NURSES' LIVED EXPERIENCE OF CARING FOR LONG-TERM MECHANICALLY VENTILATED PATIENTS IN INTENSIVE CARE UNITS

A Phenomenological Study

by

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This dissertation is dedicated to all Critical Care Nurses ...

... it is far far better to fail at an attempt at excellence than to succeed at mediocrity ...

ABSTRACT

Nurses' lived experience of caring for long-term mechanically ventilated patients in intensive care units.

This phenomenological study was prompted by questions about intensive care nurses' experiences of caring for long-term mechanically ventilated patients in a potentially hostile environment. Data were collected by tape-recorded interviews and a focus group from five registered nurses in the intensive care units of a major tertiary level government hospital in Cape Town who volunteered to participate in the study.

Data from the tape-recorded interviews and from the focus group were transcribed verbatim and analysed using Colaizzi's phenomenological research method of inductive reduction. Four themes emerged: 'bonding', 'maintaining', 'stress-inducing' and 'unpredictability'. Resultant descriptions of caring that these participants delivered were identified as physical, technical and emotional caring. Theme clusters descriptive of these three modes of caring are respectively 'being close', 'being experienced' and 'being supportive'.

Available literature illuminated themes and theme clusters, particularly the concept of 'Dasein' (being there) as described by Martin Heidegger.

Implications for nursing practice, management, education and further research are considered and recommendations are made.

OPERATIONAL DEFINITIONS

Assumption

A belief which has not been scientifically verified (Holloway & Wheeler 1996, p.207).

Bracketing

Holding assumptions and presuppositions in suspension (Holloway & Wheeler 1996, p.207).

Bias

A distortion or error in the data collection or analysis which has its origin in strongly held values or in the very presence of an observer or interviewer (Holloway & Wheeler 1996, p.207).

Bridging Programme

Governed by scope of practice under Section 45(1) of The Nursing Act 1978 (Act 50 of 1978). Duration of training is an additional 2 academic years [from an enrolled nurses to registered nurse] (www.sanc.co.za).

Care

In a generic sense refers to those assistive, supportive or facilitative acts toward or for another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway (Leininger 1988a, p.4).

Caring

Refers to the direct (or indirect) nurturant and skilled activities, processes and decisions related to assisting people in such a manner that reflects behavioural attributes which are empathetic, supportive, compassionate, protective, succorant, educational and others dependent upon the needs, problems, values and goals of the individual or group being assisted (Leininger 1988a, p.4).

Critical Care

The specialised medical and nursing care provided to patients facing an immediate life-threatening illness or injury.

Critical Care Unit

A location in a tertiary hospital where critical care is provided. Frequently referred to as an Intensive Care Unit. Critical Care Units include the Respiratory and Medical unit (RICU), the Surgical Intensive Care Unit (SICU) and the Coronary Care Unit (CCU).

Dross rate

The amount of material of no particular use for the researcher's study (Holloway & Wheeler 1996, p.55).

Enrolled Nursing Auxiliary (ENA)

Governed by scope of practice under Section 1(1) of The Nursing Act 1978 (Act 50 of 1978). Duration of training is 1 academic year (www.sanc.co.za).

Enrolled Nurse (EN)

Governed by scope of practice under Section 45(1) of The Nursing Act 1978 (Act 50 of 1978). Duration of training is 2 academic years (www.sanc.co.za).

Epistemology

The relationship between the researcher and the subject (Lincoln 1992, pp. 379-380).

Generalisability

The extent to which the findings of the study can be applied to other events, settings or groups in the population (Holloway & Wheeler 1996, p. 208).

Hermeneutics

Hermeneutic phenomenology has both descriptive and interpretive elements. It's primary objective is the direct investigation and description of phenomena as experienced in life (Van der Zalm & Bergum 2000, p.212).

Heterogeneity

The researcher's attempt to obtain subjects with a wide variety of characteristics to reduce the risk of bias in studies not using random sampling (Burns & Grove 1993, p.769).

Intensivist

A Critical Care Physician whose medical speciality is focused entirely on the care of the critically ill and injured patients.

Limitations

Theoretical and methodological restrictions in a study that may decrease the generalizability of the findings (Burns & Grove 1993, p.772).

Lived experience

The intention is to examine and describe phenomena as they appear in the lived experience of the individual (Field & Morse 1985, p.138).

Methodology

The theories i.e. phenomenology; philosophy of science and principles on which particular methods are based (Holloway & Wheeler 1996, p.208).

Ontology

A branch of philosophy concerned with the nature of being (Holloway & Wheeler 1996, p.208).

Participant

An individual who provides the researcher with information relevant to the study or who consents to be observed during the course of the research. Informants are also participants and the two terms may be used interchangeably (Field & Morse 1985, p.138).

Phenomenology

Phenomenology is a philosophy and a research approach that focuses on the meaning of the *"lived experience"*. The intention is to examine and describe phenomena as they appear in the lived experience of the individual. Thus human experience is inductively derived and described with the purpose of discovering the essence of meaning (Field & Morse 1985, p.138).

Professional Nursing Care

Refers to those cognitive and culturally learned behaviours, techniques, processes or patterns that enable (or help) an individual, family or community to improve or maintain a favourable healthy condition or lifeway (Leininger 1988a, p.4).

Purposive sampling

Judgemental sampling that involves the conscious selection by the researcher of certain subjects or elements to include in a study (Burns & Grove 1993, p.777).

Registered Nurse (General, Psychiatric and Community) & Midwife

Governed by scope of practice under Section 45(1) of The Nursing Act 1978 (Act 50 of 1978). Duration of training is 4 academic years (www.sanc.co.za).

Rigor (Rigour)

The striving for excellence in research through the use of discipline, scrupulous adherence to detail and strict accuracy (Burns & Grove 1993, p.762).

Saturation

Sampling until no new categories emerge and all the elements of all categories are accounted for (Holloway & Wheeler 1996, p.209).

Text

A phenomenological text is a description of the current life-world of a person, and will not reflect the continually changing social reality of a person's life-world (Cushing 1994, p408).

Thick description

Dense and detailed description which gives a picture of events and actions within the social context (Holloway & Wheeler 1996, p.209).

Toxic Epidermal Necrolysing Syndrome (TENS)

An eruption of the skin and mucous membranes following oral or intravenous administrations of certain drugs characterised by large areas of loosened, easily detached epidermis that gives the appearance of a scald or burn. It is often fatal (operational definition, self knowledge).

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CHAPTER 1

INTRODUCTION

1.0 BACKGROUND TO THE STUDY

The phenomenon of interest is nurses' lived experience of caring for long-term mechanically ventilated patients in intensive care settings. Exploration of the literature unfolded a problem: a paucity of literature on the phenomenon, resulting in a crystallisation of the research question, leading directly to the aim of the study.

1.1 THE PHENOMENON OF INTEREST: LONG-TERM MECHANICALLY VENTILATED PATIENTS

A layperson entering an intensive care unit (ICU) is at once bombarded with an array of sensory stimuli, some emotionally neutral but many highly charged. Initially the greatest impact comes from the machinery: flashing lights, buzzing and beeping monitors, gurgling suction pumps and whooshing respirators. Critically ill and battered human beings are hooked up to these machines. Simultaneously, doctors and nurses are rushing saving lives. The atmosphere is not unlike that of the tension-charged strategic war bunker (Hay & Oken 1972, p.110). One can hear moaning, screaming and the last gasps of human life. Sights of blood, vomitus and excreta, exposed genitalia, mutilated wasting bodies, and unconscious and helpless people assault the sensibilities (Hay & Oken 1972, p.110).

This type of nursing requires specialist knowledge and skills, particularly knowledge of the biosciences and of ventilatory and monitoring equipment and the use of effective communication skills. The technological world of the ICU however, creates the potential for an impersonal character and therefore, is one of the major challenges that the critical care nurse must face. *"Nowhere is the paradoxical nature of the relationship between technology, an offshoot of science, and care more evident than in the micro-culture of an intensive care unit, where the dominance of technology renders many experiences of care invisible or at best obscured"* (Cooper 1994, p.402). There is also a real possibility that nurses working in ICU's may choose to respond more to the demands of the machinery and less to the needs of the patient. The reason for this apparent insensitivity to patients' needs may be that caring for long-term ventilated patients is emotionally demanding.

1.1.1 LONG-TERM MECHANICAL VENTILATOR DEPENDENCE

Long-term mechanical ventilator dependence is a secondary disorder that occurs when a patient requires assisted ventilation for more than three days. It is the result of complex medical problems that do not allow the normal weaning process to take place in a timely manner and results in ventilator dependence (Burns 1998).

A wide variety of physiological and psychological factors contribute to the development of long-term mechanical ventilator dependence. Physiological factors include those conditions that result in decreased gaseous exchange, increased ventilatory workload and demand, decreased

ventilatory drive and increased respiratory muscle fatigue. Psychological factors include those conditions that result in loss of breathing pattern control, lack of motivation and confidence and delirium. The development of long-term mechanical ventilator dependence also is affected by the severity and duration of the patient's current illness and any underlying chronic health problems. The goal of medical and nursing management of the patient with long-term mechanical ventilator dependence is successful weaning. The patient, however, has many obstacles to overcome for the weaning process to be successful. A problem of communication whilst on the ventilator by both the patient and the nursing staff is a major problem. This is often compounded by the use of sedation, anaesthetic agents and muscle-relaxants. The incidence of patients developing ventilated associated pneumonia is high as is haemodynamic instability and ventilator induced lung injury. These factors put patients at a higher morbidity and mortality risk, but more so if they are long-term mechanical ventilator dependent.

1.1.2 VENTILATOR CARE

Every step taken during management of long-term mechanically ventilated patients must be directed toward relieving the patient of his dependency on the ventilator. Regardless of the techniques used, the critical care nurse needs to organise a plan of care that is individualised and to approach weaning as the first priority of the day. The critical care nurse has the responsibility of coordinating all other services involved in the weaning process, involving ambulation, muscle training,

communication, proper nutrition and emotional support. Caring for long-term mechanically ventilated patients is complex and demanding, but can be rewarding with a successful outcome (Wilson 1993).

1.1.3 Stress Associated with Critical Care Nursing

The psychological stress associated with ICU nursing has been widely discussed in the literature. One of the most poignant arguments compares intensive care practices to torture (Woodrow 1997, p.153). Deprived of the ability to speak, make decisions or alter their environment, patients in ICU are confronted with a barrage of unusual, and a deficit of usual, sensory inputs. Some of the most basic human physiological functions such as breathing and heartbeat are now performed by machines. The ICU environment clearly has the ingredients for successful psychological and physical torture (Woodrow 1997, p.153).

A critical care nurse should try to humanise the environment for each patient and minimise suffering. Caring for critically ill patients and in particular for long-term mechanically ventilated dependent patients in a potentially hostile environment is emotionally, physically and mentally demanding.

But little is known about nurses' feelings and experiences of such caring.

My study explores these experiences and was conducted in a specialist, tertiary academic hospital in Cape Town, South Africa, presently operating on 906 beds of which 61 are in Intensive Care Units. The 'target' bed status for the ICU's however is 58, of which 3 are in High Care but the

bed status changes daily according to availability of nursing staff. A chronic shortage of critical care nurses results in fewer admissions, whereas ideally, admission should depend on patient acuity. Sixty-three Registered Nurses are allocated to the ICU's of whom only twenty (32%) hold the qualification in Critical Care Nursing.

In 1995 the Government of South Africa developed a framework for socio-economic development through its Reconstruction and Development Programme (RDP), to address major racial, gender and provincial disparities as a result of former apartheid policies. This necessitated the formation of a National Health System in order to provide caring and effective services through a primary health care approach. Tertiary health care services and resources were rationalised in accordance with a national human resource policy appropriate to the needs of South Africa. One of the strategies of the rationalisation process was to cut back on staff and beds. This was achieved by offering severance packages and other monetary incentives to public servants. Within the curative health services this resulted in a dramatic decline in the number of nurses, nursing posts and hospital beds. Large numbers of highly skilled critical care nurses flocked to hospitals in the private sector and to the Middle East, United Kingdom and the United States of America, leaving a crippled and battered nurse workforce to achieve more with fewer resources (Fouché 2002). Often, the needs of the patient and the family are not met thus further adding to the critical care nurses' stress and guilt in not being able to maintain a reasonable standard of care.

Up until the rationalisation process in October 1998, patients at the research setting were admitted to a 3 bedded Source Isolation ICU within the Respiratory ICU if they required long-term isolation and/or mechanical ventilation for: antibiotic resistant nosocomial infections or other infective conditions such as *Varicella* pneumonitis and multi-drug resistant pulmonary tuberculosis and also for neuromuscular disorders such as Guillain-Barré Syndrome, myasthenia gravis and muscular dystrophy. Further criteria included the respiratory and haemodynamic complications from ethanol and substance abuse and violence related assault.

Patients were monitored from a central nurses' station as well as at the bedside. Staff shortages made it impossible to mechanically ventilate more than two patients. The third patient was not intubated. The length of stay varied from 10 days to 90 days or longer with an average of 15.3 days. This is unusual for intensive care patients in general. The Source Isolation Unit was closed in 1998 and since then this category of patient has been nursed in various intensive care units. The team of nurses who had staffed the Source Isolation Unit were scattered amongst the remaining intensive care units.

I was the Head Nurse of the Source Isolation Unit from 1995 - 1998 and I became increasingly interested in the interpersonal dynamics between the nursing staff and the long-term mechanically ventilated patients and their families.

1.2 ASSUMPTIONS

Phenomenology offers scholars and clinicians an approach to inquiry that has a good fit with nursing philosophy and nursing art: understanding unique individuals and their meanings and interactions with others and the environment (Lopez & Willis 2004, p.726). A problem with many novice researchers is the absence of linkage between the method used and a clear statement of the philosophical underpinnings that should guide the method. Implementing a method without an examination of its philosophical basis can result in research that is ambiguous in its purpose, structure and findings (Lopez & Willis 2004, p.726). Because assumptions drive methodological decisions, it was necessary for me to be cognizant of the values and claims of different qualitative approaches before making a commitment to a choice of method. It was necessary for me to choose an approach to knowledge development that would achieve most effectively the objectives of the proposed nursing inquiry: *nurses' lived experience of caring for long-term mechanically ventilated patients in intensive care units.*

My assumptions were:

ONTOLOGICAL

- My extensive experience as a critical care nurse had allowed me to form close relationships with patients and their families as well as with the nurses who cared for them. Therefore I had a "lived experience" of caring for long-term mechanically ventilated patients;

- My "lived experience" of caring for long-term mechanically ventilated patients in the intensive care units at the research setting had been stressful, time-consuming and at times, tedious.

EPISTEMOLOGICAL

- Researchers within the phenomenological paradigm work within a 'lingual/linguistic' epistemology, which is open to interpretation and multiple realities. I anticipated that the participants would view the concept of caring differently and would also express these differences. I was not sure to what extent this could hamper and/or delay the study considering that South Africa is a multi-cultural society.

METHODOLOGICAL

- I expected difficulties as qualitative research, by virtue of its highly unstructured nature, is extremely taxing on novice researchers;
- I was concerned that I would not get enough "workable data" and therefore not be able to complete my study within set timeframes.

The motivation for the methodology as defined in this study, that is, the theories and principles on which particular methods are based will be discussed in the next chapter.

1.3 Research Problem

Although there is a vast body of literature addressing caring in nursing, relatively little appears to be related to the ICU environment. Research literature on ICU nursing deals mainly with the lived experiences of patients and their families. No research appears to have been conducted

into nurses' lived experience of caring for long-term mechanically ventilated patients.

Questions about ICU nurses' experiences of caring for patients who require long-term mechanical support in an environment that is both 'high tech' and hostile arose from comments by medical colleagues during patient rounds in the isolation unit, such as:

"How can you bear to see the same patients day after day?"

"Don't you get bored or frustrated by these long-termers/chronics?"

These comments and my reflections on my extensive experience of caring for long-term mechanically ventilated patients framed the following question that is fundamental to this study.

1.4 Research Question

"What are nurses' lived experiences of caring for long-term mechanically ventilated patients in intensive care units?"

1.5 Purpose of the Study

The aim of the study is to describe nurses' lived experience of caring for long-term mechanically ventilated patients in intensive care units.

To achieve this aim the study intends to:-

- examine critical care nurses' descriptions of caring;
- reveal or uncover meaning in their experiences;
- articulate the ways which critical care nurses respond to caring for long-term mechanically ventilated patients.

CHAPTER 2

LITERATURE REVIEW

2.0 INTRODUCTION

Decisions about conducting a literature review prior to data collection for a qualitative phenomenological study range from not consulting the literature at all, to conducting a full examination. This places the researcher in a quandary.

Reason and Rowan (1981) suggest that the researcher should not be biased about the construct of the phenomenon being researched, thereby supporting the notion of not consulting the literature. A full investigation into the literature may put the credibility of the study at risk as the researcher could be influenced by the assumptions made by others. Oiler too suggests that *"since the researcher's intent is to bracket explanations about the phenomenon, the literature review should be delayed until the data is in"* (Oiler 1982, p.180). Beeby (2000, p.77) states that when using phenomenology, the predominant school of thought echoes that of Reason and Rowan (1981), so that understanding and derived meanings originate from the data collected and, citing Swanson-Kauffman and Schonwald (1988), not from the previous readings and experience of the researcher.

Conversely, Field and Morse (1985, p.35) are of the opinion that examining previous work may be an advantage in guiding the novice researcher in justifying the need for the study. Oiler Boyd (1993, pp.99-132) argue that to see the phenomenon clearly, the researcher must bring the phenomenon

into view by explicating what he or she thinks about the phenomenon, and that reading competitive views of the phenomenon may help this. Bassett's study that explored nurse teachers' attitudes to research reveals that he first emersed himself in the literature hoping that *"this approach would enable the researcher to distance him/herself from the whole experience"* (Bassett 1994, p.587).

Having been a critical care nurse for fifteen years and a critical care nurse educator for five years, it was impossible for me not to have come across literature concerning caring in ICU. I therefore aligned myself with authors supporting the need for a literature review. For this study, I read the literature relevant to the research question (2.1.) and methodology (2.2.) to re-orientate myself to the topic, confirm the need for the study and to help the development of the research design.

The literature relevant to the research question does not provide a conceptual framework for the study but the studies by Bush and Barr (1997) and Beeby (2000) in particular have been found useful to organise most of the data from this study. The literature relevant to the methodology as defined in this study, that is, theories and philosophies upon which the method is based, relates to nurses' lived experience of caring for long-term mechanically ventilated patients in intensive care units.

2.1 Caring - An Everyday Word in Nursing

Human caring in nursing has been studied since Leininger brought caring to the forefront in the nursing literature in the 1980's (Bush and Barr 1997, p.387). Morse, Sloberg, Neander, Bottorff and Johnson (1990) reported on their review of 35 nurse author's perspectives on human caring, concluding that, despite the volume of articles and books on caring in nursing, there is confusion as to the definition, components and the process of caring, and some information is even contradictory.

Gaut (1983, p.314) considered the meanings given to the word *'caring'* in both lay and scholastic terms. The notion of caring involves three major attributes:

1. attention to or concern for another;
2. responsibility for or providing for another;
3. regard, fondness or attachment for another.

Gaut (1983, p.316) concluded that caring is a word that is vague and ambiguous, with a family of meanings that shift according to the context of the situation. Caring is a practical activity associated with the perspectives, attitudes and expectations of those doing the caring.

The literature to date offers two dimensions of caring in nursing. The first concerns a definitional approach (Watson 1979, Leininger 1981) and the second focuses on the meaning and intuitive values of care (Benner 1984, Benner and Wrubel 1989). The definitional approach utilizes lists and taxonomies in order to enlarge our understanding of the phenomenon.

Watson (1985) created a list of ten 'carative' factors and Leininger (1981) developed a taxonomy of caring constructs. This knowledge contributes to our understanding of professional care.

2.1.1 Watson's Theory of Caring

The structure for the science of caring is built upon the following ten carative factors:

1. The formation of a humanistic-altruistic system of values.
2. The instillation of faith-hope.
3. The cultivation of sensitivity to one's self and to others.
4. The development of a helping-trust relationship.
5. The promotion and acceptance of the expression of positive and negative feelings.
6. The systematic use of the scientific problem-solving method for decision making.
7. The promotion of interpersonal teaching-learning.
8. The provision for a supportive, protective, and/or corrective, mental, physical, socio-cultural, and spiritual environment.
9. Assistance with the gratification of human needs.
10. The allowance for existential-phenomenological forces.

Of these ten carative factors, the first three form the *"philosophical foundation for the science of caring"* (Watson 1979, p.10). Watson views caring as the most valuable attribute nursing has to offer to humanity, yet caring has, over time, received less emphasis than other aspects of the practice of nursing in that:

"the human care role [in nursing] is threatened by increased medical technology, bureaucratic-managerial institutional constraints in a nuclear age society" (Watson 1988, p.33).

Watson (1988, p.54) sees the nurse as scientist, scholar, clinician, humanitarian and moral agent and she has high expectations of the capacity and knowledge of nurses in being skilled in all these areas. Nurse and patient work together in a symbiotic relationship from an ethos of caring, rather than that of curing. The outcome of this approach promotes growth and development of the individual, portraying nursing as a *"deeply human activity"* (Watson, 1979 p.7). This approach relies on a relationship of interdependence between the nurse and the patient, resting on the assumption that patients are always able to express themselves.

Although Watson acknowledges the importance of fundamental needs such as nutrition, elimination and ventilation, in her writings little attention is given to the pathophysiological and technical aspects of caring that predominate the speciality of intensive care nursing (Watson 1985, pp.28-39). This may suggest that working in ICU where nursing includes technical skills, attending to the biophysical needs of the patient may have little caring value because of the difficulty in forming an interpersonal relationship or in getting to know the patient.

Watson's theory (1988, pp.28-29) emphasises the subjective experience for both the nurse and the patient, promoting personal growth and self-actualisation for both parties. This may suggest that nursing in a technical, highly specialised environment such as an intensive care unit

and attending to the biophysical needs of patients, may have little caring value when the interpersonal relationship cannot be fully realised by knowing the patient.

2.1.2 Leininger's Theory of Transcultural Care

Leininger (1988a, p.5) views caring as a universal phenomenon, but the expression and pattern of it may vary across cultures. Her model has been used predominately to generate a theory, however Leininger intended its use for both theory and practice.

For nurses to provide therapeutic nursing care using Leininger's theory, they should have knowledge of the caring values, beliefs and practices of their patients. Again, as with Watson's theory (1979, 1988), implicit within this statement is the belief that the patient is articulate and expressive and that the nurse is skilled in understanding the meanings given by the patient. If extrapolated to patients who are mechanically ventilated in ICU, caring is determined by the meanings and assumptions given by the nurse.

Leininger's (1988b, p.45) definition of professional caring, that is, taking responsibility and providing for, fits within Gaut's (1983) dimensions of caring. These supportive, assisting and facilitative acts towards patients are learnt within the culture of the health care system (Beeby 2000, p.78).

Leininger (1988a, p.7) believes that, by ascertaining the cultural influences on caring, a nurse can begin to provide meaningful care for the patient. Both Watson and Leininger value the humanistic sciences. From this

perspective, caring, a fundamental part of nursing, has therapeutic benefit that is distinct from but complementary to that of curing (Beeby 2000, p.79). Leininger's (1985) classification of caring describes many important factors that are also important in ICU practice namely: assisting, supporting and enabling caring behaviours including the elements of trust, compassion, nurturing, concern and presence.

2.1.3 Benner and Wrubel on Caring in Nursing

Benner (1984), and later Benner and Wrubel (1989) attempted to unravel meanings of care through hermeneutic interpretation of 'narratives'. Clarke and Wheeler (1992, p.1284) suggest that although such interpretations contribute a great deal to the study of the phenomenon of care they offer an American perspective, and can be criticised for being too analogous. Benner and Wrubel (1989, p.368) describe caring as *"a basic way of being in the world."* Not all persons are caring and perhaps Benner and Wrubel (1989) are pointing to a deeper sense of care, a sense of care which is appropriately described as ontological care (Edwards 2001, p.168). It is a form of care which all humans, by definition, must instantiate, a kind of care which features in the very make-up and constitution of all human persons (Edwards 2001, p.168).

This appeal to caring as a way of being in the world is derived from the work of Heidegger (1962). Indeed *"[D]asein, when understood ontologically is care"* (Heidegger 1962, p.237). Heidegger (1927 cited by Mills 1997, pp.44-45) therefore offers an existentialist ontology of selfhood as *Dasein* (being-there), the concretely existing human being who is there, as a

participant in the world. In Dasein's original disclosedness as Being-in-the-world, one is thrust into the ontological contingency of "being-in" (around-world) an environment (*Umwelt*) and "Being-with" (with-world) others (*Mitwelt*) and with-oneself (own-world) (*Eigenwelt*), which underlies all participation, engagement and concrete involvement with the world. Thus, the world itself is constitutive of Dasein's Being, for "*Being-in-the-world is a state of Dasein that is a necessary a priori but it is far from sufficient for completely determining Dasein's Being.*" The nature of the selfhood or Dasein of participants may be revealed during the interviews in this study.

2.1.4 Caring in Critical Care

Rushton (1991, pp.238-240) maintains that professionals in critical care areas, although overworked and overwhelmed, are diligent in their caring. However, she states that "*the critical care environment can be dehumanising for caregivers by virtue of (1) inconsistent philosophies about patient care delivery and decision making, (2) personal and professional value conflicts, (3) poor communication patterns, (4) unresolved ethical dilemmas, (5) increased technology, (6) shortages of human and material resources, (7) inadequate support systems, (8) lack of professional skill, (9) inadequate administration support, and (10) the physical design of the unit environment.*"

There is much published literature on the stressors experienced by critical care nurses but my search revealed only three articles that offered any information regarding the experiences of nurses in intensive care. Simpson's (1997) grounded theory study examined the experiences of ICU

nurses caring for patients whom they did not believe were going to survive. The study findings suggest that inexperienced ICU nurses often find it difficult to understand why decisions are made to continue or discontinue treatment. Simpson further suggests that in order for these patients to be cared for humanely and with dignity, an overt multi-disciplinary approach to care is necessary to ensure sound decision-making processes (Simpson 1997, p.196).

The second study was conducted by Bush and Barr (1997) who used a phenomenological approach to formulate the fundamental structure of caring as a lived experience of critical care nurses. They looked at fifteen critical care nurses who were employed in six large metropolitan hospitals in the south western region of the United States of America. The results demonstrated that caring was composed of affective, cognitive, action and outcome sub-processes. The caring process originated in the nurses' feelings and knowledge and moved the nurse to competent actions that contributed to patient, family and nursing outcomes (Bush & Barr 1997, pp.387-398).

The third study by Beeby (2000) addresses intensive care nurses experiences of caring which was conducted in a twelve-bedded ICU and coronary care unit (Beeby 2000, pp.76-83). Unstructured, in-depth interviews were used to collect data on the experiences of nine registered nurses who volunteered to participate in the study. Three major themes were drawn from the data using Colaizzi's inductive reduction approach to data analysis. These were:

1. Being involved
2. Sustaining
3. Having frustrations

A resultant description of caring identified three types of care that these nurses delivered: physical, technical and emotional labour.

In my review of literature on caring in critical care nursing, authors' perspectives on caring were generally in agreement with what constitutes caring as described by Rushton, Simpson, Bush and Barr and Beeby. The heaviest focus was on the role of family members in the care of critically ill patients. The patient, the nurse and technology received less consideration.

Family

The family's perceptions and needs when a member is hospitalised and in a critical care unit play a prominent role in nursing literature on caring. The literature is overwhelmingly in support of the notion that the care of critically ill patients should include the family and significant others (Hogg 1994). Caine (1991) believes that, under these circumstances, families are in a crisis and are emotionally and physically distressed and need caring. A study of roles and relationships of families, social support systems and nurses, revealed that when a family's needs were met, they were better able to support their ill family member (Kupferschmid, Briones, Dawson and Drongowski 1991). A literature review showed that information was the most important need of families (Kleinpell 1991). Swanson's study (1990) conducted in a neonatal ICU, underscored how

"mundane nursing acts... are actually laden with scientific and caring principles." For example, caring is manifested by nurses and parents in their quiet and tender voices and gentle touching and holding while engaged in daily activities of bathing, taking temperatures, changing nappies and feeding (Swanson 1990, pp.60-73).

Perceptions of patients and nurses

White (1989, p.26) states that critical care nursing requires involvement at all levels of caring and is so integrated into nursing that caring is not recognised by critical care nurses. She categorizes some actions of caring as follows but in no particular order of significance: reassuring, explaining, comforting, acting quickly and calmly, holding the patient's hand, sitting with the patient's family, crying with the patient and family over the diagnosis and blending caring with the technical components.

Rosenthal's (1992) study looks at coronary care patients' and nurses' perceptions of important nurse caring behaviours. The following (in descending order of importance) were important to patients: (1) injections, intravenous lines and machines, (2) the nurse being on time with treatments and medicines, (3) the nurse knowing when to call the doctor, (4) the nurse responding quickly to a call, (5) the nurse informing the patient about his disease and treatment, (6) the nurse giving good physical care, (7) the nurse encouraging the patient to call if he has problems, (8) the nurse listening, (9) the nurse being honest, and (10) the nurse being well organised. These findings are supported by Bush and Barr who reported that actions that provide evidence of competence and knowledge

are the most valued nurse behaviours by patients in critical care units (Bush & Barr 1997, p.388).

Differences are noted when nurses' perceptions of the ten most important nurse caring behaviours are shown in descending order of appearance: (1) listening, (2) knowing when to call the doctor, (3) allowing the patient to express feelings and keeping selected information confidential, (4) giving good physical care, (5) touching, (6) quickly responding to a patient's call, (7) encouraging the patient to ask questions, (8) including the patient in the plan and management of care, (9) encouraging the patient to call if he has problems, and (10) being calm (Rosenthal 1992)

Technology

Cooper (1994, p.403) writes about softening the impact of technology by touching, speaking and gesturing while using equipment in the critical care unit. The emphasis on caring for the patient is made visible by the nurse's response to the patient in pain, empathizing with the patient's fears, providing information about the patients' condition and acknowledging his vulnerability with her comforting touch. Cooper (1994, p.404) further states that often what patients see are nurses who seem to focus more attention on the data gathered from the equipment than on the needs of the patient, but critical care nurses understand that technology is used to enhance caring. Bosque (1995, p.71) further states that *"machines can become an extension of a person and can result in a type of symbiotic relationship."*

Beeby (2000, p.81) reviews three qualitative phenomenological studies dealing with the concept of caring (Barr 1985; Forrest 1989; Ford 1990). Unstructured interviews were used to collect data from nurses about their experiences of caring. Ford's (1990) sample consisted of six registered nurses who were working with cardiac patients. Forrest (1989) interviewed seventeen nurses working in medicine, surgery, psychiatry and paediatrics. Barr's (1985) fifteen participants were from a range of critical care settings. A comparison of themes of caring from studies by Ford, Forrest and Barr is presented in Table 1.

Table 1. Comparison of themes of caring from three research studies (Beeby 2000, p.81).

Ford (1990)	Forrest (1989)	Barr (1985)
▪ Sensing the patient's vulnerability ▪ Beyond the call of duty ▪ Being in tune with the patient's world ▪ Being attentively present ▪ Centering on the patient ▪ Being comfortable with the patient	▪ Being there ▪ Respect ▪ Feeling with and for ▪ Closeness ▪ Touching and holding ▪ Picking up cues ▪ Being firm ▪ Teaching ▪ Knowing them well ▪ Patient perception of outcomes	▪ Totality of care ▪ Priority of care ▪ Nature of caring ▪ Blending of attitude with action ▪ Recognition of patient's individuality ▪ Family involvement ▪ Teaching and communication

In the three studies cited, all participants were volunteers and each study used themes generated from the data to provide a description of caring. Whilst these studies add a further dimension to the discourse on understanding the phenomenon of caring, it is important to remember that generalisations from these findings can not be made due to the small sample sizes and the non-random sampling methods used. Beeby (2000) compares Barr's (1985) study with that of Forrest (1989) and Ford (1990)

and suggests that there may be commonalities of caring between nurses with critical care backgrounds and general nursing backgrounds.

More recently, the concept of the meaning of caring in the practice of intensive care nursing has been explored by Wilkin (2003). The literature discussed here is along the lines of those already mentioned. Wilkin states that *"the concept of caring in the ICU is central to the social relationship between the nurse, the patient and his/her relatives. However, there is still little clarity in the understanding, description and relevance or function of caring in nursing"* (Wilkin 2003, p.1178).

A literature search revealed little on the lived experiences of nurses caring for patients in the critical care setting and nothing on nurses' experiences of caring for long-term ventilated patients. However, what can be gleaned from existing literature on caring is that it is a multi-dimensional concept open to many interpretations. These interpretations can be derived by using different research methodologies.

2.2 METHODOLOGY - Methods of Inquiry

There are two major approaches to research: qualitative and quantitative. These approaches are based on different paradigms of viewing the world and knowledge. These paradigms are *positivism* (also called traditional, experimental or empirical) and *naturalism* (also referred to as interpretivist, constructivist or interactionist) (Creswell 1994). In the past, the traditional quantitative approach was the favoured method for social and behavioural research. Quantitative research is based on the positivist

and early natural science paradigm which has influenced the social sciences throughout the nineteenth and twentieth centuries. Experimental research and survey research have their origins in positivism in which theories and hypotheses are tested. The interpretive model has its roots in philosophy and the human sciences, particularly in history and anthropology. This approach centers on interpretation and the creation of meaning by human beings, and their subjective reality (Holloway & Wheeler 1996, p.12).

2.2.1 POSITIVISM AND NATURALISM

Holloway and Wheeler (1996, p.10) state that positivism and naturalism are fundamentally different when one examines the assumptions of each with regard to their own explanations of ontology, epistemology and methodology as summarized below.

Table 2. The differences between the positivistic and naturalistic paradigms.

	POSITIVISM	NATURALISM
ONTOLOGY [the nature of reality and human behaviour]	Belief in an objective reality, which can be explained, controlled and predicted by means of natural laws. Human behaviour can be explained in causal (cause-effect) ways and so can be manipulated and controlled.	Belief in multiple realities, which are constructed and which can be explained by discovering the meanings that people in specific settings attach to it. Human behaviour is intentional and creative and can be explained but not predicted.
EPISTEMOLOGY [the relationship between the researcher and the subject]	The researcher is detached or separate from the object being studied. The researcher is thus able to be objective and will not influence or be influenced by the study subject.	The researcher is subjective and interacts with the subject or object of investigation. The result is created by the interaction between the researcher and the researched.
METHODOLOGY [the principles and ideas on which research is based]	Uses a strategy that is both experimental and manipulative. Hypotheses are stated and then subjected to empirical testing to verify them.	Dialectical and interpretative. During a process of interaction between the researcher and the participant, the participant's world is discovered and interpreted.

(Summarised from Lincoln 1992, pp.379-380).

Quantitative research which is rooted in positivism, looks for relationships between variables in an attempt to explain causality and give accurate predictions; these relationships are deduced from previous knowledge or research and the purpose of the research is to test this deductive theory (Field & Morse 1985).

Qualitative research is concerned with the in-depth study of human phenomena in order to understand the nature and meanings they have for the individuals involved (Hockey 1991, Holloway & Wheeler 1996). A summary of the essential aspects of qualitative research is provided in Table 3.

Table 3. The essential aspects of qualitative research.

Qualitative Research	
Aim	Exploration of participant's meaning. Understanding, generation of theory from data.
Approach	▪ Broad focus ▪ Process orientated ▪ Context-bound, mostly natural setting ▪ Getting close to the data
Sample	▪ Participants, informants ▪ Sampling units such as place, time and concepts ▪ Flexible sampling which develops during research
Data Collection	▪ In-depth non-standardised interviews ▪ Participant observation/fieldwork ▪ Documents, photographs, videos
Analysis	Thematic, latent content analysis. Grounded theory, ethnographic analysis etc
Outcome	A story, an ethnography, a theory
Relationships	Direct involvement of researcher. Research relationship close
Validity	Trustworthiness, authenticity

Adapted from Holloway & Wheeler (1996, p.10).

The outcome of this type of research is to document and interpret as fully as possible the phenomena being studied (Leininger 1985). Qualitative research is often used to discover and document unknown phenomena and is especially useful when trying to research the attitudes, values and feelings of individuals and groups (Leininger 1985). It is this approach that has been applied to my study.

For the purposes of this study, only literature pertaining to the qualitative research methods will be described.

2.2.2 Qualitative Research Methods

Several approaches to conducting qualitative research have emerged from different disciplines such as grounded theory, ethnography and phenomenology.

> GROUNDED THEORY was developed by sociologists to generate theoretical constructs that explain a process or answer the question ***"what is going on here?"***
>
> Research at Master's level is not intended to generate a new theory so the grounded theory research method was not suitable.
>
> ETHNOGRAPHY is a research approach initially used in anthropology to provide descriptions of cultural groups. My research question did not entail observing and interpreting rituals of a culture and therefore ethnography was also deemed inappropriate.
>
> The early roots of PHENOMENOLOGY lie in biblical interpretation but more recently has been developed and refined by 20th century philosophers. Phenomenology attempts to uncover the meaning of human experience through analysis of participants' detailed descriptions (Habermann-Little 1991, p.188).

Common characteristics of the three qualitative designs are that: (i) they are inductive; (ii) they occur in social or human settings; and (iii) describe or explain human experience. The qualitative research method of phenomenology is appropriate for my study as I wanted to describe the

nurses' experiences of caring for long-term ventilated patients in intensive care.

2.2.2.1 PHENOMENOLOGY

The two main phenomenological approaches evident in the nursing literature include descriptive (eidetic) and interpretive (hermeneutic) phenomenology.

Phenomenology is a philosophy of describing and classifying phenomena, *'philos'* being the object of a person's perception. The focus is the description of the lived experience, concentrating almost entirely on the subjective aspect of social life that is internal to the individual consciousness (Thornton & White 1999, p.267). It is not merely a method of enquiry but also a way of thinking and perceiving, a phenomenological view of the past, the present and future (Ray 1990). The word phenomenology comes from two Greek words: *phainomenon* meaning appearance and the other *logos* meaning reason (Walters 1995, p.792). Phenomenology grew out of a philosophical movement that is still in the process of being clarified. As a result, one can find multiple interpretations and modifications of phenomenological philosophy (Omery 1983, p.50). Two of the approaches to the study of philosophy, are the analytic and the continental approaches.

Analytic philosophy is derived from ancient philosophers such as Socrates and Aristotle and is concerned with analyzing and defining abstract concepts (Holloway & Wheeler 1996, p.116). Continental philosophy takes

these abstract concepts of Socrates and Aristotle and constructs theories about them. Phenomenology, a form of continental philosophy (Holloway & Wheeler 1996, p.116) is frequently described as a movement to indicate how the philosophy has changed and continues to change over time (Cohen & Omery 1994, p.136). The two philosophers who have had the most influence on this movement are Edmund Husserl and Martin Heidegger. The two main schools of phenomenology carry their names.

2.2.2.1.1 The Phenomenology of Edmund Husserl (1859-1938)

Husserl, a mathematician, is designated as the founder of the modern phenomenological movement. There are three dominant ideas central to Husserlian phenomenology.

- Intentionality
- Essences
- Reduction or bracketing

Intentionality originates from the work of Franz Brentano (1838–1917) and is a way of describing how the conscious mind directs thoughts towards an object, *"One does not just think, one thinks about something"* (Holloway & Wheeler 1996, p.116). Husserl believed that in forming knowledge of reality one should start with this conscious awareness; and that in describing the phenomenon, one would, by determining the essences, be able to "return things to themselves" (Koch 1995, p.828). Experiences are therefore studied to reveal consciousness, which Husserl believed are always intentional (Cohen & Omery 1994, p.138).

An important component of Husserlian phenomenology is the belief that it is essential for the researcher to shed all prior personal knowledge to grasp the essential lived experiences of those being studied. This means that the researcher must attempt to remove all prior expert knowledge as well as personal biases from her consciousness. Some researchers advocate that the descriptive phenomenologist not conduct a detailed literature review prior to initiating the study and not have specific research questions other than the desire to describe the lived experience of the participants in relation to the topic of study (Streubert & Carpenter 1999).

The goal of the researcher is to achieve transcendental subjectivity, which means that the impact of the researcher on the inquiry is constantly assessed, and biases and preconceptions neutralised in order not to influence the object of study (Lopez & Willis 2004, p.728). To achieve this, descriptive phenomenologists use bracketing which involves the researcher holding in abeyance ideas, preconceptions and personal knowledge when listening to and reflecting on the lived experiences of participants.

Because of my long and ongoing involvement in critical care nursing, I was unable to adhere to this rigour and therefore did not choose this school of inquiry.

Husserl's phenomenology was further developed and used to guide the work of researchers such as Giorgi, Colaizzi, Fischer and van Kaam (Cohen & Omery 1994, p.140).

2.2.2.1.2 The Phenomenology of Martin Heidegger (1889-1976)

While the phenomenology of Edmund Husserl has as its focus a description of the lived world that conceptualizes people as detached subjects existing in a world of objects, the phenomenology of Martin Heidegger is based on an existential perspective which considers that an understanding of the person cannot occur in isolation from the person's world (Walters 1995, p.792).

Martin Heidegger was an assistant to Husserl, interested in the ontological aspects of the nature of *being*. He took phenomenology past the simple descriptions into interpretative or hermeneutical forms of enquiry. In his book *Being and Time*, Heidegger shifts the philosophical debate from epistemology (from mere description of core concepts and essences) to ontology (to look for meanings embedded in common life practices). These meanings are not always apparent to the participants but can be gleaned from the narratives produced by them.

Heidegger refers to human existence as ***'Dasein'***, or being-there, which emphasizes the situation of human reality. Heidegger's analysis of the human condition is that people are 'in and of the world rather than subjects in a world of objects' (Reed 1994, p.338). Heidegger is often referred to as an existential phenomenologist because of this thinking.

Heidegger's analysis of *Dasein* commences with an interpretation of being-in-the-world which is written with hyphens to symbolize its unified nature. The concepts comprising this phenomenon are 'in-the-world', the

quality of the existence and the uniqueness of 'being-in'. According to Heidegger, a consideration of any one of these phenomena has to involve reference to the other two. The most fundamental way of being-in-the-world, Heidegger says, is ***Sorge.*** This word is usually translated into English to mean 'care'. Care is about Being and it is about caring for things and people (Walters 1995, p.793.). It is not the pure content of human subjectivity that is the focus of a hermeneutic inquiry but, rather what the individual's narratives imply about what he or she experiences everyday (Lopez & Willis 2004, p. 729).

An important concept to interpretive inquiry is that of freedom. Heidegger (1962) asserted that humans are embedded in their world to such an extent that subjective experiences are inextricably linked with social, cultural and political contexts. This *"situated freedom"* is an existential phenomenological concept that means that individuals are free to make choices but their freedom is not absolute; it is circumscribed by the specific conditions of their daily lives (Lopez & Willis 2004, p.729). This concept of situated freedom is in direct opposition to Husserl's concept of radical autonomy (humans are considered as free agents who bear responsibility for influencing their environment and culture). The hermeneutic phenomenologist, rather than seeking purely descriptive categories of the real, perceived world of narratives of the participants, will focus on describing the meanings of the individual's being-in-the-world and how these meanings influence the choices that they make. In interpretive phenomenology, it is the interpretation of the narratives

provided by participants in relation to various contexts that is foundational (Lopez & Willis 2004, p.729).

Another philosophical assumption underlying interpretive phenomenology is that presuppositions or expert knowledge on the part of the researcher are valuable guides to inquiry and, in fact, make the inquiry a meaningful undertaking. Therefore personal knowledge, according to hermeneutic scholars, is both useful and necessary to phenomenological research and the technique of bracketing, as described by descriptive phenomenologists is questionable within an hermeneutic approach (Annells 1996).

Furthermore, hermeneutic phenomenology differs from the descriptive approach, in that an interpretive approach does not negate the use of a conceptual framework. In an hermeneutic study, the conceptual framework can be used to focus the inquiry and make decisions about sample, subjects and research questions that need to be addressed. If a framework is used, it should be used to interpret the findings and explain how the framework was used in the interpretation of the data and in generating findings (Lopez & Willis 2004, p.730). A conceptual framework per se was not used, but studies by Bush and Barr (1997) and Beeby (2000) were useful to some extent to organise the findings.

Heidegger's philosophy influenced the work of French philosophers such as Gabriel Marcel (1889–1973), Jean Paul Sartre (1905–1980) and Maurice Merleau Ponty (1908–1961). These philosophers did not want to be called phenomenologists, but preferred to be called existentialists, as

existentialism tries to focus on the fact that something *is* rather than describing features (Holloway & Wheeler 1996, p.120).

2.2.2.1.3 Hermeneutic Phenomenology

Hermeneutics is the study of the interpretation of texts. The purpose of hermeneutical interpretation is to obtain a valid and common understanding of the meaning of text (Kvale 1996, p.46).

Gelven (1989) defines hermeneutic phenomenology as *"...an analysis by which the meaning of the various ways in which we exist can be translated from the vague language of everyday existence into understandable and explicit language of ontology without destroying the way in which these meanings manifest themselves to us in our everyday lives"* (Gelven 1989, p.6).

This approach has both descriptive and interpretative elements. Van der Zalm and Bergum (2000) believe that the predominant aim of hermeneutic phenomenology is to directly investigate and then describe phenomena as experienced, by the practice of phenomenological reflection and writing. This gives voice to the human experience just as it is, and attempts to provide understanding of the experience. A Heideggerian phenomenological approach was chosen for this study because Heidegger saw phenomenology as ontology - a way of being. It is a means of studying modes of being-in-the-world and everyday activities within it. It is also a way of discovering how phenomena present themselves in the lived experience of human existence through self-interpretation and self-involvement. An hermeneutic phenomenological study therefore

describes the context of this experience. These descriptions can always be challenged by alternate explanations since a complete description is not possible; our complex world does not remain constant. Meta-theorists are of the opinion that the weaknesses and strengths of hermeneutic phenomenology lie within its descriptions. A phenomenological text is merely the life experience of a particular person at a particular time and does not reflect the fluctuating meanings of this life world. Phenomenological descriptions can provide understanding with which to initiate the process of forming theory, or to inform other research utilizing diverse methods and larger numbers of participants.

It has been shown thus far that phenomenology is an approach within continental philosophy because it takes abstract concepts (analytic approach) and constructs a theory to explain such things such as knowledge and existence. Continental philosophy, as the name suggests, is mostly practised in continental universities. In qualitative research, phenomenology has been adapted and used as a framework within the so-called interpretative tradition which broadly includes grounded theory and ethnography (Holloway & Wheeler 1996, p.121).

2.2.3 The Phenomenological Process

Phenomenological research is primarily about wanting to know the world in which we live (van Manen 1990). Hermeneutic phenomenology comprises an interplay between six research activities:

1. *"Turning to the nature of the lived experience.*
2. *Investigating the phenomenon as it is lived, rather than as it is theorized or conceptualized.*
3. *Reflecting on the essential themes that characterize the phenomenon.*
4. *Writing and rewriting to describe the phenomenon, as it is present in the lived experience.*
5. *Maintaining a strong and orientated relation to the phenomenon.*
6. *Balancing the research context by considering parts and whole"* (van Manen 1990, pp.30-31).

Oiler Boyd, a nurse researcher, agrees with Van Manen and summarises some important points relating specifically to nursing research:

1. Phenomenological research is the study of lived experience and the explication of phenomena as they present themselves to consciousness.
2. Phenomenological research is the study of essences.
3. Phenomenological research is the description of the experiential meanings we live as we live them.
4. Phenomenological research is the human scientific study of phenomena.
5. Phenomenological research is the attentive practice of thoughtfulness.
6. Phenomenological research is a search for what it means to be human.
7. Phenomenological research is a poetizing activity. *"Phenomenological description is then characterized by inspirational insight won through reflective writing. Research and writing are thus closely related"'* (Oiler Boyd 1993, pp.125).

To begin the process of phenomenological enquiry, the researcher needs an area of interest or concern or a gap in general or specific knowledge about a phenomenon. In all research approaches the researcher has a responsibility to justify the type of theoretical framework and specify and

outline the approach to data analysis, for example using Colaizzi's (1978) approach for phenomenological research.

In data analysis for phenomenological enquiry, the researcher aims to uncover and produce a description of the lived experience. The procedural steps to achieve this vary with the approach taken by the researcher in terms of the three main types of phenomenology. However, there are several interpretations of the data analysis process depending on the school of phenomenology chosen. In selecting a school of phenomenology the researcher will be guided by which methodology to use for data analysis.

Questions about nurses' experiences of caring in intensive care settings have only been partially addressed in the literature. The literature does not however, address the research question: *nurses' lived experience of caring for long term mechanically ventilated patients in intensive care units* at all. An hermeneutic-phenomenological study was conducted in an attempt to answer this question.

CHAPTER 3

RESEARCH DESIGN

3.0 INTRODUCTION

In previous chapters, the concept of methodology has been explained to mean the principles and ideas on which researchers base their procedures and strategies (Holloway & Wheeler 1996, p.9). For the purpose of this study, these theories refer to the Heideggarian hermeneutical, phenomenological research approach. The aim of phenomenological research is to explore the participant's meaning of a phenomenon and to gain understanding of the data. The approach has a broad focus, is process orientated and context-bound. This chapter on research design describes the actual research method. Phenomenological research is conducted mostly in the natural setting. Sampling of participants is flexible and develops during the course of the research study. The researcher is directly involved and a close relationship is formed between the participants and the researcher. Data is collected using in-depth non-standardized interviews and participant observation. The analysis of the data is thematic and the outcome results in a story or description of a phenomenon.

3.1 AIM

The nature of the research question determines the method to be used. This study was directed towards gaining in-depth knowledge, insight and understanding of the meaning of a relatively unexplored phenomenon ~

Nurses' lived experience of caring for long-term mechanically ventilated patients in Intensive Care Units.

3.2 The Research Design

From examining the literature pertinent to the phenomenon of interest and the philosophical roots and multiple interpretations and modifications of phenomenological philosophy and the descriptive approach of phenomenology more accurately, Heidegger's (1962) phenomenological hermeneutics (the interpretation of phenomena), is the appropriate choice for this study. This approach is based on an existential perspective, which considers that an understanding of the person cannot occur in isolation from the person's world. Thus, Heideggerian phenomenology does not advocate "bracketing" or remaining objective, as is the case in Husserlian phenomenology (Annells 1999). This was an important consideration when selecting the specific phenomenological approach to be used.

Having been a critical care nurse for thirteen years and a critical care nurse educator for five years, I did not feel that I would be able to bracket presuppositions surrounding the phenomenon of nurses' lived experience of caring for long-term mechanically ventilated patients in intensive care units. It would be difficult, if not impossible to extract parts of previous experience and knowledge and set them aside. Indeed, it would be appropriate to support the philosophical assumption underlying interpretive phenomenology that presuppositions or expert knowledge on the part of the researcher are valuable guides to enquiry and in fact, make the inquiry a meaningful undertaking rather than bracketing. Thus in

realization, Heidegger's idea of inextricability of one's "being-in-the-world" was supported (Annells 1996; Heidegger 1962).

The research process included a series of steps to achieve the aim of the study.

- The setting was limited to ICU's and so context-bound, allowing me to get close to the data.
- Sampling was flexible, developing during the research, nevertheless the sample size had to be adequate to generate data up to the point of saturation.
- Selection criteria were determined by the aim of the study that is, participants who had experience of caring for long-term mechanically ventilated patients in an intensive care environment.
- Out of ethical considerations steps were taken to avoid harm to participants.
- Data collection tools were designed for the interview guide and subsequently for a focus group, with full knowledge that I, as researcher would be a part of the data collection process, directly involved in establishing close relationships with participants.
- Planning for thematic data analysis followed. Findings were then interpreted alongside the literature.
- Scientific rigour was aimed at throughout the process to ensure validity by trustworthiness and authenticity of transcriptions of the recorded voices of the participants and subsequent sense making into descriptions of caring.
- Conclusions were reached and interpreted for relevance to nursing practice, nursing education, nursing management and further research.
- Recommendations were made for implementation at local level but which may have relevance nationally and internationally.

3.3 THE SETTING.

The study was conducted in the privacy of the seminar rooms of selected ICU's in one specialist, academic, government hospital in Cape Town. Having worked in all of these ICU's for thirteen years facilitated negotiations for conducting research in these areas. Familiarity with the Source Isolation Unit for long-term mechanically ventilated patients before it was closed in 1998, and my experience of the phenomenon that was being researched, provided me with an insider persona, which was an advantage. Furthermore, I knew the participants well as I had occupied a senior clinical position.

However, my role subsequently as a critical care nurse educator could potentially have been seen as influential and this may have affected the study in two ways. Firstly, the participants could have seen the role of researcher as a guise to make judgements about the quality of care that is being given to long-term mechanically ventilated patients. Secondly, the participants may have felt pressured to participate in the study out of a sense of either duty or loyalty. However, from reports and feedback from the participants following completion of the data collection process, I was accepted as a colleague who understood the language and the nuances of the ICU world and the participants quickly became comfortable in my presence.

Gaining access to the setting occurred in two phases, formal and informal. Negotiating access formally consisted of submission of the proposal to, and receiving approval from the Research Ethics Committee of the Health

Sciences Faculty (Appendix A), ensuring credibility of the study, as well as authorisation for access to the ICU's from the Deputy Director for Nursing (Appendix B). Informal access was negotiated with the Unit Managers as well as the nursing staff in the selected ICU's.

3.4 Sampling Method

In qualitative research, sampling has to be appropriate and adequate (Morse 1991, p.128). Appropriateness means that the method of sampling fits the aim of the study. I employed a convenience sampling method and invited suitable participants who were known to me on my rounds in the intensive care units. I anticipated that these participants would give honest, credible as well as 'rich' data.

3.4.1 Selection Criteria

Beneficial participants are those who have undergone an experience or who are experiencing a phenomenon that the researcher wants to study. It is also important to ensure that the participants are at different levels of experience in order to ensure that all the nuances of the phenomenon are fully described, therefore avoiding elitist bias (Sandelowski 1986). This concept was applied by recruiting participants of different ranks, pre-registration preparation and years of intensive care nursing experience.

I favoured the term 'participant' rather than 'respondent' as I wanted to set the tone of the study as one of sharing.

The ICU nurses who had the most experience of caring for long-term mechanically ventilated patients (beneficial participants) were those who

had worked in the Source Isolation Unit. At the time of the study these nurses were scattered amongst the various ICU's. A sample from this group was recruited to participate in the study.

The nurses selected were the ones who were still working in the hospital and who more vocal about their feelings whilst working in the Source Isolation Unit before closure in 1998.

To avoid elitist bias, selection criteria included:-

- Two Registered Nurses (RN's)
- Two Enrolled Nurses (EN's)
- Two Enrolled Nursing Auxiliaries (ENA's)
- English or Afrikaans speaking/or competence in either but the interviews would be conducted in English although participants could respond to questions in either English or Afrikaans
- The nurses must be directly involved in providing care for patients at the bedside.

Although biographical data were collected during the interview process, it has been omitted to maintain the anonymity of those involved. The participants' length of nursing experience in intensive care ranged from five to eighteen years, the age range was 26 to 51 years and all were female.

All six participants were interviewed using the interview guide. Before analyzing the data, one enrolled nurse had obtained the qualification of registered nurse through the 'bridging programme'. At this point I made a decision not to use the data obtained from the remaining three participants i.e. one enrolled nurse and two enrolled nursing auxiliaries, and the first methodological error occurred here. After collecting the data I was concerned that the interpretation of the concept of caring by the

three categories of nurses was too disparate. Each category of nurse had a statutory scope of practice which framed their specific responses and interpretations. I should have anticipated this and not included enrolled nurses and enrolled nursing auxiliaries in the sample, particularly as the available literature describes studies of nurses who have the same professional preparation and not samples comprising 'mixed' groups. On my subsequent rounds to the ICU's, I personally informed the nurses concerned that their data may be used for a subsequent study if they were agreeable. The issue of elitist bias for the final sample was subsequently interpreted differently as meaning registered nurses of different ranks, pre-registration preparation and years of intensive care nursing experience.

3.4.2 Sample Size

Holloway and Wheeler (1996, p.78) are of the opinion that the sample size in qualitative research may be small or large, depending on the type of research question, material and resources, but in general, qualitative sampling consists of small sampling units studied in depth. In qualitative research, sampling takes place after the research focus has been decided. Although participants were selected at this stage, the process continued throughout the study to allow for emerging ideas to achieve rich data.

Sandelowski (1995, p.182) recommends that at least six participants are required in a phenomenological study if the essence of the experience is to be found. From a population of one hundred and forty-nine nurses assigned to work in the Intensive Care Units at the research setting, fifteen

had been assigned to the Source Isolation ICU prior to closure of the unit in October 1998. Of these, a convenient, heterogeneous sample of six was initially selected for the interview guide. All six were interviewed but for reasons mentioned in the preceding paragraph, only three registered nurses were retained in the study.

Initial attempts at analysis revealed that data generated from the interview guide were insufficient for meaningful analysis. This was the second methodological error: not realizing the importance of transcribing the interviews soon after conducting the interviews and then not 'getting into' the transcriptions early enough for immersion in the data resulted in a delay in recognizing that data were not saturated after interviewing the three registered nurses. These three participants were interviewed only once.

As I needed to get rich data and had not achieved saturation through individual interviews, it was felt that more participants had to be recruited rather than re-interviewing the same participants. Also a focus group with all participants, may generate thick, rich data. This was rectified by recruiting two more reliable registered nurses, experienced in critical care nursing into the study from a visit to one intensive care unit. Furthermore, they were recruited for two reasons: first to validate the emerging themes from the other participants' data, and second, to be participants of the focus group with the three participants who had previously been interviewed in an attempt to elicit further ideas, thoughts and perceptions of caring for long-term ventilated patients. Prior to the

focus group the two new participants were given the emerging themes from the interview guide after permission had been obtained from the participants. Revealing emerging themes to the newcomers is the third methodological error as this may have curtailed the naturalness of lived experience and is not in line with the openness of qualitative research in general and existential phenomenology in particular. A focus group was held with the three participants from the first sample group and the two new participants.

3.5 Ethical Considerations

In any research which involves human subjects, there must be safeguards for their protection (Holloway & Wheeler 1996, p.39). All participant observation, and indeed qualitative interviewing, is covert to some extent. It is never possible to explain to the research participants exactly what will be done with the material that the researcher is collecting. This is partly because qualitative research is creative, and what will emerge from the data cannot be predicted in advance. All the researcher can do is give the best account of her intentions at each stage in the research process and to ensure confidentiality and anonymity.

3.5.1 Informed Consent and Voluntary Participation

Respect for autonomy means that the participants in the research must make a free, independent and informed choice without coercion (Holloway & Wheeler 1996, p.39). Signed consent (Appendix C) was obtained from the research participants after the following information was disclosed to them:-

1. The nature and purpose of the study.
2. Potential benefits of the research.
3. Assurance of confidentiality.
4. Implication of signing the consent form by the research participant and the investigator.
5. The right to withdraw from the study at any time.
6. An opportunity to ask questions pertaining to the study (adapted from Kyriacos 1993, p.85).

However, informed consent is difficult to obtain in qualitative research as the course of the research is not predictable, and also because of the inherent flexibility and unexpected ideas that arise during data collection. Therefore, the researcher is not able to inform research participants of the exact path of the research, and informed consent is not a once-and-forever permission but an ongoing process of informed participation (Holloway & Wheeler 1996, p.43).

3.5.2 Confidentiality and Anonymity

Confidentiality concerning the personal information revealed by the participants is the most important ethical consideration. Facilitation of the process of giving information requires trust and no fear of recrimination. Qualitative research may be more intrusive than quantitative research and therefore the researcher requires sensitivity and good communication skills. Anonymity is a controversial issue in qualitative research where the researcher and others can identify the participants especially when interview guides and focus groups are utilized to generate or validate data.

Limited anonymity but strict confidentiality were guaranteed and the participants were informed that they not only had the right to refuse to take part in the study, but that they could withdraw at any time without recrimination or prejudice. However, after experiencing difficulty during the sampling phase and the need to conduct a focus group about the emerging themes, permission had to be obtained from the initial three participants to reveal the themes to the two new participants and explore them further at the focus group.

Every attempt was made to ensure that this study represents the experiences described by the participants. In order to protect their identity, a full transcript of an interview has not been included as an example. To further ensure anonymity, detailed descriptions of the participants have not been given. Participants were allocated numbers (e.g. P1) so that their names could not be linked to any interview transcripts. All transcripts were stored on micro floppy diskettes and locked in a drawer in my office. All audiotapes will be destroyed after one year.

3.5.3 Use of Transcribing Equipment

All of the participants agreed to the use of the audio tape recorder for the duration of the interview. Only after the participants had read and understood the purpose of the research and had signed the consent form, was the tape recorder switched on. Following the interview, the tape was dated and labelled. Participant numbers appear on the tapes and

transcriptions, but a list of the participants' names and corresponding numbers are stored in a different place from the tapes under lock and key.

3.5.4 Researcher-Participant Relationships

Lincoln recommends that the researcher be subjective and interact with the subject or object of investigation. The result is created by the interaction between the researcher and the researched (Lincoln 1992, p.379-380). The following characteristics are important for qualitative researchers when conducting any form of research: they should be good listeners, non-judgemental, friendly, open and honest and flexible (Holloway & Wheeler 1996, p.8). This required me to adopt an ethical rather than a methodological position regarding the thoughts and words of the participants and I also reassured the participants that there is no right or wrong answer. I had asked each participant to make available about one and a half to two hours for the duration of the initial interview, thus allowing time for preliminary introductions to allay anxieties and to answer questions which might have been unanswered during the initial contact.

3.6 Data Collection - Techniques and Strategies

The process of interaction between the participants and myself allowed me to discover their world by collecting data in three ways: an interview guide, a focus group discussion and reflective journaling. Following the analysis of the transcripts of the interview guide, a focus group discussion was convened.

3.6.1 Interview Guide

For the interviews, I had designed an interview guide. This instrument consisted mostly of open-ended questions which allowed the participants to answer in their own words (Appendix D). This data collection technique allowed me to collect data from three participants who had a shared experience. In this way, I was able to develop questions to pursue in the focus group discussion. I thought this appropriate in that I was an inexperienced interviewer and was likely to generate material that had a high 'dross rate' which would be of no relevance to the study (Holloway & Wheeler 1996, p.55).

Audio taped interviews need to be planned carefully. The following strategies were employed:-

1. The participants were contacted well in advance of the interview and reminded a few days after the initial notification. The three interviews were conducted within a three week period and on days when participants were on-duty. This was their choice.
2. Ethical issues and access were considered. This included informed and signed consent being given prior to the interview, following an explanation about the nature and purpose of the study and assurance of confidentiality and anonymity (see 3.5.1. and 3.5.2. pp.45-47).
3. The research setting was spacious and well ventilated to accommodate the participants and the tape-recording equipment.
4. Each participant was given a copy of the interview guide to prevent deterioration of the interviews into vague and chaotic discussions.
5. From the beginning, I established ground rules, so that the participants knew how to proceed.
6. A top quality tape recorder was used so that voices would be distinguishable for purposes of transcription. The audio equipment

was tested before the participants were accommodated in the venue so as not to cause any anxiety.

7. A reflective journal entry was made immediately after the session about unusual, interesting or contradictory ideas as well as gestures, pauses and body language.

The recursive process of qualitative research methodology became evident at this point: data collection, transcriptions, simultaneous analysis and interpretation and further need for data collection.

At this point the need for further sense-making of the clusters of formulated meanings and emergent themes became evident following validation, independently, by an intensive care trained researcher until consensus was reached. The majority of the participants were English second language speakers and often not able to express themselves fully despite being given the assurance that they could speak Afrikaans. It was decided that a focus group would be useful to achieve depth and clarification therefore at least two more registered nurses were recruited into the study.

3.6.2 Focus Group Discussion

The focus group consisted of three participants from the interviews and another two registered nurses who were recruited into the study because they had experience of nursing ventilated patients but not necessarily long-term ventilated patients. Consent was obtained firstly from the three participants from the interviews to reveal the emerging themes to the new participants and secondly from all five participants to take part in the focus group discussion. Focus group interviews differ from interviews

with individuals in that they explore and stimulate ideas based on shared perceptions of the world. A small sample can generate rich data and a great deal of information as was evident in this study. Most social science researchers agree that the ideal number of participants for a focus group is three and no more than six participants. The larger the group, the more difficult the transcription becomes as the participants start talking together and the group becomes lively, so that distinguishing voices becomes difficult.

Familiarity between the participants and between participants and I was useful because the 'warm-up' time was shorter and I could focus on the research question immediately. The experienced facilitator used her skills to guide the participants towards effective interaction without directing the debate or coercing them. The group was kept focused on the discussion of the emergent themes and appeared comfortable about disclosing their perceptions and feelings.

3.6.2.1 Conducting Focus Group Interviews

The same procedure for conducting an audio taped interview was followed for the focus group except that the following was implemented:-

1. Cold drinks and light snacks were provided as two of the participants were on duty and participated in the focus group discussion during their lunch break.
2. The participants sat in a semi-circle during discussion and the tape-recording equipment was positioned in the middle of the table to ensure the clarity of individuals' contributions and to avoid difficulty during transcribing.

3. The participants had a clearly identified agenda (Appendix E) to keep the group focussed.

3.6.2.2 The Involvement of the Interviewer

The epistemology of qualitative research is in essence the relationship between the researcher and the subject. The interviewer becomes the facilitator or moderator in the group discussion and requires interviewing skills. In this case my role was that of co-facilitator and observer. I needed to be able to stimulate discussion amongst the participants. The intention was to make the group feel at ease with the interviewer and the facilitator, for the interaction to be open and productive, and for the participants to be comfortable about disclosing their perceptions and feelings (Holloway & Wheeler 1996, p.149). For this reason, a facilitator who is a PhD prepared registered nurse but not from the hospital, was invited to facilitate the focus group discussion.

3.6.2.3 Strengths and Limitations of Focus Groups

The main strength of focus groups is the production of data through social interaction. The dynamic interaction stimulates the thoughts of participants and reminds them of their own feelings about the research question. All participants including myself, had the opportunity to ask questions with the intention of generating more ideas than individual interviews would have done.

However there are some disadvantages to conducting focus groups. Firstly, the researcher generally has more difficulty managing the debate and less control than in one-to-one interviews. Having never facilitated a

focus group before, I wanted to concentrate on the participants' interactions and gestures and this could only be realised with the assistance of a facilitator. One or two participants may dominate the discussion and influence the outcome or perhaps even introduce bias as the other participants may be merely compliant. This was very evident in the focus group as one particular participant dominated the discussion and had to be "restrained" and asked to focus on the question under discussion a number of times.

A member who is unable to verbalise feelings and thoughts will not make a good participant. The two additional participants were expressive and forthright. It was anticipated that rich data would be generated. Holloway and Wheeler (1996, p.151) emphasise the importance of good educational homogeneity of the group as the status of a few well-educated individuals may inhibit the rest of the participants and may even silence them. This heterogeneous sample, in terms of rank, pre-registration preparation and years of critical care nursing experience [no participant had the qualification of registered critical care nurse and one was a 'bridging' programme registered nurse], was not dominated or silenced by the more experienced individuals which may have been the case. The uniqueness of having eleven official languages in South Africa and diverse cultures, also reflected within the nursing profession, contributed to the richness of the data but the participants' limited vocabulary was not anticipated. It became evident that expressiveness does not guarantee extent of vocabulary.

3.6.3 Other Strategies

Journal entries were made immediately after each interview and the focus group discussion. Reflective journaling related to how I felt about the interview, what, if any, problems had occurred, and my impressions of the process.

3.7 Data Analysis

The purpose of data analysis is to grasp the essential meaning of a phenomenon. This means reducing an enormous amount of information into categories and themes by a simultaneous process of analysis and interpretation. Data analysis is guided by the methodology. The work of Colaizzi (1978) was found to be most explicit and therefore appropriate for this study.

3.7.1 Transcriptions

It is important that transcriptions accurately represent both what has been said and how it was said (Sandelowski 1994, p.311). I personally transcribed the first six interviews which proved to be time consuming but a valuable part of the research and learning process.

I then transcribed the focus group recordings. Although this also took a long time, I was concerned that non-verbal interactions and important nuances may be omitted if left to an outsider. These nuances enabled me to gain a better sense of the whole interview during later data analysis.

3.7.2 Analysis and Interpretation of the Data

The interviews were recorded, and each listened to several times before making transcripts. All tapes, field-notes and memoranda were dated and labelled. A wide margin was left on the transcript for coding and categorising. The transcriptions included laughter, pauses and emphasis and other field notes that were made on anything unusual, interesting or contradictory. Hycner (1985, p.282) suggests that only once the researcher has transcribed the interview, bracketed presuppositions and attempted to stay true to the data is she ready to examine the interview to elicit the participant's meaning. This process must be conducted with openness and awareness so that the participants give the meaning, rather than the analytical process attempting to answer the research question. When I identified my assumptions, experiences, feelings and thoughts, these were written down in a reflective journal. This process of reflective journaling was done to the best of my ability throughout the study.

The transcriptions were analyzed using Colaizzi's (1978) seven steps to a point where there were groups of formulated meanings, clusters of emerging themes and finally, themes (Appendix F). Colaizzi suggests that the steps should be viewed flexibly and freely by individual researchers. These consisted of the following:

1. I read all the participants' transcriptions a number of times to acquire a feeling for them and to make sense out of them. I then began coding. A code is a word or phrase close to the meaning to that which is in the data. For example, when a participant spoke of a

patient or a patient's needs, the code was "patient". This code was given a colour for ease of tracking and consistency. Further codes were identified. Being inexperienced, to me it seemed that repetition became evident after the three transcriptions of the semi-structured interviews had been analysed. This proved not to be the case upon deeper analysis, so the focus group was arranged to generate more data and step one was repeated.

2. I then returned to the transcriptions of each data set and extracted phrases or sentences that directly pertained to the research question. This is known as extracting significant statements. In this second step, I wrote words and phrases, and quoted descriptive statements. Samples of two significant statements : (a) *"You don't know the patient at that time, but, as the time goes, you actually get to know the person even better – you don't ask a lot of questions but you listen,"*(P4) and (b) *"Because I knew in my heart that I was making a little bit of a difference here… Yes he wanted too many things but it's part of the caring"* (P4). At this point, the transcriptions had been read numerous times and I had listened to the tapes again to hear the tone of voice and to remind myself of the participants' facial expressions, gestures and feelings.

3. At this stage, I tried to spell out the meaning of each significant statement, known as formulated meanings. I tried to go beyond what was said and made an inference about what was meant or implied. Formulated meanings of the two significant statements in

step two were seen as (a) *"As time goes by in ICU, the nurse initiates a relationship of caring by listening, and a bond is formed with the patient"* (P4) and (b) *"The nurse has a deep intuitive sense of knowing that by doing the little things for patients' comfort, she makes a difference"* (P4). At this point the participant clenched her fist and rubbed it over her heart. The inference was that there was limited time available for the "little things" but that these little things made a great difference to the patient.

4. I then organised the formulated meanings into clusters of themes and then into condensed themes. Once the themes from the data from the individual interviews were extrapolated, they were compared with the themes from the data from the focus groups. This process of reduction resulted in similar themes but these were expanded. I again returned to the transcriptions for significant statements and formulated meanings to check whether there was data not accounted for in the themes, or whether the themes suggested ideas that could not be accounted for in the original data. This was an attempt to validate the themes. I tried to not ignore data or themes that did not fit. These formulated meanings and emerging clusters of themes and themes were validated independently by an intensive care trained researcher. Similarities and differences were discussed until consensus was reached.

5. I then integrated the results into an exhaustive description of the phenomenon under study. This description included both

formulated meanings and clusters of themes as well as quoted statements from the participants e.g. 'knowing the patient'.

6. For the next step, I formulated an exhaustive description of the investigated phenomenon into a single statement of identification: Nurses' experience of caring for long-term ventilated patients in this research setting was one of bonding and maintaining but their experience was also very stress-inducing which resulted in unpredictability in the quality and delivery of care to their patients.

7. Colaizzi's final step of checking and validating the phenomenological process was achieved by running a focus group thereby linking step one and seven. My interpretation of the individual tape-recorded interviews of the participants' *"lived experience of caring for long-term mechanically ventilated patients in intensive care units"* was discussed with them. The five participants' agreed that my description of the themes contained the essence of caring as they lived it in their ICU's.

This approach is supported by Hycner (1985, p.291). The participants may then agree or disagree with the researcher's interpretation and have the opportunity to expand further on the interpretation. This was done during the focus group interview but not during the individual interviews.

3.8 The Scientific Rigour of the Study

The concept of trustworthiness or rigour is used to demonstrate validity in qualitative research. Trustworthiness exists when the findings of the study represent reality (Holloway & Wheeler 1996, p.162) and when these findings are *credible, dependable and transferable* (Koch 1994, pp.976-977). The identification of four aspects of trustworthiness namely *truth-value, applicability, consistency* and *neutrality,* has been successfully used by qualitative researchers for some time (Krefting 1991, p.215).

3.8.1 Truth-Value or Credibility

Truth-value relates to how the researcher has established confidence in the *truth* of the findings. As truth in qualitative research is participant-orientated rather than researcher-defined, the truth-value of a study relates to the credibility or accuracy of the description of the phenomenon or experience being studied (Lincoln & Guba 1985). A study is trustworthy if the research was conducted fairly and the results *"represent as closely as possible the experiences of the people who were studied"* and if the people who have had the experience immediately recognise it from the descriptions or interpretations (Ely, Anzul, Friedman, Garner and Steinmetz 1991, p.93). This study was shown to be credible when the first three registered nurses who were interviewed recognised the themes as representing their own experience at the focus group discussion.

Lincoln and Guba (1985) warn the researcher against a number of common distortions of the truth. These distortions arise from the

researcher's presence at the site, the researcher's involvement with the participants, bias on the part of either the researcher or the participants and the data collection techniques that are used.

As the primary instrument of data collection, it was important that I was familiar with the participants and that adequate time was allowed for the formation of trust and rapport. Intimate familiarity enhances research findings and leads to the discovery of hidden facts, as this enables participants to volunteer more sensitive information than they would otherwise have done (Krefting 1991, p.218). Krefting also warns that it is equally important that the researcher should guard against over involvement with the participants, as this may lead to the researcher finding it difficult to separate his/her own experience or biases from that of the participants (Krefting 1991, p.218).

Biases are held by all and it is the responsibility of the qualitative researcher to understand this and to come to terms with his/her own personal biases both honestly and completely, so as to not distort the data. I followed Ely *et al's* advice by recognising my own prejudices, stereotypes, assumptions and other thoughts or feelings that could cloud or distort the perception of other's experiences. While it was not possible to lose subjectivity, this greater self-knowledge helped me to separate personal thoughts and feelings from those of the participants and to be less judgemental and appreciative of experiences, which deviated from my own (Ely *et al* 1991, p.95).

To establish credibility in this study, I did the following:-

- I kept field notes and a reflective journal that documented the research process.
- The analysis of the tape-recorded interviews was discussed in a focus group facilitated by a neutral facilitator. The focus group participants acknowledged and recognised the themes as those experienced in ICU. This added to the richness of the data.

3.8.2 Applicability or Transferability

Applicability or transferability refers to the degree to which the findings can be generalised to a larger group if applied to other contexts or settings. Transferability is **not** relevant to phenomenology where the aim is to describe a certain phenomenon or experience in the natural setting (i.e. without controlling conditions) rather than generalise the results (Krefting 1991, pp. 220-221). Fittingness is the criterion that is more appropriate to qualitative research (Sandelowski 1986, p.32). Fittingness means that a study meets the criterion if the findings are applicable to, or fit contexts outside of the current study; or if the findings are meaningful and applicable to the reader in terms of their own experiences (Appelton 1995, pp.995-996).

Fittingness of this study was demonstrated when critical care nurses from other ICU's, that is, the two new recruits for the focus group found the themes to be relevant to their own experiences. The findings must *fit* data from which it comes and reflect both the typical and atypical elements of the phenomenon being studied. In this study, the sample included nurses with different levels of experience, pre-registration preparation and

ethnicity. A thick description of the findings is presented in the following chapter.

3.8.3 Consistency or Dependability (Auditability)

In qualitative research, consistency or dependability refers to the ability of the reader to follow the research process (Appelton 1995, p.996). I have attempted to ensure dependability and consistency by providing in-depth descriptions of the methodology and in the use of a field journal and memoranda. Koch (1994, p.978) and Sandelowski (1986, pp.32-33) state that the researcher is able to demonstrate dependability by maintaining an accurate decision trail which enables the reader to audit the events, influences and actions taken by the researcher from the beginning to the end of the study.

Excerpts from Reflective Journal

28 July 2002.

Finding it really difficult to get the participant that I interviewed today to share her experiences of caring. Maybe I am too inexperienced in the interviewing technique or the participant is too blasé about caring for the chronic type of patient. Seems to be more concerned about dressings, vital signs etc. I know that it is well documented that patients become desensitised when in ICU for long periods. Can this be a phenomenon found in Critical Care Nurses who work in ICU for far too long ? Nurses generally appear to be terrible participants. Am concerned about getting decent data.

6 August 2003.

Finally completed transcribing six interviews. Found this process extremely time-consuming. Tried really hard not to put my feelings and experiences of ICU into seeing the participants 'real world' of their ICU world. Nothing has really changed since my ICU days. They all sound so burnt-out and tired working in this environment. I hope that I am able to formulate some themes from this data.

Qualitative research is really difficult. It changes all the time. Nothing is cast in stone.

3.8.4 Neutrality or Confirmability

Neutrality refers to the inter-subjective agreement (Lincoln & Guba 1985), which is freedom from bias in the research process and is essentially dependent on all of the other criteria for trustworthiness being met (Appelton 1995, p.996). There are two major techniques for ensuring confirmability; these are triangulation of the data and the audit trail. The latter has already been discussed. Triangulation refers to the use of several methods or data sources in the study of one phenomenon (Holloway & Wheeler 1996, p.164), for example there are four different modes of triangulation: data, investigators, theories and methods. In triangulation researchers look at the same phenomenon in different ways or from different angles. In this study, limited triangulation, but certainly validation was achieved by presenting the initial themes to two new critical care nurses in the form of a focus group discussion. Formulated meanings and theme clusters were compared and expanded upon until a single statement of identification of the research question was achieved.

Summary

This phenomenological study explores nurses' lived experience of caring for long-term mechanically ventilated patients in intensive care units and was conducted in a large tertiary hospital in the public sector. A convenience sampling method was used to recruit a sample of five registered nurses. Data was collected by an interview guide and a focus

group. Data was transcribed verbatim and analysed using Colaizzi's (1978) inductive reduction approach.

In the following chapter, I will present the findings of this study.

CHAPTER 4

DESCRIPTION OF THE THEMES

4.0 INTRODUCTION

In this chapter, I present the themes that emerged from the analysis of the data and aim to give the reader an understanding and insight into nurses' lived experience of caring for long-term mechanically ventilated patients in intensive care units. The participants' voices are incorporated as quotes that enable the reader to judge how well the results have been derived from the data and so establish credibility for the themes (Sandelowski 1994). Only the most illustrative quotes have been used.

4.1 DESCRIPTION OF THE THEMES

Four themes were generated from the data obtained from the individual interviews and the focus group: 'bonding', 'maintaining', 'stress inducing' and 'unpredictability'. Themes and theme clusters are presented in Table 4.

Table 4. Themes and theme clusters generated from the data.

THEMES	BONDING	MAINTAINING	STRESS INDUCING	UNPREDICTABILITY
THEME CLUSTERS	▪ Knowing the patient	▪ Being supportive	▪ Intensity of work	▪ Patient deterioration
	▪ Knowing the family	▪ Being experienced	▪ Time and resource constraints	▪ "Busyness"
	▪ Dependence	▪ Effort and energy put into nursing care	▪ Conflict	
	▪ Being close		▪ Emotional neglect of patients and self	

4.1.1 THEME 1. BONDING

Bonding, the experience of bringing and holding people together was apparent in the theme clusters of 'knowing the patient', 'knowing the family', 'dependence' and 'being close':

> *... you know their routine, what they like, what they don't like*
> *you even bond ... um ... we sort of became a little family ...* (P4)

> *... you don't know the patient at that time, but, as the time goes, you actually get to know the person even better – you don't ask a lot of questions but you listen ...* (P4)

Knowing the Patient

The Collins Paperback English Dictionary (1990, p.465) defines the word 'know' as 1. *to be or feel certain of the truth or accuracy of (a fact, an answer, a person)* and 2. *to understand or be aware of (a fact, an answer, a person).*

This was illustrated by the physical and psychological presence of the critical care nurse and her relationship with the patient. Examples included anticipating patients' needs, giving physical care, listening to the family and providing basic comfort measures to the patient:

> *... you must feel for the patient... especially an unconscious patient. You must think for the patient, feel for the patient and that's what I liked ...* (P3)

> *... you form like a bond between you and the patient, because the patient is so used to you and you are used to the patient... so you know what the patient wants at certain times ...* (P1)

> *...you are more with the patient when the patient is long term in the units ...*(P1)

The physical presence of the critical care nurse at the bedside did not occur in emotional isolation. Her feelings about the severity and futility of the situation demonstrated caring:

> *... but you still see them having pain, and the wounds are so big and you think will this ever heal?... won't the patient be better off... [pause] ...to die or being put out of his misery? ...* (P3)

On the other hand, elation and triumph as the patient's condition improved was also seen as caring:

> *... you feel really good everyday because your patient is getting brighter ...*(P1)

> *... when you see the person looking well, and they are turning around ... you rejoice ...* (P4)

Knowing the Family

Knowing the patient and family was illustrated by evidence of empathy and understanding, especially when a patient died or his/her condition had deteriorated:

> *... I can very clearly remember this very long-term patient, he was there for three months, and I started nursing him from the second day. I didn't know that this patient was going to be with us that long but he stayed with us for six months because I think that I looked after him for three and a half to four months. It plays on your emotions a lot, when you come back after three days and you see that the patient has relapsed... I feel for the family. What if it was one of my kids or my husband ? ... (P4)*

The critical care nurse in this instance imagined her own family member in the same predicament and tried to determine what would be needed in

terms of caring for this patient and his family. The nurses' world view of the patient was broad enough to recognize and value social roles and the need for him to return to his family to fulfil these roles:

> *... this patient is a husband, a father, a brother. You want to get them better...* (P4)

It was well illustrated that caring for the family was an important part of the caring process and could not be dealt in isolation:

> *... you look at the body language, and you try and socialise a little bit with the family. Not just direct family, but extended family or friends as well. And...umm... you pick up a lot of things...about their needs and fears ...* (P4)
>
> *... I taught the family how to do this because I said to them umm... touching is very important and what they do is they sit there and look at him. He can't talk back to them because he is on a ventilator and half of the time he is a bit depressed and falls asleep while they are there. I said to them "listen if you really want to be involved in his life, why don't you take that cream that you have brought and start doing his feet because his feet was in a bad state ?" And his wife started enjoying doing that and the bonding part, because whilst he is in the hospital, they also haven't been like husband and wife. They were them, to make up for the lost time you know, the quality of time that she also missed out on with the kids and all, and even brought them more closer ...*(P4)
>
> *... you also involve the family with the treatment, with the caring of the patient because the patient might go home still needing the care so the family should know how to look after the patient. You care for the patient and the family socially ...* (P1)

Understanding the family's concerns and needs was shown by giving information, explanations and reassurance. Caring was seen as providing emotional support for the family by listening and helping them come to

terms with the situation that they were in, so that they could support the patient.

Dependence

The critical care nurse speaking and doing things on the patient's behalf demonstrated the acknowledgment of the patient's dependence. Here caring was seen as being technically competent, understanding the equipment and the physiological and psychological status of the patient. Being clinically adept and having knowledge to understand, interpret and act on data and 'hunches' at times was seen as essential in making decisions that would benefit the patient:

> *... the patient had a problem with his trachy [tracheostomy]. The ENT [Ear, Nose and Throat] doctors had to put in the trachy because our doctors couldn't put it in. The patient had some constriction. I assisted the ENT doctor with the trachy change. After he left, I looked at the patient and saw that the patient's chest was not moving and that the ventilator wasn't sounding right. It was making a funny noise and the patient got anxious and sweaty. He couldn't breathe. I managed to get hold of the ENT doctor at the lift and he came back and found that the trachy tube had been put in wrongly and the patient was not ventilating at all ...* (P3)

The utter reliance of the patient on the critical care nurse for meeting the most basic of caring procedures was interpreted as dependence:

> *... and with mobilisation some of them have a tendency to think that they can't do anything on their own because we are helping them most of the time especially when the patients are on the ventilator. When it comes to mobilisation, they expect the nursing staff to do everything for them not wanting to show us how much they can do so we can meet them half way ...* (P1)

Certain nursing interventions that were an integral part of caring, involved crossing the boundaries of nursing and medicine and were interpreted as an extended role of the critical care nurse. The patient depended on the nurse to make and act appropriately on laboratory data and trends:

> *...you have to change the ventilator settings according to the ABG [arterial blood gas], sometimes the doctors don't know what to do, and you have to do this in between looking after the two sickest patients because you are the shift leader* ... (P1)

Being Close

The theme cluster of 'being close', marked a change in the nature of the relationship with the patient, one of seeing the patient as a person. There seemed to be a difference between 'being close' and 'dependence'. 'Being close' acknowledged that the patients were people, rather than just a 'body' whose physical and psychological systems required support. Caring for 'the person' and not 'the patient' was illustrated by the following comments:

> *... that was my little secret – myself and ....(patient's first name used), and he respected that. We had this beautiful relationship and...it was sad for me the day I had to leave and move on upstairs... it's quite amazing how you get to know these people* ... (P4)
>
> *... in the long run, she fared better because she was a nice person and Mr. X was not such a nice person* ... (P5)
>
> *... we knew her as a person; (patient's name)* ... (P2)

In this theme cluster, the findings showed that the emotional quality of caring had changed the relationship between the critical care nurse and

the patient. The relationship had deepened and intensified and had probably originated from being personally involved with the patients and their families or significant others:

> *... the nursing staff and the doctors first come to you whenever anything comes up about the patient... "you know the patient better than us"... "just sort this out quickly"* ... (P4)
>
> *... this doctor came to the unit... the patient had been there 3 months already... and he went to the patient's wife and said "there is nothing we can do. Nothing we can do [emphatically]. Your husband is going to die anyway. We are going to stop the treatment. The wife was in tears. I just thought of all our hard work, all our caring, everything you've put in just shattered in a couple of seconds. The wife waited for me on my way off duty... just to hear from you... as a sister* [registered nurses] ... *as well* ... (P4)

The use of warmth and tenderness when performing professional tasks such as washes, dressings and procedures and giving affection was also described as 'being close'. This involvement was both personal and professional for the critical care nurse:

> *... especially for patients from afar... they don't have a family... you show them love* ... (P3)
>
> *... it's part of the caring but it's just like he was so finicky with this. You can't rub there too hard, you can't turn him, you can't lift his legs too high. (Patient's name) was very concerned about his appearance* ... (P4)

Having respect for the patient and family was indicative of maintaining dignity and integrity and understanding of cultural beliefs and was frequently referred to. Valuing the trust given by all parties motivated the critical care nurse to care:

> *... he just does not have a wife, he has 2-3 other girlfriends as well... His wife was a teacher. She's a high school teacher. She didn't even know nothing and you know what? I kept my confidentiality and I never said a word to her about these others. I didn't want any friction because they were all very happy ...* (P4)
> *... it's funny how secrets come out when they are in hospital ... it all comes out ...* (P4)

4.1.2 THEME 2. MAINTAINING

Maintaining, within caring, for the critical care nurse, means providing support, encouragement and a sense of equilibrium or control. The critical care nurse provides a foundation of care that maintains a situation of stability and security for the patients, thus allowing an opportunity for recovery and a favourable outcome. The skills and abilities that the critical care nurse brings into the situation maintain and sustain both the patient and the work environment. Maintaining, as a theme, evolved from the theme clusters of 'being supportive', 'being experienced', 'effort and energy put into nursing care'.

Being Supportive

Being supportive meant caring for the patient, family and nursing colleagues. For the patient, it was providing what was described as basic nursing care, making the patient comfortable and tending to hygiene needs:

> *...washing the patient, cleaning them and making them feel better was most important. They feel good and that's very good for the healing of the patient because if you feel better the healing process takes place quicker ...* (P3)

> *... if they have diarrhoea, you don't say "I'll change it later" ... You change it now ...* (P1)
>
> *... you need to make time for both of your patients and sometimes for the nurses who work with you as well ...* (P2)
>
> *... we were giving them more extra attention than normal because they were long term ...*(P1)

Carrying out these activities provided opportunities for the critical care nurse to be with the patient and at times with the family. Being supportive of the family was described as giving information, explanations and reassurance. Caring was seen as providing emotional support for the family, listening and helping the family come to terms with the severity of their loved one's condition, so that they in turn could support the patient and themselves. Working closely with, and supporting colleagues was seen as vital to caring:

> *... then there are the radiographers and physiotherapist taking up your time and you can't do your procedure. You have to wait for them. Give them time to do what they need to do. After all, it is for the patient's benefit ...* (P1)

Being Experienced

'Being experienced' or having experience originated mostly from working in the ICU for a considerable time and was seen in terms of enhancing the capability of the critical care nurse to provide care. This was illustrated in terms of inherent ability, personal attributes and time management of the critical care nurse influencing caring:

> *... you work at your work, try to make a difference ...* (P4)
>
> *... all the little things that you did that made a difference. I made time ...* (P4)

> *... that means you leave your tea and come in. You think of the orders that you need to follow up before you can catch up with your routine that is still waiting for you ...* (P4)
>
> *... you get those days when you can't take lunch on time and time is so limited because you are scared that the Agency person is there and doesn't know the place or patients well and there are four ventilated patients ...* (P1)

In addition to having experience, the participants expressed strong views that acquiring technical competence, knowledge and professional experience helped them in becoming self-assured to provide a high standard of care. When competence had been gained in the technical aspects of ICU nursing, the critical care nurse then had time and energy to spare to further develop her relationship with the patient. Emotional caring takes place when physical caring becomes second nature:

> *... I will cut down on certain things, just so to spend some time with the other patient ...* (P1)
>
> *... there's this new sister [registered nurse] . You have to keep an eye on her. See that things are OK with her, but the show goes on and you try and push in this little extra thing... maybe just spend some time with him ...* (P3)

Having knowledge and understanding of the patient's disease condition was also perceived as fundamental to enhancing caring. Learning from experience and from others was seen as crucial but was often difficult as credible role models were in short supply. The lack of managerial support was also seen as an obstacle in delivering care:

> *... the person in charge, who is well organised, who can sort out an unit, see that the equipment is working, makes such a difference.*

The management of ventilated patients needs good management … (P5)

… they (Nursing Management) are only interested in quantity, not quality. They send you Agency Staff who are not ICU experienced and have never seen an open abdomen, let alone a patient in ICU for six months …(P1)

Effort and Energy put into Nursing Care

This theme cluster was strongly evident throughout all the participants' experiences and a sense of being valued by the patient and the family enabled the nurse to continue ploughing her energies and efforts into caring. These endeavours undoubtedly maintained a high standard of care:

… sometimes on nights it's very hectic. I never get to do all those little things and then when we have a little more time, and our unit isn't too chaotic, then I make time … (P4)

… I'll shave him because I know his wife is coming at 10 o'clock. I will quickly shave him before I go off duty … (P4)

… it's part of the caring, the extra things … (P2)

… it was one of those really difficult cases where you actually had to force yourself to do all those little things for the patient, but you still cared … (P5)

… I need to do that little bit extra without neglecting my other patient, I have two patients to look after … (P4)

… the aseptic technique that we had to keep to for the TENS [toxic epidermal necrolysis syndrome] … sometimes it came to a push that we had to do the dressings twice…(P3)

4.1.3 THEME 3. STRESS-INDUCING

Stress-inducing factors that hinder caring result from a variety of stressors. These stressors are illustrated within the theme clusters of 'intensity of

work', 'time and resource constraints', 'conflict' and 'emotional neglect of patients and self'.

The critical care nurse's ability to care is curtailed by extraneous factors, difficult patients and their families and low morale. Being praised and valued enables the nurse to care both physically and emotionally. Having the appropriate staffing complement, time and equipment all enhance caring. Caring for one patient allows the critical care nurse to care for the patient 'holistically':

> *... to care for chronic long-term ventilated patients means that you must care for them holistically from head to toe ...* (P1)
> *... you need to do everything for that patient. And you need time* (P3)

Intensity of Work

Routine work is an essential part of caring for the critical care nurse which includes monitoring and interpretation of vital signs and acting upon any change in the patient's condition. It is precisely such changes in physiological status that are stressful. The critical care nurse's attention is drawn away from the patient by announced interruptions and this is frustrating:

> *... it is very stressful when it comes to the afternoon and you are trying to catch up on routine things and the doctors come on their rounds and shout and moan at you ...* "why is this patient not in a chair?" *or* "why wasn't this patient mobilised?" *Sometimes they don't listen to you. They just want the patients mobilised ...* (P1 and P4)
> *... it is very trying ... it plays on your emotions a lot especially after your days off and you come back to work to see that the*

patient has relapsed and then from that recovery phase, a person goes back to being ventilated and everything else … (P4)

The intensity of the patient's disease is stressful and frustrating for the critical care nurse:

… these patients with muscle disorders … I used to get so frustrated by looking after them for so long. The one day they can do something, the other day they can't. So now you expect them what they did yesterday, they must do again today and that makes you … sometimes you can't see the balance, you can't balance it because you don't know what to expect when you see the patient the following day. Because the muscles can be stronger or weaker, but you never know what to expect and that makes you cross but as the day goes and the patient achieves something, it brightens up your day again. You are not so mad at the patients anymore … (P3)

… what I hated was looking after the burns and TENS patients, the big dressings … oh I hated that [very emphatic] but I know that they needed the caring, but that part of the caring was not nice … (P3)

… the skins of the patients that came off … you see the raw sore there, the openness of the sore … how do you handle the patient? The oozing … oh that was yucky, I can't handle that … I did not want to take burns and TENS patients … (P3)

The intensity of the ICU environment causes stress especially with the continuous exposure to bacterial infection. The critical care nurse feels "contaminated" and threatened by the work environment and feels that she is a source of contamination for her family and loved ones:

… I just peel everything off I had on because of all that suctioning, whether it was in Respiratory or Surgical ICU. You just want to peel everything off that you had on … and quick quick because I

have small children I have to think about. I am so scared that I am going to carry something home. Something foreign … (P4)

Time and Resource Constraints

The inconsistent availability of resources being available affects the process and ability to care. Having the appropriate staffing complement, time and equipment enhances the critical care nurse's caring:

… I start giving my antibiotics early because one patient may have five antibiotics. So you need more time and also make time for both your patients and sometimes for the nurses who work with you as well … (P3)

… in an emergency if both patients need to be attended to then you must use your discretion which one to attend to first because both patients are ventilated and you are the only sister in the unit … (P1)

… you are busy the WHOLE [emphatic] day, but if I started working out when will I do this, when will I do that extra thing, then I won't neglect my other patient because you have two patients – you run the shift, you are shift-leader. There's maybe another new sister and a staff nurse. You have to keep an eye on them. See that things are OK with them and the show goes on but you still try to push in this little extra thing. You couldn't fit it in now, but tomorrow you maybe quickly catch up for yesterday, as long as you did it … (P4)

Conflict

Difficulties within the team and with patients themselves impair the critical care nurse's ability to care. The team is comprised of mostly nursing staff on one level and to a much lesser extent of medical staff at another. The critical care nurse's expectations of her respective team members cause the most conflict. Not receiving feedback or support from

colleagues counteracts the caring behaviour and attitude of the critical care nurse. Lack of understanding from the medical staff regarding resources and lack of understanding of the patient and the family, compounds the frustrations experienced by the nursing staff and negates all attempts of caring:

> *...I actually put a lot into the patient and actually felt good about it even though there was a lot of negativity from other staff members but I never used to take too much note of it because I knew in my heart I was making a little bit of a difference here. They'd (nursing colleagues) say he (patient's name) is too full of nonsense, he's too cranky, he complains too much, he's too difficult. You must spend such a long time with him. Yes he wanted too many things but it's part of the caring ...* (P4)
>
> *... you are so exhausted at hand-over. You have given all the info about what happened during the day and then you feel that the night-staff didn't even listen to your reaction. And I said to myself ... goodness gracious me if these people knew what we went through today."...* (P4)
>
> *... when you start seeing your patient recovering and everybody who was so negative, especially the doctors, sad to say, some of the doctors are so negative in their comments to us and the patients ...* (P2)
>
> *... the only thing that really stresses me out is mobilising patients. For me it is a big thing. It's a big task in terms that we don't have the manpower and that we all have back problems. The patients are heavy and the doctors just come and say "*mobilise*" as if it's like no problem ...* (P5)

Emotional Neglect of Patients and Self

These theme clusters resulted from an assortment of events that the critical care nurse identified as neglect of the patients and of herself and felt

emotionally and spiritually compromised in the delivery and quality of care to the patients:

> *... it was a bit stressful because the patients are long term they actually feel isolated from other people and it's only you and the patient and it can be stressful if the patients need something that you can't give them. How can I say this now? ... sometimes they just need a family member or someone to care because we nurses do not have time, especially now, because the good nurses have gone and the workload has got heavier, they need someone to listen to their problems. Sometimes we can not attend to their emotional needs as we are so busy doing the observations, handling the meds that we don't have the time to give empathy and sympathy ...* (P2)
>
> *... they were really isolated when it came to the environment. Even if we had a chance to be with them, they were just prisoners to their cubicles ...* (P1)
>
> *... you are so busy you can't really see to the emotional needs of your patients ...* (P3)
>
> *... at the end of the day you are emotionally exhausted. After hand-over I can't wait to get out ...*(P4)
>
> *... you work at your work, and you get home and you start working all over again ...* (P4)

4.1.4 THEME 4. UNPREDICTABILITY

Patients admitted to ICU with a critical life-threatening illness will often experience episodes of uncertainty characterised by the unpredictability of flare-ups, setbacks, recurrences and exacerbations. The theme of unpredictability resulted from a variety of theme clusters, two of which predominate. These were 'patient deterioration' and 'busyness'. Both of these theme clusters illustrated how emotionally and mentally demanding

critical care nursing can be and in parallel affected the delivery and quality of caring.

Throughout the study, unpredictability was a common thread tightly interwoven among all the themes.

Patient Deterioration

The responsibilities of the critical care nurse include appropriate use and understanding of advanced technology, intricate and invasive interventions as well as the ability to assess and monitor a patient's condition for sudden deterioration and the skill to intervene appropriately. These sudden 'on-the-spot' situations requiring immediate and appropriate responses can be emotionally and mentally draining. This implies that critical care nurses are responsible for caring in its broadest sense of the patients in the ICU:

> *... all of a sudden, (patient's name) develops this resistant bug and has to go to E26 (Source Isolation Unit). Just as we thought that he was on the mend. It is so emotional. I feel sorry for the family* ... (P4)

> *... in cases of emergency if both patients need to be attended to then you must use your discretion which one to attend to first because both patients are ventilated and you are the only sister in the unit. I really hate those days* ... (P1)

Another form of unpredictability was seen as an unexpected emotional response from family members and from one of the participants:

> *... we knew that (patient's name) was going to die. We were all with her at the end. When (patient's name) died the family just stood there. I cried, I sobbed. She was part of us. I even went to the funeral* ... (P2)

Patient deterioration was also perceived as a cause of the busyness of the ICU. Prevalent words and phrases used by the participants included *hectic, chaotic, frantic, quickly, rushing, priority, suddenly and catch-up.*

> *... sometimes you can't see the balance, you can't balance it because you don't know what to expect when you see the patient the following day ...* (P4)

Busyness

This theme cluster of busyness impacted heavily and negatively on the delivery and quality of patient care. Busyness causes stress for the critical care nurse but because of the uncertainty and intensity of the busyness, this theme cluster fitted more appropriately under unpredictability:

> *... you are so busy you can't, you just can't see to the emotional needs of your patients. You have to do the 10 o'clock observations, the meds, full-wash and the patient must sit out. Then the patient pulls out his ETT (endo-tracheal tube) and then the other patient starts playing up ...* (P1)
>
> *... you must set up your priorities. Plan early morning. Because normally we shift-leaders take the very sick patients. Your priorities are to your sick patients and your long-term patients tend to be neglected ...* (P2)

Summary of Findings

For the participants in this study, caring for long-term mechanically ventilated patients was far more than the assumed technological ventilator care per se. For them, it involves making the effort to address the patient's and family's needs. The constant and crucial activity of caring includes giving technical support and nursing care. Bonding with patients is dependent upon the nature of the relationships formed with them and

occurs when rapport and kinship is felt for the patient and family. Such personal involvement results in physical care being administered with emotional warmth and compassion. These findings may imply that caring is selective and may be an area for further research. Specific care for the family is an integral component of caring for the patient and is achieved by supporting and involving the family in caring for the patient.

The critical care nurse's life experience and professional learning brings abilities and attitudes inherent to the process of caring. This process of caring requires time, resources and support from the critical care team as well as from nursing management. Feeling good and valued enhances and motivates caring, but energy and effort available for caring are reduced when frustrations and stress are experienced in the daily routine. In these situations, the critical care nurse continues to give physical caring, but the level of emotional caring is reduced.

In describing the four themes, I have used the participants' own words to describe their experiences of caring for long-term ventilated patients in intensive care units. This is a linear description of the participants' experiences, however, caring is a non-linear, multifaceted, complex process and emotion. In the last chapter, I will discuss these themes and relate them to the literature.

CHAPTER 5.

DISCUSSION AND CONCLUSION

5.0 INTRODUCTION

"Doing qualitative research is by nature a reflective and recursive process" (Ely et al 1991, p.179) and therefore this chapter becomes a reflection on the research process and self-introspection. I will reflect on some of the issues and paradoxes that have emerged from the study and discuss how these relate to the literature. I will also discuss the concept of ***Dasein*** in relation to the lived world of critical care nursing. I conclude this chapter by highlighting the limitations and strengths of the study and recommendations for future research in critical care nursing.

5.1 DESCRIPTION OF THE PHENOMENON OF CARING

Analysis of Bush and Barr's (1997) study of critical care nurses' lived experiences of caring showed that caring was a process and was described by the nurses in four areas:-

- nurses' feelings
- nurses' knowledge and competence
- nurses' actions and
- patient and family outcomes.

I compared Bush and Barr's (1997) findings of caring to the four themes of my study. The results of my study concurred with aspects of Bush and Barr's findings to some extent, illustrating that caring is a relational process. The process as described by Bush and Barr is depicted in Figure 1.

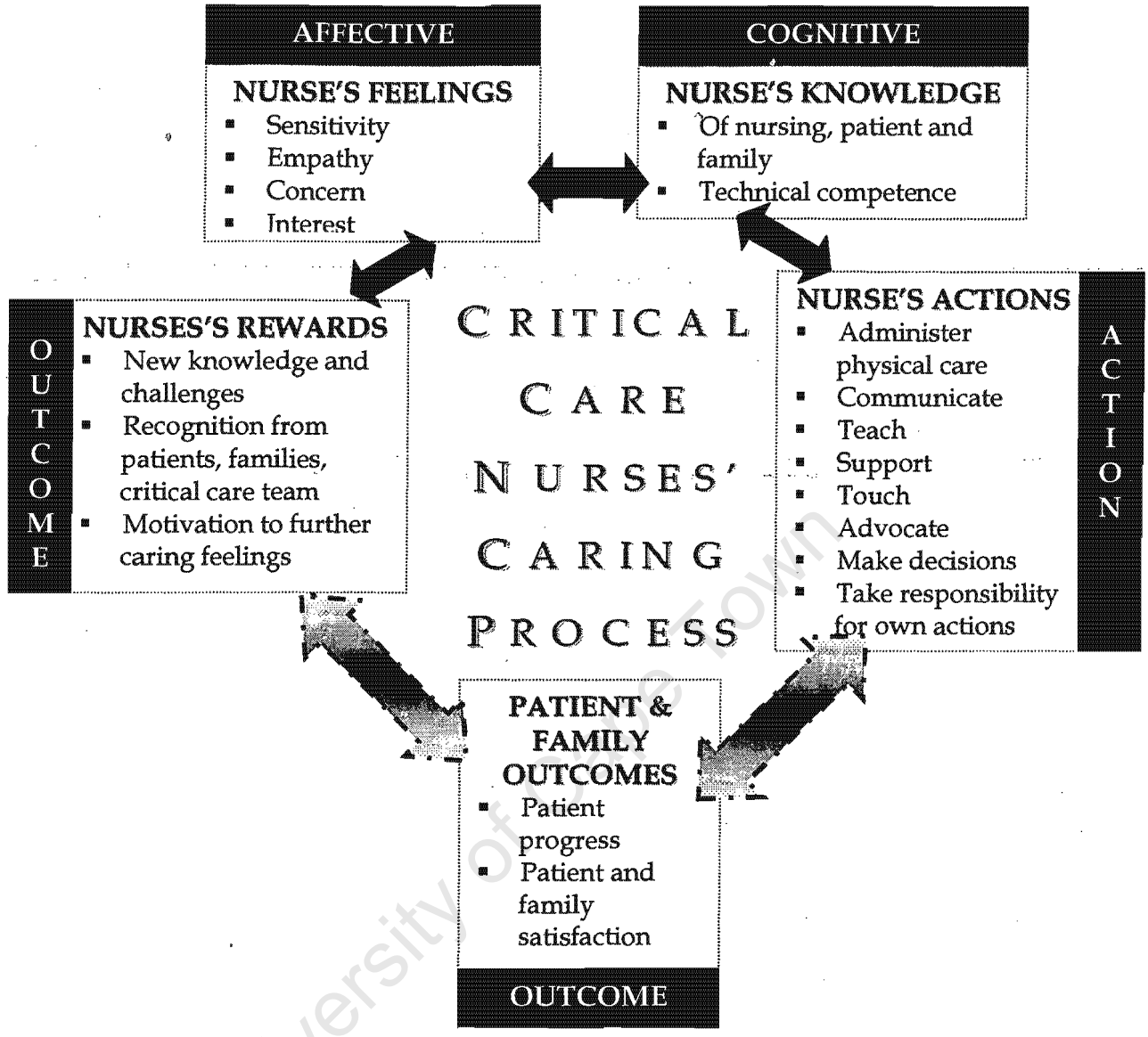

Figure.1. Critical Care Nurses' Caring Process described Bush & Barr, 1997, p.391. Broken arrows and schematic cycle have been added as an adaptation of this process to reflect the findings from my study.

From the participants' descriptions in my study, the cycle of caring begins with the participants' feelings of sensitivity, empathy, concern and interest. These feelings move the nurse to use knowledge of the profession and of critical care nursing in particular of the patient and family as well as technical competence in the caring process. At this stage the nurse calls on her knowledge to guide her assessment, planning and

implementation of a nursing care plan for the critically ill patient. Technical competence is a link between knowledge and actions and guides and supports the selected caring actions. This confirms Dunlop's (1987) study that describes a science for caring as opposed to a science of caring. As the patient progresses, outcomes may be positive or negative; for the patient and family it may be improvement and satisfaction and for the nurse, new knowledge, challenges, recognition and rewards. This in turn motivates the nurse to further caring feelings and the cycle begins again.

However Bush and Barr do not describe the negative outcomes on the patient, family and the nurse. In my study, negative outcomes such as a devaluing of nurses and sudden and unpredictable patient deterioration did not motivate critical care nurses to care at all; in fact it hampers the quality and delivery of care. For this reason, I have indicated this aspect on the caring cycle without a solid arrow as I feel that this is a truer reflection of what is happening in the research setting. Although Bush and Barr's model may depict the caring process as relatively simple, in reality, the process is multidimensional and complex.

5.2 Discussion of the Four Themes

In this research setting, nurses' experience of caring for long-term mechanically ventilated patients, is one of bonding and maintaining but this experience is also very stress-inducing which results in unpredictability in the quality and delivery of care to patients.

A comparison of the theme clusters of caring from qualitative phenomenological studies by Barr (1985), Forrest (1989) and Ford (1990) and more recently by Beeby (2000) as outlined in Table 5, reveals similarities with the theme clusters found in this study although none of these studies explored nurses' experiences of caring for long-term mechanically ventilated patients.

I have tabulated the similarities in Table 5 in italics for ease of discussion.

Table 5. Comparison of formulated meanings of caring relevant to the study.

Barr (1985)	Forrest (1989)	Ford (1990)	Beeby (2000)	Fouché (2003)
▪ *Totality of care* ▪ Priority of care ▪ Nature of caring ▪ Blending of attitude with action ▪ *Recognition of patient's individuality* ▪ *Family involvement* ▪ Teaching and communication	▪ *Being there* ▪ *Respect* ▪ *Feeling with and for* ▪ *Closeness* ▪ Touching and holding ▪ Picking up cues ▪ Being firm ▪ Teaching ▪ *Knowing them well* ▪ Patient perception of outcomes	▪ *Sensing the patient's vulnerability* ▪ Beyond the call of duty ▪ *Being in tune with the patient's world* ▪ *Being attentively present* ▪ *Centering on the patient* ▪ *Being comfortable with the patient*	▪ *Being there* ▪ *Being close* ▪ *Respecting the person* ▪ *Having feelings for the patient* ▪ *Involving family* ▪ *Being supportive* ▪ *Having experience/ expertise*	▪ *Knowing the patient* ▪ *Knowing the family* ▪ *Dependence* ▪ *Being close* ▪ *Being supportive* ▪ *Being experienced* ▪ *Effort and energy put into nursing care*

Barr's (1985) study consisted of fifteen critical care nurses working in a variety of ICU settings. The theme clusters from this study of 'totality of

care', 'recognition of patient's individuality' and 'family involvement' compare similarly with theme clusters of 'effort and energy put into nursing care', 'being supportive', 'knowing the patient' and 'knowing the family' from my study.

The study done by Forrest (1989) explored the experiences of caring of seventeen registered nurses working in medical, surgical, psychiatric and paediatric areas. The derived theme clusters of 'being there', 'respect, 'feeling with and for,' 'closeness' and 'knowing them well' match up with the theme clusters of 'being close', 'supportive,' and 'knowing the patient' in my study.

Ford's (1990) sample consisted of six registered nurses working with cardiac patients. The theme clusters of 'sensing the patient's vulnerability', 'being in tune with the patient's world', 'being attentively present, 'centering on the patient' and 'being comfortable with the patient' compare similarly with the theme clusters of 'knowing the patient', 'being close' and 'being supportive' as found in my study.

But it is Beeby's (2000) study of nine staff nurses [registered nurses] working in ICU and a Coronary Care Unit (CCU), which compares more closely with my study. Beeby's theme clusters of 'being there', 'being close,' 'respecting the person', 'having feelings for the patient,' 'involving the family', 'being supportive' and 'having experience and expertise' are similar to the theme clusters of 'knowing the patient', 'being supportive', 'being close', 'knowing the family' and 'being experienced' in my study.

I will now discuss each theme more fully in relation to the literature.

5.2.1 BONDING

This study illustrates the importance of caring from the perspective of those giving care. Bonding is an integral component of the concept of caring. However, in the present research setting, the emphasis is placed more on the physical attributes and efforts of caring. Despite this interpretation of caring, I preferred the term 'bonding' because of the length of stay of the patients in the ICU.

Yet, when a critical care nurse did identify with a patient and with the family, emotional bonding was apparent and was described as 'being close' to the patient and/or family. This finding is consistent with Beeby's (2000) study and with the concept of 'connecting' described by Benner and Wrubel (1989).

The physical aspects of caring were performed with emotional warmth, demonstrated through gentle touch, dignity and affection (Swanson 1990). This occurred when a bond had developed between a particular patient and nurse. The intimacy of giving of self is considered to be important in this relationship. The participants in this study equate this with the feeling of love for the long-term patients, but recognise that it was different from the love they have for their families and friends; the differences described being in the intensity and intimacy of the feeling. Ray (1984, pp. 95-112) has also described this expression of love in her study on caring.

The impersonal technological environment of the ICU (Cooper 1994; Bosque 1995) may be softened by critical care nurses displaying warmth and kindness as was shown in this study, particularly when the nurse feels a bond with the patient. Empathy, an emotion evoked within the nurses in this study, is used to relate to patients and appears to be consistent with Bush and Barr's (1997) study of critical care nurses. In contrast, when this warmth and kindness of emotional involvement is absent, caring becomes that of giving a service (Graham 1983).

5.2.2 MAINTAINING

'Maintaining' within caring, means that the critical care nurse supports and encourages the patient, family and colleagues. The participants in this study provided a foundation of care that maintained a situation of stability for the patient to recover. This foundation of care is developed through knowledge and skill as well as experience. Giving physical care, technological support and being experienced dominated this theme. Preoccupation with being 'ventilator competent' that is, being able to look after a critically ill patient who is being mechanically ventilated, was apparent. Once this is achieved, the critical care nurse can put her effort and energy into the other components of caring.

Learning is essential in maintaining caring. Learning from experience and gaining expertise through role models as well as a feeling of being valued enables the nurse to maintain caring.

Swanson's study conducted in a neonatal ICU underscored how *"mundane nursing acts ... are actually laden with scientific and caring principles"* (Swanson 1990, p.66). This was evident in my study by the effort and energy put into basic nursing care and attending to the hygiene needs of the patients by *"shaving, applying creams and lotions"*. Caring for the physical needs of patients is an important aspect of caring, and this is in agreement with both Bush and Barr's (1997) and Beeby's (2000) studies of critical care nurses' experiences of caring.

5.2.3 STRESS-INDUCING

In this theme, time and resource constraints and the intensity of the work dominated. The fact that the critical care nurse has to wait for resources such as medication, staffing and equipment and that she works in an environment that dictates immediate responses and competent and efficient performances is extremely stressful and impacts both on the delivery and quality of care. Such is the seriousness of the patient's illness that caring becomes orientated around tasks and routines and the emotional aspect is forfeited consequently. Similar findings were found in Beeby's (2000) study.

White (1989, p.26) states that critical care nursing requires involvement at all levels of caring and is so integrated into nursing that caring is not recognised by critical care nurses. She categorizes some actions of caring as reassuring, explaining, comforting, acting quickly and calmly, holding the patient's hand, sitting with the patient's family, crying with the patient and family over the diagnosis and blending caring with the technical

components. This was also evident in my study and the participants experienced anxiety and guilt when these emotional components of caring were not addressed as a result of time and resource constraints. The participants in my study see this as a significant cause of stress.

Rushton (1991, pp.238-240) maintains that professionals in critical care areas, although overworked and overwhelmed, are diligent in their caring. However she states that *"the critical care environment can be dehumanising for caregivers by virtue of inconsistent philosophies about patient care delivery and decision making and personal and professional value conflicts.* This was evident in this study as one participant was almost deserted by her colleagues over a dispute regarding her 'intense' involvement with one particular long-term patient and the lack of understanding and empathy shown by her colleagues after enduring a hectic and chaotic twelve hours on duty.

Rushton describes the *"dehumanising environment"* further and mentions that *"increased technology, shortage of human and material resources, lack of professional skill and inadequate administration support"* are all stressful to those working in ICU (Rushton (1991, pp.238-240). Again these issues were brought up by participants in my study.

5.2.4 UNPREDICTABILITY

This theme appears to be new, not evident in the current literature pertaining specifically to critical care nursing. This theme also had a commonality with the other three themes. Hilton (1992, p.70) describes uncertainty as a cognitive state created when an event cannot be

adequately defined or categorised due to lack of information. In order to organise information, a person must be able to recognise and classify it. This requires that the stimuli be specific, familiar, consistent, complete and limited in number and clear in boundaries. Critical care nursing seldom has these characteristics and therefore I preferred the term unpredictability. There appears to be more rapid change in patient status and therefore more unpredictability in this type of environment where patients with life-threatening pathologies are nursed than in non-critical care settings.

The irregularity of 'spare' time to do *"the little things"* and in the availability of resources, fluctuations in the patient's condition and in length of stay as well as conflict, seem to contribute to emotional neglect, both of the patient and of self. Unpredictability can make working in this environment more difficult because it interferes with the ability to assess a situation in an attempt to predict nursing outcomes with some degree of accuracy.

Hilton (1992) states that the person may not know what to do to help or change a situation and therefore may do nothing. This was evident in my study where the participants were reluctant to initiate change in the units that they were working in. This may result in withdrawing emotional care to their patients and to themselves. Hilton (1992) suggests that these uncertain states may trigger emotion-focussed coping strategies to manage the uncertain state created by the situation. Emotion-focussed strategies include such behaviours as absenteeism, smoking, over-eating and the

excessive use of alcohol and chemical substances. There is much published literature on such incidents in nursing within all the nursing specialities (Bailey, Steffen & Grout 1980; Cilliers 1991; Cornock 1998 and Cartledge 2001). The unpredictability of critical care nursing may be a cause of reluctance on the part of nurses to enter this specialised area of nursing. It may be a reason that tired and emotionally depleted nurses are leaving ICU. This may require further research in the future.

5.3. Discussion of Critical Care Nurses' Experience of Caring

In my study, the lived experience of nurses caring for long-term mechanically ventilated patients in intensive care units is consistent with the conceptualisations of caring in general and in critical care in particular found in the literature, albeit, a new theme of unpredictability was generated from the data. The participants describe caring as originating in their feelings of empathy, sympathy, love and attentiveness towards both the patient and the family. Both Leininger (1981) and Benner and Wrubel (1989) acknowledge the subjective feelings of the caring nurse. Caring is the motivator of nursing actions (Leininger 1981) and caring fuses thought, feeling and action (Benner & Wrubel (1989).

Some of Watson's "carative" factors are evident in my study. Specifically a humanistic-altruist value system that *"lays the philosophical foundation for the science of nursing"* (Watson 1979, p.10) is evident in the participants' heartfelt concern about tending to the emotional needs of patients. This concept of emotional caring can also be found in McFarlane's (1976) charter of caring and Rushton's (1991) blueprint for humanism in critical

care. In the process of caring, the participants' emotions were related to their knowledge and competence. In Gaut's (1983) theory of caring, knowledge and competence are two major findings. Gaut explains that the competent range of caring demands that the nurse has knowledge and skills (both analytic and synthetic), and the disposition to utilise the knowledge and skills to accomplish a complete instance of caring. Watson (1979) included the systematic use of the scientific problem-solving method for decision making as one of the ten "carative" factors, indicating the need for knowledge and competence in caring. This notion is supported by Burfitt, Greiner, Miers, Kinney and Branyon (1993) who interviewed thirteen critically ill patients. The patients in this study indicated that caring meant highly skilled practice, a great deal of knowledge and a high degree of technical skill.

The predominant nurse caring as perceived by the participants in my study (physical care, talking, listening, touching, teaching, arbitrating, making decisions and taking responsibility) are located in the literature of caring and are not specific to critical care nursing.

Descriptions of caring within my study concur with those of Watson (1988) and Leininger (1985, 1988) in relation to valuing the person and holism, however in my study, emotional caring was linked with meeting the physiological needs of the patients and the unpredictability of the environment in which these nurses worked. Watson (1979) and Leininger's (1985, 1988) theories may have value in terms of caring in most

nursing situations, however the appropriateness of their theories may be challenged in the context of caring in critical care settings.

5.4 DASEIN *(being there)*

Heidegger's writings concentrated on the nature of human existence in its "everydayness". It is through our everyday dealings with things in the world and with other people, in our goals and projects, the intentions we hold and the way we live out our hopes and values that we are defined. Heidegger used the word Dasein to refer to this human existence (Heidegger 1962). This study interpreted and described nurses' lived experience of caring for long-term mechanically ventilated patients [human existence]. Heidegger's Dasein, then, is the methodology that underpins this study. Dasein is the theoretical foundation.

Hall (1993, pp.122-140) interprets Heidegger's work and explains that Dasein relates to the fact that we are already in the world which 'was not of our making but with which we are nonetheless stuck'. Heidegger's view suggests that each of us is an individual, who must come up against history and the future in such a way that we make our own life according to our choices, within certain limits that constrain us. Since our world includes our history and our cultural orientations, society's understanding of these concepts and of critical care nurses and nursing, colours the beliefs held by other professional carers, patients and families. This links with Lincoln's (1992) multiple realities.

Van Manen (1990) takes Heidegger's philosophy further and explains that all phenomenological research has four essential lifeworld themes as

existentials that pervade the life-worlds of all human beings. These four themes or existentials are:-

- Lived space (spatiality)
- Lived time (temporality
- Lived body (corporeality) and
- Lived human relation (relationality)

These four fundamental existentials may be seen to belong to the existential ground by way of which all human beings experience the world, although not all in the same modality. These lifeworld themes can be recognised in the data and will be discussed in the light of the findings in my study.

5.4.1 Lived Space (Spatiality)

Lived space can be seen both as the physical space in which we work and also the way in which we respond to that space or environment. In the life world of the critical care nurse, the physical space is the ICU. This highly technological space dominates the working space of all who work and are cared for in ICU. In order for the critical care nurse to be effective and proficient in this environment, she must have an understanding of and control over the machinery and often dehumanising medical procedures and interventions that are performed daily. This is achieved by developing knowledge and skill which enables the critical care nurse to have some control over her environment. Within this hostile and mechanical environment, the essence of nursing is still to provide care,

comfort and to relieve distress. Beeby (2000, p.78) illustrates this point by describing caring as not just an emotion, concern, attitude or benevolent desire, but also the moral ideal of nursing to protect and enhance and preserve human dignity. Walters (1995), in reviewing the literature in relation to the use of technology and how it relates to the practice of critical care nursing, cites several authors who dispute that technology and caring are in contradiction to one another and that the ICU environment is dehumanising for the critically ill patient.

From personal experience, new and or inexperienced nurses entering this environment are so overwhelmed, that they are often not effective as carers until they have mastered the equipment and technology. Reflecting on the study, the participants had become efficient carers within this environment and were seen as 'masters' of the technology. This was evident from excerpts concerning the 'ventilator competence' of agency staff working in the ICU's at the research setting. The participants saw this knowledge and skill base as a priority to function effectively. However, the intensity of working in such an environment (often with no windows and constant lighting), limited bed-space between patients and the incessant hum of machinery, often desensitises the critical care nurse to these phenomena and she concentrates solely on delivering nursing care and providing support to the family. This can also be viewed as a coping mechanism for critical care nurses working in this environment.

5.4.2 Lived Time (Temporality)

Lived time refers to subjective time and not to objective or clock time. Lived time is inclusive of the past, present and the future and make up the dimensions of our temporal way of being in the world. Sandelowski (1999, p.80) describes lived time as *"in-here time"* and is fundamental to *"all human beings regardless of, although shaped by biographical and historical time"*.

In this study, lived past time relates to the participants' prior experiences of caring for long-term mechanically ventilated patients in intensive care units. Time, coupled with resource constraints is a huge concern for this group of critical care nurses, who feel that they just do not have enough time. Present time, for one of the participants, was illustrated by her arriving late for the focus group as she was involved in resuscitation and could not leave the environment with novice doctors and nurses at that time. The theme of 'unpredictability', a common thread throughout all the themes, seems to have a predilection for time. No single person can predict or foretell when patients are going to deteriorate, fall out of bed or extubate themselves and the list is endless. But for the critical care nurse, using the words of the participants, *"she must make time, prioritise, cut-back, take shorter lunch breaks to fit things in"*. From my own personal experience, 'unpredictability' seems to rear its head more over weekends, when the unit is severely short staffed or staffed with inexperienced personnel (both nursing and medical) and on night duty.

For the future, with more improved knowledge and skills acquired from working in ICU and from the findings of this study, it is hoped that critical care nurses may continue to care effectively and efficiently and be able to tolerate the unpredictability of events. Improving *"clinical forethought"* as described by Benner, Hooper-Kyriakidis and Stannard (1999, p.2), is the ability to anticipate and prevent potential problems. This ability can be enhanced and 'fine tuned' by critical care nurses' experiences, enabling them to become more intuitive so that they can recognise early changes in the patient's condition and predict and implement appropriate actions.

5.4.4 Lived Body (Corporality)

Lived body refers to the fact that one is always physically in the world. This existential in critical care nursing is perhaps the most significant. The environment in which the critical care nurse works can lead to an imbalance between the emotional and physical needs.

The participants struggled to see to the emotional needs of their patients and this weighed heavily on their mind until they had prioritised care or managed to *"fit everything in"*. This also affected the participants emotionally as they felt that they were being negligent in their nursing care. The 'unpredictability' of events, intensity of work and lack of positive feedback left the participants' feeling angry and frustrated and often powerless. This may have an effect on caring as individuals shift from positive caring to negative uncaring. This shift in behaviour puts individuals at high risk for burn-out. Added to this, Vachon (1987) describes how nurses sometimes distance themselves from patients and

their relatives through technology, to prevent themselves from identifying with them.

Some of the participants expressed physical manifestations of stress including fatigue, backache and headaches as well as emotional changes (irritability, impatience and being withdrawn). They described measures to cope with these which included talking with other nurses, their husbands, relaxing on their days off and being with friends.

5.4.4 Lived Human Relation (Relationality)

Lived relation refers to the relationship we maintain with others within the interpersonal space we share with them. The participants described the 'bonding' and 'relationship' that formed between them and the patients and families in this study. Because of the length of stay of the patients in the ICU, these bonds and relationships were likened to 'being a family', 'being part of you' and 'one of us'. Vachon (1987, p.104) explains that as a result of various personal factors, nurses identify with particular patients and refers to this identification with *"counter-transference"*. This counter-transference may be negative or positive or unconscious or conscious. Vachon (1987) explains that nurses are more likely to identify with patients who are similar to themselves in personality, age or lifestyle or who remind them of significant people in their lives. However, Reynolds and Scott (2000) have found a significant amount of literature to support the perception that nurses as well as other health care workers have a limited ability to empathise with their patients. This was not evident in my study. The findings of my study are supported by Rushton

(1992) in that critical care nurses suffer with their struggle to balance their obligations to others with their obligations to self. The theme cluster of 'emotional neglect to patients and to self' can illustrate this. The participants struggled trying to juggle the intensity of the work and time and resource constraints, so that they could give emotional care often to the detriment of themselves.

The relationships with other nurses in the team were somewhat at a superficial level and could be as a result of the large contingency of migrant agency staff who have replaced the older more experienced and role model type nurse. This did not allow for 'bonding' to occur and was seen as a stress-inducing phenomenon. This is supported by Vachon (1987) who reports that poor team communication is the greatest environmental stressor in ICU.

The relationships between doctors and nurses have been explored extensively in the literature and within the ICU environment. These relationships are mostly collegial with the sharing of opinions and giving of advice especially about nursing related issues. As with all human relations, there will be conflict as was evident from an excerpt from one of the participants' altercation with a doctor who had *"undone all the good of three months intense nursing by his comments to the family"*. Comments like these frustrate nurses and add to the stress levels which impact on their caring abilities.

The relationships with family and friends were not given too much attention by the participants in this study other than having *"worked hard*

at their work environment all day, they often had to come home and start working again" as all of them had families.

5.5 Limitations and Strengths of the Study

As I reflect on my personal journey, it seems I have learnt more about the research process than about the phenomenon of interest. In that sense, then, I have achieved my personal objective but it does not mean that the aim of the study has been achieved in every respect.

Ironically, my journey of discovery resulted in the greatest limitation of the study: poor mastery, at the planning stage, of the ontology and epistemology of the phenomenological research process. The consequence was superficial understanding of the methodology, with specific reference to sampling and data collection. This resulted in premature termination of the interviews after the third interview, in the belief that data saturation had been reached and, by honest admission, that data collection was not proceeding as planned. Despondency had set in. As I gained experience in data analysis, I started to understand that, essentially two cognitive processes are involved: first, a process I call 'cognitive scanning' to determine if data saturation has occurred and this means that no new thoughts are being offered by participants, and second, a process I call 'cognitive delving', a more difficult process of going deeper and developing skill in deep interviewing and in extrapolating meaning from other people's words. What became increasingly clear is that the dialectical and interpretative nature of the data analysis process in phenomenological research, is not easy. Discovering and interpreting the

participants' world through interviewing, discussion and deep engagement with their words, require enormous energy, time, sensitivity and consistency. Once I had unlocked the reality of this process, I got back on track. Perhaps the greatest understanding I now have, in retrospect, is that Dasein should have been given a 'philosophy of science' slant as this is the philosophical foundation of this study: an interpretation of nurses' lived experience of caring for long-term mechanically ventilated patients in intensive care units. Dasein is the methodology as defined for the purpose of this study.

In summary, at the start of the study I had failed to appreciate the enormous amount of time and effort it takes to move away from belief in objective reality and predictable outcomes (positivism), to belief in multiple realities, abstraction and an understanding that human behaviour can be explained but not predicted (naturalism). Even more so, there was insufficient appreciation for the role of researcher as data collection tool in phenomenological research. Although subsequently rectified, it made the journey so much longer than it ought to have been.

A strength of this study is my extensive experience of critical care nursing which enabled me to establish quick rapport and relationships of trust and confidence with the participants. This had a positive effect on the quality of the interviews and data that was produced.

The theme of unpredictability was a finding and was not evident in any of the studies discussed. This may have opportunities for further research and should be incorporated into critical care nursing curricula.

Despite my experiencing difficulties throughout the phenomenological process and the size of the study, it was encouraging for me to find that the findings of my study concurred with most of the findings of Bush and Barr's (1997) and Beeby's (2000) studies.

The participants' feelings, thoughts and experiences are specific and personal only to those who participated, therefore applying the results of my study to other groups of critical care nurses is difficult. However, other critical care nurses may see a similarity with the resulting descriptions and analysis of caring.

5.6 Recommendations for Further Research

This study concerns all health professionals involved with caring for critically ill patients in intensive care units. For nurse educators, curricula should be planned and designed to demonstrate the centrality of professional caring rather than just the 'care of' approach to nursing. Added to this, nurse educators should be clinically competent and up to date in the latest trends and modalities that affect caring in the intensive care units. Role modelling caring in its broadest sense, particularly through innovative bedside teaching will provide knowledge and skill to enhance nurses' processes of caring. The concept of mentorship or the "buddy system" which appears to be evident in most Cape Town privately run ICU's may be seen as an opportunity to achieve and enhance the caring process. Unfortunately this is not a concept that is entertained in government run ICU's, where reasons range between a nursing

shortage, widely varying degrees of experience and competence and workload pressures.

For unit and nurse managers, finding ways of working together and promoting opportunities for caring behaviours would be beneficial and rewarding for both the patients and the critical care nurses at the bedside. A greater sense of being valued and involved may increase critical care nurses' motivation and thus have a positive effect on caring.

Recognising and acknowledging that critical care nursing is stressful and has a detrimental effect on the quality and delivery of caring is essential so that strategies can be implemented to reduce stress and the burden of caring under these circumstances.

The availability of critical care nurses has changed dramatically in the last decade. Almost all ICU's in South Africa, regardless of whether government or privately operated, employ a large contingency of migrant nursing agency staff. Nurse and hospital managers need to understand the stress that these "floating" nurses have on the continuity of patient care. Debriefing sessions with the critical care team could be used to reflect upon stress inducing events. The concept of debriefing in South African ICU's appears to be seldomly considered and opens an area of research for the future. For researchers, further exploration of the themes especially the theme of 'unpredictability', would supplement the understanding of caring already gained in this study.

Ultimately, the entire nursing profession should openly value caring. This means demonstrating a caring approach to colleagues and peers, so that caring can be reflected back to patients.

5.7 CONCLUSION

Hermeneutic phenomenology emphasises the ontological over the epistemological, thus placing this approach within a constructivist/interpretive paradigm of inquiry. Hermeneutic phenomenology is suitable for nursing research and offers prospects for informing nursing practice. Within the nursing literature, there is only limited critique and a lack of cautionary advice regarding the use of hermeneutic phenomenology. It is essential that a researcher who is investigating a phenomenon and is contemplating the application of the hermeneutic phenomenological approach, should be cognizant of not only the philosophical basis of the tradition and the inquiry paradigm within which it lies, but also of its current use within the discipline of nursing.

This hermeneutic phenomenological study offered a group of critical care nurses the opportunity to describe their experience of caring for long-term mechanically ventilated patients in intensive care units. The phenomenological inductive reduction process provided rigorous and thorough analysis of the experience of caring within the context of this study. Caring, for the participants, involved physical, technical and emotional caring. These findings are consistent with Beeby's (2000) study of intensive care nurses experiences of caring, but my study uncovered an additional theme of unpredictability. The findings of my study are also

supported by Bush and Barr's (1997) study of critical care nurses lived experience of caring, described as a series of processes consisting of an affective process, a cognitive process, an action process and an outcome process. But in my study the negative outcomes hampered the quality and delivery of care given by the participants.

The participants' lived experience has provided some answers for a South African perspective of nurses' lived experiences of caring for long-term mechanically ventilated patients in intensive care units.

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UNIVERSITY OF CAPE TOWN

APPENDIX A

Research Ethics Committee
Faculty of Medicine
Anzio Road, Observatory, 7925
Queries: Martha Jacobs
Tel: (021) 406-6492 Fax: (021) 406-6390
E-mail: Martha@medicine.uct.ac.za

05 May 2000

REC REF: 323/99

Ms N Fouché Nursing

Dear Ms Fouché

NURSES' LIVED EXPERIENCES IN CARING FOR LONG TERM MECHANICALLY VENTILATED PATIENTS IN THE INTENSIVE CARE UNITS AT GROOTE SCHUUR HOSPITAL

Thank you for your application submitted to the Research Ethics Committee on 21 December 1999.

I have pleasure in informing you that the Research Ethics Committee has formally approved the above study on 24 April 2000.

You may proceed with the trial once the financial agreement/contract and protocol have been processed through the department of Research Development and duly signed by the authorised University of Cape Town signatories.

Included is a list of Research Ethics Committee Members who have formally approved your protocol.

Please quote the above Reference number in all correspondence.

Yours sincerely

PROFESSOR DM DENT ACTING-CHAIRPERSON

Queries:

Martha Jacobs
Research Ethics Committee Room 212 Werner and Beit UCT Medical School

APPENDIX C.

Participant Code №.....
Nurse Researcher: N.A. Fouché
Address: Division of Nursing & Midwifery
School of Health & Rehabilitation Sciences
University of Cape Town
Telephone № (021) 406-6672
Supervisor: Mrs U Kyriacos. UCT Division of Nursing & Midwifery

CONSENT FORM.

I certify that I have explained that the purpose of this study is to explore and describe the nurses' lived experiences of caring for long-term mechanically ventilated patients and that the results of the study may be of value in providing new knowledge for patient care.
I have answered any questions that have been raised.

CONFIDENTIALITY: I have explained that all information is confidential and that the name of the participant will not appear on the interview sheet. I have also explained that I am the only person who will have a copy of his/her name and the number assigned to his/her data.

RIGHT TO WITHDRAW: I have explained that the participant has the right to withdraw from the study at any stage.

_____ _____
Date Researcher's signature

I agree to participate in this research study on the terms specified above.

_____ _____
Date Participant's signature

Adapted from U. Kyriacos. Division of Nursing & Midwifery, University of Cape Town, Observatory, Cape 7925.

NOTES

DATA COLLECTION TOOL

Participant Code №.....
Nurse Researcher: N.A. Fouché
Address: Division of Nursing & Midwifery
School of Health & Rehabilitation Sciences
University of Cape Town
Telephone № (021) 406-6672
Supervisor: Mrs U Kyriacos. UCT Division of Nursing & Midwifery

INTERVIEW GUIDE.

"Hello, my name is Nicki Fouché. I am conducting a study into nurses' lived experiences of caring for long-term mechanically ventilated patients in intensive care units. The results of this study should contribute to new knowledge for patient care.

All participants will be asked the same questions.

1. Tell me in your own words *WHAT IT MEANS TO "CARE"* for long-term mechanically ventilated patients?

2. Tell me in your own words *A SITUATION OF "CARING" THAT YOU WILL NEVER FORGET.*

3. Describe in your own words *WHAT YOU DO NOT LIKE* about caring for long-term mechanically ventilated patients.

NOTES:

APPENDIX E.

FOCUS GROUP AGENDA

Participant Code №.....
Nurse Researcher: N.A. Fouché
Address: Division of Nursing & Midwifery
School of Health & Rehabilitation Sciences
University of Cape Town
Telephone № (021) 406-6672
Supervisor: Mrs U Kyriacos. UCT Division of Nursing & Midwifery

The purpose of the focus group is to follow up on clusters of themes that were generated from the audio tape-recorded interviews held previously. They are the following:-

1. **BONDING** ~ getting to know the patient, families, being close to patients and families
2. **SUPPORT** ~ what we do everyday, including colleagues, effort and energy put into nursing care
3. **STRESS** ~ intensity of the work that we do, time and resource constraints, conflicts with colleagues, patients and families, emotional neglect
4. **UNPREDICTABILITY** ~ patient's condition, busyness of the unit

PARTICIPANT CONSENT AGREEMENT

I agree to participate in the above research study. This has been explained to me by the researcher, Nicki Fouché. I understand the purpose of the study and I am participating voluntarily. I grant permission for the data to be used in the process of completing a Masters Degree.

I agree to be interviewed and grant permission for the interviews to be tape-recorded. I understand that all personal information will be kept confidential and no identifying information will be used in the writing up of the research.

I understand that I am free to withdraw from the study at any time should I choose to do so.

_____ _____

Date Researcher's signature

I agree to participate in this research study on the terms specified above.

_____ _____

Date Participant's signature

PARTICIPANT 1. TAPE-RECORDED SEMI-STRUCTURED INTERVIEW. 28/06/2001.				
ACQUIRE FEELING (OVERVIEW)	**EXTRACT SIGNIFICANT STATEMENTS**	**FORMULATED MEANINGS**	**ORGANISATION OF MEANINGS INTO CLUSTERS OF THEMES**	**THEMES**
in your own words, Please tell me what it means to care for long-term ventilated patients ?" To care for chronic long-term ventilated patients means that uh in the first place you must care for the patient holistically from the head to the toe	Care for the patient holistically from the head to the toe	To care for the patient you need to care about his emotional, spiritual, and physical well-being	Knowing the patient Being close	BONDING
in caring you must also involve the patient's family because uh…[pause]… thinking of the family when the patients goes home; how the family must care for the patient	▪ Involve the patient's family ▪ How the family must care for the patient	To care for the patient you need to care about his emotional, spiritual, and physical well-being and his family. The family must be involved in the caring	Knowing the family Being close	BONDING
that you form like a bond between you and the patient	▪ That you form like a bond between	The patient gets to know you and a	Knowing the patient	BONDING

PARTICIPANT 1. TAPE-RECORDED SEMI-STRUCTURED INTERVIEW. 28/06/2001.				
ACQUIRE FEELING (OVERVIEW)	**EXTRACT SIGNIFICANT STATEMENTS**	**FORMULATED MEANINGS**	**ORGANISATION OF MEANINGS INTO CLUSTERS OF THEMES**	**THEMES**
because the patient is so used to you and you are used to the patient so you know what the patient wants at such and such a time	you and the patient because the patient is so used to you and you are used to the patient	relationship starts. You anticipate the patients needs	Being close	
when you caring for the long-term patients in the units you tend to see if the patients are responding to the treatment and and if you see any improvement as far as the treatment is concerned and you might also let the doctor know that the patient is responding because we as nursing staff are more next to the patient than the doctors	▪ you tend to see if the patients are responding to the treatment ▪ you see any improvement as far as the treatment is concerned and you might also let the doctor know the patient is responding ▪ we as nursing staff are more next to the patient than	Part of caring is being vigilant and interpreting and acting on any change in vital signs because the nurses are at the bedside with the patient more than the doctors are. The doctors need to know if there has been a change in the patient's condition. Watching over the	Being supportive Being experienced Being close	MAINTAINING

PARTICIPANT 1. TAPE-RECORDED SEMI-STRUCTURED INTERVIEW. 28/06/2001.				
ACQUIRE FEELING (OVERVIEW)	**EXTRACT SIGNIFICANT STATEMENTS**	**FORMULATED MEANINGS**	**ORGANISATION OF MEANINGS INTO CLUSTERS OF THEMES**	**THEMES**
	the doctors	patient and our expertise is part of caring		
Is there anything different that you do from looking after other patients who are short-term ventilated patients ? Not really ~ you basically do the same thing even if the patient is short term that you do in the units..... there is no difference that much besides that you are more with the patient when the patient is long term in the units	▪ basically do the same thing even if the patient is short term that you do in the units ▪ you are more with the patient when the patient is long term in the units	Nursing care is the same for long-term and short-term patients even though you are more at the bedside with them	Being close Dependance	BONDING
Anything else that you can think of caring ? As I've mentioned earlier on. You care for the patient holistically. You care for the	▪ Care for the patient holistically ▪ You care for the patient mentally and	To care for the patient you need to care about his emotional, spiritual,	Knowing the patient	BONDING

PARTICIPANT 1. TAPE-RECORDED SEMI-STRUCTURED INTERVIEW. 28/06/2001.				
ACQUIRE FEELING (OVERVIEW)	**EXTRACT SIGNIFICANT STATEMENTS**	**FORMULATED MEANINGS**	**ORGANISATION OF MEANINGS INTO CLUSTERS OF THEMES**	**THEMES**
patient mmh...you care for them mentally and spiritually. You care for the patient uh.....(mumble), physically and uh.....(mumble) and you also involve the family also with the treatment, with the caring of the patient because the patient might still go home still needing the care so the family should know how to look after the patient and there might be changes uh with the patients uh daily activities that needs the family to help the patient The patient might need to do light jobs when he comes	spiritually ▪ You care for the patient physically ▪ You involve the family also with the treatment and caring of the patients ▪ the patient might still go home still needing the care so the family should know how to look after the patient ▪ changes with the patients daily activities that needs the family to help the patient ▪ so you also care for the patients	and physical well-being and his family. You care for the patient and family socially. The family must be involved in the caring especially when the patients go home	Knowing the family Being close Being supportive	MAINTAINING

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back and some patients might not go back at all to work so that the social problems also comes in…so you also care for the patients socially	socially			
Anything else ? And with the treatment of the patient, the nurse needs to know the side effects of the treatment that you are giving to the patient, which patient you could give the treatment to and what the complications of the treatment….. should ask the patient if not in a position to talk to you, ask the family if the patient is not allergic to the	▪ the nurse needs to know the side effects of the treatment that you are giving to the patient ▪ ask the patient if not in a position to talk to you, ask the	Caring also means that you need to have knowledge and skill in everything that you do for the patient. You do not want to harm the patient. The family may be able to give you helpful information that may benefit the patient	Being experienced Knowing the patient Knowing the family	MAINTAINING BONDING

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treatment that you are going to commence.	family if the patient is not allergic to the treatment			
tell me in your own words a situation of caring that you would never forget TENS…[pause]….the the way we were looking after the patient, how we received them, were more looking like umm burns and they way we were looking after them ***In what way are you caring for them that was different ?*** From reacting to that drug that they are given, they tend to be more like a burns patient so they need to be isolated because they are prone to infection so in the	▪ the way we were looking after the patient, how we received them, were more looking like umm burns ▪ reacting to that drug that they are given, they tend to be more like a burns patient so they need to be isolated because they are	The intensity of nursing care, skills and knowledge required to look after burns type patients is enormous and very stressful Caring means paying attention and being diligence	Intensity of work Effort and energy put into nursing care Being experienced	STRESS-INDUCING MAINTAINING

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E26 they were isolated and treated..... we used to dress them, we used to put them on sterile towels and changing them daily and when the need arises when they get soiled and the handwashing, before and after touching the patient..... ***the question was a situation of caring that you would never forget. So what did you do differently for the TENS patients that you did not do for another patient? What was specific to the care of that patient ?*** how we used to dress the patients and the daily dressings that we were not doing to all the patients in the unit. The aseptic	prone to infection ▪ to dress them, we used to put them on sterile towels and changing them daily and when the need arises ▪ how we used to dress the patients and the daily dressings that we were not doing to all	towards infection control and keeping the patient clean and comfortable Caring for this type of patient was labour intensive and required knowledge and skill to care for	Being experienced	MAINATINING STRESS-INDUCING

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ACQUIRE FEELING (OVERVIEW)	**EXTRACT SIGNIFICANT STATEMENTS**	**FORMULATED MEANINGS**	**ORGANISATION OF MEANINGS INTO CLUSTERS OF THEMES**	**THEMES**
technique that we used to do that we used to use when we were dressing the patients and making sure that the patients were on the sterile green gowns, I mean green sterile dressings that needs to be changed and sometimes it came to a push that we need to change the patient twice depending how the patient get easily soiled after the dressing and the technique we used to do when we did the dressing and the special uh… cream used to dress the patients.	the patients in the unit. ▪ making sure that the patients were on the sterile green gowns, I mean green sterile dressings that needs to be changed and sometimes sometimes it came to a push that we need to change the patient twice	them properly. It was very stressful because of the enormity of the dressings and the time that it took. It was important to keep the patient free from infection	Intensity of work Time and resource constraints Effort and energy put into nursing care	MAINTAINING
What did you not like about them? The chronics in the ICU?	▪ Most of the patients when it comes to the	Caring for the chronic patients in ICU is stressful	Dependance	BONDING

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Most of the patients when it comes to the weaning that are so used to the ventilator when we put on a CPAP, they don't want to breathe on their own. They are so used to being on a ventilator. The ventilator does everything for them. It used to be a big problem when it comes to weaning	weaning that are so used to the ventilator ▪ when we put on a CPAP, they don't want to breathe on their own ▪ The ventilator does everything for them	because the patients are so used to being supported by machines and the nurses that they are reluctant to even breathe for themselves and this becomes a nursing problem when the patients are being weaned from the ventilator	Knowing the patient Being close Effort and energy put into nursing care	STRESS-INDUCING
And with the mobilisation some of them have a tendency to think that they can't do anything on their own because we are helping them most of the time when they are on the ventilator.	▪ with the mobilisation some of them have a tendency to think that they can't do anything on their own	When we care for a the patient on a ventilator, we do almost everything for them. When it is time to mobilise the patient, the patient	Knowing the patient Dependence	BONDING

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When it comes to mobilisation they expect the nursing staff to do everything for them not wanting to show us how much they can do so we can meet them half way and um …..	▪ we are helping them most of the time when they are on the ventilator ▪ they expect the nursing staff to do everything for them ▪ not wanting to show us how much they can do so we can meet them half way	now expects us to again do everything for them. The patients do not want to show us just how much they rely on us to care for them	Being supportive Being experienced Intensity of work Conflict	MAINTAINING STRESS-INDUCING
And the environment? They were really isolated when it comes to their environment because even if they can like walk up and about, they can't walk and see over there; they are prisoners in their rooms	▪ They were really isolated when it comes to their environment ▪ they are prisoners in their rooms	Caring for these type of patients was stressful because they were in isolation and could not be free within the environment that they were in	Intensity of work	STRESS-INDUCING

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I was also thinking that in cases of emergency if both patients need to be attended to the you must use your discretion which one to attend to first because both patients are ventilated and you are the only sister in the unit	▪ in cases of emergency if both patients need to be attended to the you must use your discretion ▪ which one to attend to first ▪ you are the only sister in the unit	Sometimes you have to prioritise your care because you are the only registered nurse on duty. This can be stressful because there are two patients to care for and the other may be neglected.	Patient deterioration Time and resource constraints Emotional neglect of patients and self	UNPREDICTABILITY STRESS-INDUCING
[long pause of silence … thinking] ***Anything else that you would like to share with me?*** No, I think that's all ***Thank you P1.***				