is seen in incident number 7:
" I went down to radiology and they stuck a long needle in - they were trying to drain an abscess - and this nurse.. it wasn't very sore but I was being a real coward about the

whole thing, and this nurse...took my hand and said "don't worry, you're doing fine."

Hugging need not involve great enthusiasm on the nurse's part to be helpful, an arm around the patient is as important as holding the patient's hand as indicated in incident number 16:
" I was upset one day - I was crying and this nurse came and put her arm around me - it was so helpful. I was down in the dumps and it made me feel much better."

With regard to facial expression, smiling was the action that featured prominently. The only other thing mentioned was "a pleasant facial expression" which in all probability included a smile. Nine patients commented on the importance of smiling. One would think that it was so much part of our being human that it would not have been mentioned, but it became obvious that nurses do not smile enough.

Incident number 8 reads:
" This nurse has a smiling face. She comes in in the morning and greets you and seems happy to see you. It is not what she says it is because she smiles."

3.4.3. Summary of Category "Interpersonal Abilities"

A total of 32 recording units were classified under this category. 53.1 % were in the verbal communication subcategory and 46.9 % in non verbal subcategory.

Apart from the unit "explaining to the patient" every one of the incidents mentioned in this category could have, or should have, been effected by a normal, well balanced, happy individual, with no special training. One wonders then which of these criteria is missing from the nurses in the wards. Hopefully they were selected to train as nurses because they showed ability to relate to people, but we do know that not all the nursing colleges interview prospective students, which is the only true way of gauging this quality. Nurses often seem unhappy, which is also disturbing and warrants attention by those in management positions.

Women appear to find interpersonal aspects more important than men as 32.2% of the women patients and 20.8% of the male patients related incidents included in the interpersonal abilities category. No other trends could be discerned.

3.5. PERSONAL ATTRIBUTES

This category concentrates not on what the nurse does, but on what she is. These are, then, inherent characteristics and personality traits of the nurse.

There were five themes identified in this category viz..

- Pleasant disposition
- Patience
- Dependability
- Gentleness
- Kind, Considerate and Understanding

3.5.1 Pleasant Disposition

When referring to the nurse's pleasant disposition, this was more than a pleasant facial expression. The units conveyed more "action" than merely smiling and indicated that this was characteristic of the nurse. The units were, enjoys what she is doing, seems happy to see patients, friendly, displays a sense of humour, and always in a good mood. This pleasant disposition seems important for the patient's welfare as seen in incident number 28:
" When she comes in in the morning and you feel depressed, she calls you by your name and says, "how are you this morning? " and makes a little joke which gets you up for the day. "

3.5.2 Patience

Eight patients indicated that patience was an important attribute for the nurse. There were three units identified amongst these incidents, with one including statements that actually stated that the nurse was patient, and others that she dealt with a difficult situation or patient patiently, and the other that she did not rush the patient. One would have thought that the attribute of patience would have been particularly important to elderly people, but, although elderly people did give incidents in this theme, as many younger people did likewise. It is particularly important not to be rushed when in pain or incapacitated as indicated by a 76 year old patient who had had a hip replacement in incident number 25:
" When she gave me the bedpan, she did it nicely. She made it warm and she lifted me - didn't just shove it in. She didn't rush me. She waited until I had finished."
This nurse was obviously skilled as well as being patient, but the incident says little for the other nurses on the ward, implying that others do not wait for the patient to finish and are very rough when administering a bedpan. This is a particularly worrying feature in an orthopaedic ward where patients are often in a great deal of pain and where rough treatment could jeopardize the success of the operation.

3.5.3. Dependability

With regard to dependability, patients were impressed when a nurse came to work despite being ill herself, that a nurse did work that others refused to do and that she was consistent. Again, one worries when reading incident numbers 19 and 73 regarding the irresponsibility of some of the nurses in the hospital. Incident number 19 reads:
" These two good little nurses - they are always there to do the heavy work. The others run away but these ones aren't shirkers - they stay and do the work - even the unpleasant tasks."

Incident number 73 reads:
"There's one nurse who does all the work at night while the the rest of the staff sleep.... "

Were the level of care better, the only incident that is likely to have been included, is the incident regarding coming on duty when the nurse was herself sick, and that in itself gives rise to some interesting questions.

3.5.4. Gentleness

The last theme of gentleness is self explanatory. Incident number 50 says all that needs to be said:
" There - you saw that - she just pulled off the plaster - it hurt. The other one - she pulls it off little by little - she is gentle...it doesn't hurt when she does it."

3.5.5. Kind, Considerate and Understanding

Three qualities were combined to form the theme Kind, Considerate and Understanding as these qualities have much in common, and it was not justified to have each as a theme on its own, as only one incident was given per quality.

The incidents that mentioned kindness were difficult to assess as, though the patients mentioned the fact that the nurse was kind and gave a specific incident, it was not possible to see what distinguished her from many of the other nurses mentioned, who were not actually labelled as "kind". Davidson defines the word "kindness" as "disposed to do good to others, benevolent" (1985:531) which does nothing to solve the dilemma. Nevertheless as patients had actually used the word, it was included in the classification system.

A similar problem occurred with the word "understanding" as illustrated by incident number 83:

" The tall nurse, she is very nice. She is very understanding. When you can't wash yourself properly, she

takes you and go and wash you in the bath. . ." Although the patient obviously thought that the nurse understood the patient's need to be clean and assisted her to be so, this is by no means clear. As it was the patient's interpretation, however, it was included.

3.5.6. Summary of Category "Personal Attributes"

As explained above, it was difficult to categorize this group of data, due to the lack of substance or supporting evidence. However, patients actually stated that these were attributes of the nurses they considered competent. It is also interesting to note that the patients were not asked to give attributes of a nurse, but nevertheless, many did, indicating that this is important. They are also important in terms of student selection, as research needs to be done to determine whether such attributes are inherent or whether they can be learned.

3.6. NURTURANCE

The category on nurturance was the last to be formulated and arose due to a problem in classifying some of the incidents. The problematical incidents indicated "something" more than fulfilling needs, possessing knowledge or interpersonal abilities, or having certain personal attributes. All the incidents indicated that the nurse had spent time with the patient, or had gone out of her way on the patient's behalf, and yet seemed to involve an element of caring for the individual patient which indicated support for that patient. The problem of naming the category was solved on reading an article based on the Greenberg-Edelstein model of nurturance. (Geissler 1990)

Leiniger (1970) originally used the term nurturance to indicate a concept of caring defined as "a feeling of compassion, interest, and concern for people." Ruth Greenberg-Edelstein, however stated that nurturance was a more inclusive term than caring because it can take place without caring, and says that nurturance can include aiding, comforting,confiding, nursing, exchanging, fondling, establishing solidarity and promoting development and growth.

Greenberg-Edelstein broke the concept into 5 levels, and the two highest levels are the ones included in the concept Nurturance for the purposes of this study. " At level four, nurturance is therapeutic, the exchange is democratic and personal with emotional content capable of changing views, attitudes and behaviour. At level five, nurturance transcends the self the exchange is deep and solid, exposing the very core of each member." (Geissler 1990:74)

Having named the category, it was possible to classify the incidents and the following themes were developed:

- Availability
- Attentiveness
- Advocacy

3.6.1. Availability

Although the verb "avail" means "to be of value or service to". the term "availability means "that one may avail oneself of, accessible, within reach." (Davidson 1985:65). This indicates that, when the nurse makes herself available, she does not necessarily do anything. This word describes this theme well as the patients valued the nurse's presence rather than what she did.

This theme was subdivided into two, namely, unsolicited availability and solicited availability, to indicate a hierarchy of responses on the part of the nurse.

Unsolicited availability indicates that the patient did not have to ask for the nurse to come to him, and to be with him. Solicited availability indicates that the nurse came to the patient and spent time with him quite spontaneously, without being asked to do so.

There were three units identified under unsolicited availability viz. staying with the patient, accompanying the patient and coming to check on or help the patient.

Incidents forming the unit for Staying with the patient were most often cited, which indicates that they are particularly important.

Incident number 26 illustrates this unit well:
" I had a very bad attack (asthma) - and this one staff nurse ....she was constantly with me. ...I was comatose and she never left my bedside. She was incredible. She actually prayed for me .... she was always there."

Part of the problem of nurses not spending sufficient time with their patients is possibly because of the abolition of functional nursing in favour of "total patient care". When nurses were allocated specific tasks to do, they were forced to spend time with the patient, e.g. when tidying his locker, or offering him a bedpan or urinal. The tendency now is to avoid making contact with the patient as nurses feel awkward if they are not there for a specific purpose.

Patients often comment that the only person who talks to them is the nursing assistant when she comes to take his

temperature. The important thing for the patients in this theme, is not what the nurse does but the fact that she is there, as illustrated by incident number 33:
" The old lady next to us is forgetful, but always the nurse is coming to her ..."

Solicited availability included two units, viz. came straight away when called, and made time to do what the patient asked. It was alarming how many patients mentioned the fact that the "good" nurse they were describing came immediately when called as it implies that most nurse do not. Incident number 18 illustrates this point well:
" This nurse, you don't have to shout and scream for her to give you something. You just say "Nurse" and she comes immediately with it. She helps you ..."

3.6.2 Attentiveness

Whereas the term availability did not indicate that the nurse necessarily did anything for the patient, the theme "attentiveness" did.

Chambers Thesaurus (Seaton 1990:43) gives the following synonyms for the word attentive, " accommodating, alert, conscientious, courteous, devoted, heedful, obliging, thoughtful ' which conveys the meaning the term had in this context.

The theme was divided into two units, viz. carried out tasks outside normal requirements, and went out of her way for the patient.

With regard to carrying out tasks outside normal requirements, the nurse carried out tasks which, in the patient's opinion should have been done by another category of worker or someone junior to the nurse in question. Incident number 37 illustrates this latter situation:
" I had this terrible pain in my bladder, but there is a Sister here - she was so kind - she spent the whole day saying "drink lucozade, drink water, and have the pan." She was going up and down. It helped me to get rid of the pain in my bladder. All that and she is a Sister."

The unit, "Went out of her way for the patient" nurses did things for the patient that the patient thought were over and above what could reasonably have been expected of a nurse.

This is illustrated by incident number 82:
"On Monday I was very ill. I had a temperature. I couldn't sleep and Nurse T came every hour to see if I was alright. She gave me water to drink and stood with me."

The last theme in the category "Nurturance" was Advocacy. According to the Oxford dictionary,(Fowler & Fowler 1961:13), an advocate is one who speaks on behalf of another, or a professional pleader, or a supporter." In compiling this theme, the "professional pleader" definition was used but it was realised that this process occurs in two ways. One is for the nurse to speak to someone on behalf of the patient to plead his cause, but another is to speak to the patient to explain another person's point of view. This latter aspect is becoming increasingly more important as health services become multi-cultural as it is not always possible for all health personnel to make themselves understood to all patients. Doctors, particularly, rely on nurses to act as advocates in this way as the nurses often come from the same cultural group as the patients. This involves more than translation as often meaning is lost in translation, which affects the chances that the patient will co-operate.

The first aspect described, that is the situation when the nurse spoke to another person on the patient's behalf was most commonly cited as seen in incident number 53
" I was upset by an incident concerning a social worker who wasn't very nice to me. I went to see the Sister who talked to the social worker for me. She reprimanded the social worker and the social worker came and apologized to me. This made me feel like an individual again."

In a hospital where patients are often unable to speak for themselves due to their illness or the strange environment, it is important that someone is able to do this for them, and it is gratifying that, in the hospital where the study took place, several similar incidents were related.

3.6.3. Summary of Category "Nurturance"

This category includes behaviours and attitudes that are unique to nursing in that the other aspects of care mentioned in this research study could, conceivably, be carried out by other categories of nurses other than the professional nurse and other health care professionals. Nurturance is the core of nursing, and yet is difficult to define. For this reason, it would seem essential that further research be continued on this aspect.

3.7. SUMMARY OF FINDINGS

There were few particular trends noted with regard to the sex, age or type of illness of the patients and the types of incident they related, rather that the important aspects of care mentioned by the patients were a requirement in all the areas involved. It is possible that, had there been a

larger sample, trends would have started to appear, but there is little evidence of this thus far.

What is striking from the data collected is how basic the requirements of the patients are. They are not asking for highly specialized, knowledgeable people to look after them. What they require is a friendly person who has the patient's interests at heart. It makes one wonder why it is so difficult to find nurses who are capable of being such a person. Certainly, the idea has been expressed by many people that one cannot care for other people unless one has been and is cared for oneself. If this assumption is correct, nurse managers need to look closely at this phenomenon.

Another significant factor is what has not been said by patients. As pointed out earlier in the chapter, the fact that they were only asked to describe incidents that they had witnessed, automatically excluded aspects of care not occurring in the hospital which may, nevertheless, have been important to the patient.

Much of what has been said in this chapter casts a negative light on the nursing care at the hospital, however, it is important to emphasize that there are many committed nurses who are caring and competent and should be encouraged to continue caring. An incident which was given after the classification was completed and therefore too late to include, demonstrates this point.
" The patient had had a very bad stroke - I don't know which side was affected but he couldn't speak as a result. The nurses had tried to put a tube into his stomach to feed him but had failed and he was distressed by it - you could see on his face. This little nurse - a young one - came up to him with a piece of paper and a pencil and asked him if he would like to write something. He just shook his head - but at least she tried."

The next step in the research procedure is to compare the findings of this study with those of other researchers and to the available literature, which will be done in the next chapter in an attempt to compare and contrast findings and thus view the findings in a wider context

CHAPTER FOUR

COMPARISON OF FINDINGS WITH THE LITERATURE

This chapter will be divided into three sections:
Section One will compare the final classification system based on this research project with classifications developed by various authors and groups.
Section Two will compare the findings with selected nursing care studies written up in recent journals and
Section Three will compare the units, themes and categories described in the report with similar descriptions found in the current nursing literature.

The purpose of comparing findings with the literature is to determine whether the findings are supported in the literature, or not, which will assist in the process of validating, or otherwise, the research.

4.1. SECTION ONE - CLASSIFICATION SYSTEMS

4.1.1. SELECTING THE LITERATURE

In selecting the literature for this first section, authors were sought who had attempted to classify "caring" and related concepts. Studies were selected with vastly differing methodologies and aims, as the purpose here is to examine as many different ways of viewing these concepts as possible, in an attempt to determine whether similarities exist between the classification system used in the study and other authors.

The amount of literature available is staggering. So many authors have written on the concepts "caring" and "nursing" and related concepts, that one begins to wonder why nurses find it necessary. It seems as though nurses are trying to justify their existence and also to determine for themselves what their task is in life. If one looks only at the so-called "models of nursing", one finds as many differing models as there are nurses to write about them. In Fitzpatrick and Whall's book "Conceptual Models of Nursing" (1989), they compare the nursing models of twenty four different nurse authors, all with differing perspectives. No other profession appears to have found it necessary to go to these lengths. It is also interesting to note that few seem to have consulted the patients while drawing up their models.

The authors of the nursing models did not, necessarily, set out to classify or categorize their work in relation to nursing practice, but a few authors have done this, or others have done it on their behalf. In this event it becomes possible to use part of their work for comparative purposes in this study.

In each case, a summary will be given of the author's classification, together with a brief discussion and a comparison with the findings in this study. Authors will be dealt with in chronological order.

It becomes obvious when reviewing the various studies that there are many different ways of classifying, and it is important to look at the themes as well as the broad categories, as similar units often appear in a classification system, but not necessarily under the same heading, depending on the author's particular perspective.

4.1.1.1. Florence Nightingale

It is traditional, if not always useful to examine Florence Nightingale's writings when discussing nursing care. She believed that nurses should provide fresh air, light, warmth, cleanliness, quiet and a good diet for her patients. The nurse should also have specialized knowledge as well as knowledge of the laws of health for their wider scope of practice and "careful inquiry". The curriculum at the Nightingale School included observation of the sick, bandaging, making of occupied beds, application of leeches, use of surgical appliances, management of the convalescent, and preparation of special diets. The goals of nursing activity were directed at prevention of infection and injury, recovery from illness, health teaching and environmental control. (Fitzpatrick 1989:36)

When comparing Nightingale's ideas of what nurses should do, with the classification developed for the Johannesburg study, it is noted that several themes are shared e.g. Hygiene needs and general comfort needs, Theoretical knowledge, observation skills, and psychomotor skills.

What is even more interesting is what Nightingale did not include in her goals for nurses or her curriculum, i.e. meeting the social needs of the patients, interpersonal abilities apart from those required when teaching patients, and nurturing the patient. She did, to some degree, address the issue of personal attributes of the nurse, as we know that she chose her nurses carefully from "genteel stock". We have to hope that apart from being well spoken and having good manners, they were kind, dependable, patient and pleasant. It is likely that this is the case as they had chosen nursing as a vocation and were presumably motivated by altruism.

4.1.1.2. Faye Abdellah

Abdellah's model of nursing is particularly useful as she was one of the first nurses to collect information from patients in an attempt to draw up a nursing model. She attempted to elicit client's stated and implied nursing problems, which she categorized with the view to teaching the nurse how to assist the patient. She drew up twenty one nursing problems which formed the basis of her model. (Abdellah 1960, as quoted by See in Fitzpatrick 1989:126) The typology of nursing problems was as follows:

1. To maintain good hygiene and physical comfort
2. To promote optimal activity; exercise, rest and sleep
3. To promote safety through prevention of accident, injury or other trauma and through prevention of infection
4. To maintain good body mechanics and prevent and correct deformities
5. To facilitate the maintenance of a supply of oxygen
6. To facilitate the maintenance of nutrition
7. To facilitate the maintenance of elimination
8. To facilitate the maintenance of fluid and electrolyte balance.
9. To recognize the physiological responses of the body to disease conditions
10. To facilitate the maintenance of regulatory mechanisms and functions.
11. To facilitate the maintenance of sensory function
12. To identify and accept positive and negative expressions, feelings and reactions
13. To identify and accept the interrelatedness of emotions and organic illness
14. To facilitate the maintenance of effective verbal and non verbal communication
15. To promote the development of productive interpersonal relationships.
16. To facilitate progress toward achievement of personal spiritual goals
17. To create and/or maintain a therapeutic environment
18. To facilitate an awareness of self as an individual with varying physical, emotional, and developmental needs.
19. To accept the optimum possible goals in the light of limitations, physical and emotional
20. To use community resources as an aid in resolving problems arising from illness
21. To understand the role of social problems as influencing factors in the cause of illness

The only aspects identified in the Johannesburg study that are not specifically mentioned by Abdellah are Demonstrating knowledge, and personal attributes of the nurse. These are,

implied as it would not be possible to meet all the above requirements without these two aspects. Abdellah has, however identified many additional aspects, but the two studies have identified many similar themes, probably because they were both from a patient perspective. Abdellah sees the nurse as "someone" different to the doctor, and the patient as an holistic individual. Bearing in mind that this work was completed in 1957, it is remarkable, and has come a long way from Florence Nightingale's original perceptions.

4.1.1.3. William Gorham

Gorham conducted a similar study to the Johannesburg study, using a critical incident technique and content analysis. (1962:4-11) Although his study was also conducted three decades ago, there are many similarities between the two studies. The names of his categories vary considerably, but the themes within categories are similar.

Area 1 **Improving Patient's adjustment to hospitalization or illness** included the themes "explaining condition or treatment to the patient", "helping the patient in relieving emotional tensions" and "teaching patient self-care".

Area 2 **Promoting Patient's Comfort and Hygiene** included themes "increasing the patient's physical comfort", "preventing deterioration in the patient's general physical condition and progress" and "fostering physical rehabilitation and healing".

Area 3 **Contributing to Medical treatment of the Patient** included "carrying out medical orders", "initiating medical procedures", "reporting on patient's condition" and "using and checking operation of apparatus".

Area 4 **Arranging Management Details** included "scheduling patient's treatments", "directing the work of non-professional personnel", "maintaining general supplies", "referring patient to non-medical sources" and "supervising visitors".

Area 5 **Personal Characteristics** included "behaving in a warm and friendly manner" and "behaving in a professional manner".

It can be seen that many of the themes included in Gorham's work were included under different categories in the Johannesburg study, thus emphasizing the need to look beyond category names when reviewing a work of this nature.

Explaining conditions or treatment was identified in both studies, while Gorham's helping the patient to relieve emotional tension included aspects from the "social needs" category as well as the theme "emotional security". Area 2 was also markedly similar to the Johannesburg study. Area 3, however, was almost completely absent in the Johannesburg study. An occasional reference was made to initiating medical procedures but even then, the doctor was not mentioned as having ordered the treatment in the first place. One negative incident was, however, given during the interview phase of the Johannesburg study, which had to be discarded because it was negative. The patient who related the incident commented that if the treatment had been carried out when the doctor had ordered it instead of 3 days later, she would have had a shorter stay in hospital. Area 4 is also completely absent in the Johannesburg study. The patients here are apparently not aware of the management tasks of the nurse, or, do not see them as important. It is also possible that, as most management tasks occur away from the patient's bedside in the hospital where the study was conducted, that the patient never sees them being carried out, and therefore could not comment on them. Area 5 was well demonstrated in the Johannesburg study with many similarities between the two studies.

Many of the themes and units included under "demonstrating knowledge" in the Johannesburg study, were included in Gorham's "contributing to medical treatment" area, notably the skills. Communication was referred to but not named or given specific importance in Gorham's study. The nurturance aspects were almost entirely absent in his study.

On must bear in mind that Gorham's study took place in the United States of America where the definition of nursing tasks and the allocation thereof is somewhat different, although the needs of the patients presumably remain the same. It is therefore of interest to look at another South African classification next.

4.1.1.4. Wilhelmina Kotze

In her book "Begeleiding in die Verpleegkunde" (1979), Kotze divides nursing tasks into two, instrumental and expressive functions. The instrumental functions include activities based on the nursing process viz. planning ways to collect information, collecting information, objective evaluation of available information, diagnosing a situation, setting priorities and aims, therapeutic planning, goal-directed implementation of planning, management of emergency situations and evaluation of nursing actions. (1979:153)

The expressive function of the nurse includes meeting aims which lead to the promotion of a therapeutic environment. Examples are, the promotion of healthy interpersonal relationships, a meaningful intervention whereby all needs of the nurse's fellow man are met, and the co-ordination of all services that are offered to the sick person which will guarantee his safety and will offer him explanations of various aspects to ensure they are meaningful and acceptable. (p.154)

The above description of the nurse's functions are very broad, so that any one of the aspects identified in the Johannesburg study could be included. Central to Kotze's model, however, is that the patient must be assessed and cared for as an individual and that his social and psychological needs are at least as important as his physical needs. This being the case, there are many similarities between Kotze's views and the findings of the Johannesburg study. However, in fairness to Kotze, it must also be pointed out that it was not her intention to list nursing functions, but rather to explain the essence of nursing from a phenomenological perspective.

4.1.1.5. Ray's Classification System of Institutional Caring

During the 1980's Ray (Leiniger 1988:95 - 111) developed a classification system based on interviews held with various categories of nurses and other groups of hospital personnel. She developed four categories, psychologic, practical, interactional and philosophic.

The psychologic category was subdivided into 3 levels. The characteristics of the Affective, or feeling level were, empathy, concern, feeling, compassion, givingness, friendliness, enjoyment, sympathy, patience, sensitivity, kindness, interest, motivation, cheerfulness, intimacy, strength, tenderness, peak experience and vulnerability.

The characteristics of the cognitive or knowing level of the psychologic category were, Teaching, meeting needs, knowledge, observation, decisions, assessment, evaluation, problem solving, integration and intuition.

The Practical category was also subdivided into 3 levels. the characteristics of the social organization level were economic, organization, time, legal, presence, political competition, safety, paperwork, woman's movement, control, policy making, audit, provision of activities and managerial development.

The characteristics of the technical level were, skill, equipment maintenance and design, research, scientific care and therapeutic maintenance.

The interactional category was subdivided into physical and social levels. The Physical level (also known as "doing for") included the characteristics comfort (physical) and Touch. The social level (also known as "doing with") included characteristics communication (talking), interaction (sharing), listening, helping, involving, reassuring, supporting, counselling, rapport, protection, and nurturing.

There are several factors that must be born in mind before making an attempt to compare this study with the Johannesburg study. It was a study to determine institutional caring rather than caring behaviours amongst nurses per se. It was, however , conducted in a health care setting and the majority of respondents were nurses. Ray (Leiniger 1988:107) herself points out that "meaning is always within context and context incorporates meaning". What may have been meaningful to this study is not necessarily so outside the confines of the study. She also points out that categorization is an artificial activity done for the purpose of research and that there is an integral relationship between the definitions and the social and cultural environment of the participants.

With these cautionary remarks in mind, it is interesting to note the similarities between the characteristics of the interactional category and the Johannesburg study, as the interactional category includes the units and themes placed in the interpersonal relationships category and the Nurturance category in the Johannesburg study.

Ray's Practical category bears little resemblance to any aspect of the Johannesburg study, again emphasizing the difference in approach to health care between the United States of America and South Africa.

The level "knowing' of Ray's study is similar to the "Knowledge" category of the Johannesburg study, but Ray's feeling component is more closely allied to the social needs category and the personal attributes of the nurse of the Johannesburg study.

Despite the differences in approach, sample and context there are important similarities in these two studies, and it is encouraging to see that two out of the three categories relate to the "people" aspects of caring, whilst acknowledging that practical skills are also needed.

4.1.1.6. B.H.Cottrell, B.H. Cox and S.J. Kelsey

B. Cottrell et al (1986) drew up an evaluation form for student nurses indicating how their functioning should be assessed according to the headings of the nursing process. The reason this evaluation form has been included, is because the Johannesburg study was carried out with a view to eventually developing criteria for evaluation. What is particularly interesting in Cottrell's tool, is the weighting given to the various criteria, indicating the importance placed on each of these aspects.

Under the Assessment part of the form, Data collection counts for 30%, data analysis 40% and priority setting 30%.

Planning includes Goal Setting (40%), family (30%) and teaching (30%)

Implementation includes interventions (15%), client communication (10%), legal communication (15%), medication (10%), intravenous therapy (5%), organization (10%), safety (15%), teaching (10%) and initiative (10%).

Evaluation/Modification includes 60% for evaluation and 40% for modification.

Another aspect "Professional Behaviours" is added which includes self evaluation (40%), conference participation (30%) and punctuality (40%)

In examining the above instrument critically, one must remember that it was developed for a specific set of circumstances and requirements. The fact that 40 % of the last aspect is allocated for punctuality gives a clue that this is a particular concern in the particular institution.

The criteria common to the Johannesburg study are patient teaching (in the planning phase), interventions, which include skills, client communication, safety, initiative, and possibly professional behaviours. The "cognitive" part of this assessment far outweighs the patient contact, or "doing things for" the patient, which seems a pity in the light of what patients say is important. This again, seems to be a characteristic of professional nursing in the United states of America where sub-professionals do much of the hands on nursing care.

4.1.1.7. South African Nursing Council Scope of Practice

The South African Nursing Council published the Scope of Practice for Registered Nurses in 1987 (R 1469) to regulate the practice of the nurse and indicate what she may do for patients in her capacity as a registered nurse. For this reason, this document should give a good indication of what the Nursing Council believes are the tasks of the nurse. As stated in chapter 2, 13 of the 22 behaviours appearing in the scope of practice were mentioned by the patients interviewed in the Johannesburg study.

It is easier to see this document in perspective if one groups the behaviours. The document includes Administering, monitoring and assisting with diagnostic therapeutic functions, monitoring the patient, teaching and counselling, facilitation of meeting patient needs, establishing a therapeutic environment and co-ordination of regimes provided by other categories of health personnel. The vast majority of aspects mentioned in this document fall into the category of facilitation of meeting patient needs. The following needs are mentioned : hygiene, comfort, exercise, rest, sleep, oxygen, fluid balance, skin integrity, nutrition, elimination and communication. The patients only described hygiene, elimination, comfort, communication, exercise and mobility needs as being important. This meant that six out of the eleven needs mentioned in the Scope of practice were mentioned by the patients.

Administering, monitoring and assisting with diagnostic therapeutic functions were only mentioned in passing by the patients, monitoring the patient was not mentioned at all, teaching and counselling were mentioned, as was creating a therapeutic environment, if not in so many words. The co-ordination of regimes provided by other categories of health personnel was also not mentioned.

There are, therefore wide discrepancies between this document and the findings of the Johannesburg study. One cannot believe that the aspects mentioned in the Scope of Practice such as oxygen needs, fluid needs and nutrition needs are not important to the patients. Presumably patients either take these aspects for granted, or do not see them being met, or it indicates that the Johannesburg study should be extended before being used as a tool for evaluation purposes.

4.1.1.8. Patricia Benner

The work of Patricia Benner is well worth considering here as it is comprehensive and used a similar methodology to that used in the Johannesburg study, i.e. collection of critical incidents. The classification system that will be discussed here is published in her book "From Novice to Expert" (1984:46). She refers to them as "Domains of Nursing Practice".

The domains include the helping role, the teaching coaching function, the diagnostic and patient-monitoring function, effective management of rapidly changing situations, administering and monitoring therapeutic interventions and regimens, monitoring and ensuring the quality of health care practices, and organizational and work role competencies.

Each of these domains includes several themes.

The Helping Role (1984:50) includes creating a climate for healing, providing comfort measures, presencing, interpreting kinds of pain and selecting appropriate pain management, providing comfort and communication through touch, and teaching. It can be seen that many of these aspects were includes by the patients, and included in the themes, comfort needs, emotional security, observation skills, interpersonal abilities, and nurturance. The aspects mentioned by Benner, which were not included by the Johannesburg patients, included providing support to patients' families, and maximizing the patient's participation in his own recovery.

The Teaching Coaching function (1984:79) includes eliciting and understanding the patient's interpretation of his illness, and providing interpretation of the patient's condition which were mentioned, if somewhat superficially by the patients. The aspects not mentioned by them but included by Benner were timing the teaching, assisting patients to integrate the implications of illness and recovery into their lifestyles, and making culturally avoided aspects of an illness approachable and understandable.

The Diagnostic and Monitoring Function (1984:97) includes, detection and documentation of significant changes in a patient's condition, understanding the particular demands and experiences of illness. These aspects were mentioned by the patients in Johannesburg, if only to a superficial degree. They did, for example, mention that observation was important but did not indicate that the nurses documented such changes. Aspects not mentioned by patients but included by Benner in this domain were, providing an early warning signal, anticipating breakdown and deterioration prior to explicit

diagnostic signs, and assessing the patient's potential.

The Effective Management of rapidly Changing Situations (1984:111) includes themes, all of which deal with emergency situations. Only one such unit was identified in the Johannesburg study which was included in the Skills category.

The domain Administering and Monitoring therapeutic interventions and regimens includes starting and maintaining Intravenous Therapy, administering medication, combating hazards of immobility and creating a wound management strategy. All of these aspects were included by the patients except that references to medication only included pain medication, and references to wound management only referred to the management of the wounds themselves, rather than a strategy.

The domain entitled Monitoring and Ensuring the Quality of Health ca[illegible]ractices, (1984:137) includes providing a backup system to sure safe medical and nursing care, assessing what can be safely omitted from or added to medical orders, and getting appropriate and timely responses from physicians. Again, none of these aspects were identified by the Johannesburg patients.

Organizational and Work-role competencies (1984:147) includes, co-ordinating, ordering and meeting multiple patient needs and requests, building and maintaining a Therapeutic team, and coping with staff shortages and high turnover. Only oblique references were made to these aspects by Johannesburg patients.

When reviewing the above results, it must be born in mind that Benner's study was an extensive one and only includes incidents describing "expert" nursing behaviours rather than competent or caring ones. As can be expected, the level of functioning of the nurses described by her is higher than those in the Johannesburg study.

4.1.2. SUMMARY OF FINDINGS IN CLASSIFICATION SYSTEMS

When reviewing the works of the eight authors mentioned, one can see that there is consensus that meeting hygiene and elimination needs, comfort needs and safety needs is important as well as demonstrating knowledge and skills, and in particular, communication skills. There are few authors who refer to social needs directly, none who refer directly to personal attributes (probably due to the fact that most information was collected from models of nursing,

rather than descriptions of the good nurse) and little reference to nurturance or any of the themes mentioned therein.

Physical needs were mentioned by 5 authors, who added aspects to the ones in the study. They mentioned fresh air, light, nutrition, fluids, rest, sleep, oxygen, and skin integrity as being important.

Social needs were mentioned by 3 authors, and comfort needs by 7 authors, who also added warmth and quiet to these needs. Safety needs were mentioned by 7 authors, most of whom referred to emotional security as well as physical safety.

All 8 authors mentioned demonstration of knowledge in their work. Most referred to all three aspects, viz. theoretical, observational and psychomotor.

Communication was mentioned by 6 of the authors. Florence Nightingale did not refer to this, and nor did Benner specifically. However, Benner's exemplars quoted in her book often refer to communication, both verbal and non verbal.

Only Ray and Gorham referred to personal attributes of the nurse, for the reasons already explained. It is encouraging that Gorham, who was doing a similar study to the Johannesburg study did identify these as important.

Nurturance remains a bit of an enigma as although 5 authors refer to aspects of it, only Ray identifies all three of the themes , i.e. he mentions availability, attentiveness and advocacy. It is possible that this has occurred because it is relatively new terminology. It will be seen that these aspects are extremely popular amongst the nurses writing case studies in recent journals.

As far as the further attempt to validate the research is concerned, it would seem that the only areas of doubt are "Nurturance" and "Personal Attributes", but these aspects, and others, will be addressed in the next section where case studies are reviewed.

4.2. SECTION TWO - NURSING CARE STUDIES

4.2.1. SELECTING THE CARE STUDIES

Twenty nursing care studies were selected, mainly from the 1992 journals of nursing, on a convenience basis, i.e. they were the first twenty found. An attempt was made to collect an equal number from American, British and South African journals, however, care studies are few and far between in American and South African journals, being a wo[illegible]while and common phenomenon in British journals, and more [illegible]pecifically in the "Nursing Times". Hence 9 of the journals are British and one study from 1989 was included by virtue of the fact that it was American and therefore rare and valuable. Although the case studies in the British journals were written by British nurses and published in Britain several of them had commentaries by American "experts".

Apart from the study being recent, the other criteria for selection was that it had to be written by the nurse who had, herself cared for the patient. It would have been even more valuable had the patients written the studies, but no such articles were found. It would be useful for nurses if it were possible to persuade patients to do this once they have recovered.

A list of all the nursing care studies reviewed can be found together with the bibliography, but will be referred to in the text, as appropriate. They are also listed together in annexure 5, and a summary of the findings related to these studies can be found in annexure 6.

4.2.2. METHOD OF REVIEWING THE CARE STUDIES

Each study was read and all aspects of nursing care were highlighted. An attempt was then made to classify the aspects under each of the themes developed for the study, in an attempt to determine whether other nurses had also identified these aspects as important components of nursing care.

A commentary will follow on the findings of this exercise, according to each of the categories and themes formed for the study.

4.2.3. FINDINGS OF THE REVIEW

4.2.3.1. Assisting with patient needs

4.2.3.1.1. Physical Needs

Hygiene and elimination needs were mentioned by 5 of the 17 authors. The hygiene needs mentioned were very similar to those of the research study, comprising helping the patient to wash and taking him to the bath. The majority of references to elimination needs involved preventing or treating constipation which was not mentioned by any of the patients in the research study.

Exercise and mobility needs were mentioned by 3 of the authors and referred to helping the patient walk and also helping the patient to move in the bed, and particularly to change position in order to prevent decubitus ulcers. This latter aspect was not mentioned by the patients in the research study.

4.2.3.1.2. Social Needs

Nine of the seventeen authors referred to recognition of the patient as an individual, indicating that this is most important to the nurse authors, and four to acceptance of the patient.

With regard to recognition as an individual, most of the authors had recognized individual needs in their patients and catered for them. It is important to remember that the nurse authors had written these case studies because they found caring for the patient particularly rewarding or challenging, so that this aspect is bound to have received attention. Nevertheless, it was most encouraging to read of the ways the authors had catered for their patients' individual needs. One of the examples of this was found in the study by Julia Keachie (1992:40) who describes a patient who was in urgent need of hospitalization and dressings, but refused to go into hospital, or leave her own home. Julia Keachie describes how she treated the patient in her own home, in the gloomiest and squalid surroundings in order to make the patient comfortable, and develop trust in the nurse, to the extent that she finally agreed to go for treatment. The nurse therefore provided care on the patient's terms and did not inflict those of the health system on her.

Jane Brown's (1992:41) study is the ultimate in demonstrating acceptance of a patient. She describes a psychiatric patient

who had attempted suicide due to his inability to relate to members of the opposite sex. The author of the study, who was his nurse in the unit, married the patient and their marriage was into it's fourteenth year by the time she wrote the article !

4.2.3.1.3. Comfort Needs

Several of the authors referred to comfort needs, three to elimination of pain, two to general comfort and two to psychological comfort. In all three of the cases regarding pain relief, the nurses had assessed the patient's need for analgesia and provided it. Not one referred to the patient having first to ask for the analgesia before it was given as in the patient's examples included in the research study.

The examples of general comfort were more comprehensive than those in the research study. Changing position and the use of sheepskin were mentioned.

Two examples of psychological comfort were given, both of which referred to providing privacy for the patient (Baines 1992:26 and Shepherdson 1992:35)

4.2.3.1.4. Safety Needs

No references were made to the physical safety of the patient in the case studies. One hopes that the nurses took this for granted. Four references were made to the emotional security of the patient. Corinne Williams (1992:29) describes how she took her patient to visit the post operative ward, prior to her surgery, so that she would know the staff and recognize the environment, and thus feel more secure. She also explained procedures to her patient with the same effect.

4.2.3.2. Demonstrating knowledge

4.2.3.2.1. Theoretical knowledge

Six of the authors mentioned aspects classified under this theme. All fell into one of the two units identified, i.e. able to give patient information and knowing the correct action to take.

4.2.3.2.1. Skills

Examples of observational skills abounded in the studies, with eleven of the authors making reference to them. They referred to both noticing that the patient was in need and assessing the situation. Included in the case studies, but absent in research, were examples of assessing need by using

apparatus such as baumonometers, central venous pressure lines and thermometers, but also gave many examples of using their eyes to assess the situation.

One such an example is in Terri Holden's study (1992:28) where she describes a patient who was unable to talk as she was intubated. She says, " She was always warm and used the fan most of the day, often gesturing with it as though she was directing an orchestra. Noting this, we decided to build a "fan language". The staff and Joan worked out the following signals:Fanning the left side of her face meant that she needed a blanket for her feet..."

Only two actual examples of psychomotor skills were given. One referred to the dressing being done efficiently (Keachie 1992:40) and the other a more general reference to removing sutures.(Baines 1992:26)

4.2.3.3. Interpersonal Abilities

4.2.3.3.1. Verbal Communication

Nine of the authors made direct reference to verbal communication, which included listening, which was not evident in the patient incidents recorded for the study. It became very obvious on reading the case studies that the nurses considered communication extremely important, and they derived particular satisfaction when able to communicate or enable the patient to communicate in difficult circumstances.

One of the examples of this was the study written by Susan Lloyd (1992: 48) who had cared for a man who, due to Altzheimer's disease, was unable to communicate and was therefore frustrated and restless, to the extent that it disturbed other patients. Ms Lloyd discovered, quite by accident, that her patient loved music. She then played music and "talking books" to him on a regular basis, with remarkably positive results.

4.2.3.3.2. Non Verbal Communication

Five of the authors made mention of touch, three of facial expression and two of writing as a means of communication. This latter aspect was not mentioned by the patients in the Johannesburg study, which is not surprising as all of them could speak.

Perhaps the most touching was the case described by Sandra Summers (1992:47) of a patient whom she had not previously met, but was asked to care for in order to relieve the patient's nurse while she had a break. The patient was dying. When the nurse entered the room, she felt

uncomfortable, and made inane remarks, but then says, "as we looked at each other, I felt that no matter what I said to this man, it would be trivial, as he lay fighting for his life. I told him slowly that I did not know what to say to him, and with that he took my hand that had been resting on the bed, and enclosed it with his own two, and closed his eyes. We stayed like that for the remainder of the time I was with him - each drawing strength from the contact we had with each other."

All the references to facial expression indicated that the nurses had smiled.

4.2.3.4. Personal Attributes of the Nurse

Apart from three references to the personal attributes of the nurse, these were not mentioned in the case studies reviewed. This is not surprising as they had been written by the nurses themselves, who were unlikely to mention their personal attributes. Certainly, a reader could find many examples of patience, dependability, gentleness, kindness, considerateness and understanding shown in the stu[illegible] but these aspects were not named, or mentioned as such.

4.2.3.5. Nurturance

The studies reviewed were full of examples and references to aspects of nurturance. It is interesting to note that when nurses write about the subject of nursing, they seldom mention such aspects, but when nurses describe care they themselves rendered, they become the focal point of the study, indicating that these aspects are extremely important.

4.2.3.5.1. Availability

Eleven of the authors mentioned this aspect of care. It was not possible to determine whether the availability was "solicited" or "unsolicited" as it had been when categorizing the incidents in the research study.

Seven of the authors mentioned spending time, or staying with, the patient. Three made reference to the fact that their presence was important and that they could do nothing more for the patient than be there, with the exception of listening to them or holding their hands. One such example is Richard Gamlin's study (1992:46), where he describes his care of a patient's wife. The patient was terminal and not responding to his wife. The nurse sat with his wife and listened to her. He says "I could not give her any answers, nor did I feel the need to try. All I could do was listen." Although the listening is important, one can't help thinking

that the most important thing was that the nurse stayed with the patient's wife. It may well have been important to the patient as well. This example illustrates that availability is often combined with other aspects of care.

There were three examples of accompanying the patient (Gillan 1992:45. Williams 1992:29, Keachie 1992 40) - to the bathroom, to theatre, and back to the patient's bed, and two examples were given of nurses coming to check on, or help, the patient (Keachie 1992:40 and Canis 1992:50). The care described by Canis would have been included under the theme "spiritual needs" had it survived the validation process as, in this study, the nurse read the Bible to the patient. She says "He was a broken man, unable to speak, see or swallow. .... He lay there with a blank expression on his face. I introduced myself, smiled and shook his hand. He began to cry. Tears streamed down his face and his whole body shook with emotion. I saw his bible lying beside him on his locker, so I asked him if he would like me to read to him. He smiled and nodded ... I sat on his bed close to him, holding his hand, and opened his well-thumbed Bible at the 23rd Psalm and Psalm 121. He mouthed the words as I spoke. He knew them well. Tears streamed down his sunken face.... Daily I read to Joe. Gradually the sobs turned to tears, and the tears turned to smiles."

This nurse had made herself available to the patient, and in addition had assessed his needs, had communicated and been most attentive in meeting his needs. It would have been much easier to ignore the patient, but she didn't. This incident was also included in the theme "attentiveness".

4.2.3.5.2. Attentiveness

Fifteen of the authors described aspects of care which could be classified under the theme "attentiveness".

There were nine examples of "showing special concern". Again, it must be born in mind that, had the nurse authors not shown special concern to these patients it is highly unlikely that they would ever have written about them.

A good example of "showing special concern" is found in Jane Sheperdson's article (1992:35). She describes how she was working in the "blood room" doing what she considered was repetitive and boring work when a patient came in and, after having the blood sample taken, continued to sit in the chair. The author says "..instead of prompting her by saying "that's all, you can go now," I glanced at the blood-test card and saw the...diagnosis - loss of weight. "Have you lost a lot of weight?" I asked. The woman's face distorted, her eyes

filled with tears, and she seemed to crumple in front of me as the tears began to flow. I drew the curtains around us, grabbed a handful of tissues and sat close enough for her to grasp my arm. Then I knew that I could put my arm around her and literally offer her a shoulder to cry on." This patient must have met many other health personnel that day, and yet this nurse, in the blood room, was the one who showed special concern, which gave the opportunity for the patient to cry and talk about her problem. She had recently been widowed, but no one else had found this out and the patient had not been able to share her grief.

It is difficult to decide where the boundary is between normal nursing care and "going out of one's way" for the patient. All the case studies demonstrated elements of this. The case study by Jane Brown (1992:41) mentioned earlier is an example of this. She agreed to go out on a date with the patient because of his insecurity, not because she liked him at the time.

There were four examples of "performing duties not required" amongst the case studies. One of the cases (Clare White 1992:39) describes a young patient who had a brain tumour, and was, quite understandably depressed and non-communicative. The nurse says " One afternoon we were sitting talking about nothing in particular, when I had a sudden urge to put on her huge "piggy" slippers and dance around the room. I suddenly felt vulnerable and foolish, but then she laughed, and to my intense relief, started to roll around the bed laughing.....It was the key to my connecting with her. Play breaks down barriers. It means taking risks and being prepared to look daft." It is certainly not a traditional part of the nurse's role to entertain the patient, but in this case the nurse's actions, not part of functional nursing, was therapeutic.

4.2.3.5.3. Advocacy

Two of the authors mentioned patient advocacy. In the study by Marlene Sinclair (1992:49), she relates how she realised the patient for whom she was caring was in pain, but never once had anyone given her analgesia. "I asked the consultant to come and look at her eye.....he immediately prescribed morphine elixer." In this case, the patient had not been able to request analgesia as she could not speak due to the effects of a brain tumour, but the nurse had realised her need, and done this for her - a good example of advocacy and similar to one in the research study.

4.2.4. SUMMARY OF FINDINGS OF THE CASE STUDIES

There were many similarities between the incidents related by the patients in the research study and the aspects of care related by the nurses who wrote the care studies reviewed.

The care studies identified far more physical needs than did the patients, and certainly considered them important. Social needs were important, and particularly the recognition of the individual. Comfort needs were identified, and expanded. Psychological needs were not mentioned at all, thus not providing any validation of this aspect by this particular means, but emotional security was identified.

Theoretical Knowledge and observational skills were well documented, but little mention made of psychomotor skills. One cannot believe, however, that these are not important, but perhaps they are taken for granted.

Interpersonal aspects were extremely important as, not only were all the aspects identified in the classification mentioned, but they were added to, indicating that there is more to interpersonal abilities than verbal and non-verbal communication.

As discussed above, personal attributes were hardly referred to at all, but rather than demonstrating that these aspects are not important, other methods need to be sought for validating this aspect of care.

Although the word nurturance does not appear often, even in the 1992 Journals, the themes identified under this category are well represented in the studies indicating its importance, even if by other names.

Overall it would seem that the categorization system worked out in the research study is well supported by recent care studies.

It is important, however, to look at the literature in terms of how each of the themes is described and defined in order to determine their validity, which will be done in the following section.

4.3. SECTION THREE - COMPARISON OF THEMES AND CATEGORIES

4.3.1. INTRODUCTION TO THE SECTION

Literature searches were done to identify journal articles and books written on topics similar to those identified in the research. Journal articles were only selected if relatively recent i.e. written within the last six years unless they were "classics" or written by well known specialists in the field.

Each category, sub-category and theme will be considered separately, as done in the previous section, and will be compared with the literature, in turn. The purpose of this section is to examine the meanings given to each aspect, to determine whether there is consensus regarding the meanings between the aspects in the classification system worked out for the research study, and other authors who have studied these aspects. In doing so, the relative importance of each aspect in nursing will be examined.

4.3.2. ASSISTING WITH PATIENT NEEDS

The work of Maslow (1954) was mentioned in chapter three and formed the basis for the development of this category. Maslow categorized human needs according to their priority, based on the assumption that there are certain essential components that must be satisfied if there is to be a healthy existence, and only when these essential components were satisfied, could a human being move forward to meet "higher" needs. Maslow's categories (1954:37 - 47) were as follows, in descending order, according to the above assumption:

- Physiological needs (including oxygen, food and fluid, elimination, temperature control, sleep, rest, relaxation, activity, exercise, comfort, cleanliness, sexuality)
- Safety needs (including protection from physical harm, protection from psychological threat, stability, freedom from pain)
- Belongingness needs (including love and affection, acceptance, warm, communicating relationships, approval,companionship)
- Self esteem needs (including sense of value, adequacy, self reliance, goal-achievement, mastery of competence, independence)
- Esteem from others needs (including recognition, dignity, appreciation, reputation, attention, status and dominance)
- Self actualization needs (personal growth and maturity, awareness of potential, improved values, increased learning, full development of potential, philosophic

satisfaction, religion, increased creativity, greater satisfaction in beauty)

It will be noticed that many aspects identified in the research study are also mentioned by Maslow. Maslow's classification system however, is much more comprehensive. In a situation such as the one the patients were in, where their health was under threat, one would expect the most basic needs to be identified most commonly, according to Maslow's hierarchy of needs. Although aspects in the upper two categories were scanty, the others were fairly evenly spread between the other categories.

Campbell (1978:4) emphasises the importance for nurses to understand the concept of needs. She says "Professional nurses have long recognized that certain needs take priority over others. Some needs must be met immediately, while others can be postponed, especially during an illness in which life itself is threatened. The concept that need deprivation results in unhealthy states, led to the development of nursing diagnoses, which imply human-need deprivation and nursing interventions that resolve, diminish, or prevent human needs."

Certainly, it would seem that needs are an important concept, but Maslow is not the only person to have categorized needs. One of the best known classifications by a nurse is by Henderson (1970 :16-17) who believes that patients need to :

- Breathe normally
- Eat and drink normally
- Eliminate body wastes
- Move and maintain desirable positions
- Sleep and rest
- Select suitable clothes, dress and undress
- Maintain body temperature
- Keep the body clean
- Avoid dangers in the environment
- Communicate with others
- Worship according to one's faith
- Work in such a way that there is a sense of accomplishment
- Play or participate in recreation
- Learn, discover, or satisfy curiosity

Cooper (1970:103) summarizes Henderson's categorization of needs well, i.e. hygienic, psychologic, environmental, safety, spiritual, social, rehabilitative, health instruction, prevention and comfort."

With the exception of spiritual,rehabilitative and prevention, all these aspects were included in the research study's classification.

The foregoing discussion is all based on the "classic" nursing literature. It is important to look at more recent interpretation of patient needs.

The South African Nursing Council (Terminology Committee report 1992) have defined "health needs" as " Those signs, symptoms, and processes which denote the interaction of the individual, the family, the group and the community with any actual or potential health problem and which require nursing intervention."

The concept here appears to be that needs can only be seen in a pathological sense. Something must be wrong if the person is to have a health need. These needs are, to a great extent, related to outward signs and symptoms. This is disturbing in view of the comprehensive approach to nursing where nurses care for people in order to prevent problems as well as to assist them to regain their health. It is certainly far removed from Maslow's original concept. This concept as outlined is not universally accepted. A citation for the nominee of the Community Health/ambulatory Care Council Nurse of the Year Award in Kentucky (Ballman 1987:782) quoted the nominee as saying "What are the human needs - not just the conditions of the patient."

Another, totally different, and somewhat frightening perspective is given by Brown (1991:55-56) where she explains her method of assessing the patient rapidly. She uses an acronym "MAKING IT" to assess the patient.

M Mentation/neurological assessment
A Airway/Respiratory needs
K Cardiovascular system
I Inspection
N of the skin
G Gastrointestinal

I Invasive line assessment
T Tubes, drains, dressings

She states "Once you have used "Making It" as a reminder, you'll be able to walk away knowing you have done a rapid, yet systematic check of your patient's needs."

It can be seen that only physical needs are taken into consideration. The chances are strong that, if the patients were assessed in this way, they would have felt even more de-humanised than if no one had checked on them at all.

Fortunately, most concepts of needs are wider than this. The North American Nursing Diagnosis Association's (NANDA) Taxonomy Committee drew up a taxonomy of nursing diagnoses, based on human needs. Their taxonomy included what they referred to as human response patterns of choosing, communicating, exchanging, feeling, knowing, moving, perceiving, relating and valuing. At first glance, it sounds as though the physical aspects have been left out, but "exchanging' includes bowel elimination, injury avoidance, nutrition, cardiac output, respiration, tissue integrity and urinary elimination.

Certainly, it is a most comprehensive list of needs, but difficult to follow due to it's theoretical nature.

A very practical approach to determining patient needs was developed by Simon O'Donovan (1992:30 - 33). He adapted Orem's nursing model of self-care (1980) to provide a framework on which to base a new assessment procedure. Ten "core requirements" for living were identified. These were:

- memory/orientation
- communication
- behaviour
- washing/dressing skills
- sleep
- continence
- mobility
- nutrition
- physical frailty
- skin

Here, again, the author sees his patients as having physical, psychological and social needs although not referring to them as such. This certainly seems to be the trend in nursing, and was also indicated in the research study.

A final example of a way of classifying health needs is found in an article by Lai Koh (1990:38 - 40) who quotes a classification by Holden (1989). The broad categories are, Functional needs, Relational needs, Spiritual needs and Social needs. The functional category is sub-divided into Mind and Body. The mind includes decision making and health education, and the body, regulatory functions, survival processes, integrative functions and adaptive and compensation mechanisms. The relational category is subdivided into interpretive and interactive behaviours. The interpretive functions include attitude formation, information processing, and counselling. The interactive functions include verbal and non-verbal communication. The Spiritual category is subdivided into beliefs and aesthetics.

Beliefs include morals and ethics, and aesthetics, altruism and perceptual experience. The social category is subdivided into the context of society and the context of the environment. The former involves family and health systems and the latter the ecological basis for health and housing, warmth, work, health and safety.

Although this is a completely different way of categorizing needs to the others discussed, the basic elements remain the same. It is particularly useful for considering the needs of the patient in the context of his community, as opposed to viewing him as a sick person in hospital, and was drawn up with this in mind as it was designed for project 2000 in England. As the research study was only conducted within a hospital, it is not surprising that it was not as comprehensive as this categorization.

In viewing all the literature sources quoted above, there appears to be support for the research classification of patient needs, although each author classifies needs somewhat differently, and many more are identified than were in the research study. The themes need to be examined in more detail, however, to determine what is meant by each of them.

4.3.2.1. Physical needs

The study identified four physical needs i.e. hygiene and elimination, which were often linked together by the patients, and exercise and mobility which were difficult to separate from one another.

With regard to hygiene needs, nursing texts refer to them broadly. Catering for hygiene needs does not only mean washing the patient's skin, but also caring for the hair, nails and teeth. (Campbell 1978:1261) No mention was made of the latter two aspects in the study.

Roper (1982:67) adds the care of the mouth and feet to the aspects of skin, teeth, hair and nails already mentioned and emphasises the importance of catering for hygiene needs saying " For the majority of people, to feel clean, sweet-smelling and well groomed are essential dimensions of well-being. The many activities involved in achieving this objective are carried out independently and in privacy with pleasurable satisfaction; they are built into the daily routine to give a sense of stability and safety, and they are usually congruent with family and societal expectations."

Roper links hygiene needs to safety needs and privacy needs. There seems to be agreement between the patients and the nurse authors that hygiene needs are important, and yet this task is often, in practice, relegated to the most junior nurse, and sometimes even to domestic assistants, indicating that practising nurses do not always see it as an important aspect of their role.

With regard to elimination needs, nursing texts often separate bladder and bowel elimination from one another and deal with problems of elimination rather than normal elimination in a changed environment. (Campbell,1978; Brunner,1982)

Roper, however, deals with both aspects, explaining that people have different attitudes to elimination (1982:212) and the importance of catering for these individual needs, giving as an example some people's extreme embarrassment at having to use a bedpan or commode where there is little to "muffle the sounds!" She gives careful instruction regarding positioning patients on commodes and bedpans and providing opportunity to wash after use.(1982:212 - 223) The latter two aspects were mentioned by the patients during the research study, and referred to the embarrassment they experienced with regard to using bedpans, as well as the importance of warming the bedpan.

Mobility and exercise is most often described in nursing texts in terms of preventing complications of bedrest or hospitalization. (White 1972, Brunner 1982, Campbell 1978), Robbins 1989) Robbins (1989:53) outlines the aims of care with regard to problems associated with locomotion, as follows:

- To organize a regular programme of changing position whether in bed or sitting in a chair
- To ensure that all limbs are gently exercised and placed in anatomically correct positions
- To avoid over-tiring the patient in any therapeutic endeavour
- To co-operate with the physiotherapist in his or her efforts for the patient's comfort.

Although the patients mentioned being assisted to sit, most who referred to exercise and mobility referred to assistance with walking. This aspect is addressed by Roper (1982:171) who discusses "early ambulation" and says " The traffic in most wards is not conducive to the gentle, unhurried exercise implied in the term "early ambulation.....when a person thinks of himself taking exercise, involving good posture and movement, he thinks of himself as clothed in his daytime attire." She indicates, therefore, that there are problems

related to this. Patients interviewed referred to being assisted to walk to the toilet and bathroom rather than taking muscle building exercise." This is obviously an area requiring attention.

4.3.2.2. Social Needs

Nurses who base their practice on the theories of Travelbee (1966) do include the "social aspects" or "interpersonal aspects" of care. An example of such an author is White (1972: 9 - 11) who says "In some ways we are all alike. Everyone has certain needs that must be met. Their physical needs are for food, air, water, and shelter. In this respect we are all like one another. Similarly, we have other needs, that are common to all people, and it is the way these needs are met that removes us from being carbon copies of one another, and that helps us to become unique and singular." She goes on to give a list of needs which include the need to count on others for help when needed, the need for interpersonal intimacy, the need to experience and use rational control in relation to present and future situations, the need to feel belonging, participation, as a member of a group, and the need to maintain status and position." It is these types of needs patients were eluding to in the study when they cited incidents regarding being recognized as an individual and accepted by the nurses and other patients.

Judith Twitchell (Putt,1978:165) emphasises the importance of recognising the patient as an individual, when she says "Individuality is vital, as the patient is now a major contributing factor in his own care instead of being placed in the role of "receiver".

Viljoen and Uys((1988:1) agree with the above point of view, saying "A characteristic of high-quality nursing care is individuation, i.e. nurses adapt to the individual rather than managing patients as a stereotyped group."

The other theme identified in the social needs sub-category was acceptance. This concept is defined by Kreigh (1979:66) as follows, " Acceptance is an attitude of positive recognition and respect for a person. It is the last component needed by the nurse to promote a therapeutic interpersonal relationship and is, perhaps, the most difficult to achieve. An intellectual acknowledgement of acceptance is not enough. It must be accompanied by the emotional state of acceptance as demonstrated through attitudinal change. It is the reception of an individual's pleasant and unpleasant ideas, emotions and behaviour without

censure or retaliation." This definition by Kreigh echoes what the patients said in the incidents collected for the research study.

4.3.2.3. Comfort needs

Finding references to the concept "comfort" in nursing texts is surprisingly difficult. One has no difficulty in finding references on pain relief, but comfort needs had a broader meaning in the research study.

The explanation given by White (1972:19 - 20) describes the concept as used in the research study well. She says, "Comfort is many things to many people... Comfort (is) a state of mental and physical well-being... it has many facets : emotional, mental, physical, social, spiritual, and economic....there is no single way of creating comfort.... To make (the patient) comfortable, the nurse needs to know something about the patient's developmental needs and tasks, his social, cultural, and family background, and his nursing needs based on these factors."

Kolcaba and Kolcaba (1991) wrote an entire article on the concept of comfort, also giving the concept a wide meaning. They begin by defining the word in "ordinary language". The first definition they give is (p.1302) "a cause of relief from discomfort and/or of the state of comfort." The second, "the state of ease and peaceful contentment," and others, "relief from discomfort," " whatever makes life easy or pleasurable," "strengthening, encouragement, incitement, aid, succour, support, countenance," and "physical refreshment or sustenance; refreshing or invigorating influence."

They also quote Goodnow (1935) (Kolcaba 1991:1303) as saying "A nurse is judged always by her ability to make her patient comfortable. Comfort is both physical and mental, and a nurse's responsibility does not end with physical care." Kolcaba also points out that Goodnow devoted an entire chapter of her book "The Technic of Nursing" to "The Patient's Comfort." Perhaps modern day authors could do well to emulate her, to the advantage of the patient.

As already stated, the literature abounds with articles and references to the nurse's role in pain relief. Suggestions are made regarding the assessment of patients' pain (Price 1991:25 - 28 and Halfens 1990: 43 - 49), reducing pain and anxiety (May 1992: 25 -28), Pain palliation (Straughan

1989:31 - 33), nurses beliefs and pain management (Carr 1991: 54 - 55), non-pharmacological approaches to pain relief (McCaffery 1990:1 - 5) and pain relief for specific types of patient (Bateup 1986: 36 - 39) to name a few.

The fact that other people's attitudes to the patient vary, and therefore influence the measures that will be taken to relieve it, is well illustrated by two quotes. The first is by Ivan Illich (1975) (who,fortunately, is not a nurse) who is quoted by Straughan (1989:31) as saying, "Modern civilization tends to turn pain into a technical problem - thereby depriving it of its inherently personal meaning. People unlearn to accept suffering as an inevitable part of their conscious coping with reality, and come to interpret every ache as an indicator for the intervention of applied science."

The second quote is from Robbins,(1989:75) who says, " (Pain) is all embracing, unremitting, and destructive. It clouds the mind and prevents mental concentration and it interferes with social interests and activities."

The patients interviewed emphasized the importance of administering analgesia regularly and promptly, which is accepted, good nursing practice, but did not mention alternative practices for reducing pain. This aspect is well documented in the nursing literature. In discussing post-operative pain, Brunner (1982:127) emphasizes the importance of positioning the patient, massage, emptying the bladder and loosening tight dressings as well as administering analgesia prophylactically. Carr (1991:54 - 55) mentions other alternative pain relief measures including heat, ice, massage, aromatherapy, relaxation, diversional therapy, acupuncture, hypnotherapy, and homeopathic remedies. All of these are receiving attention amongst the nursing fraternity, but are presumably not used at the hospital where the study was carried out, or were not seen by the patients as pain relief measures of note.

With regard to general comfort, the same [illegible]s as were mentioned by the patients, i.e. rubbing the back, putting ointment on dry lips, positioning the patient (Brunner 1982:53) are referred to in the nursing literature, but with reference to preventing problems of bedrest, and other health related problems.

Older texts, written before today's obsession with dividing the patient into compartments labelled "needs", each to be dealt with as a separate entity, addressed the subject of general comfort well. Fuerst (1974:167 - 177) devotes an

entire chapter in her book to "The Patient's Immediate Environment," and has a sub section on provisions for comfort which include decor, lighting, temperature, humidity, ventilation, furnishings, personal care items, privacy and quiet. All of these could be included in the theme "general comfort" although in modern hospitals, one of the problems is that the nurse had little or no control over aspects such as temperature, humidity and ventilation.

As mentioned in the previous paragraph, Fuerst (1974:175) mentions privacy and quiet under the heading of Comfort. The patient's incidents referring to these aspects were classified under a theme "Psychological Comfort." Fuerst says, " Anyone who is being interviewed, examined, or cared for deserves and appreciates the comfort of privacy. It is very easy for nurses and for others to feel that anything routine to them is also accepted as routine by the patient. Many patients are reluctant to protest the lack of privacy. Persons caring for patients, whether in a clinic, an office, a home, or a hospital, should try to provide as much privacy as possible. They will also wish to be well aware of the legal implications of invasion of privacy." These are wise words which apply just as well nearly twenty years later, but tend to be forgotten. This is very obviously the case in the hospital where the research took place, as all the patients in a particular cubicle appeared to be aware of everything that was said and done to the patients in the same cubicle.

Viljoen and Uys (1988:27) emphasize the importance of the above discussion and support the patient views. They say, "The primary duty of the nurse-in-charge is to protect the patient's person, his name and his property and to nurse him to the best of her ability."

The other aspect mentioned by patients with regard to psychological safety, was the attitude of the nurse. This made a difference with regard to the way the patient felt when faced with potentially embarrassing situations. If the nurse had the "right" attitude, he felt psychologically more comfortable. A common example of this referred to the use of bedpans and commodes in the ward. No reference to this aspect per se was found in the literature, but a couple of quotes from Robbins (1989:8 - 10) are useful in shedding light on the phenomenon as, although her book specifically relates to care of the dying, her comments have a wider application. "Since attitudes are related to behaviour, it is important that the nurse who will care for dying patients and their families recognizes the effect of his personal thoughts and feelings about death - his or her own and other people's ... Acknowledging a common humanity, which includes at times,

feelings of inadequacy and anxiety, and talking over problems with colleagues, is a sign of growth, not weakness."

4.3.2.4. Safety needs

Patients in the research study mentioned both aspects of physical safety and emotional security. Campbell (1978:24) supports this classification, when she describes the following aspects under "Safety Needs". Protection from physical harm, protection from psychological threat, freedom from pain, stability, dependence, and predictable, orderly world. Some of these aspects were, however, included in the comfort category.

Nurses are aware of the problems relating to patient safety and resultant medico legal hazards such as the necessity of preventing falls, leaving swabs in the abdomen, burns from diathermy, nosocomial infections, and the like (Creighton 1975: 122 - 128). This seemed to be relatively unimportant to the patients as few mentioned it. It is hoped that they trust nurses sufficiently to assume these aspects will be taken care of or feel secure enough not even to consider them. What was significant for the patients, however, was the emotional security aspect.

The need for Emotional security is discussed by several authors. Kron (1975:35) says, " The need for security involves job, group and spiritual security along with personal security or safety. Everyone must be able to depend upon something or someone, to predict with reasonable accuracy what will happen to him, to know how others feel toward him. In other words, he must have that comfortable feeling of security if he is to function to his fullest capacity. This feeling of security is the end result of meeting and satisfying the need for recognition, for belonging, for understanding, and for new experiences."

Travelbee (1971:189) supports this viewpoint, saying, " The need for security is synonymous with safety. In this situation the need for security refers to the individual's need to believe he will survive the surgical experience and that he will be given expert care and not abandoned in his time of crisis." Travelbee continues to point out that knowledge is one way of ensuring emotional security, although it does not always dispel all fear and anxiety.

4.3.2.5. Summary of Physical Needs

There seems to be a great deal of support in the literature for the themes included in the literature, although they are not necessarily classified in the same way.

An interesting point is made, however, by Farrell (1991:1062 - 1070) who asks "How accurately do nurses perceive patient's needs? " If nurses are not able to perceive patients' needs, it does not help to have consensus in the literature. In his findings of a study done to compare general and psychiatric nurses' ability to perceive patient needs, Farrell states that general nurses are much less aware of their patients' emotional and physical needs compared to psychiatric nurses. Also, while the "average" psychiatric nurse and the "average" psychiatric patient may show little disagreement in perception of their needs, there is little evidence that individual nurses, whether psychiatric or general, are able to assess individual patient needs accurately. There appeared to be a tendency for nurses, particularly general nurses, to overestimate their patient's needs.

In his discussion on implications for nursing practice, Farrell says "A philosophy of individualized care now seems central to nursing. However, the present findings indicate that nurses do not know their patients very well."

In view of the fact that all nursing these days revolves around the "scientific process" which aims at assessing individual patient needs, these findings are alarming. It would seem that despite all the tools which have been developed for assessment purposes, nurses are still not communicating adequately with their patients. This aspect was dealt with separately in the research study, and will receive attention later in this discussion.

The problem appears to be that patients and nurse authors, both of case studies and other literature agree on the fact that patients do have the above needs, and that they should be catered for, but it is not necessarily happening in practice. A reason for this could be that nursing has become a theoretical discipline, rather than a practical one in an attempt to "line up" with the status of other professions. What should happen now is to encourage nurses to "get back to the bedside."

4.3.3. DEMONSTRATING KNOWLEDGE

4.3.3.1. Theoretical Knowledge

The patients in the study identified two aspects of demonstrating theoretical knowledge. One was that the nurse was able to give the patient information and the other that she knew what action to take.

Giving patients information is a topic that is well described. The community nursing and midwifery texts go into considerable detail preparing nurses for this role, which they see as a primary function of these nurse. (Jenson and Bobak 1987, Miller and Brooten 1983, Stanhope and Lancaster 1984) and most general texts give it attention, often specifically for the various disease processes. Brunner (1982:6 - 7) however, gives information on the principles of teaching and learning, variables that affect learning readiness, the learning atmosphere and teaching strategies, as well as relating health education to the nursing process and giving specific information for patients with various health problems.

Campbell (1978:1299) sees part of the nurse's role to encourage continuation of education in order to assist the patient in the realization that continuing one's education through the usual years of formal learning gives a person increased knowledge with which to meet life's problems and enhances his chances of obtaining and keeping desired and well-paying employment." This was not the patients view, however. Although Campbell is undoubtedly correct in what she says, patients in the study appreciated being given information.

There is a very important link between this ability and communication. Livingstone (1991:44) points out that "words can communicate both good and bad information." She gives several examples of how the same information given in different ways had totally different effects on the patient and cautions her readers to remember that "patients often ask questions as much for reassurance as for an answer."

Fuerst (1974:153) goes into considerable detail regarding the importance of establishing good relationships, providing a comfortable environment, using teaching aids,being free from distractions and using various teaching methods to ensure good patient education, but this all refers to formal health teaching. It seems that the patients are more concerned with informal education, and one can't help believing that the root of this is that they want the nurse to spend more time

with them and communicate well. If this was done, everything else would follow.

The closest one gets in the literature to finding information on this type of individualized, informal patient teaching is in Benner's "Coaching Function" of the nurse. (1984:91) where she refers to making culturally avoided aspects of an illness approachable and understandable. She cites as an example a relative who spontaneously asked the nurse far-reaching questions, and how she dealt with them.

The fact remains that the patients in the study were not asking for difficult, culturally avoided information. Fairly junior nurses could have dealt with the situations referred to. This aspect appears to warrant more attention by both nurse authors and nurse practitioners.

Knowing the correct action to take is a difficult aspect to deal with when searching for literature on the subject. Many nursing texts exist which give information on the correct action to take for various problems, needs, situations and people, but the only literature dealing with the specific topic is that on evaluating competence. The question is, what is <u>correct</u> action, and how did the patients know that it was correct?

This problem is partially dealt with by van Essen (1991:1363 -1374) in her research report on "patient and staff perceptions of caring:review and replication." She showed that patients and staff have different perceptions of the most important caring behaviours. She points out that perceptions are influenced by expectations. This has a direct bearing on the problem of measuring "correct action" as patients ideas of what is correct may well be influenced by previous experience. One can't help wondering whether some patients would not believe any action was correct as long as the nurse was confident in carrying it out.

This debate does not, however, detract from the responsibility of professional nurses to ensure their practice is up to standard and that they teach students correctly.

<u>4.3.3.2. Skills</u>

Although the patients in the study noted that observational and psychomotor skills were important, the South African Nursing Council (1985) does not detail that these skills should be taught during the Four Year training programme. Admittedly, the Council does not say that they should not be taught, but it is only implied for General Nursing as the

Nursing Practica guidelines are based on the Scientific Process. It is interesting, however, that in the section on Psychiatric Nursing practica, nursing colleges are informed that they should teach communication skills, group skills, counselling skills, crisis intervention skills and skills in management of stress. The midwifery skills include assessing antenatal patients, conducting internal examinations, delivering patients and giving local anaesthetic and cutting an episiotomy.

The curriculae of nursing colleges include skills training, mostly in first year to teach nurses how to make beds, change a dressing, administer medicines and many other skills, but the choice of the skills that they teach is left entirely up to the colleges.

The method of conducting a particular skill also differs between institutions, although principles are similar.

Observational skills receive a great deal of attention in the literature, under the heading "assessment" as this is the first step in the scientific process. Part of the assessme step, is history taking, but this is not what patients were alluding to. The physical examination is part of noticing whether the patient is in need and Viljoen and Uys (1988:71 - 72) cover this aspect. At first glance one thinks that they have referred to the assessment of the emotional state of the patient as these magic words are mentioned, but on closer examination, it is only to facilitate the physical examination. An example is that one should ensure privacy before conducting the examination. It is possible to gauge emotional well-being, at least to some extent by looking at the patient and this would seem important but it is omitted.

Other texts do deal quite comprehensively with this matter. Brunner (1982:835) mentions physiological, socio-economic and psychological assessment. The biggest problem in practice is that, even though the nursing process is used effectively for the initial assessment in some units, nurses tend not to continue the assessment process during the patient's stay. It is this aspect the patients were referring to as they appreciated it when a nurse noticed they needed something. What is needed here is to teach nurses to BE observant rather than to assess patients.

With regard to psychomotor skills, it has already been stated that the various institutions teach different skills, although there appears to be a core of skills that are taught by all. Patients were appreciative when nurses did dressings efficiently, and bedpans were given in an acceptable manner, and marvelled at emergency procedures, but the overriding

factor seemed to be that the nurse could conduct a procedure without causing discomfort, or, at least, with as little discomfort as possible. This aspect is not given attention in the literature.

It would seem necessary to make nurses aware of the potential for discomfort for each of the procedures they carry out, and how to avoid such discomfort. This applies as much to administering a warm bedpan as to inserting an intravenous infusion with minimal pain.

4.3.4. INTERPERSONAL ABILITIES

As stated in chapter three, Travelbee's concept of the word "interpersonal" was used in originally forming the category. Travelbee (1971:93) says, "...communication is a process which can enable the nurse to establish a human-to-human relationship and thereby fulfil the purpose of nursing, namely, to assist individuals and families to prevent and to cope with the experience of illness and suffering and, if necessary, to assist them to find meaning in these experiences."

Travelbee views communication as a vehicle for establishing human - to - human relationships, so that the emphasis is on the relationship, rather than the act of communication.

Kreigh (1979:24) refers to communication as being the process or relationship, rather than leading to it. She says, "Communication is the means we use to relate and share our thoughts, feelings, attitudes, needs, desires, pains, turmoils and crises to others. The process of communication uses words and expressions which can be interpreted or heard differently. Communication takes place between people and can be either verbal or nonverbal."

Robbins (1989:25) takes this one step further by describing "communicating security through availability and awareness" This could be described as a form of nonverbal communication, but she indicates more than touch, facial expression and body language - she describes spending time at the bedside as a type of communication. The message nurses convey by doing this is that they care. If one acknowledges this point of Robbins, the categories developed for the research study overlap, as being there, or spending time, was classified under nurturance.

For the purposes of the study, however, only verbal and nonverbal communication were identified, and only examples of touch and facial expression were identified by the patients in the nonverbal communication sub-category.

4.3.4.1. Verbal Communication

Explaining things to patients was one of the themes identified in the study. This matter was given some attention in the "Knowledge" category.

Livingstone (1991:44) has written an interesting article on this subject, saying that , in the process of explaining things to patients, words can be used that communicate both good and bad information. If explanations are too short, the patient is often left worrying more than before he asked the question. She gives as an example, the patient asking why his arm is swollen. The answer "It's fluid" is clearly inadequate and worrying. "It's just fluid" is worse as it leaves the patient feeling he is a nuisance and should not have asked the question in the first place. A short explanation with suggestions for remedial action are clearly the best way of answering the question. She concludes by suggesting that nurses take heed of the Second World War slogan, "Careless talk costs lives."

Another slant on this matter of explaining things to patients is provided by Tanner (1989:54 - 56) who says that choosing the right time to explain things is crucial in making sure the message gets across. She says "Adults become ready to learn when they experience a need to know how to cope in a more satisfying way with real life tasks or problems." One cue which may indicate a readiness to learn is when the patient begins to ask questions. The patients would probably support this theory as they appear to want answers to their questions, rather than be given formal health education. They then find out what they want to know and not what the nurse thinks they ought to know.

Noble (1991:1185 - 1189) addresses this problem when she quotes Bille (1981) "good assessment skills are the key to effective education since they can ensure individuality by finding out what the patient wants (and needs) to know." She also quotes the UKCC advisory document "Exercising Accountability" as suggesting that, "If it is accepted that the patient has the right to information about his condition, it follows that the professional practitioners involved in his care have a duty to provide such information." It would seem reasonable to extend this to providing information, not only about the patient's condition, but also about any aspect of his care which he requires, or asks for.

Patients also identified the importance of reassurance in the nurse's verbal communication. No specific references could be found on this issue, but McCrissican (1991:37) points out that "the educative component of the nurse's role ... cannot be confined to teaching medically orientated facts. It is also important to support the patient at this stressful time by providing assistance to patients ... " This can be interpreted as reassurance, although the patients were satisfied with simple acts of reassurance such as the nurse saying "don't worry, you'll be O.K."

Patients also mentioned aspects such as greeting the patient, talking to them and enquiring after them which would seem to be simple, almost automatic, in every day communication that it is surprising that patients commented on them.

Turnock (1991:39), however, suggests that nurses cannot communicate well unless they themselves are comfortable with their environment. She also says (p 38) that nurses often use strategies to avoid talking to patients. Noble (1991:1188) suggests that nurses are not adequately prepared for their role as communicators, and that education programmes for basic nurses are deficient. If this is the case, remedial action is urgently required.

4.3.4.2. Non Verbal Communication

Roper (1982:16) says that "non-verbal communication is of tremendous importance to a patient, portrayed by the way in which he watches everything that goes on in the vicinity. It is important that he does not receive contradictory messages... By the development of the conveyance of accurate non-verbal communication, it is possible to fulfil a patient's greatest need by being silently with him."

This point of view is echoed by Robbins, quoted above, and yet patients in the study only mentioned touch and facial expression, although the aspects mentioned by Roper may well be included in another category.

The theme of touch is covered quite comprehensively in British nursing journals, particularly in relation to holistic healing and complementary therapy. (Feltham 1991:26 - 28, Oldfield 1992:21, Smith 1990:31 - 32)

Feltham (1991:26) states that " the use and acceptance of touch by individual people depends on numerous cultural rules and personal characteristics." This is an important factor in South Africa which is a multicultural society, and appears best accepted and appreciated by patients in extreme states

of anxiety. The acceptable practices mentioned by the patients were holding hands, stroking and hugging, but almost all happened as a result of the patient's distress. Feltham continues to say, " Touching is an integral part of every nurse's work, but few give thought to what they can communicate through touch...Touch can convey acceptance and support better than words and is often the last resort in communication." This last comment could explain why the incidents of touch occurred during periods of emotional stress. The nurses could not convey their suppurt by means of words.

During the 1960's the term "therapeutic touch" became popular in holistic healing. The term was used to describe quite a complicated procedure to do with energy fields. The type of touch the patients appreciated did not involve this type of touch, but rather a simple method of conveying a message. Equally the stroking referred to by the patients had little, if anything to do with the "massage" advocated by holistic healers, although this undoubtedly had beneficial effects.

Oldfield (1992:21) explains that massage improves circulation, aids digestion and stimulates the lymphatic system. She says that massage has a profound effect on the nervous system, relieving nervous tension and lowering the heart rate and blood pressure, as well as encouraging the production of endorphins that reduce pain and create a feeling of well being. She is so convinced of its importance that she encourages nurses to attend a course offered to teach massage techniques.

Passant (1990:26 - 28) used massage in the care of patients in her geriatric ward and reported great success. One cannot help thinking that such procedures, however therapeutic, can only occur once basic nursing care is offered routinely, and thus are unlikely to be practiced in the hospital where the research study took place.

Smiling, as a form of facial expression, was mentioned by many patients, but not by any authors. It is an outward sign of personal attributes which will be discussed in the next section. Suffice it to say that it is valued by patients and it would seem worthwhile to encourage this simple practice.

4.3.5. PERSONAL ATTRIBUTES

The realm of "personal attributes" traditionally belongs to the psychologists. Discussion on personal attributes of the nurse is largely absent from the nursing literature. This should be of concern to nurses as this aspect affects the selection process of student nurses. The question arises, if the patients' belief that certain personal attributes are important is valid, can students learn to be pleasant, patient, dependable and gentle, or are these unalterable character traits ?

Morgan, King and Robinson,(1981:516) believe that, although people do tend to display consistency in some areas, they are able to adapt their behaviour to situations. Thus, if a student does not possess a "friendly" trait, she could still behave in a friendly manner, thus satisfying the patients.

Another problem with this aspect is that there exist 170 trait words (Morgan et al 1981:512) and selecting which ones are important in nurses would take a much more extensive one than the one carried out for this research study.

Another perspective on this matter was given by Jung (as discussed in Lindzey and Hall (1970:78 - 116). Jung believed that the personality is formed from a storehouse of unconscious archetypes ("primordial images") which one acquires automatically as part of one's genetic heritage, (the collective unconscious) and a personal unconscious. This latter part of the personality is developed from one's own experiences but have been repressed. If Jung is correct, it would seem unlikely that students could change their personality traits, and that therefore this should be considered when designing selection procedures.

Nurses have given this matter attention. In 1991, nurse counsellors in South Africa held a symposium, "Nothing Ventured, Nothing Gained", when they were addressed by Dr van Rooyen, who, amongst other topics, addressed the matter of individual behaviour preferences. She said (1991) "Each individual is unique in so far as he or she is the product of heredity and environmental influences. However, although each individual may be different from another, it is necessary for us to be able to find certain common trends amongst people which could guide us in understanding the people with whom we have to work...We must accept that not all people's minds work on the same principles as our own. ... Because of such differences some people prefer to become auditors, others airplane pilots or racing car drivers, whilst others become nurses."

The challenge to nurses, then, is to identify the common behaviour trends that assist people to be "good" nurses, to use them as a guide in the selection process, and also discover how we can encourage positive behaviours in nurses.

4.3.6. NURTURANCE

As explained in the previous chapter, it was difficult to find a suitable word to name the last category. A category which includes aspects such as availability, attentiveness and advocacy suggests compassion, personal interest and concern for the patient. The word "caring" is too broad for the purpose as this includes many other aspects. Greenberg-Edelstein's model of Nurturance (as quoted by Geissler 1990) gave several levels, the last two of which seemed to have application to the last category. Level 4 of the model describes interactions as therapeutic with personal exchanges at a level where emotional content, views, attitudes being exchanged. Level 5 describes the interaction being deep and solid, transcending the self and exposing the very core of each member." The emphasis in this category then is interaction, but on a deeper level than communication. In this category, the nurses showed concern for the patients as individual souls rather than only as patients or people, as in the category of Interpersonal Abilities.

As the word "Nurturance" has been "manufactured" to explain a level of caring, it is difficult to find literature describing the term. In time the word may well be absorbed into general usage among the nursing profession, but this is not yet the case. As a result, a search was made in the literature for related concepts to those in the study even if called by different names or words.

Benner and Wrubel (1989:367) present an interesting view on the debate of this level of caring. They start the debate by quoting Reverby (1987) who maintains that particular circumstances, ideologies and power relations create the circumstances under which caring can occur, the forms it will take and the consequences it will have for those who do it. "Because nurses have been given the duty to care, they are caught in a secondary dilemma : forced to act as if altruism (assumed to be the basis of caring) and autonomy (assumed to be the basis for rights) are separate ways of being." (p.5) Benner and Wrubel maintain that "instead of altruism being the basis of caring, ...caring is the basis for altruism. Altruism, implies concern for the good of others, its roots lie in an oppositional view of the self.... Concern for others must always be at the expense of the self, and

therefore altruistic." (1989:367) The problem for Benner and Wrubel is that, from a phenomenological point of view, one's view of the person is defined in terms of the relationships he has with others. They therefore do not see altruism and self concern as being mutually exclusive.

Whether altruism gives rise to caring or vice-versa, the above argument indicates that altruism is an essential component in caring and this is one of the elements that appears in the category labelled "Nurturance" in the study.

Gadow (1985) proposes that "the moral quality of caring in nursing emerges from the idea of commitment to a particular end....the protection and enhancement of human dignity" (quoted by Condon 1992:16) Although the moral aspects referred to by Gadow were not in evidence to any great degree in the study, the protection and enhancement of human dignity were paramount.

Another aspect that emerges in the themes within the Nurturance category is what Lyne (1990:36) refers to as "higher life satisfaction." Had the nurses not made themselves available, been attentive or practised advocacy, in the ways described in the study, none of them would have died or been ill for longer as a result, but they would not have felt "cared" for and would not have felt valued as individuals and satisfied with their care. Lyne also states (p.37) that "....what counts is the change in the individual patient in relation to what can be achieved by and for that patient....the information will be obtained after collaboration with the acknowledged expert - the patient." Lyne is arguing for the use of individualised patient goals, but the reason for her plea is that the patient is an individual - not purely a member of the human species, and should be valued and treated as such, which is fundamental to this category of "nurturance". This concept is echoed by von Essen and Sjoden (1991:1374) who issue a caution, "....(do) not assume that intended caring is always perceived as such by the patient."

Sharp (1990:54) would seem to disagree with the above concepts of altruism and companionship as she states that "Nurses enjoy caring for patients who are submissive, vulnerable and dependent." and quotes Bond and Bond (1986) to support her theory by saying, that nurses' relationships and preferences are "intimately tied to the nurses' sense of professional identity, which in turn is associated with their perceptions of authority and professional competence." When one examines these statements further, however, they could well be supporting Benner and Wrubel's idea that caring gives rise to altruism, and that the nurses are not able to be

altruistic because they have not, and are not cared for themselves. When translated into the South African context, it could well explain why so many nurses seem unable to nurture others. With a history of separate development and all the indignities that were suffered as a result, South Africa can hardly be seen as a caring or nurturant place in which to grow up and mature.

Another field of literature that seems to support the "Nurturance" concept is that regarding "Holistic Healing". If one considers that all the holistic therapies necessitate the presence of the therapist, it would seem logical to suppose that the rising popularity of these therapies may indeed be because they are meeting the fundamental need of people for the presence of others, and that conventional therapies are not meeting these needs. Most "high tech." therapies involve the use of machines, but holistic therapies require a "hands - on" approach.

Sayre-Adams (1992:52) says, " Touch has long been recognised by nurses as making an important contribution to the therapeutic benefits of caring. Intuitively, nurses have been using therapeutic touch in their practice every time they have touched a fevered brow or an arm with compassion and the desire to help." Leaving aside the debate as to whether it is still intuitive for nurses to use therapeutic touch, this author seems to distinguish between this type of touch and non-verbal communication. This type of touching, which may well fall into the category of nurturance, is touching with compassion and the desire to help.

Stevensen (1992:52) further helps to elucidate the concept of nurturance by referring to this abstract ability saying, "Our patients and clients rely on nurses to make a difference to their lives."

Yu - Mei Chao (1992: 181 - 184) defines nursing care as "one type of human caring (which) should be tailored to meet individual needs. If the person in need of nursing care is distressed, the purpose of action is to prevent or deal with this distress. ... In Chinese, nursing care is called Hoo-Lee. Hoo means protection or surveillance; Lee, logic or management." This author would presumably, then, agree that the concept of Nurturance is an important part of nursing, if not the very core of nursing.

It is quite possible that the British nurses' emphasis on "Primary Nursing" is also to individualise care and ensure availability, accessibility and advocacy. However, because one makes one nurse responsible for the total care of a patient does not necessarily mean that the patient will be

nurtured. It depends entirely on the level of relationship the nurse had with the patient. Helen Passant (1990:27) supports this idea when she says, " Being a primary nurse was in many ways very fulfilling, yet I remained dissatisfied. My patients were bathed and washed, dressed neatly, fed and hydrated, given medication to ease aches and pains; they played bingo and received visitors. It did not seem like nursing to me." She goes on to explain how she learned, and started to practice, therapeutic massage which ".... opened doors to a closer relationship with us allowing patients to speak of their dreams and hopes, of their fears and pleasures." The important question is whether it was the actual act of massaging or the time spent with the patient that was important in enabling them to share on this level.

4.3.6.1. Availability

Benner (1989) coined the word "presencing" which is relevant to the theme of availability. She defines it as follows," To be with someone in a way that acknowledges or participates in the person's experience. To presence oneself means that the person is available and accessible to another so that the other feels that he or she is understood and supported."

It can be seen that Benner separates the terms availability and accessibility, thus inferring that they have different meanings. Benner's "presencing" indicates an in-depth relationship with the patient, whereas the term "availability" used in the study simple means that the nurse's presence was appreciated. The aspect of "Attentiveness" in the study was closer to Benner's "presencing".

Campbell (1984 as quoted by Vaughan 1990:23) has "likened nursing to skilled companionship which can be interpreted as helping someone through a difficult journey with as little disease as possible." This concept of skilled companionship is illustrated in the "availability" theme within the nurturance category. Vaughan goes on to say, "confidence and trust are fundamental to the development of a therapeutic relationship as well as a deep sense of empathy which will help nurses recognise and respond to individual client needs based on their personal coping strategies and past experience." She continues, " The importance of "being with" or "presencing" is gradually being recognised as a crucial skill for nurses to learn. Yet it is not easy to help people develop in this way since there is a need to understand self before understanding can be offered to others."

4.3.6.2. Attentiveness

Actual references to this terminology were difficult to find in the literature. During discussions on the concept of caring, however, the aspect of showing concern for the patient did emerge. Benner and Wrubel (1989:1) say, "caring sets up the condition that someone or something outside the person matters and creates personal concerns." Their premise is that, without caring, nurses could not cope, indicating that caring has a reciprocal, beneficial effect for the nurse and the patient. Attentiveness is an integral part of caring, and a manifestation of the same.

Kreigh & Perko (1979:28) make a statement which lends weight to the validity of the inclusion of the "attentiveness" theme in the classification - " Accessibility and availability do not fulfil the requirements of "being there". "Being there" implies interest, expectancy, readiness and attentiveness." They continue to explain that this can be demonstrated by a nurse's behaviour, for example, " ignoring and/or eliminating distractions, looking directly at the patient, as opposed to gazing about the room, remaining quietly composed as opposed to fidgeting in the chair, sitting erect and slighily forward, as opposed to leaning back and away from the patient, and giving verbal encouragement for the patient to begin the interaction." As these authors were writing for psychiatric nurses, their examples of attentiveness are confined to interpersonal relations rather than doing things for patients as in the study.

One has to conclude, however, that if a nurse is "interested, ready and expectant" she will perform extra duties as shown in the study.

Peplau (1969:342- 360 in Bayntun-Lees 1992:37) also makes reference to these concepts, by advocating "that interactions must focus on the interests, concerns and needs of the patient." This is the very core of attentiveness.

4.3.6.3. Advocacy

No problem was experienced in finding references to this concept in the nursing literature. It appears to be well accepted as part of the nurse's role, although it may not be practiced as frequently as it should.

Gadow (1979:81 - 91) explains that there is a fine line between being a decision maker on behalf of another and being one who informs the client of available options and subsequently supports the client's decision." The units in the study fell into the former category, the latter being

described under communication. Gadow continues, " (Advocacy) is done with an appreciation of the individual as a unique human being who is particularly vulnerable because of the stress associated with injury or illness." This statement appears to support the inclusion of "advocacy" within the nurturance category.

Donahue (1978) and Spradley (1981) (as quoted by Stanhope and Lancaster 1984:751) believe that understanding, accountability, risk taking, communication and resourcefulness are all characteristics of an advocate.

Lindsey Dyer (1991:47) casts a different light on the above, saying that nurses are not and cannot be true advocates because they lack the fundamental requirement of an advocate which she sees as being independence. She says that most nurses have "established limits on their willingness to rock the boat", explaining that if a nurse acts as a true advocate she may risk losing her job, salary and career. This seems like an extreme view, but she does say that "true advocacy is also about spending time with patients, getting to know and respect an individual as a person." This latter statement also supports the view that advocacy is part of nurturance.

4.3.7. SUMMARY OF THE CHAPTER

The purpose of the literature review in this chapter was to validate the findings of the study by comparing them with existing literature. The chapter was divided into three sections, the first being a comparison of other classification systems, the second being a comparison with nursing care studies, and the third with nursing literature which described the various themes and categories developed.

The only two areas which were not well described in the literature, were personal attributes of the nurse, and nurturance. Each of the other aspects was well described although sometimes varying in terminology and approach.

Personal attributes of the nurse are considered by those involved in selection of nurses, little work of which has been described in current literature. This group of people considers it an important aspect, and it would seem important to conduct further research into this aspect, particularly from the patients' point of view.

As already explained, the term "nurturance" has been coined relatively recently, which explains the difficulty in validating this aspect, but the themes identified within the category are validated by the literature.

CHAPTER FIVE

SUMMARY, RECOMMENDATIONS AND CONCLUSION

Models of nursing, evaluation instruments for evaluating the competence of nurses and protocols for the delivery of nursing care have traditionally been developed by nurses. While this would seem sensible in the light of the fact that the nurse is the expert on nursing care, a concern exists that the person central to these activities - the patient - is seldom, if ever, consulted. The fact that the patient pays, directly or indirectly for nursing care means that the nurse is accountable directly to the patient. Patients, however, seldom exercise their right to question their care, participate in their care, and demand an acceptable level of care. Other professions, notably teachers and the police, are currently being subjected to rigorous public scrutiny and censure. Nurses have largely escaped this process, probably because illness makes people vulnerable, frightened and passive. This being the case, it is all the more important that nurses encourage patients to make a contribution regarding their care.

One of the areas where patient care can make an important contribution is the area of evaluation - for the patients to say what criteria are important in assessing whether a nurse is competent or not.

It was therefore decided to undertake a study at a large teaching hospital in Johannesburg to determine whether the patient's perception of the criteria used to determine nursing competence differed significantly from those suggested by nurse authors, educators and the South African Nursing Council.

5.1. THE RESEARCH PROBLEM

No valid, reliable evaluation instrument exists which is based on the criteria that patients use in evaluating whether a nurse is competent. The South African Nursing Council (S.A.N.C.) provides guidelines as to what the profession considers are minimum standards, in the form of behavioural objectives, and not evaluation criteria.

5.2. RESEARCH QUESTIONS

- Can a set of criteria be developed from the perceptions that patients have of what constitutes nursing competence?

- Do patients and the S.A.N.C. use common criteria when evaluating nursing competence?

5.3. THE AIMS OF THE STUDY

5.3.1. Short-term aim

- To determine the criteria used by patients in judging whether a nurse is competent or not.

5.3.2. Long-Term aim

- To improve student nurse teaching and evaluation.

5.4. OBJECTIVES FOR THE STUDY

- to collect the criteria patients consider characteristic of a competent nurse
- to categorize the criteria used by the patients
- to compare these criteria to those described in the guidelines and philosophy of the SANC for basic nurse training in order to develop a composite list of behaviours and attributes with which to evaluate student nurses.

5.5. DEFINITIONS

5.5.1. Category The highest class under which themes and units are systematically arranged.

5.5.2. Competence The quality or state of having sufficient knowledge, judgement, skill or strength (Schneider 1984:1)

5.5.3. Content Analysis A way of categorizing verbal and behavioural data based on the researcher's analytical thinking and creativity.

5.5.4. Critical Incident An observable and integral episode of human behaviour, which has a discernable impact on some outcome.

5.5.5. Patient An in-patient at the hospital where the research was carried out.

5.5.6. Qualitative Research A style of research which is used to interpret the meanings, intentions and qualities of human behaviour.

5.5.7. Theme A collection of ideas that possess a common characteristic.

5.5.8. Unit The smallest entity or item identified within a theme or category.

5.5.9. Behaviour Anything the nurse does that can be observed and reported upon.

5.6. RESEARCH METHODOLOGY

The research took the form of a descriptive study, using qualitative methodology. A critical incident technique was used to gather the data and a content analysis to analyse the data.

5.6.1. Population and Sample

Patients interviewed were in-patients in a large teaching hospital in Johannesburg who were able to communicate in English, and whose illness would not be exaccerbated by their participation in the study. Patients in the paediatric wards were excluded from the study. 92 interviews were conducted and transcribed, of which 9 were excluded. Reasons for exclusion included poor reporting, insufficient or vague data, and negative incidents. Of the remaining 83 incidents, 8 were from obstetric and gynaecological patients, 9 from surgical patients, 27 from medical patients, 3 from orthopaedic patients and 6 from psychiatric patients. Incidents were collected until no new categories were being formed, i.e. the categories were saturated.

5.6.2. The Instrument

A focused interview was conducted with each patient after posing the same question to each. Patients were asked to recall a specific incident that they had observed or were part of, that, in their opinion, illustrated competent and caring behaviour by the nurse concerned.

5.6.3. Data Collection

Permission was sought from the various authorities responsible for patient care in the institution where the research was conducted, and was granted.

The permission and assistance of the Sister-in-Charge of each of the wards where patients were interviewed was elicited. They were able to direct the researcher to English speaking, relatively well, patients.

An informed, written consent was obtained from each of the patients interviewed. Time was spent prior to commencing the actual interview in creating a conducive atmosphere for the interview, by engaging in informal conversation, totally unrelated to the research. Reluctant patients were not coerced to participate. The interviews were audio taped.

Information regarding the type of ward, the sex, age, home language and type of illness of each patient was recorded for statistical purposes.

Batches of approximately 10 interviews were conducted at a time, and each interview was transcribed verbatim once each batch of interviews was completed.

5.6.4. Organizing the Data

The data was stored on computer with the use of a word-processing programme. This was found more useful than a data base as the information was later sorted according to words and phrases, rather than statistical information.

Each interview was allocated a number to facilitate the later location of information.

5.6.5. Coding and Analysing the Data

Incidents were examined and like behaviours occurring within the incidents were identified and grouped together. The motive or result of each behaviour was examined and this was also taken into consideration. Groups of like behaviours were labelled. The smallest units identified were the actual phrases used by patients in their description of the incident. These were referred to as "units". Like units were then grouped into themes, and larger categories. As more incidents were added, new units were identified and categories and themes redefined.

Once this process was complete, a content analysis was done of relevant S.A.N.C. documentation. This included the programme objectives for the Four Year Course leading to registration as a Nurse (General, Community and Psychiatry) and Midwife, the Guidelines and Philosophy of the S.A.N.C. and the Scope of Practice for Registered Nurses.

5.6.6. Validating the Research

The sample was initially divided into two, categorized separately, and then compared for similarities. Once the sample was combined and the final set of categories agreed upon, an expert committee was used to validate the categorization.

The committee of experts consisted of four experienced registered nurses who represented each of the disciplines included in the sample, i.e. General nursing, psychiatric nursing and midwifery.

The expert committee examined each of the incidents and decided whether or not they had been correctly classified. Decisions were made by consensus. The majority of the classifications made by the researcher were left unchanged, but some were changed by the committee.

The final process of validation was to develop a rationale for the categories, and to define the categories. (Wilson 1989:476) This process was done by examining the literature for similarities. Three types of literature were used for this process.

Firstly, previous studies were examined to compare the classification systems used by other authors. For this purpose, the following studies were consulted : Nightingale F in Fitzpatrick J J and Wh[illegible] A L, 1989 ; Abdellah F G, Beland I L and Martin A, 19[illegible] ; Gorham W A, 1962 ; Kotze W J, 1979 ; Ray in Leiniger M M, 1988 ; Cottrell B H, Cox B H, and Kelsey S J, 1986 ; SANC Scope of Practice, 1987 ; and Benner P, 1984.

Secondly, sixteen case studies were reviewed to search for categories of care included in the study. (for details of these studies, see annexure 6.)

Thirdly, the current nursi[illegible]terature was examined to search for other authors' [illegible]anations and definitions of each of the themes and categories developed in the study.

5.7. RESULTS

When reviewing the research findings, it is important to bear in mind that the categories were formed from incidents that the patients considered indicative of competence in a nurse. The findings by no means constitute a complete categorization of all skills, qualities and knowledge needed by the professional nurse to render satisfactory care. The study will have to be extended considerably and be designed to include other institutions, many more patients and nurses themselves if it is to be used as a complete profile.

Five categories were ultimately formed, viz:

- Assisting with patient needs
- Demonstrating knowledge
- Interpersonal abilities
- Personal Attributes
- Nurturance

5.7.1. Assisting with Patient Needs

In this category, the aspect important to the patient was that the nurse could meet, rather than identify, a need. The need was either pointed out to the nurse by the patient, or it was very obvious, even to a lay person. The care referred to in this category was usually functional in nature.

One group of needs identified were **physical needs**, and included hygiene and elimination, exercise and mobility needs. The term "physical" need was taken to mean those needs pertaining to bodily functions rather than social or mental functions.

Another group identified was **social needs** where the word "social" was taken to mean "pertaining to life in an organized community." (Davidson 1985:946) Included in social needs were, the need to be recognized as an individual and the need for acceptance.

Comfort needs were also identified by the patients. Here, the term "comfort" was referred to in its broadest sense, that is, that it not only includes the absence of pain, but also, " a subject of satisfaction, freedom from annoyance; whatever gives ease." (Davidson 1985:192) Within this subcategory, the ability of the nurse to eliminate pain, to provide general comfort and psychological comfort, were all considered important. An example of providing psychological comfort was saving the patient from embarrassment.

The final group of needs identified were **safety needs**. Here again, the term "safety" was viewed in its broadest sense and taken to mean, "freedom from danger; security, certainty." (Davidson, 1985:874) Both a need for physical safety and for emotional security were identified. Actions making the patient feel emotionally secure included coming to check on the patient, giving explanations, and carrying out procedures efficiently.

None of the examples cited by patients to explain ways in wh ch nurses cared for their physical needs was complicated or unusually time consuming, and yet they were obviously important. Many of the incidents involved very basic care that could have been provided by a caring, untrained, or semi-trained person.

5.7.2. Demonstrating Knowledge

The category named "Demonstrating Knowledge" was formed from incidents which indicated that the nurse in question possessed some knowledge not possessed or utilized by all people. She was thus able to use this knowledge to the benefit of the patient.

There were two different types of knowledge mentioned, viz. theoretical knowledge and skills. With regard to the former, patients appreciated nurses being able to give them correct information and also that the nurses knew the correct action to take.

The skills that were considered important were observational skills and psychomotor skills. The term "skill" was used to indicate some type of action or reaction to a situation rather than the exposition of abstract principles emphasized in the theoretical knowledge subcategory.

5.7.3. Interpersonal Abilities

Within this category, examples of both verbal and non-verbal communication were given by patients.

With regard to verbal communication, it seems significant that all the incidents cited referred to the sending of messages on the part of the nurse and none referred to listening. There are two possible explanations for this, viz. either that the patients did not observe any listening behaviours, or that they did not consider them important. The latter possibility would seem to be unlikely, but the matter warrants further research.

Non-verbal communication included touch and facial expression. Even though this was identified as a subcategory, few incidents were recorded, possibly due to the cultural diversity of the patients and staff. It would certainly seem that holding a patient's hand, although valued by patients, is a rare phenomenon.

By contrast, smiling was commonly identified as an important behaviour, and was the only aspect of facial expression identified.

5.7.4. Personal Attributes

This category concentrated on what the nurse is rather than what she does. Inherent characteristics of the nurse and personality traits were included in this category. Within this category, five themes were identified, viz. pleasant

disposition, patience, dependability, gentleness and kindness, consideration and understanding. These aspects were identified due to the patient using these, or similar words to explain why they thought a particular nurse was a "good" nurse. The only outward, or physical manifestation of these characteristics was smiling, which has already been identified in the communication category, but was taken to be an outward indication of a pleasant disposition.

5.7.5. Nurturance

The final category to be developed was that of "Nurturance". This word was used by Leiniger (1970) to mean "a feeling of compassion, interest, and concern for people. Greenberg-Edelstein (Geissler 1990) developed the concept further to include aiding, comforting, confiding, nursing, exchanging, fondling, establishing solidarity and promoting development and growth. This latter definition is closer to the one developed to describe this category for the purposes of this study, where it is defined as showing concern for patients as individuals. The incidents in this category all included personalized care, based on individual needs, and involved doing things for patients that would not normally be expected of the average nurse.

5.8. COMPARISON OF FINDINGS WITH THE LITERATURE

The comparison of the findings with the literature was done in three ways. Firstly, the classifications systems used by other selected authors were reviewed. Secondly, a content analysis was done on selected case studies, and lastly, the themes and categories developed for this study were compared with selected nursing literature, including the Scope of Practice for Registered Nurses developed by the South African Nursing Council.

The classification systems reviewed revealed that most authors include "meeting needs" as part of the nurse's role, but did not often refer to social needs directly. Demonstrating knowledge, including the skills component, were usually demonstrated in one way or another. There were, however, virtually no references to personal attributes of the nurse. This could be because most of the information was collected from nursing models which would not have included this aspect, not being part of care in itself. The term "nurturance' was difficult to find in the literature, due to the fact that it has only recently been coined. Aspects included in this category, viz. availability, attentiveness and advocacy were, however, mentioned.

It was interesting to note that nursing care studies are almost entirely a British phenomenon. Very few were found in South African and American literature, although the modern American literature often refers to mini studies, or incidents which have become known as "vignettes."

There were many similarities between the incidents related by patients which were used in the research study, and the aspects of care referred to in the care studies reviewed. Physical needs received a great deal of attention in the care studies, and, so, to a lesser extent, did social needs and comfort needs. Psychological needs were not mentioned, but the need for emotional security was identified. In the knowledge category, theoretical knowledge and observational skills received attention, but little mention was made of psycho-motor skills. Interpersonal aspects were very important, mentioning far more aspects within this category than the patients in the study had done. Personal attributes were not often mentioned, but, as the care studies were mostly written by the care givers themselves, this was not surprising. Although the word "nurturance" did not appear in the studies, the themes identified under this category were mentioned.

No single author reviewed in the final section of the comparison described all the categories identified in the research study, but all the categories were described by at least one author. The Needs category, the Knowledge category and the Interpersonal Skills category were all well supported. Although the themes availability, attentiveness and advocacy were well supported in the literature, few referred to the actual category name of Nurturance. Personal Attributes were seldom mentioned, probably due to the type of literature reviewed.

5.9. RECOMMENDATIONS

5.9.1. Recommendations for Research

In order for the study to be used for its original purpose, the study needs to be extended. It should be extended to include patients in the community, as well as patients in other hospitals, and patients of all cultural groups. In order to develop a profile of a "good" or "competent" nurse, it would be of assistance to ask patients to give many incidents rather than accepting only one from most of the patients. Another method of solving the problem would be to give them the list of categories and ask for examples of incidents they may have observed in each of the categories as well as allowing them to cite incidents which do not fall within the existing set of categories. This latter method may

serve as a memory tool, without biasing the research. Patients should also be given the opportunity to mention aspects of care that they believe should occur, rather than restricting them to incidents witnessed. This would solve the problem of important aspects of care which are not occurring in the hospital from being omitted from the final classification and profile. It may also be important to interview nurses to complete the profile.

The original study was conducted in such a way that incidents were collected until the categories were saturated. It is important, however, to extend the study so that incidents are collected until no new themes and units are being formed as it is the themes and units that would form the basis of an evaluation instrument to test the competence of nurses.

The patients were often reluctant, during interview, to speak freely due to the fact that interviews were held within earshot of others. There was, unfortunately, no alternative venue available. Some were also reluctant to participate for fear of victimization in the wards. For these reasons, it would seem better, although difficult to arrange, to interview patients once they are discharged, in the privacy of their own homes, or in a neutral venue.

In order to prevent patients putting their own interpretations on incidents that happened to other patients in their wards, it would be important in a future study to restrict incidents to those occurring directly to the patient relating the incident. Longer interviews would also assist to establish the benefit of each of the incidents to the patient. This would assist in the categorization process.

A problem exists for all researchers attempting to use a content analysis technique in that there is no standardization of terminology used in this methodology. What researchers refer to as "categories" does not always mean the same thing. Some mean it to refer to the largest grouping of information, whilst others use the word to describe small groupings. It is therefore imperative that these terms are defined in each study making use of content analysis.

Further research should be done on the personal attributes of the "good" nurse. It is important to establish whether a person can learn all the attributes required of a "good" nurse, or whether they need to possess them on entering the training programme. This information is of crucial importance to the profession of nursing as the information should be made available to those selecting prospective nurses for training.

The whole realm of "nurturance" needs to be developed, and further research directed specifically at this aspect is warranted. An aspect that was not included in the categorization system was the spiritual needs of patients. This aspect also warrants further research to determine why this aspect was not identified often enough to be included in the categorization system.

5.9.2. Recommendations for Nursing Practice

It should be born in mind that the research took place in one institution only. It is therefore possible that the following recommendations may apply only to this particular institution.

Communication within the institution is a problem which needs to be addressed. Although English is the official language of the hospital, many different languages are spoken. Even the most basic communication is missing from some of the wards such as an early morning greeting. Patients feel ignored as a result and cannot approach the nursing staff to discuss their problems. It is therefore important to reinforce the policy that English be spoken. For this purpose, it may be necessary to write it into the service conditions and working contract of each new employee. Another positive move may be to offer English courses as it is possible that the nurses are not sufficiently au fait with English to use it comfortably. It is unfortunate, but apparent, that this latter problem is not the only reason for poor communication, but rather, that it is a matter of cultural arrogance. Patients are forced into a position of servility if they cannot communicate adequately with their care-givers.

Another aspect of the problem of poor communication, is that the patients, as a rule, do not stay long enough for the nurses to build up a meaningful relationship with them. As a result, nurses seem to have lost this art and even in the cases where patients do stay for a significant time, no attempt is made to get to know them as individuals.

It would seem that this type of contact was lost when nurses stopped doing what was known as the "beds and backs" round. An essential element of this practice was that the nurse spent time at the patient's bedside, even if only to straighten the locker or tidy the sheets. During this time superficial conversation occurred which often led to more meaningful exchanges in the longer term. Several patients commented that they did not feel secure because nurses did

not check on their welfare often enough, if at all, so that they did not know whether they were receiving adequate treatment or not. The bedbath, which used to be the time-honoured way of getting to know one's patient has also disappeared as the "art form" it was. When the patients are given a bed bath, it is often superficial, and more often than not carried out in a hurry by one of the most junior members of staff.

Insufficient time is spent listening to patients, probably due to the same problems outlined above.

There would also appear to be a deficit in basic care being given at the hospital. More time needs to be spent on providing for the basic needs of the patient, and particularly the comfort needs of the patient, which seem to be forgotten in a "high tech." hospital. This is an important aspect for charge-sisters to address, but it also has implications for training which will be discussed in the following section. With specific regard to the comfort needs of the patients, it would seem essential that every time a medication round is made, the patient should at least be asked if he is in need of analgesia. Patients are not assessed regularly, which leads to this neglect. For this reason, although it may sound heretical in nursing circles today, it may be better to reintroduce functional care so that one nurse has the responsibility for the patients' medication and it would be less likely to be overlooked.

Perhaps the most worrying aspect of all is that patients expressed fear of victimization should they speak to the researcher about the care they were receiving. It leads one to wonder what incidents had led to this fear, and should be thoroughly investigated by the hospital authorities.

In order to solve the above problems with regard to nursing practice, workshops need to be held at the hospital to enable staff to look at the human side of nursing which appears to have all but disappeared. Part of these workshops should allow for the development of a strategy whereby the nurses themselves can be cared for, and feel that they are valued when they do give quality care. The reason for this suggestion is that it would appear that many of the nurses have had insufficient care or nurturing themselves during their lives, and therefore find it impossible to give to others. It also leads to the question, if the human side of nursing has disappeared, with what have we replaced it ?

5.9.3. Recommendations for Nursing Education

Much more attention needs to be given to teaching student nurses the fundamentals of nursing. This would ensure they become more aware of the need for basic nursing care. Aspects that have previously been taken for granted, such as the importance of greeting a person when meeting them for the first time that day, need to be taught. Although the South African Nursing Council curriculum for the Four Year course states that a course should be offered on the fundamentals of nursing, this aspect is often integrated into Nursing Science. This has possibly led to the fundamentals being side-lined and students do not see them as being as important as they should be.

Another way of solving the poor provision of basic care in hospitals would be to educate the patient as to what he can rightly expect, and, if the problem of intimidation can be resolved, to demand his rights. This matter will have to be addressed through the media and other means of public education.

Students need to be assisted to understand themselves, the factors that influence their behaviour and their motivations and personal characteristics, so that they can begin to understand and help others.

Students also need to be taught at least basic communication in the dominant "black" language of the area, and be given the opportunity to improve their spoken English during their training course. More emphasis on non-verbal skills needs to be given during the basic and post basic training courses.

A more streamlined, effective system of nursing care plans needs to be developed to emphasise the importance of basic care and ensure that such care is given. The present system prescribed in training hospitals is cumbersome and therefore ignored.

Far more emphasis needs to be given to the teaching and evaluation of affective skills in a multi-cultural society, as it would seem that patients value these more than cognitive or psychomotor skills.

5.10. CONCLUSION

With regard to answering the research questions, this study has achieved a measure of success, but has generated even further questions that need to be addressed before the problem can be solved, i.e. to draw up an evaluation instrument to measure the nurse's competence.

It would seem clear that a set of criteria can be developed from the perceptions that patients have of what constitutes nursing competence, but further research still needs to be done before such a set of criteria would be sufficiently comprehensive.

With regard to the second research question, "do patients and the SANC use common criteria when evaluating nursing competence", it was difficult to answer this directly. This was due to the fact that the S.A.N.C. documentation is very difficult to analyse as few behaviours, as such, are mentioned.

The programme objectives of the S.A.N.C. could not be analysed by means of the type of content analysis done on the patient interviews. The Scope of Practice did, however, offer some direction. It would appear that Abdellah's model (1960) forms the basis for the Scope of Practice, and as such, patient needs are of paramount importance. This aspect, therefore coincided largely with the first category identified in the research study, although large discrepancies occurred between the study and the Scope of Practice with regard to the other categories.

The research study was limited, and, as explained in the recommendations, needs to be enlarged before being used for its original purpose. A major difficulty is that "competence" and "caring" are abstract concepts. The qualitative methodology employed does, however, greatly assist in overcoming the problem of researching abstract concepts.

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ANNEXURE 1

ABBREVIATIONS

OSCE	Objective Structured Clinical Evaluation
SANC	South African Nursing Council
CIT	Critical Incident Technique

DEFINITIONS

BEHAVIOUR	Anything the nurse does that can be observed and reported upon
CATEGORY	The highest class under which themes and units are systematically arranged
COMPETENCE	The quality or state of having sufficient knowledge, judgement, skill or strength
CONTENT ANALYSIS	A way of categorizing verbal and behavioural data based on the researcher's analytical thinking and creativity
CRITICAL INCIDENT	An observable and integral episode of human behaviour, which has a discernable impact on some outcome.
PATIENT	An in-patient at the hospital where the study was carried out
QUALITATIVE RESEARCH	A style of research which is used to interpret the meanings, intentions and qualities of human behaviour
RECORDING UNIT	The smallest entity or item identified within the theme or category
THEME	A collection of ideas that possess a common characteristic

ANNEXURE 3

INFORMATION SHEET - RESEARCH ON "PERCEPTIONS OF NURSING COMPE_ _CE"

I am currently conducting research to determine how you, the patient, evaluate who is a "good" and "competent" nurse.

In order to do this, you will be asked, by the researcher, to recall a specific incident that you observed or were part of, that, in your opinion, illustrated a competent and caring behaviour by the nurse concerned.

Participation in this research is voluntary - you are under no obligation to assist in the research. Your treatment in the hospital will not be influenced in any way by your decision whether to cooperate or not. You may, at any stage during the interview, terminate the interview if you so wish.

The interview is expected to take 3 - 5 minutes and will be audio taped.

Please sign below if you agree to participate in this research, subject to the above conditions.

Patient's signature : .....

Thank you

Miss S J Armstrong

Annexure 4

SUMMARY OF COMPARISON OF SCOPE OF PRACTICE OF PERSONS WHO ARE REGISTERED OR ENROLLED UNDER THE NURSING ACT, 1978 (R1469) AND THE CLASSIFICATION SYSTEM DEVELOPED FOR THE RESEARCH STUDY

BEHAVIOUR	SOURCE	CATEGORY	THEME
Diagnosing	a	Knowledge	Observation
Administration of medicine	c	Knowledge	Psychomotor
Monitoring vital signs	c	Not included	
Monitoring reaction to disease etc	c	Knowledge	Observation
Teaching	d	Knowledge	Theoretical
Counselling	d	Not included	
Maintenance of hygiene	e	Meeting needs	Hygiene
Physical comfort	e	Meeting needs	Comfort
Reassurance	e	Meeting needs	Psychological
Promotion of exercise	f	Meeting needs	Mobility & exercise
Promotion of rest	f	Not included	
Promotion of sleep	f	Not included	
Oxygen supply	h	Not included	
Fluid balance	i	Not included	
Protection of skin/healing	j	Meeting needs	Comfort Hygiene Mobility
Nutrition	l	Not included	

BEHAVIOUR	SOURCE	CATEGORY	THEME
Elimination	m	Meeting needs	Elimination & hygiene
Communication	n	Interpersonal skills	Verbal & non-verbal
Therapeutic acts	q	Knowledge	Psychomotor
Coordination regimes	r	Not included	
Advocacy	s	Nurturance	Advocacy
Care of dying	t	Not included	

CLASSIFICATION OF CATEGORIES

1. ASSISTING WITH NEEDS

   1.1 Physical Needs

      1.1.1 Hygiene and elimination
      1.1.2 Exercise and mobility

   1.2 Safety Needs

      1.2.1 Physical
      1.2.2 Emotional security

   1.3 Comfort Needs

      1.3.1 Elimination of pain
      1.3.2 General
      1.3.3 Psychological

   1.4 Social Needs

      1.4.1 Acceptance
      1.4.2 Recognition as an individual

2. DEMONSTRATING KNOWLEDGE

   2.1 Theoretical knowledge

   2.2 Skills

      2.2.1 Psychomotor
      2.2.2 Observation

3. INTERPERSONAL ABILITIES

   3.1 Verbal Communication

   3.2 Non Verbal Communication

      3.2.1 Facial Expression
      3.2.2 Touch

4. PERSONAL ATTRIBUTES

   4.1 Patient
   4.2 Pleasant Disposition
   4.3 Dependability
   4.4 Kind, considerate and understanding
   4.5 Gentleness

5. NURTURANCE

5.1 Availability

5.1.1 Solicited
5.1.2 Unsclicited

5.2 Advocacy

5.3 Attentiveness

CLASSIFICATION OF THEMES

ASSISTING WITH NEEDS

SUBCATEGORY	THEMES	INCIDENT NUMBERS
Physical needs (Hygiene, & elimination)	Helped patient wash	3, 11, 83, 88
	Combed patient's hair	20
	Washed patient after elimination	22, 23, 45, 49
	Gave tablets to stop diarrhoea	75
	Washed patient's hair	79
Physical needs (Exercise & mobility)	Helped patient walk	11,81
	Helped/persuaded patient to sit up	46, 69
Safety needs (physical)	Stayed with patient	3
Safety needs (emotional security)	Explanation made patient feel secure	1, 65, 78, 84
	Contact with patient made him feel secure	7, 10, 16, 26, 67, 80, 82
	Capable actions made patient feel secure	14, 44
Comfort needs (Elimination of pain)	Assisted patient to take analgesia	51
	Asked patient if needed analgesia	2
	Conducted procedure causing minimal pain	6, 27, 43, 50, 90
	Gave analgesia promptly when asked	13, 77
	Asked doctor to prescribe analgesia	17, 70
	Assessed reason for pain and took appropriate action to eliminate it.	36, 37, 39, 86

SUBCATEGORY	THEMES	INCIDENT NUMBERS
Comfort needs (General)	Gave hot drink	9
	Warmed bedpan	25
	Tuned radio perfectly	66
	Washed hair to prevent imitation	79
	Rubbed patient's back	36, 87
	Put ointment on dry lips	88
	Arranged pillows	36
Comfort needs (Psychological)	Washed patient the way she preferred	11
	Attitude during unpleasant procedure saved embarrassment	23, 49, 70, 72
Social Needs (Acceptance)	Made patient feel part of ward group	15, 28, 38, 69 70
	Accepted patient despite being different/unpleasant	20, 32, 33, 40, 49, 80
Social Needs (Recognition as an individual)	Recognized individual need	20, 22, 42, 47
	Made patient feel special	41, 78, 79, 80
	Acknowledged patient's input	74

DEMONSTRATING KNOWLEDGE

SUBCATEGORY	THEMES	INCIDENT NUMBERS
Theoretical Knowledge	Knew correct action to take	2, 16, 37, 64, 75, 76, 89
	Able to give patient information	32, 42, 84
Skills (Psychomotor)	Dressing done efficiently	4, 48, 68, 90
	Painful procedure done with minimal pain	4, 12, 27, 43, 50
	Bedpan given efficiently	25
	Difficult task done well	30, 71, 74, 81, 86
	Displays general dexterity	31
	Assisted patient to take analgesia	51
Skills (observation)	Notices if patient in need	6, 21, 38, 39, 46
	Assesses the situation	40, 44

INTERPERSONAL ABILITIES

SUBCATEGORY	THEMES	INCIDENT NUMBERS
Verbal Communication	Explained to patient	1, 84
	Managed despite communication problem	5, 32
	Reassured patient	6, 7, 65, 78
	Greeted patient	8, 15, 71
	Talked to patient	10, 18, 69
	Enquired after patient's health	29, 33, 80
Non Verbal Communication (Facial expression)	Smiled	4, 8, 24, 49, 62, 72, 87
	Pleasant expression	34
Non Verbal Communication (Touch)	Stroked/patted patient	6, 10
	Held patient's hand	7, 78
	Hugged patient	16, 69, 80

PERSONAL ATTRIBUTES

SUBCATEGORY	THEMES	INCIDENT NUMBERS
Patient	Did not rush - took time	1, 25, 31
	Dealt with difficult patient/situation with patience	5, 40, 86
	Nurse was patient	10, 23
Pleasant disposition	Enjoys what she is doing	4, 23
	Seemed happy to see patient	8
	Friendly	24
	Displays sense of humour	28, 44
	Always in a good mood	34, 70
Dependability	Consistent	35, 82
	Come to work despite being ill	62
	Does work others shirk	73
Kind, Considerate and understanding	Kind & considerate	37, 67, 84, 89
	Concerned & helpful	66
	Understanding	83
Gentleness	Gentle	50, 68, 90

NURTURANCE

SUBCATEGORY	THEMES	INCIDENT NUMBERS
Availability (Solicited)	Come straight away when called	13, 18, 46, 52 72, 73
	Made time to do what patient asked	70
Availability (Unsolicited)	Stayed with the patient	1, 3, 7, 16, 19, 26, 61, 78, 84
	Accompanied patient	11
	Come to check on patient	33, 67
	Come to help patient	45
Advocacy	Interpreted doctors explanation	1
	Asked doctor for treatment for patient	17, 89
	Called doctor when patient needed him	74, 76
Attentiveness	Showed special concern	1, 2, 3, 10, 20, 77, 82, 84, 88
	Went out of her way for patient	9, 17, 29, 37, 41, 47, 61, 75, 85
	Spent time with patient	11

ANNEXURE 7

INCIDENTS

NUMBER : 1 WARD : OBS SEX : F AGE : 28 LANG : A

ILLNESS : Addisons Disease. Pregnant

INCIDENT : The patient in that bed has something wrong with her baby. The doctor came to explain that the baby was not normal and that she would have to have a caesar to get it out. The nurse stayed with her after the doctor had gone and explained over and over again what was wrong with the baby and that the caesar would not save the baby's life but that it was necessary to get it out. She carried on explaining and explaining until she was satisfied that the patient understood. She gave attention to that patient. I could see when she finished that the patient wasn't so upset anymore.

ACTIONS/BEHAVIOURS : Gave information

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Took a lot of time and effort to explain.

THEME :
1. Explanation made patient feel safe
2. Explained to patient
3. Did not rush - took time
4. Stayed with the patient
5. Went out of her way
6. Interpreted doctor's explanation

CATEGORY:
1. Assisting with needs
2. Interpersonal abilities
3. Personal attributes
4. Nurturance
5. Nurturance
6. Nurturance

SUBCAT :
1. Safety needs (emotiona
2. Verbal communication
3. Patient
4. Availability (unsolicited)
5. Showed special concern
6. Advocacy

NUMBER : 2 WARD : OBS SEX : F AGE : 28 LANG : A

ILLNESS : Confinement. Prem baby

INCIDENT : I am always careful not to be a demanding patient, but I appreciated it when on the third day after my caesar, the nurse came into my room - she knows that the third day is bad with the winds and pain and everything - and she asked "are you comfortable, do you need something for pain?" I know you should ask if you need something, but when someone asks me - that means a lot to me.

ACTIONS/BEHAVIOURS : Came into room. Asked after patient.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Patient hates to ask for anything so didn't have to when nurse anticipated problem.

THEME : 1. Asked patient if needed analgesia
2. Know correct action to take
3. Showed special concern

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge
3. Nurturance

SUBCAT : 1. Comfort needs
2. Theoretical knowledge
3. Attentiveness

NUMBER : 3 WARD : GYNAE SEX : F AGE : 18 LANG : A

ILLNESS : Septic Abortion

INCIDENT : I decided to go for a shower and I was very weak. The nurse walked me all the way to the shower and she sat in the shower cubicle with me to see that I was OK. She helped me to wash and everything.

ACTIONS/BEHAVIOURS : Accompanied patient to the shower. Stayed with her. Helped her wash.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse made sure that patient was safe.

THEME : 1. Helped patient wash
2. Stayed with patient
3. Stayed with patient
4. Showed special concern

CATEGORY: 1. Assisting with needs
2. Assisting with needs
3. Nurturance
4. Nurturance

SUBCAT : 1. Physical needs (hygiene)
2. Safety needs (physical)
3. Availability (unsolicited)
4. Attentiveness

NUMBER : 4 WARD : GYNAE SEX : F AGE : 37 LANG : E

ILLNESS : Hysterectomy

INCIDENT : This nurse, she had to do my dressing. She was so efficient and professional. She came and set out everything so nicely and precisely ... she took out ... what do you call those things ... sterile bowls and the cotton wool ... she seemed to really enjoy what she was doing...always smiling and everything. She did my dressing in such a methodical way. I just know that she likes being a nurse ... She likes everything she does ... She is like that every day. She has such a pleasant manner with everyone.

ACTIONS/BEHAVIOURS : Did dressings methodically. Smiled

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : The nurse is happy with her job.

THEME : 1. Dressing done efficiently
2. Smiled
3. Enjoys what she is doing

CATEGORY: 1. Demonstrating knowledge
2. Interpersonal abilities
3. Personal attributes

SUBCAT : 1. Skills (Psychomotor)
2. Non verbal communication
3. Pleasant disposition

NUMBER : 5 WARD : SURG SEX : M AGE : 28 LANG : E

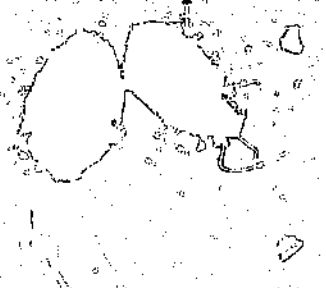
ILLNESS : Obstructed bowel

INCIDENT : That old man in the corner ... he is Italian ... he was a bit mixed up yesterday and the nurses had to restrain him ... but the way they talked to him ... they soothed him ... you know ... they kept saying "sorry, we have to do this." They were very nice to him and talked to him although they couldn't speak his language.

ACTIONS/BEHAVIOURS : Talked to the patient

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Patient made to feel calm as result of nurses' actions.

THEME : 1. Managed despite communication problem
2. Dealt with a difficult patient with patience



CATEGORY: 1. Interpersonal abilities
2. Personal attributes

SUBCAT : 1. Verbal communication
2. Patient

NUMBER : 6 WARD : SURG SEX : F AGE : 50 LANG : PEDI

ILLNESS : Thyroidectomy

INCIDENT : When the nurse came to do my dressing ... you know it is sore and I am nervous ... she says "don't worry, I won't hurt you and she touches me smoothly and gently. She watches my face and she can see when there is a change in my face that it is sore ... and she feels guilty ... and she says sorry and starts to pat you ... like this ... and then when she sees she has cooled you down, she says "is it sore here?" and then she says "don't worry, I have to press here .. there is a certain thing that I have to take out, but there, it is finished now ... now you can cool down ... it's all over." She doesn't just say "I am doing my job, ... I have to do this otherwise I am leaving you ... you can just go rotten." This one, she talks to you nicely ... she does things gently, gently like a baby.

ACTIONS/BEHAVIOURS : Talked to patient. Took out drain.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse was gentle and tried not to cause pain.

THEME : 1. Conducted procedure causing minimal pain
2. Painful procedure done with little pain
3. Notices if patient in need
4. Reassured patient
5. Stroked (patted) patient

CATEGORY: 1. Assisting needs
2. Demonstrating knowledge
3. Demonstrating knowledge
4. Interpersonal abilities
5. Interpersonal abilities

SUBCAT : 1. Comfort needs (elimination pain)
2. Psychomotor skills
3. Observation skills
4. Verbal communication
5. Non verbal (touch)

NUMBER : 7 WARD : SURG SEX : F AGE : 22 LANG : E

ILLNESS : Abdominal mass. Chrone's disease.

INCIDENT : I went down to radiology and they stuck a long needle in .. they were trying to drain an abscess .. and this nurse .. it wasn't very sore .. but I was being a real coward about the whole thing .. and I was lying there with my head turned the other way .. and this nurse came around the back of my head and said "don't worry, you're doing OK" That to me is super. Just to take a bit of time to she people you care. She took my hand and said "don't worry you're doing fine". She was a good nurse. You know they are all pretty well trained, they can do dressings and put up drips and give injections and the whole lot, but if they take time ...

ACTIONS/BEHAVIOURS : Held patient's hand. Spoke to her.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Nurse cared enough to spend time with her.

THEME : 1. Contact with patient made him feel safe
2. Reassured patient
3. Held patient's hand
4. Stayed with patient

CATEGORY: 1. Assisting needs
2. Interpersonal abilities
3. Interpersonal abilities
4. Nurturance

SUBCAT : 1. Safety needs (emotional)
2. Verbal communication
3. Non verbal (touch)
4. Availability (unsolicited)

NUMBER : 8 WARD : SURG SEX : F AGE : 67 LANG : GERMAN

ILLNESS : Surgery on liver

INCIDENT : This nurse has a smiling face. She comes in the morning and greets you and seems happy to see you. It is not what she says, it is because she smiles.

ACTIONS/BEHAVIOURS : Smiled. Greeted the patient.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Smiling indicates that she values the patient.

THEME : 1. Greeted patient
2. Smiled
3. Seems happy to see patient

CATEGORY: 1. Interpersonal abilities
2. Interpersonal abilities
3. Personal attributes

SUBCAT : 1. Verbal communication
2. Non verbal (facial expression)
3. Pleasant disposition

NUMBER : 9 WARD : SURG SEX : F AGE : 76 LANG : E

ILLNESS : Stricture oesophagus

INCIDENT : I went to have one of those pipes put down my throat. When I came back, I asked the nurse to give me a hot cup of tea. She went straight away and made me a cup of tea. It wasn't tea time ... she did it specially. I helped me.

ACTIONS/BEHAVIOURS : Made patient a cup of tea.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Patient felt valued as nurse did it specially.

THEME : 1. Gave hot drink after unpleasant procedure
2. Went out of her way for patient.

CATEGORY: 1. Assisting with needs
2. Nurturance

SUBCAT : 1. Comfort (general)
2. Attentiveness

NUMBER : 10 WARD : GYNAE SEX : F AGE : 32 LANG : A

ILLNESS : Caesar. Prem baby

INCIDENT : When my baby was first admitted to the prem unit it was a traumatic experience as you think that it is just for prem babies and babies that are going to die - that's what you see on TV. When I first went into the unit the Sister who was looking after my baby was standing at her incubator just stroking her head - you know - it was unnecessary, but is was such a loving gesture. I thought "wonderful, at least someone is going to be loving towards her. She is not going to miss me so much." It's a small thing but is meant so much. She has nicknames for the baby like "pumpkin" and "sausage". She is so patient - she is wonderful with my baby ... honestly ...

ACTIONS/BEHAVIOURS : Stroked baby's head. Called it nicknames. Stood at incubator.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse would love baby in mother's absence.

THEME : 1. Contact with patient made him feel safe
2. Talked to patient
3. Stroked patient
4. Nurse was patient
5. Showed special concern

CATEGORY: 1. Assisting with needs
2. Interpersonal abilities
3. Interpersonal abilities
4. Personal attributes
5. Nurturance

SUBCAT : 1. Safety needs (emotional security)
2. Verbal communication
3. Non verbal communication (touch)
4. Patience
5. Attentive

NUMBER : 11 WARD : SURG SEX : F AGE : 42 LANG :

ILLNESS : Hernia

INCIDENT : I hate being washed-I really need a bath. She took me into the bathroom and stood with me while I stood in the bath and she washed me there. I find it very important... it was very caring...she took the time.

ACTIONS/BEHAVIOURS : Washed the patient.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Went out of way to cater for individual need.

THEME :
1. Helped patient wash
2. Helped patient to walk
3. Washed patient in the way she preferred
4. Accompanied the patient
5. Spent time with the patient

CATEGORY:
1. Assisting needs
2. Assisting needs
3. Assisting needs
4. Nurturance
5. Nurturance

SUBCAT :
1. Hygiene and elimination
2. Exercise and mobility
3. Comfort (psychological)
4. Availability (unsolicited)
5. Attentiveness

NUMBER : 12 WARD : SURG SEX : F AGE : 43 LANG : URDU

ILLNESS : Diabetic. Gallstones

INCIDENT : This nurse - she treated me well, and when she pricked my finger for my sugar diabetes, she was kind - she didn't hurt me. She didn't do jumping and make you frightened. She has to the art of doing it - when she does it doesn't hurt so much.

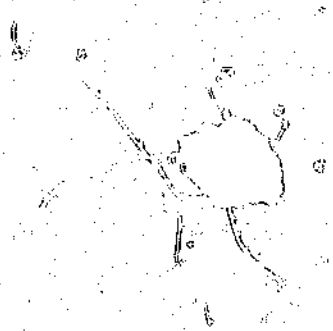
ACTIONS/BEHAVIOURS : Did dextrostix

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Did it without hurting.

THEME : 1. Conducted procedure causing minimal pain
2. Painful procedure done with little pain

CATEGORY: 1. Assisting needs
2. Demonstrating knowledge

SUBCAT : 1. Comfort (elimination of pain)
2. Skills (psychomotor)



NUMBER :13 WARD : SURG SEX : F AGE : 49 LANG : E

ILLNESS : Abdominal surgery

INCIDENT : When I tell this sister that I am in pain, she comes straight away and gives me an injection. I ask her and then she brings it .. she doesn't wait.

ACTIONS/BEHAVIOURS : Brought analgesia

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Doesn't keep patient waiting for analgesia

THEME : 1. Gave analgesia promptly when asked
2. Came straight away when called.

CATEGORY: 1. Assisting needs
2. Nurturance

SUBCAT : 1. Comfort (elimination pain)
2. Availability (solicited)

NUMBER : 14 WARD : MED SEX F AGE : 54 LANG : E

ILLNESS : Emphysema

INCIDENT : This nurse dealt with an emergency situation without panicking. She knew what she was doing-I have confidence in that nurse.

ACTIONS/BEHAVIOURS :Dealt with emergency situation

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Patient felt comforted that nurse could deal with a frightening situation

THEME : 1. Capable actions made patient feel secure
2. Knew correct action to take

CATEGORY: 1. Assisting needs
2. Demonstrating knowledge

SUBCAT : 1. Safety needs (emotional secure)
2. Theoretical knowledge

NUMBER : 15 WARD : MED SEX : F AGE : 22 LANG : E

ILLNESS : Pneumonia

INCIDENT : My best nurse says, "good morning, how are you? "when I wake in the morning. It makes me feel like a person.

ACTIONS/BEHAVIOURS :Greeted patient

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse interested as patient as a person

THEME : 1. Greets the patient
2. Made patient feel part of group

CATEGORY: 1. Interpersonal abilities
2. Assisting needs

SUBCAT : 1. Verbal communication
2. Social needs (acceptance)

NUMBER : 16 WARD : MED SEX : F AGE : 71 LANG : E

ILLNESS : Cardiac

INCIDENT :I was upset one day - I was crying and this nurse came and put her arm around me - it was so helpful. I was down in the dumps and it made me feel much better.

ACTIONS/BEHAVIOURS : Put arm around patient.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse cared enough to cheer her up.

THEME : 1. Contact with patient made him feel secure
2. Hugged patient
3. Stayed with patient

CATEGORY : 1. Assisting needs
2. Interpersonal abilities
3. Nurturance

SUBCAT : 1. Safety needs (emotional security)
2. Non verbal (touch)
3. Availability (unsolicited)

NUMBER :17 WARD : MED SEX : M AGE : 27 LANG : A

ILLNESS : T.B. Collapsed lung

INCIDENT : I'll tell you about one incident. I asked this nurse for a pain pill and she just said "the doctor hasn't prescribed one for you" but this other one, the good one, she said it wasn't prescribed but she would go and ask the doctor - and she did. She came back with the pill. She mustn't just turn and walk away or say "oh well, same old story."

ACTIONS/BEHAVIOURS : Asked doctor for analgesia for patient

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse prepared to go out of her way for patient.

THEME : 1. Asked doctor to prescribe analgesia and gave it
2. Went out of way for patient
3. Asked doctor for treatment r patient

CATEGORY: 1. Assisting needs
2. Nurturance
3. Nurturance

SUBCAT : 1. Comfort (elimination of pain)
2. Attentiveness
3. Advocacy

NUMBER : 18 WARD : MED SEX : M AGE : 23 LANG : A

ILLNESS : Renal Failure

INCIDENT : This nurse, you don't have to shout and scream for her to give you something. You just say "nurse" and she comes immediately with it. She helps you. Every now and again she asks you "how are you?" "Do you need something?" That's what I like about her.

ACTIONS/BEHAVIOURS : Came when called. Asks patient if needs anything. Asks after patient.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Most nurses have to be called. This one cares enough to come quickly or without being called.

THEME : 1. Talked to the patient
2. Came to patient when called

CATEGORY: 1. Interpersonal abilities
2. Nurturance

SUBCAT : 1. Verbal communication
2. Availability (solicited)

NUMBER : 19 WARD : MED SEX : M AGE : 53 LANG : E

ILLNESS : D.V.T

INCIDENT : These two good little nurses - they are always there to do the heavy work. The others run away but these ones aren't shirkers - they stay and do the work - even the unpleasant tasks.

ACTIONS/BEHAVIOURS : Carried out unpleasant tasks

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Most other nurses shirk unpleasant duties.

THEME : 1. Stayed with patient

CATEGORY: 1. Nurturance

SUBCAT : 1. Availability (unsolicited)

NUMBER : 20 WARD : MED SEX : F AGE : 57 LANG : A

ILLNESS : Lung problem

INCIDENT : People seldom take notice of me. I think of myself as a poor white. Then all of a sudden, a black nurse came to me and saw that I am not so good dressed and she rubbed my back and combed my hair. I think that is very good of her. It made me feel good.

ACTIONS/BEHAVIOURS : Rubbed back. Combed hair.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Black nurse cared enough to make a poor white feel good.

THEME :
1. Combed patients hair
2. Recognised individual need
3. Accepted patient despite being different
4. Rubbed patient's back
5. Showed special concern

CATEGORY:
1. Assisting with needs
2. Assisting with needs
3. Assisting with needs
4. Assisting with needs
5. Nurturance

SUBCAT :
1. Physical needs (hygiene & elimination)
2. Social needs (recognition as individual)
3. Social needs (acceptance)
4. Comfort (general)
5. Attentiveness

NUMBER : 21 WARD : MED SEX : M AGE : 87 LANG : E

ILLNESS: Electrolyte imbalance

INCIDENT : This good nurse - if she can study the patient to the extent that she can give the patient service - that is a good nurse. She doesn't just walk past and take no notice. She notices everything that is happening to the patient and assists where necessary. She sees things that need doing and does them. The patient doesn't have to ask her - she sees it and does it.

ACTIONS/BEHAVIOURS : Observes patient. Takes appropriate action.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Notices when patient in need. Doesn't first have to ask.

THEME : 1. Notices if patient in need

CATEGORY : 1. Demonstrating knowledge

SUBCAT : 1. Skills (observational)

NUMBER : 22 WARD : MED SEX : M AGE : 52 LANG : A

ILLNESS : T.B.

INCIDENT : The old man is very hairy and he's got long hair everywhere - you know what I mean - no amount of toilet paper helps but she (the nurse) realised this and brought water to wash him - that's the only way to get properly clean.

ACTIONS/BEHAVIOURS : Washed patient after using bedpan.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse assessed situation and used initiative.

THEME : 1. Washed patient after elimination
2. Recognized individualized need

CATEGORY: 1. Assisting with needs
2. Assisting with needs

SUBCAT : 1. Physical needs (hygiene and elimination)
2. Social needs

NUMBER : 23 WARD : ORTHO SEX : F AGE : 83 LANG : E

ILLNESS : Hip replacement

INCIDENT : When she has to come and clean you up and that sort of thing, she doesn't do it with a grudge. She does it willingly. She isn't bad tempered. She says things that buck me up like "don't worry, you'll be getting better, take your time." She is patient.

ACTIONS/BEHAVIOURS : Talks to patient

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Does tasks with good grace.

THEME :
1. Washed patient after elimination
2. Attitude during unpleasant task saved patient embarrassment
3. Enjoys what she is doing
4. She is patient

CATEGORY:
1. Assisting with needs
2. Assisting with needs
3. Personal attributes
4. Personal attributes

SUBCAT :
1. Physical needs (hygiene & elimination)
2. Comfort needs (psychological)
3. Pleasant disposition
4. Patience

NUMBER : 24 WARD : MED SEX : F AGE : 47 LANG : a

ILLNESS : M.S

INCIDENT : There's one - she's such a nice little girl. She is always pleasant. She is friendly. She smiles all the time - when she is washing you or giving you food. It makes me feel less sick.

ACTIONS/BEHAVIOURS : Smiles while she works

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Friendly nurse makes her feel less sick.

THEME : 1. Smiled
2. Friendly

CATEGORY: 1. Interpersonal abilities
2. Personal attributes

SUBCAT : 1. Non verbal (facial expression)
2. Pleasant disposition

NUMBER : 25 WARD : ORTHO SEX : F AGE : 76 LANG : E

ILLNESS: Hip replacement

INCIDENT : When she gave me the bedpan she did it nicely. She made it warm and she lifted me - didn't just shove it in. She didn't rush me. She waited until I had finished.

ACTIONS/BEHAVIOURS : Warmed bedpan. Lifted patient onto it. Waited for her.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse took time to complete task well and preserve patient's comfort.

THEME : 1. Warmed bedpan
2. Bedpan given efficiently
3. Did not rush patient

CATEGORY: 1. Assisted with needs
2. Demonstrating knowledge
3. Personal attributes

SUBCAT : 1. Comfort (general)
2. Skills (psychomotor)
3. Patience

NUMBER : 26 WARD : [illegible]D SEX : M AGE : 42 LANG : E

ILLNESS : Lung problem

INCIDENT :I had a very bad attack-and this one staff nurse...she was constantly with me...I was comatose and she never left my bedside. She was incredible. She actually prayed for me...she was always there.

ACTIONS/BEHAVIOURS :Stayed with patient. Prayed for him.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :Nurse was there when he needed her

THEME : 1. Contact with patient made him feel safe
2. Stayed with patient
3. Prayed for patient

CATEGORY: 1. Assisting with needs
2. Nurturance
3. Assisting with needs

SUBCAT : 1. Safety needs (emotional)
2. Availability (unsolicited)
3. Advocacy

NUMBER : 27 WARD : MED SEX : F AGE : 55 LANG : A

ILLNESS : Arthritis

INCIDENT : When I was admitted, I was in a lot of pain...I have arthritis you know...and this one nurse lifted me onto the bed so gently...she didn't hurt me at all. I just said "thank you, thank you."

ACTIONS/BEHAVIOURS : Lifted patient into bed

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse was gentle so patient wasn't hurt.

THEME : 1. Conducted procedure causing minimal pain
2. Painful procedure done with little pain

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge

SUBCAT : 1. Comfort (elimination of pain)
2. Skills (psychomotor)

NUMBER : 28 WARD : MED SEX : M AGE : 67 LANG : A

ILLNESS : Paralysis

INCIDENT : When she comes in the morning and you feel depressed, she calls you by your name and says "how are you this morning ?" and makes a little joke which gets you up for the day.

ACTIONS/BEHAVIOURS : Greets patient. Makes a joke.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Attitude is cheering.

THEME : 1. Patient made tp feel part of group
2. Displays a sense of humour

CATEGORY: 1. Assisting with needs
2. Personal attributes

SUBCAT : 1. Social needs (acceptance)
2. Pleasant disposition

NUMBER : 29 WARD : OBSTET SEX : F AGE : 35 LANG : A

ILLNESS: Caesar

INCIDENT : In my present situation, it is closely linked with the baby. She is not in this ward anymore, but the nurse popped into my room and asked "how is the baby?" That is important to me. If someone is interested in my baby, it makes me feel good and I think I will get better sooner if I feel good.

ACTIONS/BEHAVIOURS : Enquired after baby.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse was interested enough to ask after baby.

THEME : 1. Enquired after patient's health
2. Went out of way for patient

CATEGORY: 1. Interpersonal skills
2. Nurturance

SUBCAT : 1. Verbal communication
2. Attentiveness

NUMBER : 30 WARD : MED SEX : M AGE : 47 LANG : E

ILLNESS : Myocardial Infarct

INCIDENT : She does things that seem to me to be in between being a nurse and a doctor. She fills that gap. This is a very complicated drip that goes all the way up my arm. From time to time she comes and takes it apart and puts it back together again. She knows exactly what to do ... she is familiar with the whole thing.

ACTIONS/BEHAVIOURS : Connected lines of the drip

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse has advanced knowledge and can deal with equipment. Makes patient feel aware.

THEME : 1. Difficult task done well

CATEGORY: 1. Demonstrating knowledge

SUBCAT : 1. Skills (psychomotor)

NUMBER : 31 WARD : MED SEX : M AGE : 30 LANG : E

ILLNESS: Cardiac

INCIDENT : There is a very willing nurse here who does things straight away and she isn't a butter fingers. She does things without hurrying and does them well.

ACTIONS/BEHAVIOURS : Responds immediately

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse able to perform well without hurrying and making people nervous.

THEME : 1. Displays general dexterity
2. Does not rush

CATEGORY: 1. Demonstrating knowledge
2. Personal attributes

SUBCAT : 1. Skills (psychomotor)
2. Patience

NUMBER : 32 WARD : MED SEX : F AGE : 72 LANG : GERMAN

ILLNESS : Cardiac. Internal haemorrhage

INCIDENT : When you ask her a question she gives you the right answer. She tells you what you want to know. I don't want to be in the dark. When I was admitted here last week, I was in a terrible state. For two days - excuse my expression - I was a bitch. My attitude was too terrible. After two days I apologised and she accepted it. She said "I know you were very sick." It is important that she speaks your own language and doesn't use hers as I can't understand hers.

ACTIONS/BEHAVIOURS : Talked to patient

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Accepted patient as an individual

THEME : 1. Accepted patient despite being unpleasant
2. Able to give correct information
3. Managed despite patients communication problem

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge
3. Interpersonal abilities

SUBCAT : 1. Social needs (acceptance)
2. Theoretical
3. Verbal communication

NUMBER : 33 WARD : SURG SEX : F AGE : 38 LANG : TSWANA

ILLNESS : Septic Hand

INCIDENT : The old lady next to us is forgetful, but always the nurse is coming to her. Sometimes she becomes cheeky. But they understand her condition and her problems. Even with me, when I was admitted, I was very sick with this hand and I didn't want to say anything ... not because I am cross ... but she comes to me and says "hullo, how are you?" Her interpersonal relations are good ... that is what I am saying ... you know I too am a nurse.

ACTIONS/BEHAVIOURS : Talked to patient

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse tolerant of patient's behaviour

THEME : 1. Accepted patient despite being unpleasant
2. Enquired after patient's health
3. Came to check on patient

CATEGORY: 1. Assisting with needs
2. Interpersonal abilities
3. Nurturance

SUBCAT : 1. Social need
2. Verbal communication
3. Availability (unsolicited)

NUMBER : 34 WARD : SURG SEX : F AGE : 54 LANG : E

ILLNESS : Hip replacement

INCIDENT : There is one of the Sisters, whether she is bringing a bedpan or dealing with an emergency, or combing someone's hair, she is always pleasant. You can see by her facial expression, her words, her attitude in general.

ACTIONS/BEHAVIOURS : Brings bedpan. Combs hair. Deals with emergency.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse pleasant no matter what task she is performing.

THEME : 1. Pleasant facial expression
2. Always in a good mood

CATEGORY: 1. Interpersonal abilities
2. Personal attributes

SUBCAT : 1. Non verbal communication (facial expression)
2. Pleasant disposition

NUMBER : 35 WARD : ORTHO SEX : F AGE : 69 LANG : E

ILLNESS: Hip Replacement

INCIDENT : This big stout one that walks around here ... she doesn't say much but she is good. She doesn't take any nonsense. She doesn't play around. She does her job and gets on with it. If you need something she never pulls a face.

ACTIONS/BEHAVIOURS : Does her job consistently

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Does not make patients feel bad when they need something from her.

THEME : 1. Consistent in her work

CATEGORY : 1. Personal attributes

SUBCAT : 1. Dependability

NUMBER : 36 WARD : ORTHO SEX : F AGE : 62 LANG : E

ILLNESS: Dislocated knee

INCIDENT : She makes me feel so comfortable - makes me feel I am not in the way. She makes my pillows all nice and rubs my back - makes me comfortable so that I am not in pain. I had been having trouble with my bandage - it throbbed all night - I didn't want to make a fuss and I couldn't reach my bell. I didn't want to yell my head off and wake everyone, but in the morning she took off the bandage and rubbed it ... I had it off for 24 hours and it was much, much better.

ACTIONS/BEHAVIOURS :Rubbed back. Removed tight bandage. Arranged pillows.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse willing to help and knew what to do.

THEME : 1. Assessed reason for pain and took appropriate steps to eliminate
2. Rearranged pillows, rubbed back

CATEGORY: 1. Assisting with needs
2. Assisting with needs

SUBCAT : 1. Comfort needs (elimination pain)
2. Comfort needs (general comfort)

NUMBER : 37 WARD : MED SEX : F AGE : 61 LANG : E

ILLNESS : Rh. Arthritis

INCIDENT : I had this terrible pain in my bladder, but there is a sister here - she was so kind - she spent the whole day saying "drink lucozade, drink water, and have the pan." She was going up and down. It helped me to get rid of the pain in my bladder. All that time ... and she is a sister.

ACTIONS/BEHAVIOURS : Gave patient liquids to drink and brought bedpan.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Spent time giving basic care despite being a sister.

THEME : 1. Assessed reason for pain and took appropriate action
2. Know correct action to take
3. Nurse was kind
4. Went out of her way for patient

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge
3. Personal attributes
4. Nurturance

SUBCAT : 1. Comfort needs (elimination pain)
2. Theoretical
3. Kind, considerable and understanding
4. Attentiveness

NUMBER : 38 WARD : GYNAE SEX : F AGE : 61 LANG : E

ILLNESS : Carcinoma

INCIDENT : When I first came in here, I was unhappy in the ward where I was, but I wasn't going to say anything. The Sister came to me and she said "No, I am going to move you." She could see immediately that I was unhappy. I didn't say anything. She understands people.

ACTIONS/BEHAVIOURS : Moved the patient into another ward

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Patient didn't have to tell sister - she was able to see what was wrong.

THEME : 1. Made patient feel part of ward group
2. Notices if patient in need

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge

SUBCAT : 1. Social needs
2. Skills (observation)

NUMBER : 39 WARD : GYNAE SEX : F AGE : 23 LANG : E

ILLNESS : Gynae. problem

INCIDENT : I had a drip that was hurting. All the other nurses came and pressed the area and made it hurt more. They fiddled around with it but it was in the tissues. The Sister came and looked at it and said "No, it's in the tissues, I will have to remove it" and she did. It's been driving me mad since yesterday and I have been having a lot of pain but the sister was able to see it was swollen and removed it. I feel much better now.

ACTIONS/BEHAVIOURS : Realized drip was in tissues and removed it.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Sister recognised problem.

THEME : 1. Assessed reason for pain and took appropriate action
2. Notices if patient in need

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge

SUBCAT : 1. Comfort (elimination of pain)
2. Skills (observational)

NUMBER : 40 ARD : OBSTET SEX : F AGE : 28 LANG : E

ILLNESS: Confinement

INCIDENT : I had a really terrible labour, and Sister H was incredibly patient with me. She instinctively knew that I didn't want to have drugs or anything. I wanted to manage on my own. She was unbelievably good - she knew that I wasn't focusing on her and that she would have to relay through my husband. Everyone has been good, but she was great.

ACTIONS/BEHAVIOURS : Communicated with patient through husband.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Sister understood patient's unspoken needs

THEME : 1. Accepted patient despite being different
2. Assesses situation
3. Dealt with difficult patient patiently

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge
3. Personal attributes

SUBCAT : 1. Social needs (acceptance)
2. Skills (observational)
3. Patience

NUMBER : 41 WARD : OBSTET SEX : F AGE : 28 LANG : E

ILLNESS: Confinement

INCIDENT : One of the midwives down in clinic is very caring. Even though she didn't deliver the child, she came up to see me after the baby was born. She was interested in me - definitely.

ACTIONS/BEHAVIOURS : Sister went up to patient's ward to see her.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Midwife came although no longer had any obligation to patient.

THEME : 1. Made patient feel special
2. Went out of way for patient

CATEGORY: 1. Assisting with needs
2. Nurturance

SUBCAT : 1. Social needs (recognition)
2. Attentiveness

NUMBER : 42 WARD : OBSTET SEX : F AGE : 20 LANG : XHOSA

ILLNESS : Confinement

INCIDENT : She told me all about family planning. She told me what I wanted to know.

ACTIONS/BEHAVIOURS : Gave information

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Gave needed information.

THEME : 1. Recognized individual need
2. Able to give patient information

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge

SUBCAT : 1. Social needs (recognition)
2. Theoretical knowledge

NUMBER : 43 WARD : OBSTET SEX : F AGE : 24 LANG : PORT

ILLNESS: UTI Pregnant

INCIDENT : This one sister put up my drip and she was very gentle. She didn't hurt me at all.

ACTIONS/BEHAVIOURS : Sited IVI

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Did not hurt patient during procedure.

THEME : 1. Conducted procedure causing minimal pain
2. Painful procedure done with little pain

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge

SUBCAT : 1. Comfort (elimination of pain)
2. Skills (psychomotor)

NUMBER : 44 WARD : OBSTET SEX : F AGE : 25 LANG : E

ILLNESS : Pregnant

INCIDENT : A woman went into labour and was pushing. Me and another lady was telling her not to push, but this sister comes in, she quickly closes the curtain and she says "Oh no, the head." But she knew what to do immediately. She didn't panic or anything. She was laughing. She took the whole bed out in a hurry.

ACTIONS/BEHAVIOURS : Managed second stage patient.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Sister assessed situation and knew what to do.

THEME : 1. Capable action made patient trust nurse and feel secure
2. Assessed situation
3. Displayed sense of humour

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge
3. Personal attributes

SUBCAT : 1. Safety (emotional security)
2. Skills (observational)
3. Pleasant disposition

NUMBER : 45 WARD : MED SEX : F AGE : 30 LANG : E

ILLNESS: Cardiac

INCIDENT : I am on very strict bedrest, and I cannot get out of the bed. Whenever I need to use the bedpan she is always ready to do it for me. She brings me the bedpan, helps me get onto it and even helps me clean myself.

ACTIONS/BEHAVIOURS : Assisted patient with bedpan

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :Patient helpless without nurse's assistance.

THEME : 1. Washed patient after using bedpan
2. Came to help patient

CATEGORY: 1. Assisting with needs
2. Nurturance

SUBCAT : 1. Physical needs (hygiene & elimination)
2. Availability (unsolicited)

NUMBER : 46 WARD : MED SEX : F AGE : 53 LANG : A

ILLNESS : Cardiac

INCIDENT : There is this one who is wonderful. If she sees you are struggling to sit up in bed, she is helpful. If you ask her for something, she brings it straight away.

ACTIONS/BEHAVIOURS : Brings patient what she needs. Assess situation.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Helps when help needed.

THEME :
1. Helped patient sit up
2. Notices if patient in need
3. Came straight away when called

CATEGORY:
1. Assisting with needs
2. Demonstrating knowledge
3. Nurturance

SUBCAT :
1. Physical (exercise and mobility)
2. Skills (observational)
3. Availability (solicited)

NUMBER : 47 WARD : SURG SEX : F AGE : 38 LANG : TSWANA

ILLNESS: Septic hand

INCIDENT : I can't stand being without ice water. It is very difficult to get ice in this hospital, but she brings it to me. She makes sure I am never without very cold water - there - you see it there.

ACTIONS/BEHAVIOURS : Brings ice water regularly

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Went out of her way to bring what patient wanted.

THEME : 1. Recognized individualized need
2. Went out of way for patient

CATEGORY: 1. Assisting with needs
2. Nurturance

SUBCAT : 1. Social needs (recognition)
2. Attentiveness

NUMBER : 48 WARD : SURG SEX : F AGE : 38 LANG : TSWANA

ILLNESS : Septic Hand

INCIDENT : This competent nurse - she does my dressings very well. She comes and takes off the old one and makes it nice.

ACTIONS/BEHAVIOURS : Changed dressings

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Does the task well.

THEME : 1. Dressings done efficiently

CATEGORY: 1. Demonstrating knowledge

SUBCAT : 1. Skills (psychomotor)

NUMBER : 49 WARD : MED SEX : M AGE : 47 LANG : E

ILLNESS: M.I.

INCIDENT : I have seen her do things for the old man over there who can't get out of bed ... really unpleasant things .. you know, he can't go to the toilet himself .. but she does it smilingly. You don't see any displeasure on her face. If she walked around with a long face after doing something like that, it would make you feel a bit funny.

ACTIONS/BEHAVIOURS : Smiles while she does unpleasant tasks.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse's behaviour made patient less embarrassed.

THEME : 1. Washed patient after using bedpan
2. Accepted patient despite being unpleasant
3. Attitude while doing unpleasant duties saved patient embarrassment
4. Smiled

CATEGORY: 1. Assisting with needs
2. Assisting with needs
3. Assisting with needs
4. Interpersonal abilities

SUBCAT : 1. Physical needs (hygiene & elimination)
2. Social needs (acceptance)
3. Comfort (psychological)
4. Non verbal (facial expression)

NUMBER : 50 WARD : MED SEX : M. AGE : 23 LANG : A

ILLNESS : Renal Failure

INCIDENT : There - you saw that - she just pulled off the plaster - it hurt. The other one - she pulls it off little by little - she is gentle ... it doesn't hurt when she does it.

ACTIONS/BEHAVIOURS : Took plaster off arm

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Didn't hurt patient

THEME : 1. Conducted procedure causing minimal pain
2. Painful procedure done with little pain
3. Gentle

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge
3. Personal attributes

SUBCAT : 1. Comfort (elimination of pain)
2. Skills (psychomotor)
3. Gentleness

NUMBER : 51 WARD : OBSTET SEX : F AGE : 36 LANG : A

ILLNESS: Caesar

INCIDENT : I did ask for a pain killer. Obviously I was in pain. I was lying on my back on the bed and a nurse came in with it. I couldn't have reached it without killing myself so she put her hand under my head and helped me to quickly swallow the pain killer.

ACTIONS/BEHAVIOURS: Lifted patient's head to enable her to swallow tablet.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse realized problem and assisted

THEME : 1. Assisted patient to take analgesia
2. Assisted patient to take analgesia

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge

SUBCAT : 1. Comfort (elimination of pain)
2. Skills (psychomotor)

NUMBER : 52 WARD : MED SEX : F AGE : 22 LANG : E

ILLNESS : Pneumonia

INCIDENT : The good nurse responds immediately when I call her. I don't have to wait.

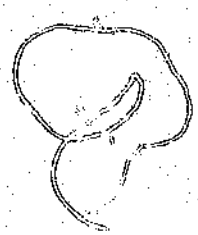
ACTIONS/BEHAVIOURS : Comes when called

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Doesn't have to wait for help.

THEME : 1. Came straight away when called

CATEGORY: 1. Nurturance

SUBCAT : 1. Availability (solicited)



NUMBER : 53 WARD : MED SEX : F AGE : 22 LANG : E

ILLNESS: Pneumonia

INCIDENT : I was upset by an incident concerning a social worker who wasn't very nice to me. I went to see the Sister who talked to the social worker for me. She reprimanded the social worker and the social worker came and apologised to me. This made me feel like an individual again.

ACTIONS/BEHAVIOURS : Sister spoke to social worker.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Sister thought patient important enough to intervene.

THEME : 1. Made patient feel special
2. Spoke to social worker on behalf of patient

CATEGORY: 1. Assisting with needs
2. Nurturance

SUBCAT : 1. Social (recognition)
2. Advocacy



NUMBER : 61 WARD : PSYCH SEX : F AGE : 57 LANG : E

ILLNESS : Bi-polar disorder

INCIDENT : On Sunday morning one of the nurses was kind enough to take 3 of us down to the chapel in a very caring manner. She is obviously a religious girl. She cared for the other patients who were there besides us from the ward. She helped us all back to the ward. She asked us whether we would like to go to the chapel - she asked everybody whether they would like to go. Usually they can't care if you go to the chapel or not.

ACTIONS/BEHAVIOURS : Asked patients if wanted to go to chapel. Took them there. Attended to them and other patients while there.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Other nurses do not care for the spiritual needs of the patients.

THEME : 1. Stayed with the patient
2. Went out of her way

CATEGORY: 1. Nurturance
2. Nurturance

SUBCAT : 1. Availability (unsolicited)
2. Attentiveness

NUMBER : 62 WARD : MED SEX : M AGE : 87 LANG : E

ILLNESS: Lung Problem

INCIDENT : A nurse by the name of E comes in with a smile and says "how are you today - feeling any better?' This is very cheering. At least one feels welcome. She has a shocking cold but continues to work. I think this is quite wonderful.

ACTIONS/BEHAVIOURS : Smiled and greeted patient. Asked after health. Continues to work despite being sick herself.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Action made him feel welcome and like an individual. Patients health more important to the nurse than her own health.

THEME : 1. Smiled
2. Came to work despite being ill

CATEGORY: 1. Interpersonal abilities
2. Personal attributes

SUBCAT : 1. Non verbal (facial expression)
2. Dependability

NUMBER : 64 WARD : PSYCH SEX : M AGE : 41 LANG : E

ILLNESS: Psychiatric disorder

INCIDENT : I slipped and fell in the shower. I reported it to the sister. Despite the fact that she was busy at the time, she took a statement, inspected the shower, did an examination, asked if I wanted to see the doctor immediately, and reported it to the day sister. On my return from a day out the doctor was waiting to see me. Afterwards I enquired why she took this so seriously, she replied, proving that she is competent and has knowledge of policy and administration, that the hospital could be held liable, and the patient could enter into litigation. It was obvious that her empathy skills, training yet firm discipline was a fundamental part of her professional makeup.

ACTIONS/BEHAVIOURS : Sister dealt with ward accident efficiently.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : The Sister had the knowledge to deal with a situation.

THEME : 1. Know correct action to take

CATEGORY : 1. Demonstrating knowledge

SUBCAT : 1. Theoretical

NUMBER : 65 WARD : PSYCH SEX : M AGE : 47 LANG : E

ILLNESS : Psychiatric Disorder

INCIDENT : I was very anxious the day I came into hospital. I admitted myself. My anxiety was caused by my lack of sleep. During the afternoon a sister told me medication would be given to me only if necessary. This got me a little more anxious ... I expected to be told that I would definitely get something to sleep that night. Lo and behold, at 20:00 the sister on duty came to my bedside and told me I shouldn't be anxious, I would be getting something. They just cannot give me things straight away. They first have to ascertain if I need the medication. She put me at ease.

ACTIONS/BEHAVIOURS : Explained medication policy to patient.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Sister put patient at ease by reassuring would get medication.

THEME : 1. Explained things making patient feel secure
2. Reassured patient

CATEGORY: 1. Assisting with needs
2. Interpersonal abilities

SUBCAT : 1. Safety needs (emotional security)
2. Verbal communication

NUMBER : 66 WARD : SURG SEX : M AGE : 59 LANG : A

ILLNESS: Ca Pharynx

INCIDENT : A little Indian nurse, very young, so concerned and helpful, make extra sure about my comfort. She even tuned my radio perfectly to the station.

ACTIONS/BEHAVIOURS : Made patient comfortable. Tuned radio for him.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Took extra effort to make patient comfortable and tune radio.

THEME : 1. Tuned radio perfectly
2. Nurse was concerned and helpful

CATEGORY: 1. Assisting with needs
2. Personal attributes

SUBCAT : 1. Comfort needs (general)
2. Kind, considerate and understanding

NUMBER : 67 WARD : ENT SEX : M AGE : 14 LANG : XHOSA

ILLNESS : ENT problem

INCIDENT : P is good and kind. She comes to check on me every now and then. This makes me feel great and makes me feel safe.

ACTIONS/BEHAVIOURS : Comes to check on patient now and then.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse's presence makes him feel safe.

THEME : 1. Contact with patient made him feel safe
2. Nurse was kind
3. Came to check on patient

CATEGORY: 1. Assisting with needs
2. Personal attributes
3. Nurturance

SUBCAT 1. Safety (emotional security)
2. Kind, considerate
3. Availability (unsolicited)

NUMBER : 68 WARD : SURG SEX : M AGE : 70 LANG : GREEK

ILLNESS: Fractured Tib and Fib

INCIDENT : A young nurse was doing the bandages this morning. She told me the bandages can stay on till Christmas. She is a wonderful person. She says things in such a gentle way. She is very gentle.

ACTIONS/BEHAVIOURS : Changed dressing. Gave information.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Nurse spoke and acted gently.

THEME : 1. Dressings done efficiently
2. Gentle

CATEGORY: 1. Demonstrating knowledge
2. Personal attributes

SUBCAT : 1. Skills (psychomotor)
2. Gentleness

NUMBER : 69 WARD : 374 SEX : F AGE : 36 LANG : PORT

ILLNESS : Fractured neck

INCIDENT : L M is a honey. She was born to be a nurse. I see the way she cares for the elderly people. She is a star. She kisses and hugs them and takes time to talk to them to convince them that they should have a bath and eat and sit up. The old people love her. Some of them are cold at first but they warm to her. She gets the old ladies eating and sitting.

ACTIONS/BEHAVIOURS : Hugs and kisses patients. Talks to them.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT : Behaviours result in patients co-operating.

THEME : 1. Persuaded patient to sit up
2. Made patient feel part of group
3. Talks to patient
4. Hugs patient

CATEGORY: 1. Assisting with needs
2. Assisting with needs
3. Interpersonal abilities
4. Interpersonal abilities

SUBCAT : 1. Physical (exercise & mobility)
2. Social (acceptance)
3. Verbal communication
4. Non verbal (touch)

NUMBER : 70 WARD : SURG SEX : F AGE : 25 LANG : E

ILLNESS: Fractured ankle

INCIDENT : Nothing irritates her. She's always in a good mood. Even though you are incapacitated, and you feel irritated that you can't do anything, she doesn't make you feel that you are irritating her.

ACTIONS/BEHAVIOURS : Tolerant of patient

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Behaviour consistent.

THEME : 1. Patient made to feel part of ward group
2. Attitude saved patient embarrassment
3. Always in a good mood

CATEGORY: 1. Assisting with needs
2. Assisting with needs
3. Personal attributes

SUBCAT : 1. Social (acceptance)
2. Comfort (Psychological)
3. Pleasant disposition

NUMBER : 71 WARD : PSYCH SEX : M AGE : 51 LANG : E

ILLNESS : Depression

INCIDENT : There's this nurse that deals so beautifully with the patients. One patient is very far gone, and she is like his mother. She calms him so he doesn't jerk around. She can feed him when others can't keep him still. She makes a patient's day with her bright "good morning"

ACTIONS/BEHAVIOURS : Calms the patient. Feeds him. Greets the patient.

SALIENT ASPECTS FROM INTERVIEWERS VIEWPOINT :
Manages task that other nurses cannot. Makes patients feel more cheerful.

THEME : 1. Difficult tasks done well
2. Greeted patient

CATEGORY: 1. Demonstrating knowledge
2. Interpersonal abilities

SUBCAT : 1. Skills (psychomotor)
2. Verbal communication

NUMBER : 72 WARD : SURG SEX : M AGE : 39 LANG : E

ILLNESS: Paralysis. Constriction urethra

INCIDENT :I asked for certain assistance and the nurse in question came without anyu problems at all and did it with a great big smile on her face. No problems at all and it was over and done with in a jiffy. She was happy and I was happy.

ACTIONS/BEHAVIOURS : Came when called. Carried out procedure efficiently.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Nurse happy to help patient. Put him at ease.

THEME : 1. Attitude saved patient embarrasment
2. Smiled
3. Came straight away when called

CATEGORY: 1. Assisting with needs
2. Interpersonal Abilities
3. Nurturance

SUBCAT : 1. Comfort (psychological)
2. Non verbal communication (facial expression)
3. Availabil cy (solicited)

NUMBER : 73 WARD : SURG SEX : M AGE : 68 LANG : E

ILLNESS : Prostatectomy

INCIDENT : There's one nurse who does all the work at night while the rest of the staff sleep. She keeps very busy and even though she is so busy, she does it very pleasantly. Even when she is running up and down and we call on her for something, she will jump up and come right away.

ACTIONS/BEHAVIOURS : Comes when called

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Comes even though busy. Works much harder than other nurses.

THEME : 1. Does work that others shirk
2. Came straight away when called

CATEGORY: 1. Personal attributes
2. Nurturance

SUBCAT : 1. Dependability
2. Availability (solicited)

NUMBER : 74 WARD : ORTHO SEX : F AGE : 53 LANG : A

ILLNESS: Bone Graft

INCIDENT : They came to take the drip out that was in the drain in my leg. I asked them whether they were sure as I was certain that it was stuck and that the Doctor should take it out. I said "go and call that Sister". She came and took the one out and said she must call the doctor to take the other one out because it was stuck. She called the doctor and he removed it himself. She was clever and she believed me that it was stuck.

ACTIONS/BEHAVIOURS : Observed that drain was stuck. Called medical aid.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Sister listened to the patient and believed him. Used her expertise to evaluate situation.

THEME : 1. Acknowledged patient input
2. Difficult task done well
3. Called doctor when patient needed him

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge
3. Nurturance

SUBCAT : 1. Social needs (recognition)
2. Skills (psychomotor)
3. Advocacy

NUMBER : 75 WARD : ORTHO SEX : F AGE : 52 LANG : E

ILLNESS: Frozen Shoulder

INCIDENT : My tummy started running terribly - 3 times. I went to the Sister and told her my tummy was running and could she give me something. She went running around all the wai is trying to find some Immodium for me. Eventually she came with it and gave it to me which was really helpful to me.

ACTIONS/BEHAVIOURS : Went to several other wards to find medical.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Went out of her way to assist.

THEME : 1. Gave tablets to stop diarrhoea
2. Knew correct action to take
3. Went out of way for patient

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge
3. Nurturance

SUBCAT : 1. Physical needs (hygiene & elimination)
2. Theoretical
3. Attentiveness

NUMBER : 76 WARD : ORTHO SEX : F AGE : 33 LANG : E

ILLNESS : Osteoporosis

INCIDENT : One nurse we call Diana Ross - she looks like her - is always very caring when she sees us. I was crying with pain and she brought the doctor to see me. She told him that he should give me strong pain killers. I found when I was crying that the way she comforted me - I was so grateful what she had done.

ACTIONS/BEHAVIOURS : Called the doctor when patient was in pain. Told the doctor what treatment to prescribe.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Nurse noticed patient in need of analgesia. Comforted patient.

THEME : 1. Asked doctor for analgesia and gave it
2. Knew correct action to take
3. Called doctor when patient needed him

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge
3. Nurturance

SUBCAT : 1. Comfort needs (elimination of pain)
2. Theoretical knowledge
3. Advocacy

NUMBER : 77 WARD : ORTHO SEX : F AGE : 33 LANG : SOTHO

ILLNESS: Fractured Knee

INCIDENT : Nurse C - she was helping me. She asked how I was feeling and gave me pills for the pain when I first came in. She was worried about me.

ACTIONS/BEHAVIOURS : Asked how patient was. Gave her pain pills.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Nurse cared enough to ask about patient and give her analgesia.

THEME : 1. Gave analgesia when asked
2. Showed special concern

CATEGORY: 1. Assisting with needs
2. Nurturance

SUBCAT : 1. Comfort (elimination of pain)
2. Attentiveness

NUMBER : 78 WARD : ORTHO SEX : F AGE : 25 LANG : E

ILLNESS : Rheumatoid Arthritis

INCIDENT : I was supposed to go in for my operation and my doctor said I'm not having the operation because my neck is not stable enough. I was crying and crying. The Sister came and sat on my bed and held my hand and talked to me. She told me that if I needed anything, I must ring the bell and she'd come. If I need to talk, I must say so. That was so nice for me. She could have said "don't worry, don't cry, it'll be alright", but she didn't. She sat down there and treated me like a real person - like a wanted person. She wanted to help me. That meant a lot to me.

ACTIONS/BEHAVIOURS : Sat on patient's bed. Held her hand. Talked to her.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Sister could have made inane remarks but treated her as individual.

THEME : 1. Made patient feel spec...
2. Explained things maki... ie. ...el secure
3. Reassured patient
4. Held patient's hand
5. Stayed with patient

CATEGORY: 1. Assisting with needs
2. Assisting with needs
3. Interpersonal abilities
4. Interpersonal abilities
5. Nurturance

SUBCAT : 1. Social needs (recognition)
2. Safety needs (emotional security)
3. Verbal communication
4. Non verbal (touch)
5. Availability (unsolicited)

NUMBER : 79 WARD : ORTHO SEX : M AGE : LANG : E

ILLNESS: Fractured Spine

INCIDENT : I was involved in a plane crash on 11 June. I have lain here for 5 weeks ... it is difficult to move around. When we crashed, there was a lot of dirty sand. The thing that really got me was that my hair was so dirty. I could feel it driving me insane and I mentioned it to Sister W. She is in charge and very busy, and the next minute she said, "dont worry, I'll make time." She came and washed my hair. I know it is a small incident but it is amazing how well I felt afterwards. I know nursing is basically medicine, but there are other parts of it too.

ACTIONS/BEHAVIOURS : Washed the patient's hair.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Not part of normal duties. Did it despite being very busy.

THEME : 1. Washed patients hair
2. Made patient feel special
3. Washed hair to prevent irritation
4. Made time to do what patient asked

CATEGORY: 1. Assisting with needs
2. Assisting with needs
3. Assisting with needs
4. Nurturance

SUBCAT : 1. Physical (hygiene & elimination)
2. Social (recognition)
3. Comfort (general)
4. Availability (solicited)

NUMBER : 80 WARD : PSYC SEX : F AGE : 41 LANG : E

ILLNESS: Bi-polar disorder

INCIDENT : I was feeling very new in the ward. Previously when I had been here not only as a bipolar disorder but also treated for alcohol abuse, I caused a lot of trouble in the ward. Since then I have sobered up in A.A. When Sister E came on duty, she recognized me and put her arms around me and gave me a big hug, and said how much better I looked. That evening I felt so much happier and it was nicer to be in the ward. She didn't hold anything against me.

ACTIONS/BEHAVIOURS : Hugged patient. Talked to him.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Accepted patient despite previous behaviour.

THEME :
1. Made patient feel special
2. Accepted patient despite being difficult
3. Contact with patient made him feel safe
4. Enquired after patient's health
5. Hugged patient

CATEGORY:
1. Assisting with needs
2. Assisting with needs
3. Assisting with needs
4. Interpersonal abilities
5. Interpersonal abilities

SUBCAT :
1. Social needs (recognition)
2. Social nees (acceptance)
3. Safety needs (emotional security)
4. Verbal Communiction
5. Non Verbal (touch)

NUMBER : 81 WARD : PSYCH SEX : F AGE : 44 LANG : ZULU

ILLNESS : Psychiatric illness

INCIDENT : That patient is tied to the chair. Nure N helps him very well. She feeds him and walks him now and then. She is not afraid of him like the others are.

ACTIONS/BEHAVIOURS : Feeds patient and takes him for a walk.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Other nurses are afraid of patient and avoid him. This one cares for him despite his condition.

THEME : 1. Helped patient to walk
2. Difficult tasks done well

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge

SUBCAT : 1. Physical needs (exercise & mobility)
2. Skills (psychomotor)

NUMBER : 82 WARD : GYNAE SEX : F AGE : 32 LANG : TSWANA

ILLNESS: Pelvic Inflammatory Disease

INCIDENT : On Monday, I was very ill. I had a temperature. I couldn't sleep and Nurse T came about every hour to see if I was alright. She gave me water to drink and stood with me. She is always good to me.

ACTIONS/BEHAVIOURS : Checked on patient regulary. Spent time with patient. Gave her drinks of water.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Patient was ill, alone and afraid and appreciated the concern and company.

THEME : 1. Contact with patient made her feel safe
2. Consistent in her work
3. Showed special concern

CATEGORY: 1. Assisting with needs
2. Personal attributes
3. Nurturance

SUBCAT : 1. Safety needs (emotional security)
2. Dependability
3. Attentiveness

NUMBER : 83 WARD : GYNAE SEX : F AGE : 50 LANG : SOTHO

ILLNESS : Fibroid

INCIDENT : The tall nurse, she is very nice. She is very understanding. When you can't wash youself properly, she takes you and go and wash you in the bath. This is when you are not well enough. She hold my arm and put Savlon as well.

ACTIONS/BEHAVIOURS : Accompanied patient to the bathroom. Helped her wash.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Patient could not meet needs on her own.

THEME : 1. Helped patient to wash
2. Nurse was understanding

CATEGORY: 1. Assisting with needs
2. Personal attributes

SUBCAT : 1. Physical (hygiene & elimination)
2. Kind, considerate and understanding

NUMBER : 84 WARD : GYNAE SEX : F AGE : 36 LANG : E

ILLNES : TOP for Downs

INCIDENT : I flew back from England when I got the results. I came in and was afraid and sad. The nurse was fabulous. She came in and sat down and explained what would happen, and what to expect. For me that is easier. If someone says "it's going to hurt like hell", its fine as long as you know. She was really wonderful. I find her good at making physical contact when she saw how upset I was. She just held my hand and to me that was hell of a nice, it really was. She was incredibly kind.

ACTIONS/BEHAVIOURS : Explained procedures. Held patient's hand.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Patient upset and scared. Nurse comforted her.

THEME : 1. Explained things to patient making her feel secure
2. Able to give patient information
3. Explained to patient
4. Nurse was kind
5. Stayed with patient
6. Showed special concern

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge
3. Interpersonal abilities
4. Personal attributes
5. Nurturance
6. Nurturance

SUBCAT : 1. Safety needs (emotional security)
2. Theoretical knowledge
3. Verbal communiction
4. Kind, considerate and understnding
5. Availability (unsolicited)
6. Attentiveness

NUMBER : 85 WARD : GYNAE SEX : F AGE : 37 LANG : ZULU

ILLNESS: Cancer

INCIDENT : Yesterday she was helping another lady who was in trouble. She had to go home and they couldn't find her husband. She was in trouble as she couldn't even dress herself. I thought she was fantastic. The patient was confused and the nurse was super.

ACTIONS/BEHAVIOURS : Assisted patient to dress and pack her things.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Patient was confused and helpless.

THEME : 1. Went out of her way for patient

CATEGORY: 1. Nurturance

SUBCAT : 1. Attentiveness

NUMBER : 86 WARD : MED SEX : F AGE : 23 LANG : E

ILLNESS : Diabetic

INCIDENT : I am impossible to drip and had to be on IV for a week. The doctors asked the nurses to look after the drip. IT kept on blocking. Instead of just yanking it out and calling the doctors as has been my previous experience, the nurse sat patiently for about half an hour unravelling all the plaster, disconnected everything and tried and tried. She eventually unblocked it and re-strapped it and everything, without having to pull the drip out. She saved me a lot of pain and the doctors a lot of agony.

ACTIONS/BEHAVIOURS : Unblocked drip

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Other nurses would not have taken the trouble. Saved the patient unnecessary pain.

THEME : 1. Assessed reason for pain and took steps to eliminate
2. Difficult task done well
3. Dealt with difficult situation patiently

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge
3. Personal attributes

SUBCAT : 1. Comfort (elimination of pain)
2. Skills (psychomotor)
3. Patient

NUMBER : 87 WARD : MED SEX : F AGE : 59 LANG : E

ILLNESS: Pneumonia

INCIDENT :The nurse, she was very kind. I had such a pain in my chest and back and she came and rubbed my back. She always smiles a very nice smile. That goes a long way.

ACTIONS/BEHAVIOURS : Rubbed patient's back. Smiled

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Helped reduce pain.

THEME : 1. Rubbed patients back
2. Smiled

CATEGORY: 1. Assisting with needs
2. Interpersonal abilities

SUBCAT : 1. Comfort (General)
2. Non verbal communication (facial expression)

NUMBER : 88 WARD : MED SEX : F AGE : 50 LANG : ZULU

ILLNESS : Cancer

INCIDENT : I got cancer very bad. I'm weak and tired and the nurse helped me in the bath and put ointment on my mouth. She say I must be happy in this room and she come all the time and talk to me because there is no other patient here with me and my daughter only comes for a short time to visit.

ACTIONS/BEHAVIOURS : Assisted patient to bath. Put ointment on mouth. Came in regularly. Talked to patient.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Patient was lonely and nurse's presence helped her.

THEME : 1. Helped patient wash
2. Put ointment on dry lips
3. Showed special concern

CATEGORY: 1. Assisting with needs
2. Assisting with needs
3. Nurturance

SUBCAT : 1. Physical (hygiene & elimination)
2. Comfort (general)
3. Attentiveness

NUMBER : 89 WARD : MED SEX : F AGE : 61 LANG : E

ILLNESS: Jaundice

INCIDENT : The nurse has a general attitude of kindness. My drip had to come out and I was getting antibiotics in it. I wanted to go home for the weekend and I wouldn't be able to if they had to put up a new drip. The nurse said "don't worry, I'll sweet talk the doctor". She said "can't we give her antibiotics by mouth - she wants to go home for the weekend?" The Doctor said "Yes". I was so pleased and grateful.

ACTIONS/BEHAVIOURS : Persuaded doctor to give oral medication.

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Action enabled patient to go home for the weekend

THEME : 1. Knew correct action to take
2. Nurse was kind
3. Asked doctor for treatment for patient

CATEGORY: 1. Demonstrating knowledge
2. Personal attributes
3. Nurturance

SUBCAT : 1. Theoretical
2. Kind, considerate and understanding
3. Advocacy

NUMBER : 90 WARD : SURG SEX : M AGE : 65 LANG : E

ILLNESS: Spinal operation

INCIDENT : She was very good. She dressed my back wound and was very good with the operations on my back. I never felt a thing - not a thing. She was a very junior nurse. Others don't actually hurt but she was very good and gentle.

ACTIONS/BEHAVIOURS :

SALIENT ASPECTS FROM INTERVIEWEES VIEWPOINT :
Did not cause pain. Was gentle.

THEME : 1. Conducted procedure causing minimal pain
2. Dressings done efficiently
3. Gentle

CATEGORY: 1. Assisting with needs
2. Demonstrating knowledge
3. Personal attributes

SUBCAT : 1. Comfort needs (elimination of pain)
2. Skills (psychomotor)
3. Gentleness

Annexure 8

CASE STUDIES USED IN CHAPTER FOUR FOR COMPARISON WITH STUDY

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SUMMARY OF CASE STUDIES REVIEWED

ANNEXURE 9

	PHYSICAL NEEDS		SAFETY NEEDS		COMFORT NEEDS			SOCIAL NEEDS		KNOWLEDGE			INTERPERSONAL ABILITIES				NURTURANCE		
	Hygiene Elimination	Exercise & Mobility	Physical Safety	Emotional Security	Elimination of pain	General Comfort	Psychological Comfort	Acceptance	Recognition	Theoretical Knowledge	Psychomotor Skills	Observation Skills	Verbal Communication	Facial Expression	Touch	Personal Attributes	Availability	Advocacy	Attentiveness
ALLEN	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
BAINES	X	X			X	X	X			X	X	X							X
BOYLAN	X												X						
BROWN								X	X			X	X				X	X	X
CANIS									X			X		X	X		X		X
GAMLIN													X				X		X
GILLAN				X				X	X			X		X		X	X		X
HOLDEN								X	X	X			X			X			
KEACHIE	X					X			X		X						X		
KIELY	X	X			X	X				X		X	X						X
LLOYD									X			X	X				X		X
MACSWEENEY		X						X	X			X					X		X
REABURN									X	X					X				X
SHEPERDSON							X									X			X
SINCLAIR					X							X	X				X	X	X
SMITH				X								X			X				X
SUMMERS												X	X		X				X
TANNER				X					X	X									X
WHITE												X	X				X		X
WILLIAMS	X			X						X				X			X		



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