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UNIVERSITY OF THE WITWATERSRAND

FACULTY OF HEALTH SCIENCES

RESEARCH REPORT

PATIENT CENTERED NURSING CARE OF CAESAREAN SECTION PATIENTS IN A PRIVATE SECTOR MATERNITY WARD.

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MSc Nursing (Research report)

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DECLARATION

A research project submitted in fulfillment of the requirements for the degree MSC (Nursing Education) by coursework and research report in the faculty of humanities, University of Witwatersrand, Johannesburg, 2019.

I declare that this research is my own work and is unaided. It has not been submitted before for any other degree, part of degree or examination at this or any other university.

Signature: R Leyds Date: 18/11/19

DEDICATION

To my husband

Thank you for your encouragement and support through the process of completing this report. I love you dearly-Aurin Leyds

ABSTRACT

Patient centred nursing care is nursing care that is centred on the patient and their specific needs in order to achieve good quality nursing care. Patient centred care is essential in achieving good patient outcomes and includes the incorporation of communication and shared decision making which emphasises the importance of respectful and responsive nursing care. The purpose of the study was to determine if the care which is documented reflects the care which the patient is experiencing. The study was conducted in the maternity ward of a large private hospital and the focus was on the post-partum care given to patients who have had caesarean sections. The research design and method were an exploratory multi-method design which incorporated collecting and analysing data from two sources, namely the patients and the nursing documentation. The patients were interviewed using semi-structured interviews which were transcribed verbatim and the nursing documentation was recorded verbatim directly from the nursing notes. A template analysis was conducted using the patient centered principles set out by the Picker Institute (1987).

The findings of the data analysed revealed that the nursing documentation does not reflect what the patients have experienced. The nursing documentation is primarily task-focused and directed at what the nurses are doing for the patient instead of incorporating what the patients are experiencing. The patients are experiencing many aspects of patient-centred nursing but there is a poor reflection of this in the nursing documentation. In conclusion, it can be said that in order for good quality nursing care to be achieved the nursing care should reflect what the patient is experiencing. This can be achieved through documenting nursing care given by applying patient centred care strategies.

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CHAPTER ONE

OVERVIEW OF THE STUDY

1.1. INTRODUCTION

Chapter one provides an overview to this study. The background to the study, problem statement, research question, purpose of the study, research objectives, significance of the study, and a definition of terms as applied in the study are provided.

1.2. BACKGROUND

Patient centered maternity care refers to the involvement of maternity patients, whether they be antenatal, intra-partum or post-partum, in the planning of the care they receive. According to evidence in literature, patient involvement may increase the empathy and affective responses from health care professionals, including midwives, which directly influences patient satisfaction and their perception of being in control (De Labrusse *et al.,* 2016).

Patient centered maternity care is said to be a "marker of quality of care in health care delivery" (De Labrusse *et al.*, 2016) and in order for good quality nursing to be practised the patient should be included in the care plan and this should be well documented ensuring that the documentation is patient centered.

The emphasis in nursing documentation is on noting the nursing tasks or aspects of functional care and the treatment that has been given. This may seem correct from a medical perspective but fails to reflect the true essence of nursing care which is ultimately about the patient, a very important element which seems to have been forgotten.

Patient centered care dictates that patients should be involved in the planning of their care. Nursing documentation should accurately reflect the patient's health status, nursing care implemented and the patient's experience of the care received (Blair, 2012). In practice and despite numerous efforts at improving the quality of the nursing records in an attempt to prevent medico-legal problems, it may be that little effort is made to record the patients' experiences of the nursing care provided ensuring that nursing documentation is patient centered (Kent &

Morrow, 2014). A failure in nursing documentation reflects poorly on the delivery of quality of nursing care and this can impact the nurse negatively in relation to maternity malpractice cases. Nurses/midwives are often unable to defend themselves in the event of a malpractice claim due to poor documentation which leads to the reimbursement of funds being denied for the parties involved (Renfroe et al, 1990).

From an ethical point of view, the patient should be respected and good quality care given. Nurses have a desire to do good to their patients and "patients have a right to make their own decisions and to defend their integrity which includes what is documented about their care" (Karkainen et al, 2005).

Most of the literature reviewed for the purpose of this study related to the quality of patient care and document reviews emanated from countries other than South Africa, as little was available locally. Patient document reviews are one of the only ways of establishing what was done for the patient but this method falls short as the researcher must assume that what was recorded was what was done. However, this being the case, nurses are obliged to ensure that nursing records do reflect the patient's viewpoint of their care. The researcher was concerned that this might not be the case and the study set out to determine whether what is written in the records reflects what really happened from the patient's point of view. This becomes most important when facing possible litigation as patients often relate a different version of events to that recorded in the nursing notes. Involvement of the patient in their care, and accurate recording of that involvement and care and the patient's opinion should go some way to reducing conflict and litigation.

Durand *et al*., (2015) conducted a systematic review in an attempt to determine whether shared decision making can lead to a reduction in malpractice litigation. While they concluded there was insufficient empirical evidence to state that there is such a relationship, they found in simulated scenarios that documentation of such practices could offer some level of medico-legal protection and suggested further research on the subject. Becker (2017) states that the lack of communication is involved in almost 60% of sentinel events. Any effort to improve the relationship between patients and nurses, and to respond to patients' perceived needs should improve this situation, providing these efforts are also recorded in the nursing notes.

In the event of patient complaints about the quality of care the failure to record patient experiences of care can lead to the patient alleging that the records are inaccurate and can lead to or promote claims of negligence. The patient, however, is often neglected not only in measuring quality of care but in the records themselves (Okaisu et al, 2014).

When planning this study, the work of Hulton et al (2000) was found to be applicable as their framework (figure 1.1.) defines quality nursing care as the "achievement of desired patient outcomes". In order to achieve good quality nursing care the focus of the nursing care provided should be on the patient and should be individualized for the patient's specific needs. Individualization of patient specific needs can refer to the patient centeredness needed to achieve quality nursing care for the patients. Hulton *et al*., (2000) states "that the use of services and outcomes are the result not only of the quality of the provision of care but of the women's experience of that care".

The framework Hulton *et al*., (2000) developed describes how quality in nursing care can be achieved through evaluating the different factors related to the two elements needed; namely, the provision of care given to the patient and the experience of care which patients perceive. Each element has different factors needed to determine whether, or not, good quality care has been provided and what the experiences of the patients were.

To determine the provision of care, six factors must be evaluated; human and physical resources, the referral system, maternity information systems, use of appropriate technologies, internationally recognised good practice and the management of emergencies (Hulton *et al*., 2000).

To determine the experience of care four factors must be evaluated; human and physical resources, cognition, respect dignity and equity and emotional support provided to the patient (Hulton *et al*., 2000). The authors' opinion is that if there is adherence to all these factors under their respective elements then quality in nursing care can be achieved and can lead to improved patient outcomes and satisfaction.

In maternity nursing care, Hulton's framework describes how quality can be achieved by highlighting the role of the provider of care and the one receiving the care given. Quality nursing

care is defined by the quality of the provided care compared to the quality of the care which is experienced by the patient or the user (Figure 1) (Hulton *et al.,* 2000). This means that what the healthcare provider does for the patient will be a clear reflection on how the patient experiences their care in a specific ward.

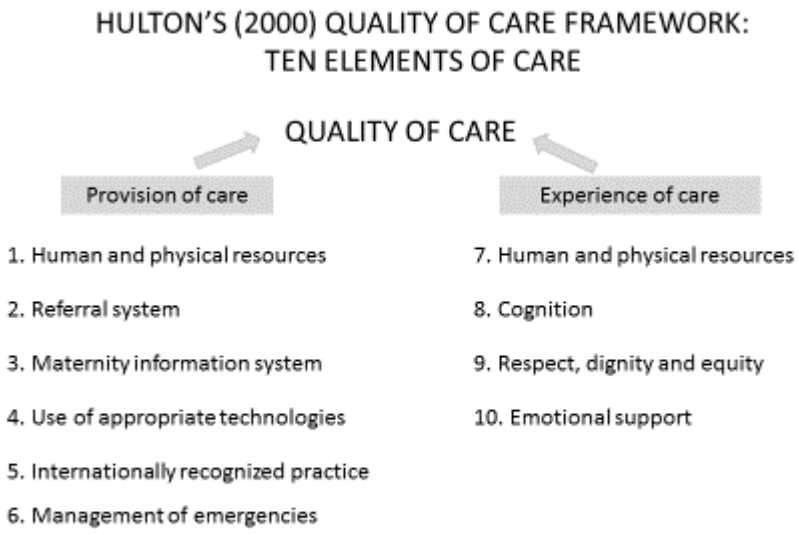


Figure 1.1. Hulton's quality of care framework

While only one criterion matches specifically in the framework, i.e. human and physical resources, all ten elements are required to ensure that quality of care has taken place and the nurse / midwife needs to consider the patient's point of view when rendering care. One would expect, therefore that the elements of cognition, respect dignity and equity and emotional support would be reflected in the nursing records if quality care has been rendered.

The provision of care was determined from the nurses documented care given to the patients and the experience of care of the patients was determined through the voice of the patients.

When measuring quality of care in a post-natal ward, it needs to be born in mind that the patients are learning to cope with the birth experience (Nayman-Vadar, 2015) and are learning to meet the needs of their new babies. During this period social support is a necessity, not just by the

patient's family but also by the nursing staff (Nayman-Vadar, 2015). Patients given support from their nurses during the post-natal period may be better able to communicate with their nurses about their fears and the trauma of the caesarean section (Nayman-Vadar, 2015). An example of post-natal care is breastfeeding which is an important factor to consider as this is not just a physical process but an emotional process and can be limited if the patient's immediate need for pain relief is not addressed. This need for support with breastfeeding is also dependant on the breastfeeding mother as each mother has different needs depending on many variable factors (Fiddler, 2016). This emphasises the need for individualised, as opposed to generalised, care plans as each mother's coping mechanisms may differ during this period. Individualized care plans in the maternity unit can lead to better quality of nursing care and patient experience.

Barry *et al.,* (2012) describes the need for patient centred care by identifying the trend that "health care has evolved over the past years where the focus of care has moved from the patient to the technology and the nursing activities". Although the technology and nursing activities are necessary in nursing care, these activities have kept the nurse or health care member from the patient which has resulted in the shift of focus from the patient. As there would be no health care system if there were no patients to care for, in particular to provide nursing care, there is a need to move the focus back to the patient to improve patient experience and patient outcomes.

The experience of the care provided to the patients is equally important as it addresses certain aspects identified through Hulton's framework relating to patient needs, for them to experience good quality nursing care. In a study conducted in Australia on patients in two different hospitals, the patients (who participated in the study or who were involved) reported that they felt empowered and acknowledged when allowed to participate in the care they received (Scand, 2016). Good quality nursing is essentially the involvement of the patient through communication and the identification of individual needs together with the provision of information and education and the appropriate documentation of the care given to the patient. It is important to note that even though high quality nursing care may be provided to the patient it may still be seen as unacceptable to the patient if they have not been included in the care they have received (Hulton et al, 2000). Patient centred care in maternity units is necessary as the nurse-patient relationship is the cornerstone for improved care. This results in enhancement of the quality of

nursing care which, in turn, directly influences patient outcomes and satisfaction (Morgan & Yodar, 2012; Farrington & Townsend, 2014).

1.3. PROBLEM STATEMENT

Quality of care is a multifaceted and complex concept with nurses and midwives having a significant effect on patient outcomes. There is growing recognition that quality should be considered as a social construct co-produced by those involved and that the patients' perceptions of quality of care drive health care utilization (Hanefeld et al, 2017). There is also long-standing recognition that, in order to improve the quality of care, such care must be measured. Currently the quality of nursing care is measured by auditing the patient records kept by the nursing staff. However, although there is recognition from a patient-centred care perspective that the quality of patient nursing care should be measured both in terms of the care provided and the experience of care received (Hulton, 2000). Perceptions of the quality of care given are only reflected from the point of view of the nurse who documents the care he/she gave. It is not only important to measure care as stated in the nursing documentation but to find a way of including the patients' experience to create a holistic basis for nursing care. It is necessary, as a first step, to compare the care the nurses perceive has been given (assumed to be that this is documented) to that of the care the patient perceives to have been given. This study aims to make such a comparison between the care provided and the experienced of care received in order to identify gaps and suggest possible ways of providing more representative patient centred care in the future.

1.4. RESEARCH QUESTION

Is there a relationship between care documented by the nurse and the care experienced by the patient as seen through a patient centred care lens?

1.5. PURPOSE OF THE STUDY

The purpose of the study was to assess whether the care that has been documented by nurses as having been given to patients, reflects what patients experience in terms of care given. This has been done with a view to ultimately measure the quality of care of the maternity service as seen

through a patient centeredness lens (Hulton, 2000). This process may highlight the need for improved methods of providing and recording nursing care of patients following caesarean section in order to provide quality, patient centered care.

1.6. OBJECTIVES OF THE STUDY

The objectives of this study were:

- To identify the stated nursing activities documented in the nursing records by means of a document audit.
- To ascertain the patient's perceptions of their experience of the nursing care that was given by means of patient interviews.
- To compare the nurses stated care with the patient's experience of care to determine if quality patient centered care is rendered in the unit.

1.7. OPERATIONAL DEFINITIONS

Quality of patient centered nursing care

"Quality of care is the degree to which maternal health services for individuals and populations increase the likelihood of timely and appropriate treatment for the purpose of achieving desired outcomes that are both consistent with current professional knowledge and uphold basic reproductive health." (Hulton *et al*.,2000).

Patient centered care

Patient centered care describes the nursing given to the patient focusing on respecting the patient's individuality, values and perspectives, knowledge and autonomy which is characterized by shared decision making emphasized by effective communication between the healthcare provider and the patient; it is care which focuses on the patient and not entirely on the task. (Tobiano *et al.,* 2016 & Rathert *et al.*, 2012).

Nursing documentation

Nursing documentation in this study refers to the individual patient records kept by the midwives and nurses in the maternity unit that reflect daily care given and the patient's response to such care as prescribed by the private hospital group where this study took place.

Patient experience

The care perceived by the patient to have been given, based on their needs during the time they were cared for in the maternity ward. In the context of this study, the time it refers to the second post-operative day after caesarean section.

1.9. CONCLUSION

This chapter has described an overview of the study. The next chapter will provide a review of the relevant literature.

CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

In chapter one, a brief overview of the study, as well as the background to this study was provided. In this chapter the literature related to patient centered nursing care, nurse/patient communication, record keeping and patient care will be reviewed.

A literature review was done to gather information about the above issues related to this study to provide context and understanding of patient -centered nursing care and communication and record keeping. The databases which were used for the search of the articles were EBSCOHOST (CINAHL) and Proquest (Nursing and Allied Health source). A total of 97 articles were extracted and 28 of them were included as they reflected on the purpose of the study and the research question. The words used to search for the articles were 'patient centered nursing care', 'patient centered maternity care', 'quality nursing care', 'communication in nursing care', 'nursing documentation practices', 'patient outcomes', 'patient information in nursing care'. The dates of the articles ranged from 2000-2017.

2.2 PATIENT CENTERED NURSING CARE

Patient centred nursing care is defined as nursing focused on the patient which involves patient autonomy and the inclusion in their health care decision making (Epstein & Street, 2011). Thus, patient centred care is the total involvement of the patient in their care during hospitalisation. The Institute of Medicine has identified "patient centred care as an essential component in the functioning of the health care system" which could imply that without patient centred care the health care system will not function optimally and best patient outcomes may not be achieved (Robinson *et al.*, 2008). It is important to understand that patient outcomes are not only dependent on the physical outcomes but also involves the patient experience. The patient experience is an interrelated network of principles as stated by the Picker Institute (1987) as they stipulate eight principles for the achievement of patient centred care. These principles include respect for patients, coordination and integration of care, information and education, physical

comfort, emotional support, involvement of family and friends, continuity and transition as well as access to care (Picker, 1987). When combined and integrated in the nursing care and documentation of care, these eight principles can guide nurses into providing patient centred nursing care and the attainment of best patient outcomes. Epstein and Street (2011) further describe patient centred care as three dimensional which involves personal, professional and organisational integration. This supports the Institute of Medicines statement that patient centred care is essential in the functioning of the health system as it involves the patient, the health care providers and the organisational structure of the hospital.

In maternal health care, patient centred care is most important as the purpose of maternity care is to facilitate the attachment between mother and baby and promote optimal health of both through the efforts of the family. The nurse is a partner in this process rather than a provider of health care. This is due to the fact that nursing in the maternity unit involves the patient, infant and the spouse or birthing partner. It may also enhance the health care professional's perspective on the need to place their focus on the patient which may increase the levels of empathy and affective responses given to the patients during labour and the post-natal journey (De Labrusse *et al*., 2016). Scand (2016) describes the patient centred care model as "holistic and therapeutic", emphasising that patients need a holistic approach to their care that incorporates their specific needs, especially in the maternity setting. This can result in improved patient care and increased patient satisfaction leading to better patient outcomes (De Labrusse *et al.*, 2016).

It is important to understand that the patient has a voice with regards to their health care, which would mean that the patient should be involved in the decisions made about their care, allowing their preferences to guide the nursing and medical staff (Barry & Edgman-Levitan, 2012). Therefore, understanding the perceptions of the patients' experience of the care which they receive is important for this study. Patient-centredness not only allows patient participation in their care but provides them with the necessary information through health education at any time during their hospitalisation (Leino-Kilpi *et al.*, 2015). Information is shared during the process of shared decision making and it is important and can improve the effectiveness of the nurse-patient communication in this therapeutic relationship. Shared decision making is two-fold as it incorporates allowing the patients to participate in the discussion of their care and giving the

patient the necessary information to make a valuable decision (Barry, 2012). In the framework for quality nursing care developed by Hulton et al., (2000) information provision is important in allowing the patient to play a cognitive role in their care. This encourages the patient's direct participation by allowing them to ask questions and by providing answers to those questions.

For the purpose of this review 2 aspects have been explored which may be important factors necessary for the achievement of patient centered nursing care. The first aspect is communication which is the foundation of a therapeutic relationship and the base of gathering information from the patient. The second is documentation, this is the written communication of the nurses about the care which has been provided to the patients.

2.3 COMMUNICATION IN NURSING CARE

Communication between the nurse and the patient is important in developing a therapeutic relationship necessary for desired outcomes to be achieved (Rathert, 2012). Peleki *et al.,* (2015) defines communication in the healthcare environment as the "exchange between two people through a common symbol system". Communication in healthcare involves the patient and the health care provider or nurse. It is a constant process and is continuous as the patient's needs may change, thus altering the communication between the patient and the healthcare provider according to the patient's immediate needs (Peleki *et al.*, 2015). Communication between the nurse and the patient will result in a relationship which is developed and which forms the crux of patient centred nursing care as it has a direct influence on the quality of care given to the patient (Morgan & Yodar, 2012). The relationship which is formed between the patient and the nurse can be defined as a therapeutic relationship as it involves communication between the patient and the nurse which is related to the healthcare of the patient and there is usually mutual respect between the two participants (Boykins, 2014). Mutual respect between the nurse and the patient encourages effective communication and creates a therapeutic environment which contributes to the improvement of patient satisfaction and patient outcomes. A therapeutic relationship is developed only when the nurse is able to comprehend the patient's feelings during their hospitalisation (Morgan & Yodar, 2012). Based on the context of where the patient is hospitalised and their individual needs, each patient has feelings related to their hospitalisation, and if this is

addressed more effective communication can be produced which encourages trust between the patient and the nurse. Farrington and Townsend (2014) stated that "good communication contributes to better care delivery and patient satisfaction". Effective communication in nursing care is a skill which needs to be developed and may need to be taught to some nursing staff. When communication is effective the patient is able and comfortable to communicate with the healthcare provider and verbalise their feelings as well as participate in an exchange of information which would result in active participation in their health care (Boykins, 2014). Active participation would encourage shared decision making between the patient and healthcare provider or nursing staff. Shared decision making is defined by Barry and Edgman-Levitan (2012) as "decisions which are made in a team, involving the clinician and the patient or their family". In this way the patient is able to gain information regarding their condition or illness and is able to make a decision based on their preferences and individual needs. Communication in patient centered nursing care is important not only to develop a therapeutic relationship but it can enhance the ability to gather the necessary information about the patients experience of the care provided to them. Communication is not only verbal but can be in the form of a written document in nursing care which is focused on the care provided to the patient. Caring and compassion was once the pinnacle of medical care which placed the patient and their family at the center of health care (Barry & Edgman-Levitan, 2012). Nurses are one of the main providers of patient care and can therefore enhance the health care received by patients by ensuring that a high quality of nursing care is provided for the patient and which will be reflected in optimal patient outcomes (Lindo *et al.*, 2016).

2.4. QUALITY OF POST NATAL NURSING CARE

While there is no shortage of literature on the subject of the quality of nursing care in the post-natal period, it becomes clear that there is no 'one-size-fits-all' description of the requirements for providing quality nursing care, or the patient's perceptions of the quality of care they receive. There is, however, consensus that the post-partum period is a difficult one for mothers who are their most vulnerable and needy due to the immense physiological, emotional and social changes which childbirth brings (Afaya et al, 2017; Apay et al, 2015; Stylianidos et al, 2016 & Rodrigues et al, 2014). This means that nurses and midwives need to strive to meet their needs.

In examining the evidence related to what those needs are, it becomes clear that, while authors differ on their emphasis of aspects that are required, and that a new mother has a combination of needs, the degree to which they are needed differs. Two studies which were published after the initial literature search, have particular relevance to this study. A South African study (Jikijela et al, 2018) of experiences of midwifery care post-caesarean, emphasized the aspect of pain and the impact it had related to the patients' ability to cope with both their self-care and the care of their baby. A study in Brazil (Ozkan et al, 2019) however, showed that the satisfaction rate of post-natal women was higher in those who had experienced a caesarean section than those who had experienced a normal vaginal delivery. This could be an indication of the differences of perceptions from one country to another, it may depend on whether the studies were qualitative or quantitative in nature, it may relate to researcher bias, or may even depend on whether studies were undertaken to explore health workers' or patients' viewpoints.

A study in Uganda (Munabi-Babigumira et al (2019) demonstrated that the viewpoints of health workers and patients, with regard to views and experiences of the quality of care postnatally, did not differ greatly, but it did show that the patients raised a concern about the communication skills of their carers. Adams et al (2016) examined perceptions of rural women in Malawi of regarding the quality of care found that aspects of care that were done best were education relating to breastfeeding and contraception, whereas they did not believe the physical assessments received were adequate. With regards to psycho-social care, this study showed deficits in nurse-patient communication. A study done in Brazil (Rodrigues et al, 2014), while using different methodology, seems to come to similar conclusions about care in Brazil. The authors concluded their study by saying that health workers used what they refer to as a biologistic and fragmented" approach when providing care to post-natal mothers which results in their neglecting to assess patients, to prepare women to care for themselves, and to generate comfort and safety.

A study in India (Kapzawni, 2006) used the Donabedian model to assess the quality of care in the postnatal units and had much wider discrepancies in care than the studies quoted thus far. The author found that only 10% of mothers were satisfied with the quality of care received and that nurses need to utilize resources, time and manpower more effectively. Highest satisfaction was with comfort and safety and 'treatment' whereas the lowest satisfaction was recorded related to

hygiene, care of the newborn and teaching. Interestingly, in this study, psychosocial support ranked the third highest factor.

A study conducted in Iran (Moosavidisadat et al, 2011) compared the quality of postnatal care given in academic and non-academic hospitals and showed that the quality of care was higher in the non-academic hospitals which would appear to be counter-intuitive. However, the authors explain that patients attending the academic hospitals were mainly from rural, poor communities whereas those attending the non-academic hospital were fee paying.

This leads one to consider whether socio-economic status and culture have a bearing on the perceptions of quality of care. Coutinho et al (2018) addressed this issue and found that, while the nurses believed they were culturally sensitive, the post-natal mothers did not agree. This study took place in Portugal where one of the main problems appeared to be the multilingual nature of the patient population resulting in the nurses lacking the language skills to communicate adequately. This problem often occurs in South Africa. A study (Hick et al, 2008) conducted in the United States of America where the differences in perceptions of post-natal care of black and Hispanic patients was examined also found that culture was a differentiator in the perceptions of the quality of care delivered. In their study, the factor that predicted positive experiences for the Hispanic patients was that of family involvement, whereas for the black patients it was continuity and transition of care. The study by Scheerhagen et al (2014) gives weight to the idea that culture is an important determinant of the perception of the quality of care received. Using the WHO model to guide the study, they found that “dignity and communication’ ranked the highest in terms of predicting positive experiences of care received.

While most of the literature concentrated on the role of the nurses in meeting the needs of the patients and so being seen to be providing quality care, there were some articles which point out that patient perceptions are influenced by their own personal issues. Stylianides et al (2016) showed that a patient’s degree of emotional intelligence influences their perception of the care they receive, especially relation to patient-nurse relationships. Chang et al (2009) found that the post-natal woman’s husband’s drinking behaviour influenced their perception of the care they receive.

2.5. QUALITY OF NURSING DOCUMENTATION

Since patient centred nursing care is focused on the patient, involving them in the decisions regarding their care during hospitalisation, the use of effective communication via the nursing documentation is an essential factor when evaluating patient centred nursing care. Documentation can also be viewed as a form of communication as it communicates the concerns of the patient, the care results and the sequence of events during a period of time (Finn, 2015). Nursing documentation is either a written or electronic document where information is generated about the care which was received and the response to the treatment given (Lindo *et al*., 2016). It can also be viewed as evidence of the care which the patient has received (Beach & Oats, 2014). With this in mind, the documentation should be a detailed description of what has been done for the patient and the patient's response.

If the quality of nursing care is questioned, the documentation about the care of the patient will be reviewed to determine if the alleged deficits in quality nursing care do in fact exist (Beach & Oates, 2014). As the nursing documentation is the direct communication about the care given to the patient, poor patient outcomes may be a result of poor patient communication and can lead to litigation (Becker, 2017). Since nursing documentation is an indicator of quality in nursing care it is imperative that nursing documentation is patient centred so that it reflects the total care of the patient and their respective individual needs (Okaisu, 2014). The benefits of nursing documentation as stated by Lindo *et al.,* (2016) are to "include patient safety, quality of care and the opportunity for research". Patient safety may also be defined as a means to eradicate patient complaints. The complaints arise mainly when desired needs have not been met. Therefore, nursing documentation should include all aspects of the patient's care and can be used as a means to investigate the complaints raised by the patient (Blair and Smith, 2012). It was suggested by Blair & Smith (2012) that nursing documentation should state "what should be done, what has been done and what the outcome was of the nursing care given". This reflects not only on the nursing care provided to the patient but also how the patients' have perceived the experience of the care provided to them. Kent and Morrow (2014) identified quality ambitions of nursing documentation which include "safe, effective and patient centred nursing documentation". Accurate nursing documentation should be patient centred and as stated by Blair & Smith (2012)

"will facilitate communication, improve or promote nursing care, meet the legal requirements and aid in the quality improvement of the patient care given". Patients want to know that they have been heard and understood. Good nursing documentation may alleviate patient concerns by the implementation of appropriate standards of communication which should incorporate thorough documentation by each health professional involved in the care of the patient (Becker, 2017).

2.6. CONCLUSION

In this chapter a review of the literature related to the study was presented. Chapter 3 will discuss the research methodology that was followed to collect the data necessary to answer the research question stated in Chapter 1.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. INTRODUCTION

In Chapter 3, a description of the research methodology will be given including the research design, research setting, sampling process, data collection and data analysis. The ethical considerations and trustworthiness of the study will also be highlighted and discussed. The focus of this chapter is the research methodology used to gain data and determine the relationship between the two variables discussed.

3.2. RESEARCH DESIGN

An exploratory multi-method design was utilised, using two methods of data collection and analysis. A multi-method design is used to "compensate the weaknesses of another (research method) in order to improve the quality of the data specifically relating to the validity and the reliability of the data" (Sim *et al.*, 1998). As the first objective of this study sought to ascertain the experiences of patients which lends itself to a qualitative approach and the second to a document review which lent itself more to a quantitative approach, it was necessary to use a multi-method design. A summative content analysis was applied to analyse both sets of data. Summative content analysis is defined as "identifying and quantifying the words or content by means of a coding system which is followed by latent content analysis that interprets the words or content identified" (Hseih & Shannon, 2005). If the content or words were only counted then the data analysis would remain in the quantitative form therefore the interpretation of the content or words converts the data into a qualitative form (Hseih & Shannon). The Multi-methods design assisted with the triangulation of the data. Triangulation arises by incorporating "multiple data sources, methods or even observations" (Esteves *et al*., 2004). As stated above, both qualitative and quantitative methods and sources of data was used which accentuates the triangulation of the data in the multi-methods design. This design was most suited for the study due to the multiple data sources need for the collection and analysis of data to be able to answer the research question. The research question poses a comparison of the relationship between two variables

needed to determine if patient centered nursing care is being implemented in the chosen nursing unit.

3.3 RESEARCH SETTING

Data collection took place in a natural setting in the maternity ward of a 450 bedded private hospital in Gauteng. Maternity wards in the private sector strives to be more family centered allowing spousal and family participation in the birth of their baby. The units have private rooms and semi-private rooms available for the duration of their hospital stay. The patients are encouraged to plan their birthing experience which allows the nursing staff the ability to offer the patients with the best expected experience to suit the patient's needs. The maternity ward has Thirty (30) beds and caters for patients with normal and abnormal pregnancies. The caesarean section rate is 76 % which, together with the fact that the ward has private rooms and two-bed rooms where the interviews could be conducted, made it the setting of choice for this study.

3.4 POPULATION AND SAMPLE

3.4.1 POPULATION

The population chosen for the study was patients who had undergone a caesarean section in the maternity unit of the selected private hospital. Caesarean section patients were chosen partly because of the large numbers of caesarean births in the unit and partly because it was only possible to interview them relating to care received on the second post-operative day. These patients were specifically chosen as patients would have been hospitalised for more than 24 hours and were mobile at this stage of their care. This encouraged optimal participation and data for the purpose of the study. These patients are kept in hospital for a minimum of three days and so were able to observe care over a period of time.

The records of the patients who were interviewed were matched to the patients. The population size was calculated on the basis of the number of patients who are, on average, admitted over a period of a month which was found to be sixty-six (66). This calculation was based on the average numbers as calculated in December 2016 in preparation for submission of the research proposal.

The population for the study was then taken to be the sixty six patients admitted during the month that the data collection was taking place.

3.4.2. SAMPLE

The patients selected for the study were required to meet the following criteria:

- Patients who remained in the hospital for a minimum of three (3) days post caesarian section delivery
- Patients who were able to communicate with the researcher.
- Patients whose records were available to the researcher

A total sample of all the patients who met these criteria were included in the study. Fifty-seven patients were therefore included for the first phase of the data collection which related to the quantitative aspect of the study.

With respect to the qualitative aspect of the study, it was planned to include all the patients whose records had been selected for the study but as data saturation had been reached by the forty-first (41st) interview, data collection was terminated after this point. Data saturation is defined by Brink *et al*., (2015, 144) as a stage during data collection when no new data received adds anymore differential value to the study, which can be reflected by the repetition of information received by either the patient interviews.

3.5 DATA COLLECTION

The data collection was commenced in two phases; the patient interviews and the review of the nursing documentation. Each phase will be discussed individually to describe the process of data collection.

<u>Phase 1: Nursing documentation</u>

Phase 1 consisted of a review of the nursing documentation of the same patient who had been interviewed. The objective set for Phase 1 was to identify the stated nursing activities documented in the nursing documentation. A requirement from the hospital to access the nursing documentation was that the researcher obtained consent from each of the nurses who entered

information on the nursing documentation. The Unit manager of the ward assisted with this process by providing a list of all the staff members who were employed in the unit and provided them information about the study. The staff members were approached as a group or individually, information was provided verbally and a leaflet with the written information handed to them. The staff members were given an opportunity to read through the information and then signed the consent form. Once the consent was obtained from all the nursing staff, the collection of data commenced.

The data that was used for the phase of the study were the verbatim nursing records. The nursing documentation reviewed consisted of nursing notes written during the patients' period of hospitalization which were transcribed onto a fresh blank record to enable analysis. Once the relevant patient record was reviewed the patient interviews commenced and both sets of data was captured on the data collection tool (see table 3.5.1 as an example) to begin the process of analysis.

Table 3.5.1: Data collection sheet

DATA COLLECTION SHEET – PATIENT RECORDS & INTERVIEWS

(Record data for each method on separate forms)

Code for patient …….

Category	Words / phrases used			
Respect for patient preferences				
Coordination & integration of care				
Information & education				

Physical comfort				
Emotional support				
Involvement of family & friends				
Continuity & transition				
Access to care				

Phase 2: Patient interviews

Phase 2 consisted of the patient interviews grounded in the second objective to ascertain the patient's perception of their experience of the nursing care that was given. Patients were identified according to the inclusion criteria stipulated in the population. Each patient was approached and given a verbal explanation of the study and then asked if they were comfortable participating in the study. If they consented then an information leaflet was given to read and sign, they were also asked to sign consent for the digital recording of the interview. The participants were asked if they were comfortable to participate in the interview in their room or if they would be more comfortable to move to a private room for the duration of the interview. All the patients felt comfortable remaining in their rooms. The patient's husbands or partners were usually in the room during the interview as well as the participants' babies.

Prior to the commencement of the interviews the interview was piloted to determine the possible duration and probes needed for the collection of data. Two pilot interviews were done, and the necessary probes were derived from the pilot interviews. All the interviews were kept anonymous by assigning a code to each interviewee. The patient codes used were P1, P2 etc. with ascending numbers until the required number of interviews were done. A voice recorder was used to record

each interview. The recordings were filed according to the codes given to each patient interview (P1, P2 etc.). A transcription of each interview was made using Express Scribe Transcription software by NCH software.

The interviews were semi-structured.

Semi-structured interviews provide an opportunity for the interviewer to ask a few structured questions and probes are allowed to follow to gain a deeper explanation from the interviewee (Brink et al,2015, pp158). The interviews were begun by asking the broadly stated question; "Please describe everything that you experienced pertaining to the nursing care you received in the ward yesterday between 07h00 and 07:00 this morning". It was envisioned that the interviews would have an average duration of 5-10 minutes, the core part of the interviews lasted approximately 5 minutes each as some patients were reluctant to provide more information when probed.

The probes were found to be necessary as a guide to help patients recall their experiences of the nursing care which they received (See annexure 10) and were based on Picker's principles of patient centred care. The eight principles were not all included for the purpose of the study as the last two principles, namely continuity and transition and access of care were not applicable to the sample group. The National Research Corporation of Canada (2015) describes the last two principles as follows; continuity of care is focused on the alleviation of fear and anxiety during the period of discharge. Access to care is ensuring that patients have the necessary healthcare for follow up visit after discharge. As the study only explored care received on the second day post-delivery and for that 24-hour period, these principles could not be explored.

3.6 DATA ANALYSIS

Of the 43 interviews conducted over the two-month period of data collection, 41 were included in the sample to be analysed. Two interviews were not included for data analysis. In one case the set of data was incomplete as the voice recorder's battery died and in the second the patient did

not answer the questions as asked and strayed from the questions describing issues not related to the study. A template analysis using Picker's eight principles of patient centered care was conducted (See table 3.6.1). The following template was developed to define the principles for the study. Each principle was redefined by the researcher to assist with the coding of the data and the analysis. As the study was analysed using a summative content analysis, it allows the researcher the ability to interpret the data according to her understanding. The principles description for the study was supervised by the researcher's supervisor. The definitions for the principles are derived from the Registered Nurses Association of Ontario (RNAO, 2015) and the Picker institute (1987).

Table 3.6.1: Template used for the analysis

CODE	PCC PRINCIPLE	DEFINITION OF THE PRINCIPLE BY PICKER	DEFINITION OF THE PRINCIPLE FOR THIS STUDY
A1	Respect for patient's values, preferences and expressed needs	Treating individuals with respect, in a way that maintains their dignity and demonstrates sensitivity to their cultural values. Keeping individuals informed about their condition and involving them in decision making. Focusing on the patient's quality of life, which may be affected by their illness and treatment (Registered Nurses Association of Ontario(RNAO), 2015 & Picker, 1987))	Patients express individual needs and preferences related to interpersonal interaction with the nurses, autonomy and breastfeeding. Treating the patients as individuals with respect by maintaining their dignity through demonstrating sensitivity to their cultural values. (RNAO, 2015 & Picker, 1987). *Focusing on the patient's quality of life through their illness and treatment was excluded in the definition as it does not*

CODE	PCC PRINCIPLE	DEFINITION OF THE PRINCIPLE BY PICKER	DEFINITION OF THE PRINCIPLE FOR THIS STUDY
			apply to this study; the patients are not ill and can be described as healthy.
A2	Coordination and integration of care	Coordinating and integrating clinical and patient care and services to reduce feelings of fear and vulnerability (RNAO, 2015 & Picker,1987)	The coordination and integration of care related to the obstetrician, paediatrician, dietician and the physiotherapist.
A3	Information and education	Providing complete information to individuals regarding their clinical status, progress, and prognosis; process of care; and information to help ensure their autonomy and their ability to self-manage, and to promote their health (RNAO, 2015 & Picker, 1987).	Information or health education which the patient received regarding their healthcare, to ensure they maintain their autonomy and provide them with the ability to self-manage their health (RNAO, 2015 & Picker, 1987).
A4	Physical comfort	Enhancing individual's physical comfort during care, especially with regard to pain management, support with the activities of daily living and	Nursing activities related to the patient's healthcare including pain management, wound care, intravenous care, observations done and catheter care.

CODE	PCC PRINCIPLE	DEFINITION OF THE PRINCIPLE BY PICKER	DEFINITION OF THE PRINCIPLE FOR THIS STUDY
		maintaining a focus on the hospital environment (RNAO, 2015 & Picker, 1987).	
A5	Emotional support and the alleviation of fear and anxiety	Helping to alleviate fear and anxiety the person may be experiencing with respect to their health status (physical status, treatment and prognosis), the impact of their illness on themselves and others and the financial impact of their illness (RNAO, 2015 & Picker, 1987).	The emotional support experienced by the patient, received from the nurses to alleviate any fear or anxiety which the patients experience (RNAO, 2015 & Picker, 1987).
A6	Involvement of family and friends	Acknowledging and respecting the role of the person's family and friends in their health care experience by: Accommodating the individuals who provide the person with support during care Respecting the role of the person's advocate in decision making	Social support from the patient's family and friends. Acknowledging the patient's family and friends who support her during the hospitalisation and respecting the role that the family and friends play in the recovery of the patient (RNAO, 2015 & Picker, 1987).

CODE	PCC PRINCIPLE	DEFINITION OF THE PRINCIPLE BY PICKER	DEFINITION OF THE PRINCIPLE FOR THIS STUDY
		Supporting family members and friends as caregivers, and recognising their needs (RNAO,2015 & Picker, 1987).	

The principles are; respect for patient's preferences, coordination of care, information and education, physical comfort, emotional support, involvement of friends and family. The last two principles were not included as stated previously. For the purpose of data analysis 2 types of analytical techniques were used to analyse the data collected (Brink et al, 2015). The analytical techniques used in the study was a template analysis and a summative content analysis. Both methods of analysis were used to code the data and aid the interpretation of the data. A template analysis is defined by Cassel & Snyman (2004) as "thematically organizing and analyzing qualitative data in various social sciences". Codes are developed to organize information rich data from either patient interviews or transcripts, the data is then coded and applied to the template to help the researcher make sense of the information gathered during data collection (Brooks & King,2014). The process of organizing and connecting data in a template analysis is described by Waring and Wainwright (2008) as "creating a code manual or scheme, hand coding the text, sorting segments to get all similar text in one place and reading the segments and making the connections that are subsequently corroborated". The template was developed based on the principles derived by the Picker institute which were then used as a priori codes for the purposes of data analysis. The principles were then coded as A1-A6. The template analysis is best suited and applied when the aim of a study is to compare perspectives of different groups which would be the patients stated care experienced and the nursing documented care (Cassel & Snyman, 2004). Data was analysed by a summative content analysis approach which directed the focus of the research question and enhanced the theoretical framework initiated by the Picker Institute (1987) (Hseih & Shannon, 2005). A summative content analysis involves counting the phrases or words identified in the

patient interviews and the nursing documentation and then relating them to the principles described by Picker (1998). The counting of the words or the phrases related to the principles described by the Picker Institute is a quantitative process in the summative content analysis. The codes were predetermined and based on the principles of patient centered care which describes the method of summative content analysis where coding is derived from the theory (Hseih & Shannon, 2005).

Phase 1: Nursing Documentation

In Phase 1 the nursing documentation was analysed to identify the stated nursing activities documented in the nursing documentation. The data collected from the nursing documentation was read to identify phrases or sentences related to the nursing care given to the patient applying summative content analysis approach. The nursing documentation for the respective patients was copied for further evaluation. Each nursing record was reviewed and copied before the patient interview to reduce the risk of the documentation not being available once the patient was discharged and to ensure that the correct patient's documentation was reviewed to eliminate any confusion. Predetermined codes were assigned and phrases or sentences were coded according to the principles of patient centered care (Hsieh & Shannon, 2005). The phrases or sentences identified were then noted on the template table created which is divided into the eight principles of patient centered nursing care. An example of the analysis is provided in table 3.6.1. Definitions of the eight principles of patient centered care which were derived from the Picker institute (table 4.1) was kept to help the researcher determine which phrases apply to which principle (RNAO, 2015).

Table 3.6.2 is an example of the coding and analysis of the nursing documentation reviewed. Each document was read and reviewed. The words or sentences applicable to a principle was coded accordingly. The words or sentences were identified by comparing it to the definitions derived for the study. For the purpose of the study the phrases and sentences were highlighted to match the principle to make it more identifiable.

Table 3.6.2: An example of the coding of the nursing documentation

7-19	
• 07h00: Patient received from night staff awake and orientated. Wound: the wound is intact, no bleeding observed. Hygiene: patients bleeding observed and lochia is minimal Interim: Patient has a drip in situ and IV site assessed. No abnormalities detected and urinary catheter in situ and draining well.	A4
Pain: Patient has no complaints of pain at the moment.	A1
• 10h30: Patient seen by doctor and requested drip and catheter to be removed.	A2
• 11h00: Patient mobilized to the bathroom to freshen up.	A2
• 12h00: patient complained of pain 2/10 and burning pain and 2 pain tablets given as prescribed.	A1 & A4
• 13h15: Patient is comfortable and complaints raised.	
• 16h00: No complaints of pain raised at the moment and patient is mobile.	A5
• 17h00: Medication; 2 stilpaine given with pain scaled 2/10 burning pain of the abdomen and Voltaren suppository given.	A4
• 18h00: Evaluation; Patient is comfortable and managed to pass urine and no complaints raised and patient is mobile.	
19-7	
• 20h00: Received from day staff and found in a stable condition clinically.	A5
Lactation: Breastfeeding her baby in NICU and coping well.	A1 & A5
• 21h00: Passing urine well and lochia not offensive. Wound clean, dry and intact.	
• 22h00: Pain medication given as prescribed. Clexane given too.	
• 23h00: Pain scale 2/10 again.	
• 05h00: Pain medication given as prescribed. Pain scale 3/10	A4
• 06h00: Pain subsided to 2/10 again. Mobilizing well.	
• 06h00: Verbalizes she will insert Voltaren when she needs it. Patient mobilizing well	

After the phrases and sentences were identified and coded, they were categorised according to the applicable PPC principle (table 3.6.3). The categorization was done to determine which principles were practiced in the nursing documentation and which were not.

Table 3.6.3: Example of the words and phrases identified, noted and categorized in the nursing documentation.

Category	Words / phrases used			
Respect for patient preferences	Patient has no complaints of pain at the moment	Patient complained of pain	Breastfeeding her baby in NICU	
Coordination & integration of care	Patient seen by the doctor			
Information & education				

Physical comfort	Wound is intact, no bleeding observed	Lochia minimal	Drip in situ, IV site assessed no abnormalities noted	Urinary catheter in situ and draining well
	Pain tablets given as prescribed	2 Stilpane given, pain scaled 2/10	Burning pain of the abdomen	Voltaren suppository given
	Passing urine well, lochia not offensive	Wound clean, dry and intact	Pain medication given	Patient mobilizing well
Emotional support	Patient is comfortable	No complaints raised	Found in a stable condition	Coping well with breastfeeding
Involvement of family & friends				
Continuity & transition				
Access to care				

Phase 2: Patient Interviews

The second objective for the study was to ascertain the patient's perception of their experience of the nursing care that was provided to them. As the directed content analysis allows the theory, namely Picker's principles of patient centered care, to focus the research question of the study, a strategy of a summative content analysis was used to analyse the patient interviews (Hseih & Shannon, 2005). Predetermined codes were used to identify phrases and sentences relating to the nursing care received from the nursing staff in the transcriptions analysed (Hseih & Shannon). A phrase or sentence related to the coded principle was identified once throughout the interview for it to be coded accordingly. The phrases were then tabulated according to the eight principles of patient centered care (Picker, 1987). The definitions of each principle (see table 4.1) were applied to determine where to place the coded phrases. In table 3.6.3 an example of the coding and analysis of the patient interviews is illustrated. The same coding process was followed as described in phase 1. The transcripts were read, when a specific principle is identified it is coded accordingly. See table 3.6.4.

Table 3.6.4: Example of the coding of a transcription of the patient interview

Nurse: So specifically i mean you are in the profession so if you can think about the nursing care specifically that you received lets say from 7 o'clock yesterday morning or when you got up until this morning basically if you can tell me about that and what did you experience?	
Patient: Um like how?	
Nurse: What did they do for you, how did you experience...	
Patient: No they come and check the take the Obs and then they check the pad and if everything is okay there is no bleeding and then they change the bedding and they ask if your okay do you need any any pain medication and you must shout if you need anything	**A4** **A1**
Nurse: Hmmm	
Patient: Ja	
Nurse: And you feel comfortable enough to call them and ask them for help?	
Patient: Ja ja because they are there when you need them even though they not in the ward but you can like actually call all of them anytime when you need them	**A1**
Nurse: And between the day and the night staff do you think that the day staff is more interactive with you than the night staff or is it the opposite	
Patient: MMMM um eish cos the thing is I spend most of my time sleeping	
Nurse: Hmmm, Ja I was here earlier and you were fast asleep	
Patient: Ja so I spend most of my time sleeping	
Nurse: So you can't really say...	
Patient: Ja I can't tell Ja, so i just see whenever they come for the Obs or if they wanna ask something then that is it	
Nurse: Okay and it was very different for you because your baby was in NICU	
Patient: Hmmm	
Nurse: How did they assist you? Are you breastfeeding?	**A1**
Patient: Yes i am	
Nurse: Are you, so how did they assist you with that since your baby was in NICU did they give you some assistance and reassurance	
Patient: Uh on the first day i didn't breastfeed, so um there is a sister that came here and said no they just need um breastmilk from me and we tried and just like press the milk out and everything and there is like liquid just coming out nd said that this is going to feed the baby whatever they got and then i gave it to them and then learned i have to go there every 3 hours	**A2 NICU staff**
Nurse: Every 3 hours..	
Patient: Ja ja ja	
Nurse: So they gave you some nice advice on how to manage	
Patient: And i fall asleep because i was suppose to go there at 2 and they they called me to my cell Ja this morning they actually called me to my cell to say no you must come	
Nurse: Ja	
Patient: Ja so	
Nurse: That is awesome, no that is good. And your pain how are you coping with your pain and how have the nurses assist you regarding your pain?	
Patient: No I don't have any pain it's just um normal surgical pain but like there is nothing severe cos um I can walk and um they have given me Voltaren everything is just like next to me when i need it and they have given me perfalgan like every now and then when I had a drip ja and ja there is uh Stilpane now	**A4**
Nurse: And it is on a schedule?	
Patient: On a Ja Schedule	
Nurse: Which is working well?	
Patient: Ja Ja so it just ask even if I feel like it's it's like severe I ask that I must just tell them maybe they can do something	
Nurse: Ja, that's wonderful	
Patient: Ja but other than that everything has been fine	
Nurse: Ja...is there anything that you can suggest that we can maybe improve concerning the care in the ward?	
Patient: Not not the nursing care just the food and stuff	**A4**
Nurse: The food everybody seems to complain about the food (laughing)	
Patient: (laughing) Ja it's just the food but ja the nursing care no	
Nurse: So you think we are on par?	
Patient: Ja everything is fine Ja everything is fine	
Nurse: And the doctors have they been accommodating you and your husband like in a family perspective has it been family orientated?	
Patient: Ja because you know when doctor (x) comes to see me the first thing she asked me is where is Jacob	**A2**
Nurse: Okay, ja	
Patient: Ja even though he is not here and I'm like he went there and there and there and she will just discuss whatever she wants to discuss with me but the first thing she will ask where is Jacob so he can be there, ja	
Nurse: You see It's Dr Q's personality is that she is quite family orientated so it is important to her.	
Patient: She is the only doctor that I have seen accept for Dr (G) I didn't see her here but it's just when I go there	

Nurse: so she hasn't come to speak to you? **Patient:** Who? **Nurse**: Dr Grobler? Does she see you in did she see you in ICU? **Patient:** Ja she saw me in ICU **Nurse:** Okay **Patient:** Ja when she saw the baby and she explained to me that everything is going fine and they so friendly **Nurse**: Ja **Patient:** It's like they just make sure that you calm and understand what is going on? **Nurse:** No that's good so you feel like your getting enough information to reassure you? **Patient:** Information….Ja...yes **Nurse**: Do you feel like you were emotionally supported um they nurses with your baby being in NICU, you didn't feel like your stranded in a way or unsure? **Patient:** No no no because they will always ask how's the baby and if everything is okay and ja I tell them then I say no if maybe some of them because there is some sister that will come from there and to just come here and just check on me and say no the baby is fine it's just so and so and so, so ja so I think they have been emotionally supportive as well **Nurse:** No that is awesome, well that's all I needed to ask you….	**A2** **A5** **A3** **A5**

Once the phrases and sentences were coded they were tabulated and categorised with the applicable patient centred care (PCC) principle. See table 3.6.5 for an example.

Table 3.6.5: An example of words or phrases identified, coded and categorized in the patient interviews

Category	Words / phrases used			
Respect for patient preferences	Ask if you're okay	Shout if you need anything	They are there when you need them	Call them anytime
	Breastfeeding: yes, I am			
Coordination & integration of care	NICU staff: assisted with breastfeeding or the expressing	The gynecologist does rounds	Pediatrician consulted patient in NICU	
Information & education	Given information			
Physical comfort	Check the observations	Check the pad	Pain medication given	Perfalgen through the drip
	Stilpaine tablets given	Food needs improvement		
Emotional support	Nurses make sure you are calm	Ensure you understand what is going on	They have been emotionally supportive	

Involvement of family & friends				
Continuity & transition				
Access to care				

Phase 3: Comparison

The third objective was to compare the nurses stated care with the patient's experience of care to determine if patient centered care is rendered in the unit. A comparison template was used to compare the patient interview transcripts with the nursing documentation (see the table 3.6.6). The purpose of the comparison template was to identify any similarities or differences between the two sets of data to achieve the objective set for this phase.

Keywords and phrases were identified and documented in both the patient interviews and the nursing documentation. For both the nursing documentation and the patient interviews the principles identified were ticked or noted in the comparison table. This forms part of the summative content analysis which requires the researcher to count the phrases or words identified. In each comparison table there may be 1 or 2 similarities which would mean that there is some degree of patient centeredness rendered. If there are different principles ticked or noted then patient centeredness is not practiced (see table 3.6.6). The comparison was made to identify any differences or similarities and to ascertain both the patient's perceptions of care that was given and the care which was received.

Table 3.6.5: Comparison table

Patient interviews	**Patient records**	Respect of patient Preferences	Coordination & Integration of care	Information & Education	Physical Comfort	Emotional Support	Family Involvement
Respect of patient preferences		● ★					
Coordination & integration of care			● ★				
Information & Education				●			
Physical Comfort					● ★		
Emotional Support						● ★	
Family Involvement							

In table 3.6.5 the occurrence of the specific principle is noted to determine similarities and differences, the symbol "●" refers to the patient interviews and the symbol " ★ " refers to the nursing documentation.

Throughout the analysis of the patient transcriptions and the nursing documentation the two sources of data were compared with the application of the Picker's principles of patient centered care (Picker, 1987). The comparison was an iterative process which was done by the researcher and the supervisor. With the comparison made, the similarities and differences were identified to conclude the findings of the study which will follow in Chapter 4.

3.7. RIGOUR

Rigour in research is defined by Brink *et al.,* (2015) as "data which is collected in an objective, systematic and thorough manner which is analyzed and interpreted in a way which minimizes contamination and enhances the accuracy of the research study". The principles of rigour have been described with reference to the study and to achieve triangulation. Triangulation is achieved by ensuring that credibility, dependability, confirmability, transferability was maintained (Brink *et al.*, 2015).

3.7.1 Credibility

Credibility can be described as a "truth formulating process", meaning the data should be interpreted accurately and be truthful (Esteves *et al.,* 2004). A method of triangulation can be utilised to enhance the credibility of the study. Triangulation is a technique of internal validity which Brink *et al*., (2015) define as a method of "using a variety of sources in data gathering". There are different types of triangulation applicable for this study which used a variety of sources for data gathering and analysis. Data triangulation is defined as "using multiple means and sources for data collection" (Brink et al, 2015). The sources of data collection which were utilised were the nursing documentation reviews which lends itself to the quantitative data and patient interviews which lends itself to the qualitative data. The use of both the quantitative and qualitative data in this study is defined as methodological triangulation (Brink et al, 2015). The data was compared against each other in order to establish consistencies and inconsistencies and to establish an answer for the third objective for the study. During the data collection process different questions were asked to allow probing for the necessary information to be collected with the patient interviews, different sources of information were also utilised from the patient interviews and the nursing documentation to enhance triangulation and the credibility of the study (Brink *et al.*, 2015). The application of triangulation in the study improved the credibility of the study which helped the researcher to accurately and truthfully collect, analyse and interpret the data collected.

3.7.2 Dependability

Dependability is required for the qualitative data in the study and In order to achieve dependability an audit of enquiry should be executed (Brink *et al.*, 2015). A second reviewer (the researcher's supervisor) reviewed a sample of the records and assisted with the template analysis. The researcher's supervisor was the selected peer reviewer who followed the process of the study to determine if they are acceptable. An audit trail of all data collection and analysis was developed and kept. Triangulation also assisted the process as this determined if similar or comparable conclusions were derived (Koch, 2006).

3.7.3 Transferability/ External validity

Transferability in the qualitative phase of the study is defined by Brink *et al* (2015) as the "degree to which the study can be generalised to other settings". This asks the question; can the results of the study be applied to other wards and if it is valuable? The data collected is detailed which allows the interpreter to decide if the study is fitting in another context (Brink *et al*., 2015). Esteves *et al.,* (2004) state that a method of establishing transferability in the study is to ensure that the conceptual framework being applied is accurately interpreted and used in the research study; it refers to content accuracy. Referring back to the framework during the process of the study was an effective technique to establish content accuracy. Therefore, reference was made to Picker's principles of patient centered care (1987) throughout the data collection and analysis process to ensure content accuracy for the transferability of the study to be achieved (Picker, 1987). For the quantitative phase of the study external validity needs to be achieved to determine "if the results of the study can be generalized to other settings or wards" (Brink et al, 2015,127). Due to the use of the conceptual framework established by the Picker Institute, the principles can be used in different wards to determine if patient centered nursing care is achieved. The principles were used in the maternity setting for this study but it is possible to transfer the study to other wards. The study was, however small so transferability outside the research setting may not be possibility. As the methods of the study have been well described, it would be possible to replicate the study in another setting to test this possibility.

3.7.4 Confirmability

Confirmability is defined by Brink *et al* (2015) as "guaranteeing that the findings, conclusions and the recommendations are clearly supported by the data". The researcher's opinions cannot be the basis of the research study, and a degree of "objectivity" is practised (Esteves *et al.*, 2004). This means that the researcher needs to ensure that the patient's voice is used accurately in the discussion of the findings. The patient interviews were transcribed using the Express Scribe Transcription Software by NCH software to ensure that every word the patient spoke was transcribed correctly and that no research bias was applied. The transcriptions were also reviewed by the researcher's supervisor to ensure that there was no researcher bias. Quotes of the patient's experience was used in the discussion of the study to validate the findings and interpretation of the findings. Concerning the nursing documentation, the nursing notes were directly copied, ensuring no bias was applied. The nursing documentation could not be photocopied as part of the audit trail due to company policy. To enhance the process of confirmability, triangulation was applied.

3.8 ETHICAL CONSIDERATIONS

The ethical considerations to be adhered to while conducting this research study relate to the protection of the patients' rights, informed consent and the involvement of the institutional review board for ethical approval (Klopper, 2009). The ethical principles practised for the duration of the study which would directly influence the patients' rights are contained in the South African Nursing Council (SANC, 2013) Code of Ethics for Nursing Practitioners in South Africa and are social justice, beneficence, non-maleficence and autonomy.

3.8.1 Social Justice

Social justice is defined by Brink et al (2015) as "the participants right to fair selection and treatment." To ensure that this principle is adhered to in the study the selection of participants was fair and just and according to the inclusion criteria. The participants referred to are the patient participants. No bias was practiced with the selection of the participants and every participant who was willing to participate in the study was included. The right to privacy also needs to be protected to ensure social justice is practiced (Brink et al, 2015, 36-37). The participant's privacy

was protected by conducting the interviews in a private room (if the participant was sharing a room with a patient a private room was made available for the purpose of the interview), one on one, the only people in the room were the patient and the nurse researcher. As the participants have the right to choose, they had the right to choose if they were comfortable in the room during the interview or if they preferred more privacy. As the study was conducted in the maternity ward, the patients had their babies with them during the interviews and their spouses. Anonymity in social justice refers to the participants being nameless (Brink et al, 2015). Anonymity was maintained during the interview ensuring that no names were mentioned of either the participant or the nurses involved in the nursing documentation. Anonymity was practiced by coding each interview and nursing document with a code namely, P1, P2 etc. The patients' names were not mentioned during the interviews to protect their identity and ensuring the interviews are anonymous. The code names were used when discussing the data with the supervisor, a master list was compiled with the patients names and the relevant code in a safe place and the list of real names were destroyed once the data was analyzed (Brink et al, 2015, 38). The registered nurse was called the RN and the other nursing staff were called assistant nurses. If by chance the names of the registered nurse or participant were mentioned then the audio interview would have been repeated and the former recording deleted. All the information acquired from the patient documents and the interview will be kept anonymous and will only be available to the researcher and supervisor. Data processing will remain anonymous (Brink *et al*., 2015). All records and data gathered from the interviews and the patient records will be kept in a safe place to ensure that the nurses' and participants' confidentiality is protected.

3.8.2 Beneficence and non-maleficence

Beneficence is defined as ensuring that no harm is inflicted on the participants during the process of data collection with regards to the patient interviews (DoH, 2015). The researcher has a responsibility to ensure that the participant is protected from harm and discomfort, this includes psychological and emotional harm (Brink *et al*., 2015). To ensure that each patient is protected from harm whether emotionally or physically a distress protocol was established to guide the researcher if the participants do experience emotional harm (see annexure 7, Distress protocol). The participants were informed of the right to withdraw from the interview at any point for any

reason. The participant was asked at regular intervals if they would like to continue with the interviews. They were informed that interviews would range from 5-10 minutes to ensure that they are aware of the time that it would require of them. The possibility was considered that participants could have become emotionally unstable since they were post-partum patients but clear clinical judgment was practised and consent to proceed with the interview was collected prior to the commencement of the interview. In the event that the registered nurses refused to allow their nursing documentation to be reviewed for the study they were informed that they had the right to withdraw, and in such a case the participant records would not be used for data collection. Part of the process of ensuring the participants are protected from harm is to ensure they have the required information regarding the research report. Both the patient participants and the nursing participants are provided informed consent. Non-maleficence is defined as doing no harm (DoH, 2015). This would imply that no intentional harm is implemented and that the participants should benefit from the research study. Ethical clearance was approved through the university to ensure that all processes and procedures are for the benefit of the participants involved. The patients participants would benefit with improved nursing care practices and the nursing participants would improve the documentation of the care which they provide to the patients.

3.8.3 Autonomy

Participants selected to participate in this study were autonomous and had the right to self-determination (Brink *et al*., 2015). Autonomy is defined by SANC Code of Ethics (2013) as a participant/ patient who makes their own decisions and choices about their healthcare. Participants who were both registered nurses and patients, were given a choice to participate as part of the process of informed consent. Each participant was given information about the study and given an opportunity to sign for consent to participate in the study, fortunately none of the nursing participants refused. There was a few patient participants who refused to participate in the patient interviews. During the patient interviews to ensure autonomy was protected, the patient participant was asked at specific intervals if they wished to continue participating in the

interview to ensure that the right to autonomy was respected. The nurses whose documentation was reviewed were given full information about the study before giving consent for their documentation to be used in the study, thereby ensuring their autonomy in deciding to participate in the study.

3.8.4 Informed consent

Informed consent is defined as ensuring "voluntary participation and protecting the participants from harm" (Brink et al, 2015). By providing both the patient and using participants with information about the study ensured that the participants were deciding to participate voluntarily. Consent was obtained from the participants involved. This included the patient and the nurses involved, and the facility in which the data was collected. Written and verbal consent was obtained at various intervals from the patient participant. The first step in collecting the consent was verbally with first contact, the patient was then given clear written information about the research and their involvement, and they were given time to read through it. The night before data collection, the participant was visited and they were asked for clear, informed consent. Prior to the commencement of the interview the researcher verified that the patient was still willing to participate. The interview was recorded on the audiotape. Consent from the participant was for both the participation interview and to review the participant's patient record. The nurses were given an information sheet to allow them to make an informed decision to consent to participate in the study. An information session was held to explain the research study and the nursing staff were given the opportunity to sign the consent form containing the relevant information. They were not obliged to participate in the study; the choice to participate was voluntary. Written permission was obtained for access, to interview patients and to use patient records from the facility in which the research was conducted.

3.9 CONCLUSION

This chapter described the research methodology that was followed to collect and analyse data. The next chapter will focus on the findings of the data analysed and will include a discussion on the findings.

CHAPTER 4

FINDINGS AND DISCUSSION OF FINDINGS

4.1 INTRODUCTION

In Chapter 4 the findings of the data analysis will be presented and discussed. The patient interviews and the nursing documentation will be discussed separately after which a comparison of the two will be made. The aim is to answer the research question attempts to determine the relationship between the documented nursing care and compare it to the nursing care experienced by the patients. The results of the qualitative aspects will be discussed first followed by the quantitative aspects and both aspects respond to the 3 objectives stated in chapter

4.2 FINDINGS OF THE QUALITATIVE ASPECT OF THE STUDY

4.2.1 PATIENT INTERVIEWS

The qualitative aspect of the study involved collecting data from the patients and analysing the transcribed interviews. Table 4.1 above provides definitions of the principles from the Picker institute (1987) and the RNAO (2015) and the definitions formulated and applied when analysing the data. Table 4.2 illustrates the phrases and sentences identified in the patient interviews and are categorised according to each principle. The phrases were identified by applying the definitions provided in table 3.6.1.

Table 4.2: Phrases or words used most commonly in the patient interviews

PICKERS PRINCIPLES OF PATIENT CENTRED CARE	PHRASES OR WORDS IDENTIFIED IN PATIENT INTERVIEWS	PATIENT CODES
Respect for patients' values, preferences and expressed needs	"Ask if you're okay" "Ask if you're coping" "Popping in to ask how's the breastfeeding" "Very supportive"	P: 39,11,38,28 P: 39,11,38,28 P: 39 P: 11

	"They are there when you need them"	P: 31,1
	"Helped me well, very helpful"	P: 24,29,21,26,20,35
	"Rooming in with the baby"	P: 19
	"Nurses assisted me with the breastfeeding"	P: 7,8
	"Greeted by the day and the night staff"	P: 6,38,10
	"Take the baby to the nursery so that can rest/sleep"	P: 36,16,3,35
	"Check if you're okay"	P: 5,38,16,3
	"Very noisy"	P:23,8
	" Assistance with breastfeeding"	P: 21,20,37
Coordination and integration of care	"Sister came in to help me with breastfeeding from NICU"	P:39
	"Paediatrician came this morning"	P:14
	"The doctor was here"	P:31
	"The paediatrician was here"	
	"Doctor asked if I want to breastfeed"	P:11
	"The physio keeps tabs on us"	P:30
	"Doctors come and check daily"	P:30
	"Doctors rounds/ visited"	P:23,15,10,20,21
	"Doctors are great"	P:16
	"My doctor came in this morning"	P:3,26
	"Doctor's care is very good"	P:21
Information and education	"Make sure you understand everything"	P:39
	"Gave me information about how everything is going to be"	P:24

	"She did a demonstration on how to latch"	P:19
	"They show you and teach you"	P:19,2
	"Showed me how to bath him"	P:34
	"They gave me enough information"	P:33
	"They explained everything, when I was unsure, they showed me"	P:15
	"Advice given"	P:17,8
	"Explain the procedures before they do it"	P:2,10,43,41
	"Paediatrician gave advice about breastfeeding"	P:1
Physical comfort	"Take my observations and check my pad"	P:39,35
	"Medication given for pain on a schedule"	P:39,24,33,7,6,18,28,23,16,21, 26,10,1,43,41,20,27,35,37
	"They gave me Stilpaine and Perfalgan"	P:39
	"I get pain medication often"	P:41
	"They are giving pain pills"	P:42
	"They cleaned me and checked my wound"	P:36
	"I'm asking for it and they bring it"	P:13
Emotional support and alleviation of fear and anxiety	"Very emotionally supportive"	P:39
	"Very concerned about you and how you are feeling"	P:10
	They ask "Are you feeling okay"	P:2
	"Make you feel at ease"	P:33,17
	"Reassuring us and comforting us"	P:18

Involvement of family and friends	"Accommodated my husband well"	P:36,1,43,41,21,35,37
	"I have 2 other children and they were here for long"	P:26
	"Husband said they involved him"	P:2
	"My family was here"	P:7
	"My husband involved himself"	P:38,23
	"My husband comes in with my son"	P:3
	"My husband is accommodated"	P:33,6
	"They have been involving him"	P:31
	"My husband was here everyday"	P:19,15

4.2.1.1. Respect for patients' values, preferences and expressed needs

Respect for patients' values, preferences and expressed needs were described or reported by the patients and were related to how the nurses spoke to them as individuals. It is described by phrases such as "ask if you're okay" (P39,11,38,28), "they are there when you need them" (P31,1), "helped me well" (P24,29,21,26,20,35) or "check if you're okay" (P5.38,16,3). These phrases identified in the patient interviews were the most commonly used amongst all the interviews analysed. As they were the most commonly used phrases for the first principle, it may be the manner in which the patients felt respected and therefore verbalised it in the interviews and how the nurses demonstrated sensitivity to their cultural values. From the patient interviews, it would appear that the patients were enabled, at least to engage in shared decision making regarding the breastfeeding and whether they were able to room in with their babies. This was illustrated by comments such as "the nurses assisted me with the breastfeeding" (P21,20,7) and "they were rooming in with the baby" (P19). Rooming in with their babies is a choice in the hospital so this can also be viewed as respect for patient preference. Focusing on the patient's quality of life cannot be determined through these interviews as no information regarding this aspect of Picker's definition was provided during the interviews.

4.2.1.2. Coordination and integration of care

Coordination and integration of care is related to the clinical care, patient care and services provided to the patient. The patients reported the presence of members of the multi-disciplinary team, mostly the doctors. No information, however, about the integration or the coordination of the care provided by the clinicians was provided by the patient. They simply stated whether or not they had been seen by the obstetrician or paediatrician. No conversations were reported. The physiotherapist was mentioned with regard to the assistance given to help the patients mobilise. The patients provided no information on how their visits and assistance reduced feelings of fear or vulnerability.

4.2.1.3. Information and education

Information and education given to the patients refers to the patients' condition and the care they were provided with by the nurses. From the phrases identified in the interviews, information was provided by the nurses, demonstrations were given and advice afforded when needed. The patients stated that the nurses "Gave me information about how everything is going to be", this demonstrates that the patients were provided with information about the care which they received. Another patient stated that "They explained everything, when I was unsure, they showed me". This statement demonstrates that the patient was unsure about a certain aspect of her care and the nurses clarified it to her by demonstration which enhanced the patient's ability to self-manage and promoted their health.

4.2.1.4. Physical comfort

Physical comfort for the patients was related to how their pain was managed by the nurses as well as care of their wounds. Physical comfort is defined by Picker (1987) and RNAO (2015) as "enhancing individuals' comfort during their care, with regard to pain management, support with activities and maintaining a focus on the hospital environment". In the study, physical comfort focused on patient related nursing activities. Similar to Picker's definition (1987) and the definition by the RNAO (2015), the activities identified by the patients were related to pain management, observations (vital data), pad checks and wound care.

4.2.1.5. Emotional support and alleviation of fear and anxiety

The fifth principle related to emotional support and the alleviation of fear and anxiety. The patients did not report any fear or anxiety which they may have experienced during their hospitalisation. They reported the emotional support which the nurses provided by asking “are you feeling okay” (P2). The assumption could be made that the patients felt supported as they said the nurses made them feel at ease and they were concerned about them. The patients mentioned they felt reassured which implied that they may have experienced a sense of insecurity about something, but no detail was provided concerning their insecurities.

4.2.1.6. Involvement of family and friends

Involvement of family and friends was reported by the patients by referring to their family members who were present with them, by allowing the family to be involved in their care, and by the nurses providing them with opportunities to ask questions. Two patients stated that their husbands have been involved in their care, the stated “Husband said they involved him” and the second stated “They have been involving him”. The patients did not give a clear explanation what the involvement entailed. As the family members were present during doctors’ rounds it may be that they were encouraged to ask questions during patient rounds by the doctors and nurses. No clear evidence from the patient interviews clarifies the degree of their involvement. The patients’ families were allowed visitations and were accommodated during the hospitalisation as they were the people who provided the patient with the necessary social support during that period. The family members referred to were mostly husbands or partners or the person the patient identified as their birthing partner.

4.2.2 NURSING DOCUMENTATION

The analysis of the nursing documentation followed the same methodology as that used to analyse the data collected in the patient interviews. Table 4.1 was used as a guide to identify the phrases and words used by the nurses in the documentation about the care which they provided to the patients. In table 4.3 below the phrases and words most commonly used by the nurses in their nursing documentation were categorised according to the different principles of patient centered care by the Picker institute (1987) and the RNAO (2015).

Table 4.3: Phrases and words most commonly used in the nursing documentation

PICKERS PRINCIPLES OF PATIENT CENTRED CARE	PHRASES AND WORDS IDENTIFIED IN NURSING DOCUMENTATION	NURSING DOCUMENTATION CODES
Respect for patients' values, preferences and expressed needs	"No complaints"	P:39,11,19,35
	"Patient verbalised that she is comfortable"	P:19,4,30,6,36,8,1,43,20,35
	"Breastfeeding well"	P:6,36,38,8,23,16
	"Stable condition"	P:36,17,21,10
	"Coping well with breastfeeding"	P:13,21,35
	"Baby nursed by mother/ rooming-in"	P:16,15,13,21,25,35
	"Breastfeeding going well"	P:4,25
	"Baby taken to the nursery"	P:2,25,20
	"Breastfeeding baby well"	P:21,25,26,10,20
	"Coping well with baby"	P:15,26
Coordination and integration of care	"Seen by the doctor"	P:39,34,30,8,28,2,25,43,20,37
	"Doctors rounds done"	P:14,11,29,7,6,5,36,38,23,1
	"Doctor saw patient"	P:24,33,21,26
	"Doctor observed the patient"	P:31,41
	"Doctor assessed the patient"	P:42,32
Information and education	"Patient needs help with breastfeeding"	P:24,43,21,37
	"Health education given about the frequency and duration of breastfeeding"	P:19
	"Patient struggles with breastfeeding"	P:23,10
	"Health education given about breastfeeding"	P:23
	"treatment plan discussed"	P:21,1

	"Advice given as needed"	P:25
Physical comfort	"Wound intact, dry and clean"	P:14,39,
	"Drip in situ, site patent and healthy"	All documents
	"Catheter in situ and draining well"	All documents
	Pain score done	All documents
	"Pain medication given" (Stilpaine, Voltaren)	All documents
	"Lochia not offensive and rubra"	P:42,19,34,7,17
	"Drip and catheter removed"	P:14,31,42,24
	"Clexane injection given"	P:14,31,28
	"PCA pump attached, functional and in situ"	P:31,42,32,30,29,7,36,38
	"Uterus well contracted"	P:31,42,32,30,29,7,36,38
	"Lactation: breasts are comfortable, nipples are soft and intact"	P:30,7,6,5,38
Emotional support and alleviation of fear and anxiety	"Coping well with breastfeeding"	P:27,8,25
	"No problems noted"	P:41
	"Patient coping well"	P:39,6,3,21,10
	"She copes well with the baby"	P:29
	"Patient verbalised she feels good"	P:24
	"Patients mood is euthymic"	P:14,2,1
	"Coping well"	P:42,29,28,41
Involvement of family and friends	"Patient left the ward accompanied by her husband"	P:41
	"Patient is socializing with family"	P:42

4.2.2.1. Respect for patient's values, preferences and expressed needs

The nursing documentation describes the principle related to respect for patient values, preferences and expressed needs by referring to the breastfeeding support given to the patient. The documentation also reported whether the patients had any complaints and the patient's condition. The phrases and sentences identified for this principle in the nursing documentation could not be comfortably related to Picker's definition. There was no evidence that the patients were informed about their condition. There was also no evidence to indicate that the patient participated in making decisions about the care that was provided. There was no referral to cultural values nor any indication that patients were treated with respect.

4.2.2.2. Coordination and integration of care

Coordination and integration of care was described by the fact that the doctors had done rounds or that the patient had been seen by the doctor. There was no recorded entry by, or about, any other members of the multi-disciplinary team. No patient fears or vulnerabilities were described or reported in the nursing documentation.

4.2.2.3. Information and education

Information and education provided to the patient was related to breastfeeding and the support provided by the nurses to facilitate breastfeeding. The nurses documented "treatment plan discussed" which indicates that the treatment plan had been discussed with the patient and could be related to Picker's definition which states that the patient was provided with information about the process of care to be provided (during that specific shift).

4.2.2.4. Physical comfort

Physical comfort was documented in detail. The nursing documentation focused on the pain management provided to the patients and other nursing activities such as wound care, insertion and removal of intravenous infusions and catheters, and the observation of the patient's blood loss, lactation and the condition of the uterus. These activities are all related to supporting the needs of patients related to their daily activities of living. The hospital environment was not mentioned in the nursing documentation.

4.2.2.5. Emotional support

Emotional support was poorly documented by the nurses. The patient's mood was described as 'euthymic', their emotional wellbeing was related to whether or not they were coping in general. Some of the documents stated that 'the patient verbalized that she feels good'. No fears or anxieties were reported. It was therefore not possible to assess whether the nurse had provided support and whether the patient had benefited from such support.

4.2.2.6. Involvement of the family

Involvement of family and friends was also poorly documented. There were only a few documents which provided any information about the patient's family or friends. The nurses did not acknowledge the family member who was supporting the patient post-partum and no communication about the involvement of the family member was evident in the documentation.

4.2.3 THE COMPARISON OF THE QUALITATIVE ASPECTS OF THE PATIENT INTERVIEWS AND NURSING DOCUMENTATION.

A comparison was done by combining table 4.2 and table 4.3 to determine if there were any similarities between what the patients said concerning their care and what the nurses documented about the care they gave. This relates to the third objective for the study which reads, "To compare the nurses stated care with the patient's experience of care to determine if patient centered care is rendered in the unit" stating a comparison is made between the stated care given with the patients experience to determine if patient centered care was rendered. Table 4.4 illustrates the comparison of the qualitative data analysed.

Table 4.4: A comparison of the qualitative data obtained during patient interviews and from nursing documentation

PICKER'S PRINCIPLES OF PATIENT CENTERED CARE	PATIENT INTERVIEWS	NURSING DOCUMENTATION
Respect for patient values, preferences and expressed needs	"Ask if you're Okay" "Ask if you're coping" "Popping in to ask how's the breastfeeding" "Very supportive" "They are there when you need them" "Helped me well, Very helpful" "Rooming in with the baby" "Nurses assisted me with the breastfeeding" "Greeted by the day and the night staff" "Take the baby to the nursery so that can rest/sleep" "Check if you're okay" "Very noisy" "Assistance with breastfeeding"	"No complaints" "Patient verbalized that she is comfortable" "Breastfeeding well" "Stable condition" "Coping well with breastfeeding" "Baby nursed by mother/ Rooming-in" "Breastfeeding going well" "Baby taken to the nursery" "Breastfeeding baby well" "Coping well with baby"
Coordination and integration of care	"Sister came in to help me with breastfeeding from NICU"	"Seen by the doctor" "Doctors rounds done"

PICKER'S PRINCIPLES OF PATIENT CENTERED CARE	PATIENT INTERVIEWS	NURSING DOCUMENTATION
	"Paediatrician came this morning" "The doctor was here" "The pediatrician was here" "Doctor asked if I want to breastfeed" "The physio keeps tabs on us" "Doctors come and check daily" "Doctors rounds/ visited" "Doctors are great" "My doctor came in this morning" "Doctors care is very good"	"Doctor saw patient" "Doctor observed the patient" "Doctor assessed patient"
Information and education	"Make sure you understand everything" "Gave me information about how everything is going to be" "She did a demonstration on how to latch" "They show you and teach you" "Showed me how to bath him"	"Patient needs help with breastfeeding" "Health education given about the frequency and duration of breastfeeding" "Patient struggles with breastfeeding" "Health education given about breastfeeding"

PICKER'S PRINCIPLES OF PATIENT CENTERED CARE	PATIENT INTERVIEWS	NURSING DOCUMENTATION
	"They gave me enough information" "They explained everything, when I was unsure, they showed me" "Advice given" "Explain the procedures before they do it" "Paediatrician gave advice about breastfeeding"	"treatment plan discussed" "Advice given as needed"
Physical comfort	"Take my observations and check my pad" "Medication given for pain on a schedule" "They gave me Stilpaine and Perfalgan" "They are giving pain pills" "They cleaned me and checked my wound" "I'm asking for it and they bring it"	"Wound intact, dry and clean" "Drip in situ, site patent and healthy" "Catheter in situ and draining well" Pain score done "Pain medication given" (Stilpaine, Voltari) "Lochia not offensive and rubra" "Drip and catheter removed" "Clexane injection given" "PCA pump attached, functional and in situ" "Uterus well contracted"

PICKER'S PRINCIPLES OF PATIENT CENTERED CARE	PATIENT INTERVIEWS	NURSING DOCUMENTATION
		"Patient assisted to the bathroom" "Lactation: breasts are comfortable, nipples are soft and intact"
Emotional support and alleviation of fear and anxiety	"Very emotionally supportive" "Very concerned about you and how you are feeling" They ask "Are you feeling okay" "Make you feel at ease" "Reassuring us and comforting us"	"Coping well with breastfeeding" "No problems noted" "Patient coping well" "She copes well with the baby" "Patient verbalized she feels good" "Patients mood is euthymic" "Coping well"
Involvement of family and friends	"Accommodated my husband well" "I have 2 other children and they were here for long" "Husband said they involved him" "My family was here" "My husband involved himself" "My husband comes in with my son"	"Patient left the ward accompanied by her husband" "Patient is socializing with family"

PICKER'S PRINCIPLES OF PATIENT CENTERED CARE	PATIENT INTERVIEWS	NURSING DOCUMENTATION
	"My husband is accommodated" "They have been involving him"	

4.2.3.1. Respect for patients' values, preferences and expressed needs.

The common factor reported by patients and documented by nurses was breastfeeding. The patients described the assistance received from the nurses and the nursing documentation reported on how the patient was coping with breastfeeding. There were many similarities in what was reported by the patient and what was documented. One difference identified between the two was that the patients reported that the nurses greeted them over both shifts but there is no reference to interaction in the nursing documentation.

4.2.3.2. Coordination and integration of care

The coordination and integration of care was not well documented by the nursing staff. The patients described the paediatrician, obstetrician and the physiotherapist attending to them on rounds but the nursing documentation stated only that the patient was "seen by the doctor" or "doctors' rounds were done". Neither set of data illustrates any coordination and integration of care provided or any communication between the patients and the health professionals.

4.2.3.3. Information and education

Information and education are described in detail by the patients. The patients state they were given information, that demonstrations were given and advice given about care as well as having had procedures explained to them. The nursing documentation simply stated that help was needed, education was given and advice provided. The education provided to the patient mostly related to breastfeeding. There is a correlation between the treatment plan discussed with the patient in the nursing documentation as the patients reported that "they gave me information

about how everything is going to be" (P24). The nursing documentation does not state that demonstrations were given to help the patient understand how to latch, or any other specifics related to education.

4.2.3.4. Physical comfort

Physical comfort was widely reported on in the nursing documentation but the patients confined their comments in this regard to pain management. The patients described the pain medication they received, when they received it, if it was scheduled or whether it was given on demand and that the nurses asked them if they needed any pain relief. The nursing documentation records the patient's pain score and the medication that was administered. No reference was made in the documentation to communication between the nurse and the patient in order to obtain the necessary information to assess the need for, and provision of, pain relief. Other nursing activities provided relating to the patients' comfort were checking the patient's pad, observations that were done, and checking the wound. The nursing documentation recorded the wound care done, checking the state of the patient's bleeding and contraction of the uterus, the intravenous infusion and the urinary catheter. There are many similarities in the care which the patients received compared to the care which was documented regarding physical comfort. The condition of the patient's breasts was also documented. Documentation indicated everything that had been done but nothing about communication that may have preceded, or followed the nursing activity to determine whether the patient's physical comfort had been enhanced by those activities.

4.2.3.5. Emotional support

Emotional support and the alleviation of fear and anxiety was reported by the patients and documented by the nurses with the exception of the identification of any fears and anxiety. The patients stated that they were supported emotionally and that they felt reassured. It appeared that the nurses cared about the patients as they asked how they were feeling. The nurses mostly documented what they observed rather than what they had asked the patient or the response they had received from the patients. An example of this was found in the nursing documentation which stated "patient verbalized she feels good" (P24). This could indicate a question had been asked.

4.2.3.6 Involvement of family

The involvement of family and friends was poorly documented by the nurses. This is indicated by the fact that they made no reference to the family support which the patient had during the shift. The patients, however, reported on their spouses and children and other family members visiting. There were only two entries in the entire nurse documentation data set which related to the involvement of family and friends; the one stated “patient left the ward accompanied by her husband” (P41) and the other – “patient is socializing with family” (P42).

4.3 FINDINGS OF THE QUANTITATIVE ASPECTS OF THE STUDY

4.3.1 PATIENT DATA

The findings of the patient data obtained during the patient interviews were analysed. Figure 4.3.1.1 illustrates the number of times the principles of patient centered care were identified in all the transcriptions analysed. It does not refer to the number of times the principle was identified in each transcription but was counted if the principle was identified in the transcript regardless of the number of times it was identified. The Y axis relates to the PCC principles and the X axis relates to the number of interviews in which the principle was identified. The total number of interviews included was 41.

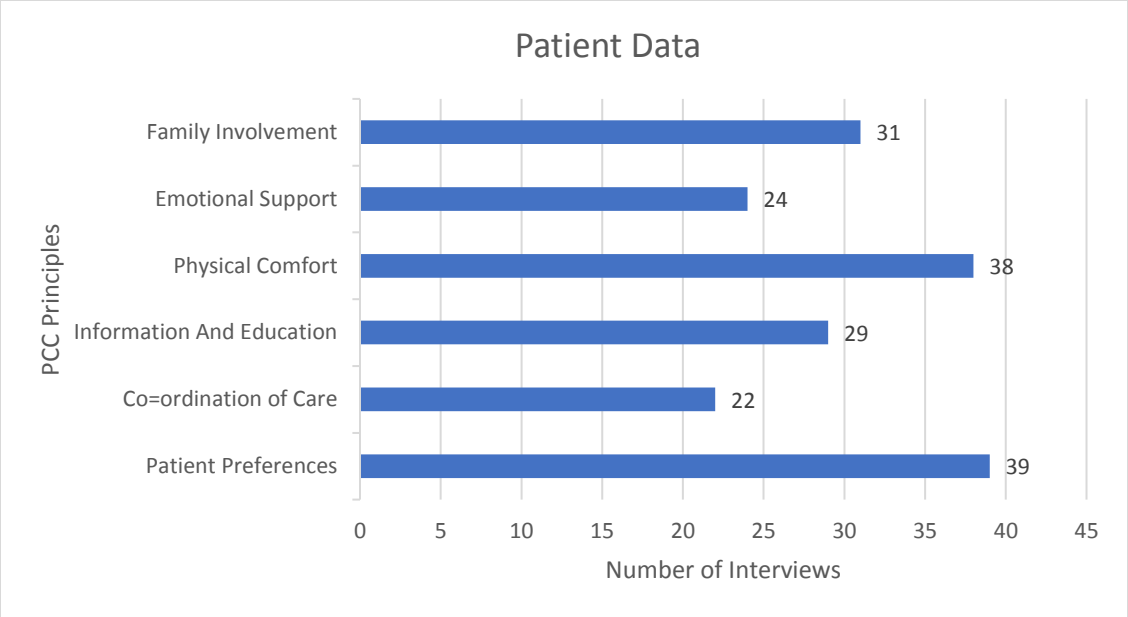


Figure 4.1: PCC principles identified in the patient data

Figure 4.1 illustrates the number of interviews in which each principle was identified i.e. where the patient mentioned an aspect of the principle during the interview. Patient preferences and physical comfort had the highest number value at thirty-nine (39) interviews and thirty-eight (38) interviews respectively. Thirty-nine (39) of the forty-one (41) interview transcripts mentioned aspects of patient preferences, values and expressed needs. Thirty-eight (38) of forty-one (41) interviews had aspects of physical comfort reported by the patient. The lowest values were related to the emotional support and coordination and integration of care. Emotional support was reported in twenty-four (24) of the forty-one (41) interviews and coordination of care was reported in twenty-two (22) of the forty-one (41) interviews. Family involvement and information and education had median values from the data analysed. Family involvement was reported in thirty-one (31) of the forty-one (41) interviews. Information and education were reported in twenty-nine (29) of the forty-one (41) interviews.

In figure 4.2 the percentages of the patient data are illustrated. The Y axis relates to the percentage value of the number of patient interviews and the X axis is related to the PCC principles.

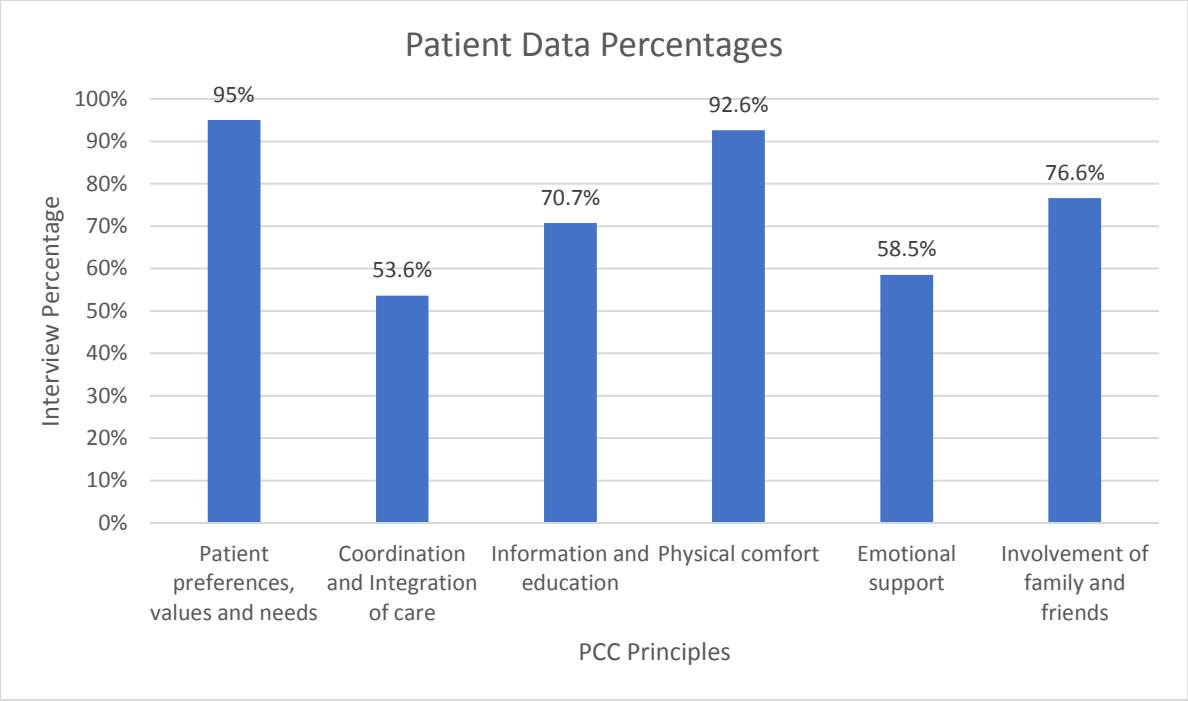


Figure 4.2: The Percentage value of the patient interview data

Percentages were calculated for the data illustrated in figure 4.1. The highest percentage calculated was for patient preferences, values and expressed needs. It is followed by physical comfort at 92.6%. The two median percentages are 70.7% for information and education and 76.6% for involvement of family and friends. The lowest percentages are 58.5% for emotional support and 53.6% for coordination and integration of care.

In the next section the findings of the data from the nursing documentation will be analysed.

4.3.2 NURSING DOCUMENTATION DATA

The review of the nursing documentation resulted in the findings illustrated in the figure below (see figure 4.3). The Y axis is the PCC principles and the X axis is the number of interviews done as forty-one (41) nursing documents were analysed. The principles were counted for all forty-one (41) nursing documents included and related to each principle a number is tallied to determine the most or the least prevalent PCC principle.

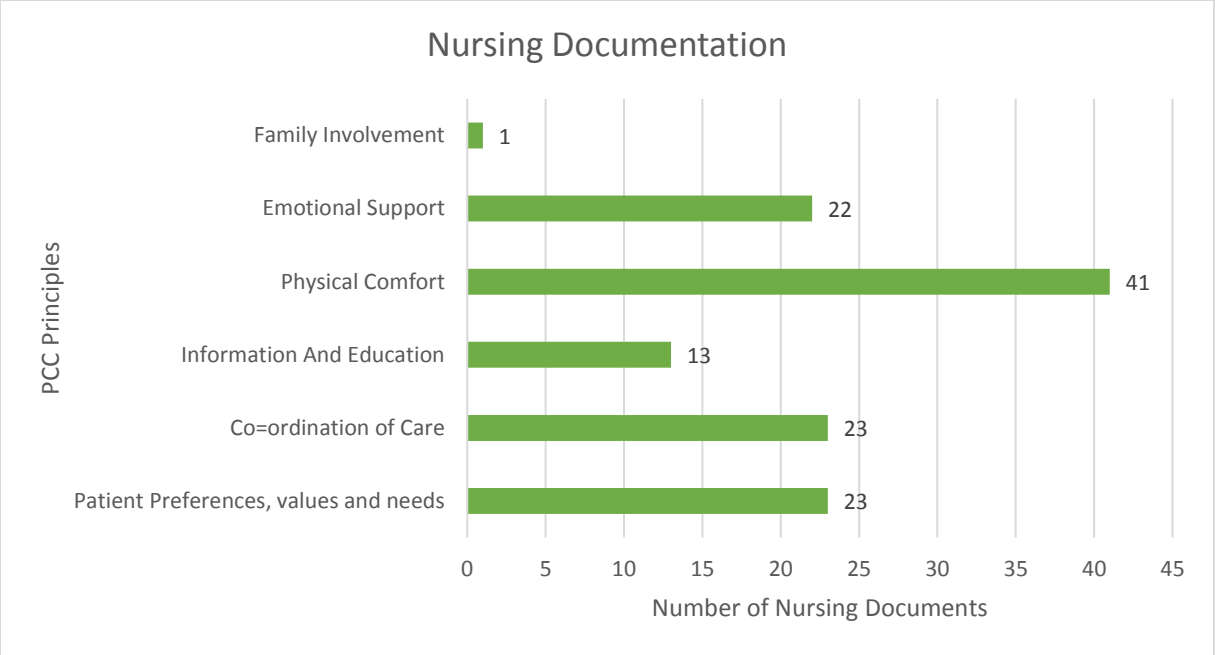


Figure 4.3: PCC principles identified in the nursing documentation

The total number of nursing documents analysed was forty-one (41). The aspects of the PCC principles were identified in the nursing documentation. In figure 4.3 values are provided in the graph. Physical comfort was reported in all forty-one (41) nursing documents analysed. Coordination of care and patient preferences was identified in twenty-three (23) out of the forty-one (41) nursing documents. Emotional support follows with twenty-two (22) out of the forty-one (41) interviews. The lowest values were documented for information and education at thirteen (13) out of forty-one (41) interviews and involvement of family and friends at two (2) out of forty-one (41) nursing documents.

The following figure illustrates the same data in percentage values to indicate the varying percentages of each principle.

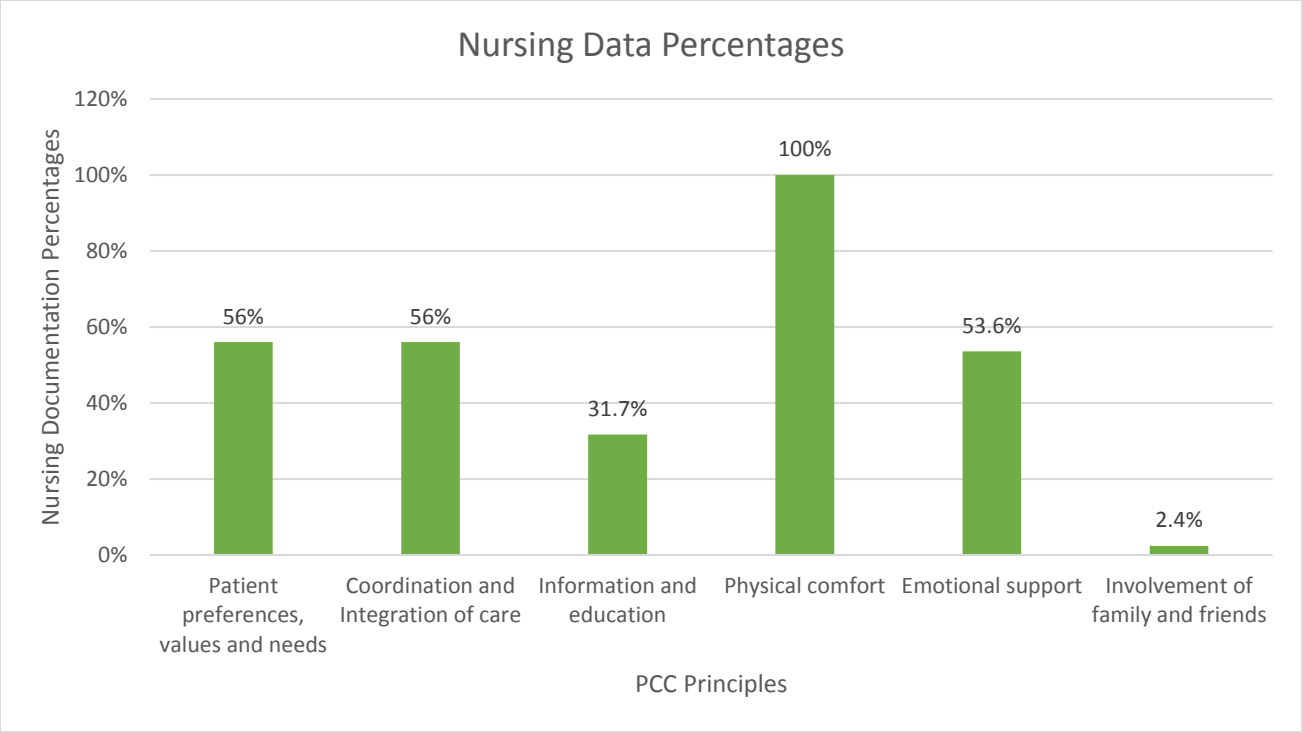


Figure 4.4: The percentage value of the nursing documentation data

In figure 4.4 the percentage values are illustrated. The Y axis relates to the percentage the nursing documentation referred to a particular principle and the X axis is related to the PCC principles. It is clear that physical comfort is the most documented principle with a percentage of 100%. Patient preferences, values and needs had the same percentage as coordination of care at 56%. Emotional support had a percentage of 53.6% and information and education 31.7%. The lowest percentage of 2.4% was for the involvement of family and friends in the nursing documentation. This is in contrast to physical comfort as the numerical value illustrates it is the least documented principle.

4.3.3 THE COMPARISON BETWEEN THE PATIENT DATA AND NURSING DOCUMENTATION DATA

A comparison figure was developed to compare the patient data with the nursing documentation data. The comparison is done to determine if patient centered nursing care is being practised. Similarities and differences are illustrated in the figure below.

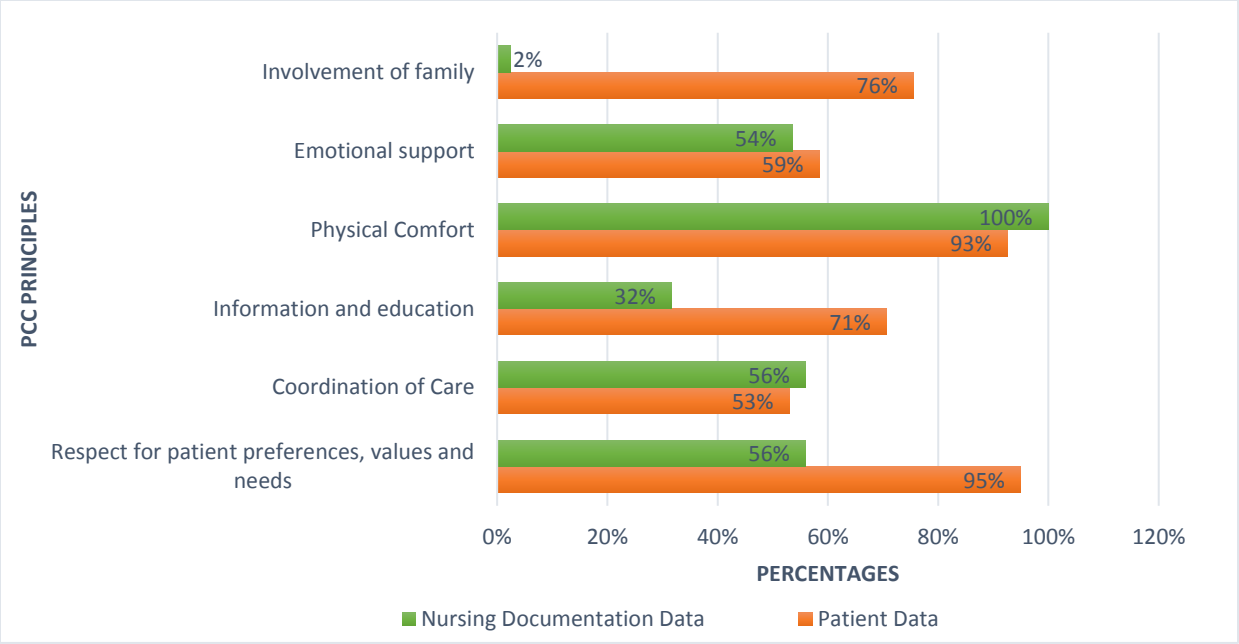


Figure 4.5: Comparison between the nursing documentation and patient interviews

The differences between the two sets of data is evident in the figure above. Physical comfort for both the nursing documentation and the patient data has high percentages of 100% and 93% respectively. Physical comfort achieved the highest percentage for the nursing documentation and second highest for the patient data. The highest percentage obtained for the nursing data is with respect to patient preferences at 95% and the nursing documentation attained 56%. The lowest percentage obtained was 2.4% for the documentation of family involvement and 76% for the patient data. There are some similarities recorded with close percentages obtained for coordination of care and emotional support. Coordination of care was documented in 56% of the nursing documentation and reported in 53% of the patient interviews. Emotional support obtained 54% in the nursing documentation which implies that it was recorded in 54% of the nursing documentation whereas it obtained 59% for the nursing interviews. There are similarities and differences noted in the data collected as the percentages obtained for what the nurses documented compared to what the patients experienced vary quite significantly. The discussion of the findings to determine if patient centered nursing care is being practised will be found in the next section.

4.4 DISCUSSION OF FINDINGS

The discussion of the findings will focus primarily on the differences which were discovered to answer the research question: “Is there a difference between what the nurses document as care given to that of the patients’ experience of care they received?” Each principle will be discussed firstly relating to the patient interviews and then to the nursing documentation.

4.4.1 RESPECT FOR PATIENT PREFERENCES, VALUES AND EXPRESSED NEEDS

Respecting patient’s preferences includes the respect for their values and most importantly their expressed needs (RNAO, 2015). To achieve patient centered nursing care the principle based on the respect for patient preferences, values and expressed needs should be attained. This can be done by treating each patient with respect through maintaining their dignity and demonstrating sensitivity to their cultural values (RNAO, 2015). Culture is not only related to the physical characteristics of a patient but, as stated by Epner and Baile (2012), also to “communication skills, cross-cultural awareness, social skills and health beliefs”. Thus, it can be concluded that awareness of cultural values involves determining what the patient needs are through the process of effective communication.

The importance of the need for communication and the presence of the nurses in the ward or in the patients’ rooms were common factors reported by the patients as they made reference to how it made them feel supported and cared for. Communication is crucial to the delivery of the nursing care provided to patients and it can be a form of connection with the patients psychologically, socially and physically (Farrington & Townsend, 2014). For the nurses to be physically present in the ward and ensuring that the patients are aware of their presence enhances the patients’ feelings of being supported if there are needs that must be addressed. The nursing documentation described the patients’ preferences, values and needs in a different way. The nursing documentation focused primarily on patient complaints, the patient’s comfort, and mostly whether or not the patient was coping with breastfeeding. The nurses stated in their documentation that “No complaints” and “Patient verbalised that she is comfortable”. Breastfeeding was extensively emphasised in both the nursing documentation and the patient interviews and is deemed an important factor during the post-natal phase. The nurses

documented the patients are “breastfeeding well” or “coping well with breastfeeding” and the patients reported that “Nurses assisted me with the breastfeeding”. There are many health benefits for both the mother and the infant by initiating breastfeeding and it can cause some distress if it fails due to a lack of support by the nursing staff (Dieterich *et al*., 2013). Lack of support and poor pain management are common factors that can influence the success of breastfeeding and this may influence the bonding effect between the mother and her infant (Fielder, 2016). Bonding is probably the most important reason for maternity patients wanting to breastfeed and studies have proved that there is an increase in the maternal brain responses to their infant’s needs (Dieterich et al, 2013). Preferences can be determined through identifying patient needs during communication between the nurse and the patient. Good communication between the patients and nurses can contribute to better care delivery (Farrington and Townsend, 2014).

Analysis of the quantitative data has demonstrated that this principle has differing importance for the patients and the nurses. This assumption is made on the basis of the large difference between the calculated ratings. As seen in the qualitative data the patients valued the interaction with the nurses whether it was verbal or non-verbal but the nursing documentation only stated what was assumed to be the patients’ observed preferences or expressed needs. Peleki *et al*., (2015) stated that “when a therapeutic interactive relationship is established the nursing staff may be able to comprehend the patient’s feelings”. It is not only important to understand a patient’s feelings but also to determine their preferences and needs. The nursing documentation was entirely related to the patient’s comfort, observed condition and the patient’s breastfeeding practices. It may be assumed that the large difference in the numerical value could be related to the culture of documenting what has been done for the patient and that it may be difficult to document patient preferences or patient needs. There may be other factors which could be limiting the nurse’s ability to not only communicate with the patients effectively but also to be able to document this communication effectively in the nursing documentation. Epner & Baile (2012) state that “communication skills such as exploration, empathy and other techniques are a gateway to understanding patient needs, values and preferences”.

The difference in the numerical value between the patient data and the nursing documentation data may suggest that the nurses do communicate with the patients, and based on what the

patients said, their preferences, values and needs are respected but not documented. The nursing documentation does reflect what was done for the patients but it lacks the detail of how they have respected the patient's values, preferences and needs. The qualitative data also indicates this difference since what was recorded and categorised under this principle related more to observed behaviour noted by the nurses than patient preferences per se.

4.4.2 COORDINATION AND INTEGRATION OF CARE

Co-ordination and integration of care is defined as the clinical and patient care provided which may reduce feelings of fear and vulnerability experienced by the patient (RNAO, 2015). This principle has been modified for the purpose of the study and was defined as the co-ordination and integration of care provided by the multi-disciplinary team. This included all the doctors involved in the medical care of the patient and also the physiotherapists and dieticians. In the qualitative data gathered, the phrases and sentences most used by patients to describe the multi-disciplinary team's involvement in their care were: "the doctor was here" (P31), "the paediatrician came this morning" (P:20), "the doctors visited" (P23,15,10,20,21). There is an acknowledgement of the doctor's presence but the patients did not describe any interaction which would indicate that there was no communication between the patient and the doctors. The communication which could have occurred between the patient and the doctors may be more doctor-centered and not patient centered as demonstrated by the fact that they only mentioned the presence of the doctors during rounds. It could indicate an authoritarian interaction between the patients and the doctors, discouraging patient involvement and further does not allow the patient to participate in shared decision making about their health care. An authoritative approach of health care from the doctors can be defined as a traditional perspective about providing health care to patients. A traditional approach implies that health care was provided to the patients without the consideration to their preferences and thus is in contrast to patient centered health care (Robinson, 2007). Patient centered care encourages health professionals to be less authoritative and to create communication styles and relationships which encourage collaboration and the involvement from the patient through shared decision making (Epstein and Street, 2014). Understanding and gaining insight to the patient's goals for their healthcare may increase the probability of adherence towards the healthcare (Robinson, 2007). During the interviews the

patients had to be probed to determine if the doctors were involved or present during the 24-hour period. It was determined in the interviews that patients noted their presence but there was no description of the quality of the time spent by the medical team with the patients. No detailed information was provided by the patients. This poses the question whether or not the doctors' rounds add value to the patients' experience in the hospital or if the doctor-patient relationship is an authoritarian one, meaning that the patients are given no opportunity to ask questions and to have a patient centered hospital experience that will reduce their fears and vulnerabilities. A good doctor-patient relationship can be linked to effective, therapeutic communication when the patient is able to ask questions and receive information from the doctors. It may also be seen as shared decision making which reflects the importance of communication between the patient and the healthcare provider in providing the patient with information about their care and allowing them the opportunity to be actively involved in decisions made about their care (Kitson et al, 2012). One patient reported that the physiotherapist assisted her during mobilisation after the caesarean section but the other patients did not identify any interaction with a physiotherapist. Doctors' rounds require communication with the patients to allow them to ask questions; it is clear that effective communication that is memorable requires time (Peleki et al, 2015). It can be assumed that if the time spent by multi-disciplinary team members with the patient was memorable, the patients would remember the detail of the doctor's visit.

The nursing documentation reported the doctors' rounds done by both the obstetrician and the paediatrician. The orders given to the nursing staff were documented as well as the follow through of the orders that were given. As registered nurses or shift leaders accompany doctors on their rounds, the omission in some of the documents of the orders given in the documentation could be due to poor communication between the registered nurse who had done the rounds and the nurse who is responsible for the patients' care. No record of the physiotherapist was found in the documentation.

The quantitative data of both the patients and the nurses are similar. The nurses document the presence of the doctor during rounds and the patients recall the rounds which were done. There was no documentation of the integration or coordination of the care which the patient received or which was given to the patient.

As the percentage for the nursing documentation was only 56% it does reflect in some way that not all the documents state or acknowledge the doctor's rounds. This could be a risk to the patient as there was no evidence of what was discussed during the doctors' rounds concerning further management and plan of the patients' care. Regulation 2598 (1984), Regulations Relating to the Scope of Practice of Persons Who are Registered or Enrolled under the Nursing Act, 1978, Chapter 2, (2)(a) requires the nurse to diagnose and to prescribe, provide and execute a nursing care plan to meet the need. In the same chapter, paragraph 2 (c), the nurse is required to monitor the patient's vital signs and response to "disease conditions, trauma, stress, anxiety, medication and treatment". This implies that all care planned for the patient should be documented in order for the nurse to meet legal requirements as determined by the Scope of Practice. Any omissions from the nursing documentation for the care of the patient could be seen as unsafe practice and each nurse is responsible for their omissions (Regulation 387, 1985 Chapter 2 (5)). Thus, it can be determined that the medico-legal risk is high if care is not documented due to the fact that there is no evidence of the care planned or implemented.

4.4.3 INFORMATION AND EDUCATION

Information and health education are defined as the provision of complete information to the patients about their health and to promote autonomy and good health (RNAO, 2015). Patients reported that the nurses had provided information and given education when needed concerning breastfeeding. They stated that if they did not understand the information given the nurses would demonstrate it to them "She did a demonstration on how to latch" and "They show you and teach you". All the education they received was related to breastfeeding. The nursing documentation also stated that breastfeeding advice and education was given as needed stating "Health education given about the frequency and duration of breastfeeding" and the "treatment plan was discussed" with the patient and was also documented. The differences between what the patients stated concerning their experience and what was documented was not very different as the nursing documentation seemed to reflect what the patients were experiencing.

The quantitative data, however, illustrates a vast difference in the reporting and the documenting of the information and education provided to the patients. The patient data illustrated that

patients reported that they had received information and education about their care, regardless of what the content of the education was. Only 32% of the nursing documentation reviewed reflected that information and education was given to the patients. This raises the question of what was said to the patient regarding breastfeeding or other needs which may have been verbalised, as well as the reassurance she may or may not have received as a result of the information provided since no detailed information on what was said was recorded in the documentation.

Patient information scored one of the lowest percentages in the nursing documentation even though, according to the interviews held with patients, it was provided. The low rating of the documentation could be a reflection of insufficient health information provided to patients about their nursing care. The phrases or sentences used in the documentation to describe the health education was focused on breastfeeding. No other aspects of the patient care were explained in the documentation. Breastfeeding information was given during the breastfeeding sessions but the records only stated that the patient was breastfeeding and that health education about breastfeeding was given.

There was a difference between the qualitative and quantitative data of the education and information given to the patient. The nursing documentation which did incorporate the education and information which was given to the patient included the information which the patients reported to have received. There were, however, patients who did receive information and education but there is no evidence of this communication between the patient and the nurses in the corresponding nursing records. Although the patients stated that the nurses had provided information with some patient's stating "They gave me enough information", which could indicate that a therapeutic relationship had been established, the fact that there was no proof of how this relationship was established through communication of the information given to the patients is problematic. Providing patients with information and increasing their knowledge about their health supports self-empowerment and is important in the development of a good nurse-patient relationship (Leino-Kilpi *et al*., 2015). Maternity information systems are directly related to record keeping, or nursing documentation, and specifically to the patient care which was provided (Hulton et al, 2000). This means that the information given to the patient should be documented

to improve the quality of nursing care given to the patient and to reduce the medico-legal risks related to nursing documentation.

4.4.4 PHYSICAL COMFORT

Physical comfort is defined by the RNAO (2015) as “enhancing individual’s physical comfort during care, especially with regard to pain management”. Other aspects of physical comfort included in this study relate to any nursing activity which involved the patient. The patient interviews demonstrated that physical comfort is mostly related to pain management. Pain management is an important factor as it may influence other aspects of the patient’s experience like breastfeeding practices. After a caesarean section, poor pain management may influence the patient emotionally and could also affect the patient’s ability to breastfeed optimally (Fiddler, 2016). As communicated during patient interviews, breastfeeding was notably important to the patients and pain should be managed effectively. Other aspects of physical comfort reported by the patient referred to their observations (vital data) being done, wound care as well as checking their post-partum bleeding as patients reported “Take my observations and check my pad” and “Medication given for pain on a schedule”. The nursing documentation focused on the total physical care of the patient to ensure comfort. The nursing documents recorded that pain had been managed, the type of medication that was administered, wound care that had been given, intravenous line and catheter care, breast comfort and the state of the uterus post-partum. There was substantial detail concerning these aspects which appeared to be the focus of the nursing documentation. The patients, however, also reported physical comfort in much detail but their reports focused on how their pain was managed.

Physical comfort was the highest scoring documented principle at 100% and the second highest scoring principle (92%) reported by the patients. The quantitative values differed only slightly. The nursing document reflected a fair amount of information about the physical comfort of the patient but the patients had to be probed during the interviews to gain information concerning this principle. The similarity in numerical values for both patients and nurses suggests that physical comfort is an important principle for both parties.

Pain management is an important aspect in patient comfort and in the nursing documentation. Other nursing activities appeared to be less important to the patient as they did not recall the removal of the infusion line or the catheter or the fact that they were assisted to mobilise. It may also be possible to conclude that other nursing activities did not bring much comfort to the patients, hence they did not recall any of those activities. The nursing documentation was rich with information about the nursing activities done for the patient illustrating the importance of what the nurses had done for the patient. Physical comfort for patient's post-caesarean section is an important aspect and should be managed attentively as it is evidently being done. Martin (2015) states that "it is important to recognize and support women physically during the post-natal period as women use this time to cope with the birth experience and all the feelings related to it".

4.4.5 EMOTIONAL SUPPORT

Emotional support is the alleviation of fears and anxiety the patients may have during their time of hospitalisation (RNAO, 2015). As stated by Martin (2015) "it is important to recognize and support women to deal with the emotional impact of their birth experience". This most certainly includes caesarean section deliveries as they may seem more severe than vaginal deliveries because they involve abdominal surgery. Patients may need more social support, specifically from the post-natal nursing staff, as this may help mothers overcome their fears and deal with their anxiety more effectively (Nayman-Vekslar, 2015).

The emotional support reported by the patients and documented by the nurses was very similar in the content and in the lack of depth in terms of what the patient experienced as emotional support, and what the nurses documented. No fear or anxiety that may have resulted in the need for reassurance or emotional support was reported by patients. The nursing documentation recorded the observed emotional condition of the patients. The nurses documented that the patients were "coping well", specifically with breastfeeding and the baby, and no problems were noted as the nursing documentation stated the patients are "coping well with breastfeeding". If questions had been asked by patients, they were not documented. The quantitative data produced very similar numerical values for both the patient interviews and the nursing

documentation. 59% of the patients reported that they had been emotionally supported and 54% of the nursing documentation recorded the observed emotional state of the patients. On average, 50% of what the patients experienced was documented in the nursing documentation even though no conversation which may have indicated fears or anxiety experienced by the patients was documented.

Emotional support is not only the responsibility of the patient's family and friends but is an important role for the nursing staff to fulfill (Hulton, 2000). Emotional support is directly related to communication with the patient and as already discussed, childbirth is traumatic; therefore effective communication and affirmation by the nursing staff may be valuable in helping the patients cope during post-natal recovery (Martin, 2015).

4.4.6 INVOLVEMENT OF FAMILY

The involvement of family is defined as acknowledging and respecting the family members of the patient who provide the patients with support during their care in hospital (Dieterich et al, 2015). In this study the family members were seen as the spouse or the birthing partner who was with the patient for the majority of time in hospital.

Family involvement was evident in the patient interviews when patients reported that family members were present for visits, their children could visit, their husbands were involved in the care of their spouses because they were given an opportunity to ask questions. It was clear that husbands or birthing partners were accommodated and were involved in the care of their wives or partners as the patients stated they "accommodated my husband well". The nursing documentation did not acknowledge the presence of the family, children or husbands. There were only two entries referring to family involvement; one which described the presence of the husband with his wife stating "patient left the ward accompanied by her husband" and the other, the observation made by the nurses that the patient is "socializing with family". Family involvement was not reflected in the nursing documentation and what the patient experienced concerning having her family with her was not documented.

In the quantitative data the involvement of the family received the lowest percentage in the nursing documentation at 2% while the patient data achieved 76%. This significant difference

demonstrated that 76 % of patients mentioned the importance of family involvement or the presence of their husbands and partners in hospital. Only 2 % of the nursing documentation had recorded any information about the social support received from families and friends during the patients' hospitalisation. Family involvement may not be seen as a factor for recording in the nursing documentation since it is not related to the physical care of the patient and their wellbeing. Although it may not be seen as important to the nursing staff it is an important factor in patient centered nursing care and the holistic approach to nursing care to ensure that the patient is the focus of care.

The patient's family is an important factor to consider as they need information about their family member's (the mother) health status and therefore effective communication can be beneficial to the patient's wellbeing. Boykins (2014) states that "effective communication is necessary between the patient, their family and the nurse or healthcare professional". Effective communication with the family, may ensure that patients feel emotionally supported. Therefore, emotional wellbeing and social support from family may be documented as one since each factor could be dependent on the other. Nursing documentation needs to be thorough and accurate as it is essential to good quality nursing care provided to the patient, ensuring that each patient is cared for as a whole. This includes reporting on their support structure and their emotional needs if that structure is not available (Beach & Oates, 2014). Having their family in the room with them could aid their emotional wellbeing and may improve the patients' experience of care provided by the facility (Hulton et al, 2000). The patients experience of the hospital may be enhanced if they have family or friends supporting them and therefore emotional wellbeing is enhanced by allowing the patients' spouses or birth partners to be with them. It is equally important to document the presence of the family or friends for evidence of a social structure or support. Having no family or social support may have a negative influence on the patient's emotional wellbeing and it is therefore important to document whether or not family or friends are involved.

4.5 CONCLUSION

In this chapter the findings of the data analysed was discussed. Chapter 5 will present the conclusions drawn with emphasis on the main findings and the limitations identified in this study.

Recommendations will be developed for nursing education and research to improve the culture of nursing documentation and to better reflect the patients' experience of care in relation to the principles of patient centered care.

CHAPTER 5

CONCLUSION, SUMMARY, MAIN FINDINGS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In this chapter a summary of the study will be given covering the main findings, explaining the limitations of the study and recommendations for further research to be conducted in nursing education and nursing practice.

5.2 SUMMARY

Patient centered care focuses on care given by nurses based on patients' specific needs. It includes communication and shared decision making and emphasises the importance of respectful and responsive care. This implies that patients and nurses need to have the same understanding of the patient's needs and agree upon how to respond to them. The framework developed by Hulton *et al*., (2000) relating to quality of care was used to guide the objectives in this study. The framework states that to determine quality of nursing care, the provision of care should reflect the experience of care received by patients. This study was conducted to determine whether there was consensus in this regard and used patient interviews to determine what nursing care had been provided from the patient's point of view, and the nursing records to determine what nursing care had been provided from the nurse's point of view. In other words, the purpose of the study was to determine whether the care that was documented reflected the care which the patient had experienced. The methodology and analysis of data was guided by implementing Pickers principles of patient centered care (1987). The study was conducted in the maternity ward of a large private hospital and the focus was on the post-partum care given to patients who had undergone caesarean sections.

An exploratory multi-method design was used which incorporated collecting and analysing data from two sources, namely the patients and the nursing documentation. The patients were interviewed using semi-structured interviews which were transcribed verbatim and the nursing documentation was recorded directly from the nursing notes. A template analysis was conducted using the patient centered principles set out by the Picker Institute (1987).

5.3 MAIN FINDINGS

5.3.1 Respect for patient preferences, values and expressed needs

Respect for patient preferences, values and expressed needs attained very similar results in the data but through the analysis it appeared that the patients experienced this principle in a very different manner to how they were documented and perceived by the nurses. The nursing documentation focused primarily on the observed patient preferences and needs; not much detail was provided in terms of what the patients expressed as their needs. The main perceived need in the nursing documentation was breastfeeding. The time that breastfeeding was commenced, the problems encountered with breastfeeding were recorded in minimal detail as well as whether or not the patient was coping with the practice. The patients placed more value on the interactive therapeutic relationship which was established with the nurses. This included communication and the presence of the nurses in the ward as the qualitative data revealed that it made the patients feel supported.

5.3.2 Coordination and integration of care

The coordination and integration of care reported by the patients and documented in the nursing documentation reflected very similar results. Both sets of data indicated that although there was acknowledgment of doctors during ward rounds no information regarding the coordination or integration of the care received by and given to the patients was provided. The doctors' rounds were clearly reported by both the patients and the nurses. The nursing documentation provided some detail on the orders given by the doctors but it was not clear whether patients were given an opportunity to participate in their care through the doctors' rounds. A more patient centered approach to the doctors' rounds would be to incorporate the patient's insight during rounds and this should be documented in the nursing notes by the nursing staff member who assists the doctors on ward rounds.

5.3.3 Information and education

A common topic in which education and information was provided and documented focused largely on breastfeeding. Although there were varying median values in the quantitative data

between the patient interviews and the nursing documentation breastfeeding practices were most frequently reported. The detail of what information and education was given concerning breastfeeding was not included in the nursing documents. Documentation did not provide detail on what the patient needs were and if they were experiencing any difficulties with breastfeeding. Identifying patient needs and the difficulties which they experienced may be an indication for education which is needed and information that must be provided to the patient.

5.3.4 Physical comfort

Physical comfort was mostly related to pain management in the patients' views. They reported that pain medication was very effective, especially when given on the schedule prescribed by the obstetricians. At times the type of pain medication was mentioned but it appeared to be of little relevance to patients. Some patients said that no pain relief was needed and yet they were still receiving pain medication. The nursing documentation described a wide variety of nursing tasks or activities provided to the patient with the inclusion of the patient's pain relief. This principle obtained similar results relating to the quantitative data and reflected that physical comfort had equal value and importance for both nurses and patients. Physical comfort was the crux of what the nurses documented and may be a result of task-centered nursing currently being practiced.

5.3.5 Emotional support

Emotional support is described as the alleviation of fears and anxiety which is identified by the nurses. There were no fears or anxiety reported by the patients or in the nursing documentation. The nursing documentation reported what the observed emotional state of the patient was but there was no indication that the patient had been asked how she was feeling. The emotional state documented by the nurses about the patient was mostly related to breastfeeding practices and whether the patient was coping. Only when probed, patients reported that they were emotionally supported but did not provide any additional information on the subject.

5.3.6 Involvement of family and friends

The involvement of family and friends was documented very poorly by the nurses. There were one or two nursing documents which recorded the presence of family members but no indication

of the involvement of the family in their care. The patient interviews revealed that husbands were involved and it appears they were present during the day for the duration of their hospitalisation.

It can be concluded that the nursing documentation did not reflect the patient experience of the nursing care provided to patients in the ward. While the patients experience patient centered nursing care as it became evident by the results of the study, the nursing documentation did not reflect the same. The reasons for this could be varied and would call for further research. The objectives for the study was first to identify the stated nursing care in the nursing documentation which was achieved. The second objective was to ascertain the patient's perception of the experience of the care provided to them, this was achieved and insight was gained through the interviews done with the patients. Patient-centeredness was not achieved by comparing the two objectives as there were many differences in what was documented and how the patients perceived the care. As health care is refocusing towards the patient and away from the nurses and what they do for the patients, it is essential that nursing adopts a holistic strategy towards achieving this goal. Patient centeredness is valuable in nursing care delivery and should also be reflected in the nursing documentation. The provision of care given to the patient is not accurately documented and as stated by both Picker (1987) and Hulton (2000) it should reflect not only what was done for the patient but also what was experienced by the patient. In this way quality nursing care may be achieved and may alleviate many problems experienced by hospitals regarding patient satisfaction, complaints and medico-legal aspects.

5.4 LIMITATIONS

The limitations identified in the study related to the methodology and the limitations for the researcher will be described.

5.4.1 LIMITATIONS OF THE METHODOLOGY

SAMPLE SIZE

Since there was a quantitative element to the study, the sample size was based on the average number of patients who were admitted to the ward in one-month period. The sample size was therefore large for the qualitative aspect of the study (the patient interviews) and saturation was

reached after twenty (20) interviews. Interviews were, however, continued as it was difficult to predict when saturation would be reached with the corresponding nursing record for each patient as the document review was the quantitative aspect of the study. The relatively large sample size, however, aided in obtaining more comprehensive data from the nursing records. Even though the data collected was comprehensive through this large sample size, aiding the value of the information gathered, it was a time-consuming process in collecting and analyzing the data for the researcher. This could influence the quality of the data negatively.

LACK OF AVAILABLE DATA

Many of the patients were quite reluctant to participate in the interviews and those that did were not very spontaneous in answering questions. This required detailed probing by the researcher and may have influenced their answers. Even though some patients were reluctant there were others who were quite enthusiastic and therefore counteracted this potential limitation. The fact that interviews were recorded may have contributed to the reluctance by some patients to speak freely. It could also have limited their responses as it forced them to think on the spot. This problem was exacerbated by the fact that being day two post caesarean section, most of the patients appeared to be tired and in discomfort.

The data collected from the nursing documentation was limited and could have resulted in very limited conclusions with respect to the actual nursing care provided to patients. The nursing documents are, however, the only way one has of retrospectively determining what care was given. Although a limitation for this study, it could be seen as a subject for further research into the culture of nursing documentation.

LACK OF PRIOR RESEARCH ON THE TOPIC

The study was done in one maternity ward in a private hospital. A broader perspective could be achieved if the study had been conducted in more than one research site. Using interviews to gather data from patients and transcriptions of nursing records for nursing data could have caused variances in results. If nurses had been interviewed about the care they gave, it may have given rise to different results. As many nurses are responsible for the care of any one patient in a 24-hour period, this would, however, have been challenging. Concerning the research studies

available on this topic, incorporating Picker's principles of patient centered care, only a small number of recent studies are available.

5.4.2 LIMITATIONS OF THE RESEARCHER

ACCESS

The approval of the study by the head office of the hospital was a lengthy process and required motivation by the researcher's supervisor which caused a delay in the commencement of data collection. The process of obtaining approval is controlled by the company's research department and could not be avoided. Access to the nursing documentation was also limited as no photocopying was allowed which resulted in the researcher having to transcribe all the nursing notes. This may have increased the possibility of transcription errors or missing data. The nurses appeared to be uncomfortable with the transcription of their nursing documentation although no active attempt was made to prevent this. The researcher had obtained informed consent at the beginning of the study from all nurses to do this. Having done so could have resulted in nurses documenting differently to their normal practices which may have resulted in either a positive or negative slant to the data.

LONGITUDINAL EFFECTS

Since the data was collected over a two-month period the researcher's presence was well known, and it is not clear whether the data collected over the period of time was a true reflection of the nursing documentation culture as discussed in the previous section.

CULTURAL AND OTHER BIAS

With the selection of the patients in the post-natal ward, only patients who had undergone caesarean sections were used for the study due to the fact that they had a longer stay in the hospital and the assumption that a better quality of data could be retrieved from the patients. In retrospect it may have been beneficial if the study included all patients who had birthed a baby whether it be by caesarean section or vaginal delivery. Both forms of birth are very different but a broader perspective on the patient needs could have been explored.

Cultural bias concerning the different ethnic cultures in the ward limited the study. Some members of certain cultural groups were reluctant to talk over a voice recorder and this limited the quality of data received from the patients.

5.5 RECOMMENDATIONS

Recommendations for nursing education, research and practice have been developed to help implement patient centered nursing care in the hospitals and educational institutions. The implementation of patient centered care is important and further research can be done to determine how this can be achieved to refocus nursing care towards the patient.

5.5.1 Nursing Education

Many of the private sector hospitals have started to adopt the concept of patient centered care, especially in the hospital where the study was conducted. Their vision and mission for improved nursing care has incorporated patient centered care which could improve the current nursing care provided to patients and hopefully reduce the number of complaints received daily. Nursing staff workshops and communication sessions have been held already to help change the nurses' perspectives on their current care practices to become more patient-focused. It may be a lengthy exercise to change the perspectives and culture of practising nursing with the older nurses who have been in practice for some time but change may be possible for the newer nurses. In terms of nursing education, the curriculum would need to incorporate patient centered nursing care in their teaching practices, both the content and the practice. This could be achieved by using a problem-based learning approach in which communication skills, shared decision making and patient needs are incorporated. Different teaching methods can be applied and the importance of teaching nurses how to document in a manner that would reflect a patient centered nursing approach as opposed to a task oriented approach could be emphasised. Various case studies and role plays can be used to help orientate the students to the different social, community and environmental issues with which the patients can be faced. The students could also practice their skills through simulation, as this will help the educator and the student determine whether these skills have been adopted.

5.5.2 Nursing Research

Patient centered care and research in patient centered nursing care is almost a continuous process. Further research needs to be conducted in different settings to determine how best to implement patient centered care and what the different patient needs are in the different social settings. It was evident through the study that the voice of the nurses was through the nursing documentation but may not be entirely reliable. A qualitative study should be done conducting interviews with nurses on their perspectives of patient centered care. This could be beneficial to the implementation and education of patient centered care to determine the limitations for implementation. Nurses may also share their thoughts on how they think patient centered care can be better documented. An observational study could also be conducted to determine what nursing practices are like and to also determine future outcomes or the limiting factors for the implementation of patient centered nursing care.

5.5.3 Nursing Practice

An audit of the hospital should be done to review the current policies, infrastructure and resources needed for the implementation of patient centered nursing care. Together with the audit of the hospital, an audit of the current nursing practice should be done. An audit of the patients perceptions of their experience of care provided to them should also be done to gain insight into how they experience the current practice of nursing care. This will highlight what needs to be changed or improved. Patient records will need to be amended to guide nurses in documenting the implementation of patient centred nursing care principles in the provision of their nursing care. In practice nursing is concerned with the patient, through transformational leadership the implementation of patient centered care can be led, to guide the nurses in their care of patients and improve the service delivery. The leaders in nursing will have to develop innovative practices to steam roll the change and to help the nurses “buy into” a changed way of nursing.

5.6 CONCLUSION

The research report entitled Patient centered nursing care of caesarean section patients in a private sector maternity has been concluded. The conclusion included a summary of the study and the main findings derived from the data collected and analysed. The limitations were

identified and recommendations for further research to be done in nursing practice, nursing research and nursing education. The references used in the report will follow.

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ANNEXURES

Annexure 1

PATIENT CENTERED NURSING CARE OF CAESAREAN SECTION PATIENTS IN A PRIVATE SECTOR MATERNITY WARD

INFORMATION SHEET: PATIENT PARTICIPANT

Good day, my name is Romy Fortuin. I am an MSc Nursing student in the Department of Nursing Education. I am undertaking a research study entitled, "Patient Centered Nursing Care of Caesarean section patients in a Private Sector Maternity Ward".

I would like to invite you to participate in the research study. Before agreeing to participate, it is important that you read and understand the following information about the purpose of the study, the study procedures and your right to withdraw from the study at any time. This information sheet is to help you decide if you would like to participate. You need to understand everything before you agree to take part in this study.

The purpose of this study is to to measure the quality of care by comparing the nursing activities documented to the patient's experiences. This process may highlight the need for improved methods of providing and recording nursing care of patients following caesarean section in order to provide patient centered care.

I will ask you to describe everything that you experienced pertaining to the nursing care you received in the ward yesterday between 07h00 and 07:00 this morning.

Before the start of the interview I will ask for your permission to record the interview, which will later be transcribed. The interview is expected to last less than an hour.

The interviews will be tape-recorded. Data, including tape recordings, will be stored securely in the Department of Nursing Education at the University of the Witwatersrand for a minimum of two years after publication, or six years in the absence of publication. The results of the research will be confidential. No names will be used during the interviews, and each transcript will be assigned a code to ensure anonymity. Should quotations of your input be utilised in the report or

publication, these will be designated a code so that it will not be possible to identify you in any way.

Participation will not be of any direct benefit to you personally but may benefit patients in the future. You may withdraw your participation from the study at any time without any prejudice to yourself or negative consequences.

Should you have any questions about your rights as a study participant, or questions or concerns about any aspects of this study, please call the Ethics Department of the University of the Witwatersrand on +27 11 717 1234 or my supervisor, Dr Sue Armstrong. The contact details are listed below:

Dr Sue Armstrong (Supervisor)

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Thank you for your consideration.

……

Romy Fortuin (+72734570019)

Annexure: 2

PATIENT CENTERED NURSING CARE OF CAESAREAN SECTION PATIENTS IN A PRIVATE SECTOR MATERNITY WARD

INFORMATION SHEET: NURSING PARTICIPANT

Good day, my name is Romy Fortuin. I am an MSc Nursing student in the Department of Nursing Education. I am undertaking a research study entitled, "Patient Centered Nursing Care of Caesarean Section patients in a Private sector Maternity Ward."

I would like to invite you to participate in the research study. Before agreeing to participate, it is important that you read and understand the following information about the purpose of the study, the study procedures and your right to withdraw from the study at any time. This information sheet is to help you decide if you would like to participate. You need to understand everything before you agree to take part in this study.

The purpose of this study is to to measure the quality of care by comparing the nursing activities documented to the patient's experiences. This process may highlight the need for improved methods of providing and recording nursing care of patients following caesarean section in order to provide patient centered care.

Your participation will include the use of all nursing documentation required over a 24-hour period. I will ask the patient participants to describe everything which they experienced pertaining to the nursing care they received in the ward yesterday between 07h00 and 07:00 this morning.

The interviews will be tape-recorded. Data, including tape recordings, will be stored securely in the Department of Nursing Education at the University of the Witwatersrand for a minimum of two years after publication, or six years in the absence of publication. The results of the research will be confidential. No names will be used during the interviews, and each transcript will be assigned a code to ensure anonymity. Should quotations of your input be utilised in the report or publication, these will be designated a code so that it will not be possible to identify you in any way.

Participation will not be of any direct benefit to you personally but may benefit patients and nurses in the future. You may withdraw your participation from the study at any time without any prejudice to yourself or negative consequences.

Should you have any questions about your rights as a study participant, or questions or concerns about any aspects of this study, please call the Ethics Department of the University of the Witwatersrand on +27 11 717 1234 or my supervisor, Dr Sue Armstrong. The contact details are listed below:

Dr Sue Armstrong (Supervisor)

Department of Nursing Education,

School of Therapeutic Sciences

Faculty of Health Sciences

University of the Witwatersrand

7 York Road, Parktown 2050

Johannesburg, South Africa

sue.armstrong@wits.ac.za

Tel: +27(0)114883094

Professor P. Cleaton-Jones

(Chairperson, HREC Medical)

Tel: +27(0)117171252

Zanele.ndlovu@wits.ac.za

Thank you for your consideration.

……

Romy Fortuin (+72734570019)

Annexure: 3

PATIENT CENTERED NURSING CARE OF CAESAREAN SECTION PATIENTS IN A PRIVATE SECTOR MATERNITY WARD

INFORMED CONSENT FORM: PATIENT PARTICIPANTS

I hereby confirm that I have been informed by the researcher,

(Name of researcher)……., about the nature of her study entitled "Patient Centered Nursing Care of Caesarean Section Patients in a Private Sector Maternity Ward".

I have received, read and understood the written information sheet regarding the study.

I am aware that the results of the study will be anonymously processed into a study report and all information will remain confidential.

I may, at any stage, without prejudice, withdraw consent and participation in the study.

I have had sufficient opportunity to ask questions and of my free will, declare myself prepared to participate in the study.

…… ……

Signature Date

Annexure:4

PATIENT CENTERED NURSING CARE OF CAESAREAN SECTION PATIENTS IN A PRIVATE SECTOR MATERNITY WARD

INFORMED CONSENT FORM: NURSING PARTICIPANTS

I hereby confirm that I have been informed by the researcher,

(Name of researcher)……., about the nature of her study entitled "Patient Centered Nursing Care of Caesarean Section Patients in a Private Sector Maternity Ward".

I have received, read and understood the written information sheet regarding the study.

I am aware that the results of the study will be anonymously processed into a study report and all information will remain confidential.

I may, at any stage, without prejudice, withdraw consent and participation in the study.

I have had sufficient opportunity to ask questions and of my free will, declare myself prepared to participate in the study.

…… ……

Signature Date

Annexure: 5

PATIENT CENTERED NURSING CARE OF CAESAREAN SECTION PATIENTS IN A PRIVATE SECTOR MATERNITY WARD

Consent to digital recording

I ……, consent to be interviewed and I understand that this interview will be recorded for the sake of accuracy and reliability. I understand that the consent is voluntary and that once these records are completed for its use towards this research, they shall be destroyed. I further understand that if any of my comments made during the interview are used in the research report, the quote will be anonymous.

Participant Signature…….

Date……

Annexure: 6

PATIENT CENTERED NURSING CARE OF CAESAREAN SECTION PATIENTS IN A PRIVATE SECTOR MATERNITY WARD

Consent to review nursing documentation

I ……, give consent to the use and review of the nursing documentation needed for the research study over the 24hour period stipulated in the information sheet and I understand that the documentation is needed for the sake of accuracy and reliability. I understand that the consent is voluntary and that once these records are completed for its use towards this research, they shall be destroyed. I further understand that the nursing documentation used will be kept anonymous.

Participant Signature…….

Date……

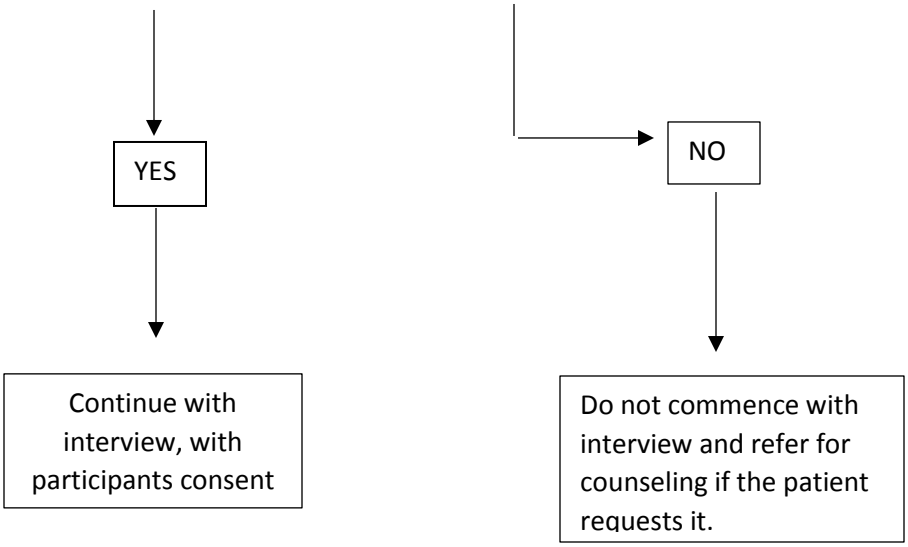
Annexure: 7

DISTRESS PROTOCOL

The following protocol will be adhered to when commencing with the interview:

1. Participants will be asked if the interview can be conducted.

Question: Do you feel emotionally able to participate in the interview?



2. If there are signs of distress identified during the interview the following protocol will be followed:

If distress is identified by the participant's behavior (crying) or by them verbalizing they are emotionally unstable

⬇

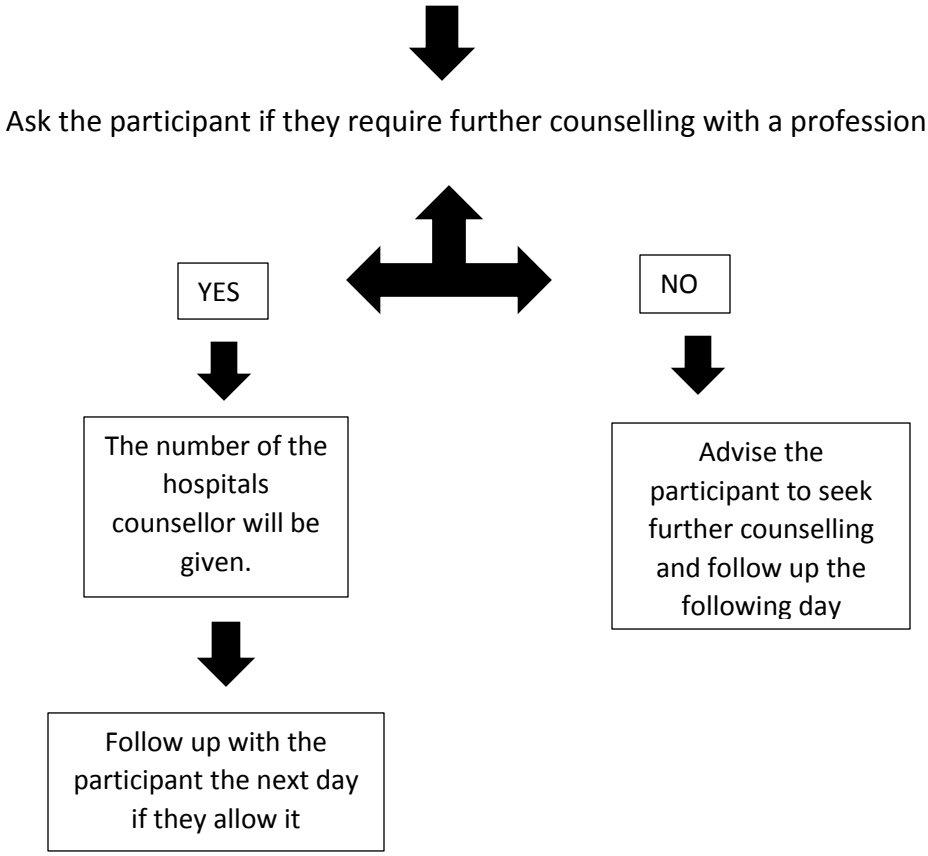
Stop the interview

⬇

Allow the participant a few minutes to regroup their emotions and thoughts

⬇

Ask the participant to explain how they are feeling and why?



Drauker et al, 2009.

Annexure 8

ETHICS APPROVAL LETTER: UNIVERSITY OF WITWATERSRAND

R14/49 Miss Romy Fortuin

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M170499

NAME: (Principal Investigator)	Miss Romy Fortuin
DEPARTMENT:	Nursing Department Unitas Hospital, Maternity Ward
PROJECT TITLE:	Patient Centered Nursing Care of Caesarean Section Patients in a Private Materity Ward
DATE CONSIDERED:	05/05/2017
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Dr Sue Armstrong
APPROVED BY:	Professor P. Cleaton-Jones Chairperson, HREC (Medical)
DATE OF APPROVAL:	23/08/2017

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary in Room 10004,10th floor, Senate House/3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand. I/We fully understand the conditions under which I am/we are authorised to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. in this case, the study was initially review April and will therefore be due in the month of April each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Annexure 9

RESEARCH CLEARANCE FROM HOSPITAL GROUP

RESEARCH OPERATIONS COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2017-0043

Ms Romy Fortuin

E mail: rfortuin25@gmail.com

Dear Ms Fortuin

RE: PATIENT CENTERED NURSING CARE OF CAESAREAN SECTION PATIENTS IN A PRIVATE SECTOR MATERNITY

The above-mentioned research was reviewed by the Research Operations Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at private Hospital, has been approved, subject to the following:

i) Research may now commence with this FINAL APPROVAL from the Committee.

ii) All information regarding the Company will be treated as legally privileged and confidential.

iii) The Company's name will not be mentioned without written consent from the Committee.

iv) All legal requirements regarding patient / participant's rights and confidentiality will be complied with.

v) The research will be conducted in compliance with the GUIDELINES FOR GOOD PRACTICE IN THE CONDUCT OF CLINICAL TRIALS IN HUMAN PARTICIPANTS IN SOUTH AFRICA (2006)

vi) The Company must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from the Committee as well as a FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.

vii) A copy of the research report will be provided to the Committee once it is finally approved by the relevant primary party or tertiary institution, or once complete or if discontinued for any reason whatsoever prior to the expected completion date.

viii) The Company has the right to implement any recommendations from the research.

ix) The Company reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental

to the subjects/ Company or should the researcher not comply with the conditions of approval.

x) APPROVAL IS VALID FOR A PERIOD OF 36 MONTHS FROM DATE OF THIS LETTER OR COMPLETION OR DISCONTINUATION OF THE TRIAL, WHICHEVER IS THE FIRST.

We wish you success in your research.

Yours faithfully

22/10/17

Prof Dion du Plessis
Full member: Research Operations Committee & Medical Practitioner evaluating research applications as per Management and Governance Policy

Shannon Nell
Chairperson: Research Operations Committee
Date: 9/12/2017

This letter has been anonymised to ensure confidentiality in the research report. The original letter is available with author of research

Anonymous

Annexure 10

PATIENT INTERVIEW QUESTIONNAIRE AND PROBES

"Please describe everything that you experienced pertaining to the nursing care you received in the ward yesterday between 07h00 and 07:00 this morning.

Probes used:

"how has the nursing care been"

"can you compare day shift to night shift"

"How has your pain been managed"

"how is the breastfeeding going"

"how has the doctors care been"

"is there anything you can suggest to improve the nursing care"

"did they ask you or was it their suggestion"

"did they explain everything to you"

"did you feel comfortable asking qustions"

List of Tables

Table 4.1: Template used for the analysis

CODE	PCC PRINCIPLE	DEFINITION OF THE PRINCIPLE BY PICKER	DEFINITION OF THE PRINCIPLE FOR THIS STUDY
A1	Respect for patient's values, preferences and expressed needs	Treating individuals with respect, in a way that maintains their dignity and demonstrates sensitivity to their cultural values. Keeping individuals informed about their condition and involving them in decision making. Focusing on the patient's quality of life, which may be affected by their illness and treatment (RNAO, 2015)	Patients express individual needs and preferences related to interpersonal interaction with the nurses, autonomy and breastfeeding. Treating the patients as individuals with respect by maintaining their dignity through demonstrating sensitivity to their cultural values. (RNAO, 2015). *Focusing on the patient's quality of life through their illness and treatment was excluded in the definition as it does not apply to this study; the patients are not ill and can be described as healthy.*
A2	Coordination and integration of care	Coordinating and integrating clinical and patient care and services to	The coordination and integration of care related to the obstetrician,

CODE	PCC PRINCIPLE	DEFINITION OF THE PRINCIPLE BY PICKER	DEFINITION OF THE PRINCIPLE FOR THIS STUDY
		reduce feelings of fear and vulnerability (RNAO, 2015)	paediatrician, dietician and the physiotherapist.
A3	Information and education	Providing complete information to individuals regarding their clinical status, progress, and prognosis; process of care; and information to help ensure their autonomy and their ability to self-manage, and to promote their health (RNAO, 2015).	Information or health education which the patient received regarding their healthcare, to ensure they maintain their autonomy and provide them with the ability to self-manage their health (RNAO, 2015).
A4	Physical comfort	Enhancing individual's physical comfort during care, especially with regard to pain management, support with the activities of daily living and maintaining a focus on the hospital environment (RNAO, 2015).	Nursing activities related to the patient's healthcare including pain management, wound care, intravenous care, observations done and catheter care.
A5	Emotional support and the alleviation of fear and anxiety	Helping to alleviate fear and anxiety the person may be experiencing with respect to their health status (physical status, treatment and prognosis), the impact	The emotional support experienced by the patient, received from the nurses to alleviate any fear or anxiety which the patients experience (RNAO, 2015).

CODE	PCC PRINCIPLE	DEFINITION OF THE PRINCIPLE BY PICKER	DEFINITION OF THE PRINCIPLE FOR THIS STUDY
		of their illness on themselves and others and the financial impact of their illness (RNAO, 2015).	
A6	Involvement of family and friends	Acknowledging and respecting the role of the person's family and friends in their health care experience by: Accommodating the individuals who provide the person with support during care Respecting the role of the person's advocate in decision making Supporting family members and friends as caregivers, and recognising their needs (RNAO,2015).	Social support from the patient's family and friends. Acknowledging the patient's family and friends who support her during the hospitalisation and respecting the role that the family and friends play in the recovery of the patient (RNAO, 2015).

Table 4.2: Phrases or words used most commonly in the patient interviews

PICKERS PRINCIPLES OF PATIENT CENTRED CARE	PHRASES OR WORDS IDENTIFIED IN PATIENT INTERVIEWS	PATIENT CODES
Respect for patients' values, preferences and expressed needs	"Ask if you're okay"	P: 39,11,38,28
	"Ask if you're coping"	P: 39,11,38,28
	"Popping in to ask how's the breastfeeding"	P: 39
	"Very supportive"	P: 11
	"They are there when you need them"	P: 31,1
	"Helped me well, very helpful"	P: 24,29,21,26,20,35
	"Rooming in with the baby"	P: 19
	"Nurses assisted me with the breastfeeding"	P: 7,8
	"Greeted by the day and the night staff"	P: 6,38,10
	"Take the baby to the nursery so that can rest/sleep"	P: 36,16,3,35
	"Check if you're okay"	P: 5,38,16,3
	"Very noisy"	P:23,8
	" Assistance with breastfeeding"	P: 21,20,37
Coordination and integration of care	"Sister came in to help me with breastfeeding from NICU"	P:39
	"Paediatrician came this morning"	P:14
	"The doctor was here"	P:31
	"The paediatrician was here"	
	"Doctor asked if I want to breastfeed"	P:11
	"The physio keeps tabs on us"	P:30
	"Doctors come and check daily"	P:30

PICKERS PRINCIPLES OF PATIENT CENTRED CARE	PHRASES OR WORDS IDENTIFIED IN PATIENT INTERVIEWS	PATIENT CODES
	"Doctors rounds/ visited" "Doctors are great" "My doctor came in this morning" "Doctor's care is very good"	P:23,15,10,20,21 P:16 P:3,26 P:21
Information and education	"Make sure you understand everything" "Gave me information about how everything is going to be" "She did a demonstration on how to latch" "They show you and teach you" "Showed me how to bath him" "They gave me enough information" "They explained everything, when I was unsure, they showed me" "Advice given" "Explain the procedures before they do it" "Paediatrician gave advice about breastfeeding"	P:39 P:24 P:19 P:19,2 P:34 P:33 P:15 P:17,8 P:2,10,43,41 P:1
Physical comfort	"Take my observations and check my pad" "Medication given for pain on a schedule" "They gave me Stilpaine and Perfalgan"	P:39,35 P:39,24,33,7,6,18,28,23,16,21, 26,10,1,43,41,20,27,35,37 P:39

PICKERS PRINCIPLES OF PATIENT CENTRED CARE	PHRASES OR WORDS IDENTIFIED IN PATIENT INTERVIEWS	PATIENT CODES
	"I get pain medication often"	P:41
	"They are giving pain pills"	P:42
	"They cleaned me and checked my wound"	P:36
	"I'm asking for it and they bring it"	P:13
Emotional support and alleviation of fear and anxiety	"Very emotionally supportive"	P:39
	"Very concerned about you and how you are feeling"	P:10
	They ask "Are you feeling okay"	P:2
	"Make you feel at ease"	P:33,17
	"Reassuring us and comforting us"	P:18
Involvement of family and friends	"Accommodated my husband well"	P:36,1,43,41,21,35,37
	"I have 2 other children and they were here for long"	P:26
	"Husband said they involved him"	P:2
	"My family was here"	P:7
	"My husband involved himself"	P:38,23
	"My husband comes in with my son"	P:3
	"My husband is accommodated"	P:33,6
	"They have been involving him"	P:31
	"My husband was here everyday"	P:19,15

Table 4.3: Phrases and words most commonly used in the nursing documentation

PICKERS PRINCIPLES OF PATIENT CENTRED CARE	PHRASES AND WORDS IDENTIFIED IN NURSING DOCUMENTATION	NURSING DOCUMENTATION CODES
Respect for patients' values, preferences and expressed needs	"No complaints"	P:39,11,19,35
	"Patient verbalised that she is comfortable"	P:19,4,30,6,36,8,1,43,20,35
	"Breastfeeding well"	P:6,36,38,8,23,16
	"Stable condition"	P:36,17,21,10
	"Coping well with breastfeeding"	P:13,21,35
	"Baby nursed by mother/ rooming-in"	P:16,15,13,21,25,35
	"Breastfeeding going well"	P:4,25
	"Baby taken to the nursery"	P:2,25,20
	"Breastfeeding baby well"	P:21,25,26,10,20
	"Coping well with baby"	P:15,26
Coordination and integration of care	"Seen by the doctor"	P:39,34,30,8,28,2,25,43,20,37
	"Doctors rounds done"	P:14,11,29,7,6,5,36,38,23,1
	"Doctor saw patient"	P:24,33,21,26
	"Doctor observed the patient"	P:31,41
	"Doctor assessed the patient"	P:42,32
Information and education	"Patient needs help with breastfeeding"	P:24,43,21,37
	"Health education given about the frequency and duration of breastfeeding"	P:19
	"Patient struggles with breastfeeding"	P:23,10
		P:23

PICKERS PRINCIPLES OF PATIENT CENTRED CARE	PHRASES AND WORDS IDENTIFIED IN NURSING DOCUMENTATION	NURSING DOCUMENTATION CODES
	"Health education given about breastfeeding" "treatment plan discussed" "Advice given as needed"	P:21,1 P:25
Physical comfort	"Wound intact, dry and clean" "Drip in situ, site patent and healthy" "Catheter in situ and draining well" Pain score done "Pain medication given" (Stilpaine, Voltaren) "Lochia not offensive and rubra" "Drip and catheter removed" "Clexane injection given" "PCA pump attached, functional and in situ" "Uterus well contracted" "Lactation: breasts are comfortable, nipples are soft and intact"	P:14,39, All documents All documents All documents All documents P:42,19,34,7,17 P:14,31,42,24 P:14,31,28 P:31,42,32,30,29,7,36,38 P:31,42,32,30,29,7,36,38 P:30,7,6,5,38
Emotional support and alleviation of fear and anxiety	"Coping well with breastfeeding" "No problems noted" "Patient coping well" "She copes well with the baby" "Patient verbalised she feels good" "Patients mood is euthymic" "Coping well"	P:27,8,25 P:41 P:39,6,3,21,10 P:29 P:24 P:14,2,1 P:42,29,28,41

PICKERS PRINCIPLES OF PATIENT CENTRED CARE	PHRASES AND WORDS IDENTIFIED IN NURSING DOCUMENTATION	NURSING DOCUMENTATION CODES
Involvement of family and friends	"Patient left the ward accompanied by her husband" "Patient is socializing with family"	P:41 P:42

Table 4.4: A comparison of the qualitative data obtained during patient interviews and from nursing documentation

PICKER'S PRINCIPLES OF PATIENT CENTERED CARE	PATIENT INTERVIEWS	NURSING DOCUMENTATION
Respect for patient values, preferences and expressed needs	"Ask if you're Okay" "Ask if you're coping" "Popping in to ask how's the breastfeeding" "Very supportive" "They are there when you need them" "Helped me well, Very helpful" "Rooming in with the baby" "Nurses assisted me with the breastfeeding" "Greeted by the day and the night staff" "Take the baby to the nursery so that can rest/sleep" "Check if you're okay" "Very noisy" "Assistance with breastfeeding"	"No complaints" "Patient verbalized that she is comfortable" "Breastfeeding well" "Stable condition" "Coping well with breastfeeding" "Baby nursed by mother/ Rooming-in" "Breastfeeding going well" "Baby taken to the nursery" "Breastfeeding baby well" "Coping well with baby"
Coordination and integration of care	"Sister came in to help me with breastfeeding from NICU"	"Seen by the doctor" "Doctors rounds done"

PICKER'S PRINCIPLES OF PATIENT CENTERED CARE	PATIENT INTERVIEWS	NURSING DOCUMENTATION
	"Paediatrician came this morning" "The doctor was here" "The pediatrician was here" "Doctor asked if I want to breastfeed" "The physio keeps tabs on us" "Doctors come and check daily" "Doctors rounds/ visited" "Doctors are great" "My doctor came in this morning" "Doctors care is very good"	"Doctor saw patient" "Doctor observed the patient" "Doctor assessed patient"
Information and education	"Make sure you understand everything" "Gave me information about how everything is going to be" "She did a demonstration on how to latch" "They show you and teach you" "Showed me how to bath him"	"Patient needs help with breastfeeding" "Health education given about the frequency and duration of breastfeeding" "Patient struggles with breastfeeding" "Health education given about breastfeeding"

PICKER'S PRINCIPLES OF PATIENT CENTERED CARE	PATIENT INTERVIEWS	NURSING DOCUMENTATION
	"They gave me enough information" "They explained everything, when I was unsure, they showed me" "Advice given" "Explain the procedures before they do it" "Paediatrician gave advice about breastfeeding"	"treatment plan discussed" "Advice given as needed"
Physical comfort	"Take my observations and check my pad" "Medication given for pain on a schedule" "They gave me Stilpaine and Perfalgan" "They are giving pain pills" "They cleaned me and checked my wound" "I'm asking for it and they bring it"	"Wound intact, dry and clean" "Drip in situ, site patent and healthy" "Catheter in situ and draining well" Pain score done "Pain medication given" (Stilpaine, Voltari) "Lochia not offensive and rubra" "Drip and catheter removed" "Clexane injection given" "PCA pump attached, functional and in situ" "Uterus well contracted"

PICKER'S PRINCIPLES OF PATIENT CENTERED CARE	PATIENT INTERVIEWS	NURSING DOCUMENTATION
		"Patient assisted to the bathroom" "Lactation: breasts are comfortable, nipples are soft and intact"
Emotional support and alleviation of fear and anxiety	"Very emotionally supportive" "Very concerned about you and how you are feeling" They ask "Are you feeling okay" "Make you feel at ease" "Reassuring us and comforting us"	"Coping well with breastfeeding" "No problems noted" "Patient coping well" "She copes well with the baby" "Patient verbalized she feels good" "Patients mood is euthymic" "Coping well"
Involvement of family and friends	"Accommodated my husband well" "I have 2 other children and they were here for long" "Husband said they involved him" "My family was here" "My husband involved himself" "My husband comes in with my son"	"Patient left the ward accompanied by her husband" "Patient is socializing with family"

PICKER'S PRINCIPLES OF PATIENT CENTERED CARE	PATIENT INTERVIEWS	NURSING DOCUMENTATION
	"My husband is accommodated" "They have been involving him"	

List of Figures

Figure 1: Quality of care framework: Ten elements of care (Hulton *et al.*, 2000).

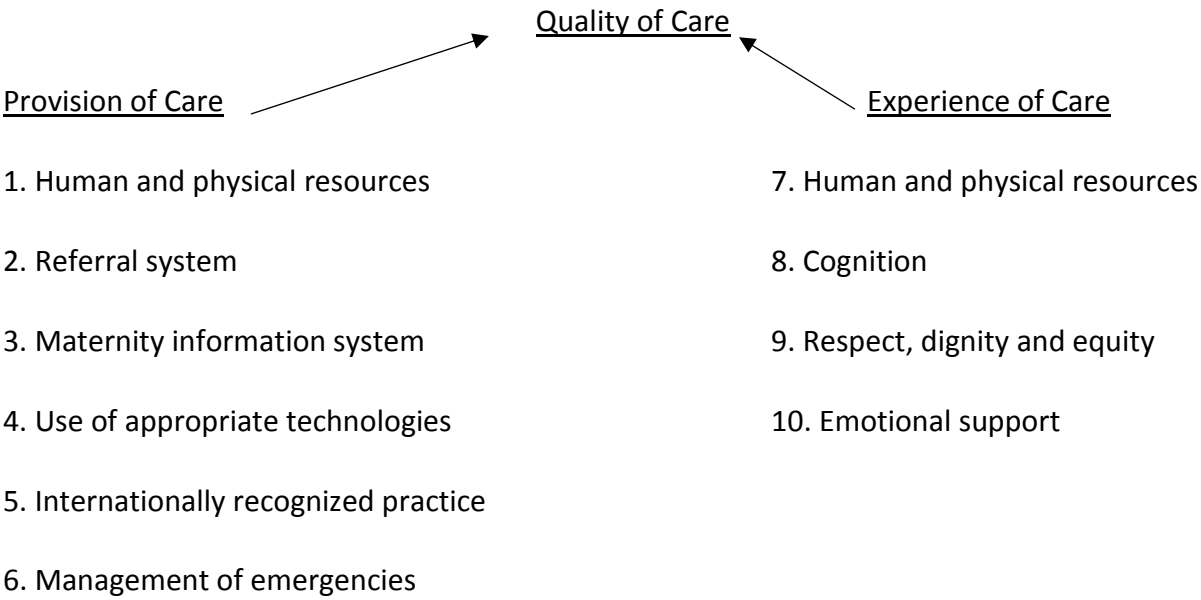


Figure 4.1: PCC principles identified in the patient data

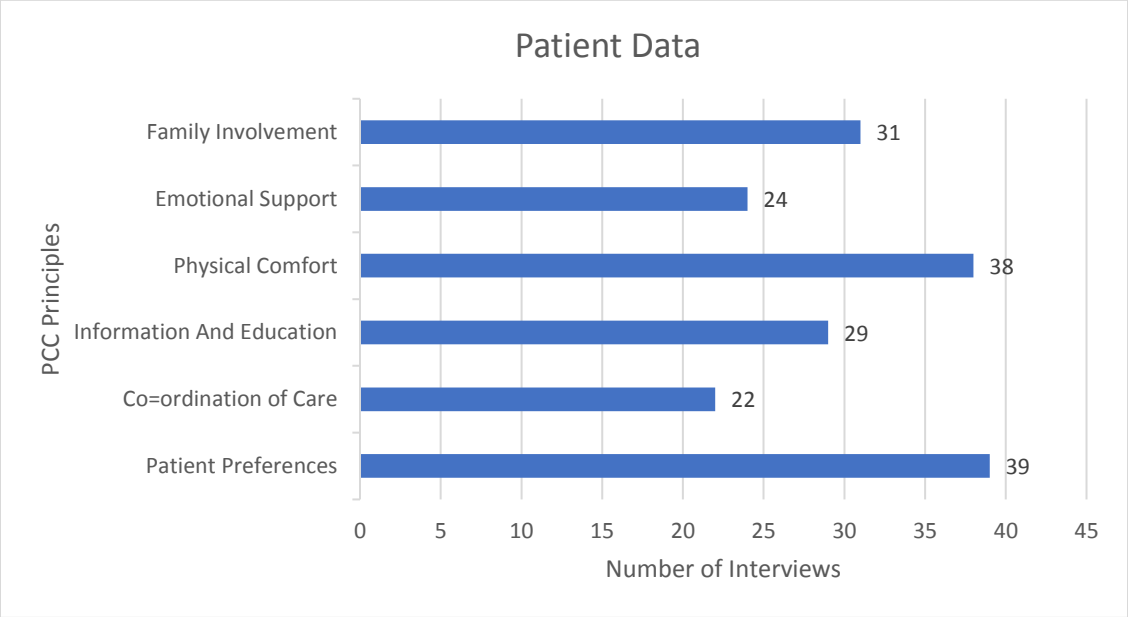


Figure 4.2: The Percentage value of the patient interview data

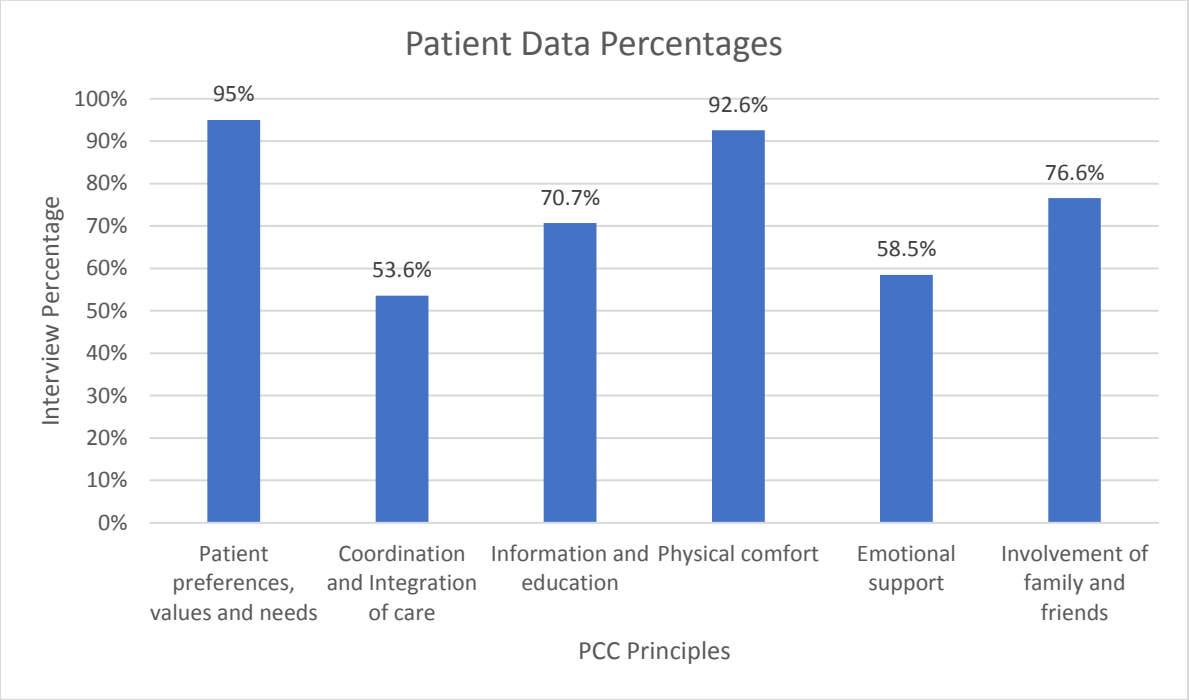


Figure 4.3: PCC principles identified in the nursing documentation

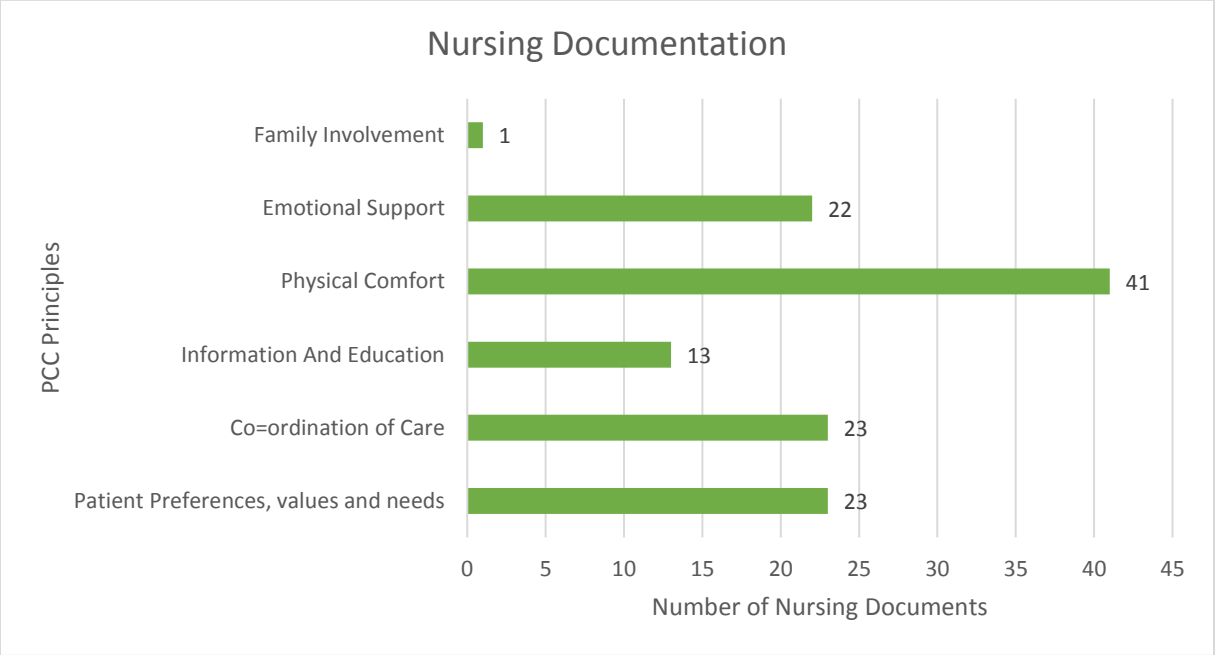


Figure 4.4: The percentage value of the nursing documentation data

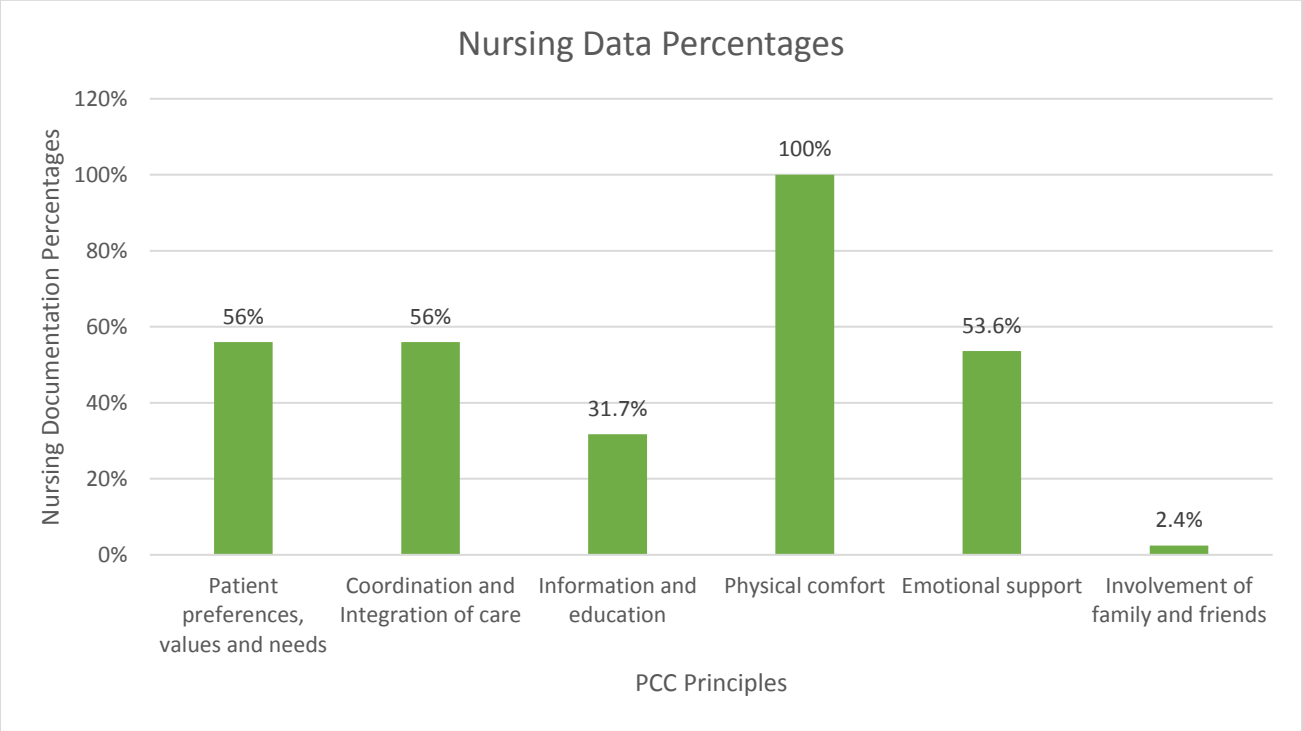


Figure 4.5: Comparison between the nursing documentation and patient interviews

