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**UNDERSTANDING THE SATISFACTION WITH NURSING  
CARE FROM PATIENTS' PERSPECTIVE IN A PRIVATE  
HOSPITAL SETTING IN SOUTH AFRICA.**

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This Dissertation and I, have come along way, longer than expected, as each wider topic compelled exploration before pointing the way forward, into the narrower straits of “Understanding Patient Satisfaction” as experienced by the patients at Hospital A and B and throughout my career as a Nurse Manager.

I owe a debt of gratitude to my late father, who instilled in me a thirst for knowledge and to never give in. To my mother who always knew I would make it and has never doubted me. To my loyal and tolerant husband Tony, my critic, and proofreader whose understanding has always encouraged me to go into the darkness and transcend my limitations, and taught me love and care and led the way for me.

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This work is dedicated to all my patients and future patients and to all the nurses who have always inspired and challenged me to search for Quality and excellence in patient care. Lastly to my staff who stood by me during this difficult time in my life, when I put my studies first before you. I will always be reminded of the wonderful work that you do everyday to ensure that we touch the lives of our patients and their families, through the findings of this dissertation.

Thank you.

## **Abstract**

The research aimed to answer the question, “**What makes [hospital] patients satisfied/dissatisfied with the nursing care they receive?**” That is, the research seeks to understand the nature of care patients receive [the skills in practice]. It seeks to understand how patients perceive and experience the type of care that satisfies and dissatisfies patients, or what is considered to be good or bad nursing care. Thus the purpose of the study was to:

- Understand the aspects of nursing care most important to patients
- Understand what makes them satisfied/dissatisfied with that care
- Interpret good and bad nursing care in order to determine the quality of nursing.

An interpretive phenomenological approach was used for the research methodology. This approach requires not only an understanding of experience but requires interpretation by making sense of text/transcripts of participants’ narratives.

Using this approach led to the uncovering of rich meanings of words and phrases that were interpreted as the theme of caring and the components of caring. These described caring actions and understandings of care that mostly satisfied patients. These satisfiers and dissatisfiers of care were then described using hermeneutics as a general theory of the interpretation of texts [or transcripts] following Ricoeur’s approach. He felt that human activity in hermeneutics is “text”. That is, the human being’s activity is a collection of symbols that express layers of meaning communicated through the continual reading of “text” [or discourses]. By this word “text” is meant the human experiences within the narratives of the research participants.

The “text” became the data that the researcher used. A methodology of “text” interpretation, according to Ricoeur, served as a paradigm case for interpretation in the field of the human sciences [e.g. nursing].

Patient expectations and perceptions of what constituted a good nursing service were identified from the interpretation of the text as the theme of “care/caring”. This supported the need for understanding the patients’ reaction or response to “care” so that action could later be taken for the improvement of patient care.

The proposed framework of patient satisfaction or, the ‘inner circle of care’, (Fig. 6.1) is so named in order to capture those ingredients of nursing care that made these

participants feel, firstly, that they could cope with their condition or disease, and secondly, those that facilitated their healing process.

The findings also showed that the concept of “caring” came from the rich descriptions of care interpreted in the “components of caring emerging as satisfiers and dissatisfiers of care” diagram and in the “framework of patient satisfaction”.

The finding “touch” was used as an exemplar to show that it is much deeper than putting a hand on another, it is the true “presence” of a nurse in developing a relationship. The use of “touch” suggested the need to first understand the perceptions of patients as a “value added” benefit of individualising patient care and secondly, as a satisfier of nursing care identified by patients. From such understandings collaborative action could be taken in the form of the proposed “framework of patient satisfaction”.

The findings point to the need for nurses to understand and deliver care which corresponds with their patient’s perception of satisfaction and that which is consistent with the emergent sense of caring.

The researcher has identified what patients understand when they say they are satisfied and dissatisfied with the nursing care received. This can be achieved by understanding our patient’s concerns and by engaging in meaningful dialogue with them.

## **Definition of terms**

- 1. Major surgical patient.**
- 2. Text and interpretation.**
- 3. Hermeneutical Phenomenology.**
- 4. Care and caring, nursing care and nursing procedure.**
- 5. Certain terms relating to the Specific methodology.**
- 6. The Coding Procedure using the Qualitative Solutions and Research Pty Ltd.**
- 7. Agency nurse.**

### **1. Major surgical patient**

The researcher using the methodology of the Ward Management Resource System for the purpose of this study has defined the term major surgical patient. This is a patented system (audited by an international group of auditors) developed by Abraxans, revised by Plexus Health Solutions for the use of the health care organisation for which the researcher is employed. The system is a computerised nursing workload measurement for use in all the clinical areas and units. The nursing workload system is planned by the unit manager or designate at least twice daily with the use of “drivers”. These “drivers” are determined by the number of patients, the type of clinical profile of those patients, the activities required to nurse those patients [the activities are pre-drawn up based on a set of activities, dependencies and acuties specific to the profile of that clinical area or unit]. The major surgical patient is graded according to clinical needs and will receive nursing care in the region of seven to eight hours a day, for which the competencies required to care for such a patient or group of patients will need to have high dependency experience to satisfy the needs of the speciality which includes monitoring of vital signs at least two to four hourly.

### **2. Text and Interpretation**

An interpretive phenomenological approach was used for the research methodology. This approach requires not only an understanding of the experience but requires interpretation by making sense of the text/transcripts from the participants narratives. The ‘text’ became

the data that the researcher used. Interpreting phenomena appearing in the text according to Ricoeur's theory was used (Van Veuren 1993: 134).

The method sought to uncover the meaning of lived experience through the interpretation of the interviewee's descriptions regarded as text (discourses).

Ricoeur describes the process of interpreting as a series of steps: Naïve understanding, structural analysis and comprehensive understanding described in 2.6.4. to reveal the interviewees meaning (Van Veuren 1993:136-7). According to Ricoeur the experience can be transferred through interpretation of narratives.

In this study I sought to express in terms of the participants understanding of the experience by making sense of participant's narratives (text) was described as the importance of an event, an expression of care or as an experience of feeling[s].

### **3. Hermeneutical Phenomenology**

Hermeneutics suggest the idea of "bringing to understanding", particularly where the process involves language.

The primary source of this language and therefore of the knowledge required is the everyday discourses and practical activity of the individuals who become the research participants. Thus hermeneutic phenomenology is a method used to interpret the lived experiences and discourses of these participants.

### **4. Care and caring, nursing care and nursing procedure**

There is confusion in nursing about care and caring in particular as to the meaning of caring. Care-givers according to Montgomery (1991:91); Rieman (1986:35) have always lived with the paradox that they are to "care" deeply about their clients, they have person-centre intentions, in other words they seek "to presence themselves". Care or caring denotes a deep sense of personal involvement Many studies according to (Brown 1986:57) have reported that it is both the expressive and the specific actions that contribute to whether a nurse cares or is caring in the components of that caring experience.

To support and identify the nursing actions in this study, the researcher's findings were influenced by different components of care and by the caring actions the participants

received. In order to experience care, patients made a distinction between caring that is perceived as an individual, emotional and supportive response and care received, and caring as a series of nurturing responses involving activities or tasks. These were described as practical care, personal care, knowledge and insight, and skills in caring. The diagram in figure 4.2 “Components of care emerging as satisfiers or dissatisfiers” illustrates and expands the theme. To care is not just any form of caring it is what makes care a value.

Nursing literature according to (Benner 1994:28) has picked up the word “caring” to describe nursing as a science of caring. Caring according to (Benner 1994:29) denotes a relationship of concern, when the “others” existence matters to you. Benner’s (1984) work the “Primacy of caring”, rests on the assumption that good nursing practice (in other words the involvement of nursing procedures, or when an event takes place) is a form of caring. For the patient “caring” involves tasks, in the carrying out of tasks, a valuing towards them as patients, a positive attitude and a commitment to them as patients. The growing usage of the word caring involves a feeling of love. The verb loving is to care. The words care and love have been linked as described by Melosh (cited in Benner 1994:31).

### **Nursing care**

Virginia Henderson (1960) stated that “the unique function of the nurse is to assist the individual, sick or well, in the performance of those activities of daily living which he or she would normally perform unaided, to help him or her to recover health or, if that is impossible, to help him or her towards a peaceful death”. The nurses responsibility (or job) ranges from maintaining the patients quality of self care to meeting the needs of the totally dependent patient Searle (1986:60).

### **Nursing Procedure**

A nursing procedure is an established and standard method of performing nursing activities and gives specific information for those performing the procedure. The procedures are usually found in a nursing procedure manual, which is standard for wards and departments within a hospital.

## **5. Certain terms relating to the Specific methodology.**

Benner's research expertise is in hermeneutic interpretation. The data analysis using Benner's (1994:59,112-118) approach to interpretive phenomenology is carried out in three interrelated processes: Thematic analysis, Exemplars and Paradigm cases. The three interrelated processes provide the basis for entering the practical worlds and understanding of socially rooted knowledge. The application of these three strategies is fully described under point's 2.7.1- 2.7.3.

## **6. The Coding Procedure using the Qualitative Solutions And Research Pty Ltd**

Microsoft, Mackintosh. June 1997 known as QSR NUD.IST 4. QSR NUD.IST 4 is a tool kit to assist and support the process of Qualitative Research.

### **The coding procedure using QSR Nud.ist 4**

The researcher in the initial and continual reading of the participants narratives used words that emerged during the interviews with the participants to form clusters of phrases which were coded as emerging components in order to find the themes. These phrases and key words are demonstrated in the diagram of "Components of caring emerging as satisfiers or dissatisfiers of care" [Figure 4.2]. They are also given in Appendix iii and iv, which comprises the nodes text for Mrs Rank, extracted from the actual transcript. The use of the Nud.ist 4 programme allows the researcher the flexibility to arrange the text under broad headings called "nodes" which form an "index system". In each "node", text is stored which is descriptive of and relevant to the key words, phrases, or descriptions used by the participants. Interpretive phenomenology makes practical knowledge visible in that themes can be immediately obvious. Often the researcher must search and work through ideas, and pulls all the words, phrases, characteristics and events into groups. These nodes were helpful in describing themes. Nodes were rearranged or merged into categories. When categories are created they may be related to and reflective of groups of words, phrases and events that were previously grouped under a node address [title]. For example under the node title or address, "Information to patients" is a group of phrases describing:

- Nothing hidden from patients.

- Nursing handovers are amazing.
- You can concentrate on yourself and healing. See Appendix ii for references from Mrs Rank's transcript.

The diagram [Figure 4.2] being discussed groups together the main components of "caring" that were emerging as satisfiers/dissatisfiers of care. The theme "caring" continuously emerged as different aspects and components of care, as experienced by the participants and interpreted by the researcher. For example, to mention a few:

- Individualised nursing care
- Personal care
- Emotional care, interpreted by acts of expressive care [the concept of touch in the expression of care and the concept of time in relation to the time spent in the interventions of care]
- Practical care
- Supportive care, safe and secure care [described as family care]
- Individual care, acts of individualised authentic care, felt special, dedicated care
- Negative care [described as day and night differences in care approaches, being afraid of nurses, had to fight for something].

The diagram "Components of caring emerging as satisfiers or dissatisfiers" [Figure 4.2] has been extracted from the nodes following the use of the Nud.ist 4 programme, to explain how the text and groups of phrases have come together. All the data and ideas, which relate to the phenomenon "patient satisfaction" were put together to grasp a growing understanding of ideas. These categories were then given a "title". For example, under "Emotional Care", the words and phrases reflect the narrative data described in the transcripts by the participants as: "You feel extra special", "Putting their arms around you". The feeling of touch emerged in this way. This is symbolic of feelings that a nurse is "present" [has a presence or is with] the patient in the experience of care, as described by (Brown 1986: 57) and explained in Appendix iii "Nodes for Mrs Rank". It became evident that interpretation of "personal care" was articulated by all respondents and has been inserted as it relates to emotional care, individual care, supportive care and practical care.

Patients' perceptions of care were a direct response to the care given, the effectiveness or in some cases the lack of care given. The adaptation to and the meaning of illness to the individual participant is interpreted in the perceptions, attitudes, emotions and morale of the nursing staff to care for a patient as described in the transcripts. If the nursing care has met their needs, and as a result patients have a better understanding of the health care needs, then the end result according to Chang (1997:30) is to produce an overall impression of nursing care quality and satisfaction with nursing care received.

## **7. Agency Nurse**

An agency nurse is any category of nurse registered as a practising nurse. This applies to persons registered under the nursing act of that country where he/she is practising granted for a period of registration.

An agency nurse is employed on a temporary basis by a commercial nursing agency that contracts the services of providing nurses on a 24-hour basis. The nurse is contracted to work for a given period of time, at a particular hospital, nursing home or community based care in the patient's home, to cover for deficiencies in the permanent staffing shortfalls. The agency nurse normally receives a higher rate of remuneration compared with permanently employed staff, as the conditions of employment are not included and makes adjustments for being temporary and available. The "no work, no pay" rule applies.

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## **Chapter One: Introduction**

### **1.1 Introduction**

The focus of this research is to understand and discover how patients experience nursing care and whether they [the patients] are satisfied or dissatisfied with the care they receive. To guide the reader through this study a bookmark is provided. This includes the title, problem statement, the research question, the hermeneutic arc, the components of care that emerge and the framework of patient satisfaction. The bookmark is meant as a quick reference resource.

### **1.2 Setting the scene for the research**

The manner in which the researcher interprets the phenomenon of nursing care should reflect how the patients felt [during their hospital experience], the information they were given and how they were cared for and responded to that care [or non-care] (Sandelowski 1986:34; Kitson 1990:1).

Sandelowski, in valuing the achievement of auditability, wants the researcher to describe how she/he became interested in the research and its subject matter. This description of the motivation behind the research leads to the research question, which in this instance is: **What makes [hospital] patients satisfied/dissatisfied with the nursing care they receive?** That is, the research seeks to understand the nature of care patients receive [the skills in practice]. It seeks to understand how patients perceive and experience the type of care that satisfies and dissatisfies patients, or what is considered to be good or bad nursing care.

### **1.3 Researcher's motivation**

I became interested in the study over a period of years influenced by:

- The six years of caring for and being with my father, and my own acute hospital admission.
- The effects of my own feelings and emotions and the scenario of being on the other side of the "fence".

- My passion over the years for wanting to make a difference to patients in nursing care and to achieve improved patient outcomes, by getting to know patient expectations of care.

For me as a nurse, the concept of true and deep caring was the very essence of what it is to nurse, and it arises out of one's natural caring instincts, beliefs and experiences. I am implying that caring in nursing means to care in every sense.

Nurse scholars such as Leininger have identified "care" as the core of nursing that distinguishes it from other professional endeavours (cited in Brown 1986:57). Dunlop (cited in Benner 1994:27-41) discusses the emergent sense of "caring". "Caring" according to Dunlop seems to involve a form of love. Paterson and Zderad (cited in Brown 1986:57) define care as an experience lived between human beings; it is the ability of the nurse to be with the patient or to be involved with the patient. There is no single meaning of care/caring but accumulated understandings from different perspectives combine to make the caring process (Haegert 1999:63).

When I commenced this research I realised for the first time that the death of my father was so final and every last minute was so precious, as it is to all families with whom we come into contact. We as a family relive our memories together of the wonderful times we shared and reliving these memories is in part one of my stories which I still share with patients. Indeed, my own experience of care in a private hospital following acute bowel surgery will always stay with me. Caring for, and preparing for the loss of a loved one, brought me to the point of really "listening" to what the patient and/or his family wanted, or what they were trying to say in their grieving state.

My own experience of hospitalisation has the vivid memories of saying goodbye to my dear and very shocked husband and then waking up in the most incredible pain imaginable. I was soaking wet with blood, every orifice had something tied or attached, but the faces of the nursing staff comforting me, and being there, holding my hand, sitting with me in the dead of night, washing me down following bouts of profuse sweating, will always remain with me. They cared so much and never left me, through what seemed hours of excruciating pain.

There was Sr. Rose, the professional nurse at night, who did everything for me, so like a sergeant major but so knowingly proper, always around and checking on everything as

well as her team. Then there was Helen (the Charge Sister) who washed and tended to my hair, even though I did not want it washed on day two, and did the shortening of my drains, and the many dressings: she was always popping in, always caring.

I felt safe, knowing that they were around, safe in the confines of the hospital, relieved at long last, following the three weeks of agonising pain and severe discomfort and nausea. The earlier lack of communication between me as a patient and the doctors who treated me led to a sense of not being believed and thoughts that I might be “going mad”. Finally after two weeks in hospital, I was discharged.

It was a similar sequence of events that had haunted my father who presented with similar symptoms all those years before. Finally he said to his medical consultant, “They shoot old horses, please shoot this one or send me to a mental institution”. He had a tumour the size of an orange in his rectum. He lived for six years following the initial operation but endured his pain and suffering so bravely. He was the bravest man we knew. He is one of the reasons, why I am so passionate about this research.

These two powerful encounters of my own experience of care in nursing, and the challenge in 1997 to return to London to study at the Kings Fund Management Institute, allowed me time to explore and achieve important personal development objectives and to discover the power of really listening to people at all levels and understanding their behaviour. This programme rekindled my interest in learning and how to learn both from my own experiences and those of others. This programme enabled me:

- To discover how I could develop and understand feelings and prejudices around everyday practical events, and about particular groups of people, both in the profession and the health care sector in general.
- To recognise the role of story telling in this discovery.
- To notice how others behaved in these health care settings and how they behaved towards me.
- To “reflect” and use that understanding in patient care.

My own beliefs and values about caring for patients have maintained my survival through these increasingly changing and challenging pressures of being a nurse manager. To provide care within budgetary constraints, with reduced nursing resources, and changing political and financial pressures of managed health care in South Africa. Managed health

care in South Africa has as one of its compelling goals that of improved health care. But for whom? Certainly the shorter length of patient stay has left the nursing profession a legacy of under-caring for their patients, and is well described in the report by Aiken, Clarke, Sloane, Sochalski, Goivannetti, Hunt *et al.* (2001:42-53).

#### 1.4 Problem statement

The focus of this research is:

- To understand how patients perceive and experience satisfaction with regard to nursing care.
- To understand the issues that relate to how patients perceive nursing care.
- To understand how nursing care directly or indirectly influences how patients interpret satisfaction and dissatisfaction of nursing care.

The experience that patients have in hospital may confirm/disconfirm their expectations because of nursing service or the non-nursing side of care [commonly known as the hotel services of the hospital] such as the catering and housekeeping services that are either good or bad. According to Williams (1994:509-516) quantitative studies of “patient satisfaction” have tended to yield high levels of satisfaction, while qualitative reports reveal greater levels of disquiet. As active participants [patients] in the involvement of their care, treatment and services can identify what is right and what is wrong with the nursing care provided, the role of the patient as a consumer of the health care service can give nursing and general management early warning signs in the detection of difficulties and concerns regarding their care. Patient satisfaction, says Williams, rests on a number of assumptions:

- Often misinterpretation of survey results.
- The nature and meanings of expressions of satisfaction may often be described in alien terms.
- Currently we do not know how patients evaluate “satisfaction”; the inferences made from satisfaction surveys may not accurately reflect the true beliefs of the client [patient, the user of the service].

This study demonstrates that patients may have a complex set of important and relevant beliefs, which cannot be explained or understood in simple expressions of satisfaction.

According to researchers Bond and Thomas (Bond, Thomas 1992:52-63; Thomas, Bond 1996:747-756), who reviewed studies of patient satisfaction with nursing care and those measuring the quality of care, it was clear that the majority of studies failed to state what was meant by the concept of patient satisfaction, or indeed what was being measured, from a patient's point of view.

Nursing care takes place amongst very complex factors, including diagnosis, medical treatment, food quality, previous experiences of care, previous knowledge and pain; therefore can we really paraphrase patient satisfaction and state that patient satisfaction is what the patient says it is, and will it in most cases produce a high rating (Walsh, Walsh 1999:307-308)?

The challenge is to define the concept of "patient satisfaction" and to understand to what extent patients seek [expect] the same, or different things in their nursing care.

### **1.5 Literature review**

The literature suggests that if the concepts of patient satisfaction are known and identified, this will reduce the gap between patients' expectations and their actual experiences of the care received (Cleary, Edgman-Levitan, McMullen, Delbanco 1992:53-59; Linder-Pelz 1982:175-183; Bond, Thomas 1992:52-63).

This literature review will discuss the extant literature [dating back to the 1950s] from three perspectives:

- The role of the consumer
- Patient satisfaction
- Quality nursing care.

The reason for this is that commonly patients' views of their care are described as "satisfaction" or "dissatisfaction". These are the most widely used outcome measures when evaluating care. "Patient satisfaction" is generally considered to be integral to the assessment of the quality of nursing care (Chang 1997:26-37). The two terms quality and satisfaction are interdependent. The presence of one regularly predicts the occurrence of the other dimension (Steibers, Krowinski 1990:20; Vuori 1991:183-189).

The importance of coming to terms with a valid and reliable understanding of the patient's perspective on satisfaction and quality will be discussed in this dissertation. How the

patients perceive the nursing care they received is explored using the key concepts as outlined above. There has been considerable interest in recent years in the delivery of improved patient care. Who better to monitor care than the patients themselves? Over the past decade considerable research has documented the importance of the role patient satisfaction can play in influencing the quality of care rendered (Aharony, Strasser 1992:50-51). Providers of health care, namely the managed health care organisations in South Africa and the National Health System [NHS] in the United Kingdom, need to respond to the new policy environments as well as to socio-political and cultural changes. Extremely competitive environmental changes that emphasise the importance of informed patients has become the key to gaining and maintaining market share. This requires meeting efficiency standards and developing new responsibilities in clinical performance. Also to be encouraged are new and improved working relationships with patients and involvement with them in their care (Department of Health 1999:2-3,44-51; Booyens, Roos 1994:22). As will be discussed later, no studies were found in a search using Cumulative Index to Nursing and Allied Health (CINAHL) and Biomedical Journal [Medline] relating to patient satisfaction and quality nursing care that reflect private hospital experiences in South Africa. Against this historical background the researcher decided to investigate patient understanding of nursing care. In order to influence change, patients' evaluations of their care need to be returned to the originators of care [in this case nurses]. Perhaps the future lies in the reflection, education and the motivation of nursing staff in linking patient experiences and views of the service [both nursing and non-nursing] in a quality improvement programme resulting in better outcomes for patients and caregivers [nurses]. In South Africa the external forces of the managed health care organisations and spiralling medical costs have resulted in immense financial pressure being applied to hospitals and individuals [members of medical schemes]. As a result the value for money equation is becoming an essential component of relationships between the health care providers [hospitals] and the consumers [patients] in this increasingly competitive environment. Patients are becoming more and more critical of the services and looking for different and improved types of care [both nursing, medical and hotel services] because the services are becoming more costly and limited in private health care in this country.

### **1.5.1 The role of the consumer**

The concept of patient involvement in the evaluation of care is not new. Patient satisfaction with health care has received great attention from administrators, consumers and evaluators of health care (Linder-Pelz 1982:577-582). Patient satisfaction is believed to be one goal of health care delivery and is seen as a necessary outcome to care. The measurement of objective patient outcomes is to:

- Ascertain whether “nursing” makes a difference.
- Decide whether it defines the input, the effect and usefulness that nursing makes in the value of this contribution (Bond, Thomas 1991:1492-1502).

The ever-increasing costs of health services and the better use of available resources is a concern for developed and developing nations (Scardina 1994:38-46). Consequently it has become evident that to measure the efficiency of health care is to determine if the proper use of resources is being made. Consumerism has led to increased competition amongst the health care providers to meet the demands of the consumer [and high patient demand for health care excellence] for greater responsibility by all those involved in the services. The consumer's attitude within the private [managed health care] sector has changed. Patients are better informed. They have moved from a passive to an active role. They are better educated and are more critical towards the services (Peters 1993 cited by Merkouris, Infantopoulos, Lanara, Lemonidou 1999:19-27). Moreover patients are seeking an improvement of the services and researchers must acknowledge that patient satisfaction is not simply a measure of quality, but the goal of health care delivery (Linder-Pelz 1982:577-582). The difficulty involved in interpreting patient satisfaction surveys lies in the absence of reliable theories of patient satisfaction. Much of the research is based on the assumption that satisfaction, or a positive attitude to care, results from the patient's perception that the service has fulfilled his or her expectations (Vuori 1991:183-189). The studies done by Calnan (1988:927-933) and Fitzpatrick, Hopkins, Harvard-Watts (1983:501-510) described dimensions of hotel-related aspects of the health services, which were frequently mentioned. Here patients were more likely to comment negatively, as they felt more comfortable using their everyday knowledge to criticise the quality of the food, the cleanliness of the bathroom or how quickly the call bell was answered. Fitzpatrick, Hopkins (1983:297-311) revealed that qualitative studies might bring in more information,

experience and knowledge. Such studies lead to more informed and critical evaluation of the service.

Those who doubt the value of including patient satisfaction measures as indicators of quality point to a number of factors that limit the validity of the approach (Vuori 1991:183-189). This study showed that:

- Patients lack expert knowledge to accurately assess technical competence.
- Their physical and emotional status can easily impede accurate judgement.
- Patients are influenced by “medical factors” such as the doctor-patient relationship and interpersonal skills.
- A good bedside manner can mask technical quality [incompetency].
- Patients are reluctant to disclose what they really think because they fear retribution.
- Patients often cannot accurately recall aspects of the delivery process.

Despite this Cleary, McNeil (1988:25-36) stated that patients can play an important role in defining quality of care by determining what values should be associated with different outcomes. It is important to listen to what patients are telling us and what has been noticed by patients to improve interpersonal competence and to facilitate caring, e.g. allowing staff to spend more time with patients. Satisfied patients tend to be more compliant with their treatment and this can affect outcomes, such as patient health status and continuity of care and even the length of hospitalisation (Aharony, Strasser 1992:49-79). These studies suggested that there are serious reservations in the literature about the meaning of satisfaction for patients when evaluating their care. The concept of satisfaction is such an elusive and subjective quality, meaning different things to different people. It is difficult for a patient to respond to “How satisfied are you with your care?” There is clearly a need to separate out nursing issues and to use a qualitative approach (Walsh, Walsh 1999:307-315).

### **1.5.2 Patient satisfaction**

The assessment of patient satisfaction is a complex issue. The definition of patient satisfaction is the difference between what the patients expected in terms of the health care episode, and the perception of what actually happened to them. The larger the gap between

what patients expect from their health care episode and what they perceived actually happened to them, the greater the degree of dissatisfaction (Parasuraman, Zeithaml, Berry 1985:41-50).

According to George, Read, Westlake, Williams, Fraser-Moodie, Pritty (1992), and Hardy, West (1994 cited by Thomas, Bond 1996:752) the concept of patient involvement in the evaluation of care is not new. In some studies the meaning of the concept "patient satisfaction" is described in loose terms. It appears to be "what makes the patient happy" (Nelson, Larsen 1993:89-94). This concept of a closer relationship of patient expectations to their actual experiences may be linked to exceeding or disappointing patient expectations and service characteristics.

Early studies of patient satisfaction date back to the 1950s in the U.S.A. There has been an increase in interest, and surveys designed to test "consumer views" relating to patient satisfaction with hospital care date back to the 1960s in the United Kingdom. Several important developments in the British NHS, for example the Griffiths Report, Department of Health and Social Services 1984 (DHSS), stressed the importance of the need for the NHS to be accountable to the patient, or consumer, and the importance of consumer choice. The publication of the British government's White Paper "Working for Patients" (DHSS, 1989) and the introduction of The Patients' Charter (Department of Health 1991) addressed all aspects of quality of care and services. These two publications expressed the importance of putting the interests and wishes of patients first and understanding what patients think about health care and are powerful monitoring tools for finding out what the consumer thinks.

A review of the computerised literature search using Cumulative Index to Nursing and Allied Health (CINAHL) and Biomedical Journal (Medline) revealed 69 South African studies in which the keywords/phrases "patient satisfaction" and "nursing care" were used. Three studies related to satisfaction and quality nursing care in general ward settings, and were undertaken in provincial hospitals. No studies relating to patient satisfaction and quality nursing care were found to reflect private hospital experiences. Booyens, Roos (1994) and Bruwer (1986) found that patients usually evaluated their whole experience of hospitalisation rather than a particular aspect of their nursing care (Booyens 1987:169).

Booyens and Roos (1994: 20) found that patients usually evaluated their nursing care as being satisfactory when they were diagnosed correctly on admission, treated without delay, progressed without complications, their treatment proved effective and they were fit for discharge in a short period of time.

Relatively few studies have attempted to define "patient satisfaction" despite the extensive measurements. The studies have been difficult to compare because they have included different dimensions of care in their satisfaction instruments. Among the probable variables are the patient's attitudes and perceptions prior to experiencing care, with their evaluations. Little has been theory tested and a lack of attention has been given to the conceptualisation of patient satisfaction. There is no valid and reliable quantitative measurement of "satisfaction with nursing" (Linder-Pelz 1982:577-582; Williams 1994:509-516; Thomas, Bond 1996:747-756; Sitzia, Wood 1997:1829-1843). Linder-Pelz (1982:577-582) used the basis of theoretical studies related to jobs/work using social psychological variables that affect satisfaction ratings as they represent a school of psychologists who have been able to make distinctions between attitudes and perceptions.

The review of Sitzia, Wood (1997:1841) highlighted the complexity of the various models and the number of problems related to the use of patient satisfaction as an indicator of quality of care. The studies referred to previously demonstrate that researchers should be cautious when reviewing patient satisfaction to assess the quality of health care delivery. The interpretation of high responses must form "part of a wide-ranging review of service quality".

There are powerful reasons for finding out what patients think: identifying a patient's dissatisfaction can provide nursing/health care management with early warning signs of potential problems (Rogers, Karlsen, Addington-Hall 2000:768-774). From my own reading it has become apparent that a theoretical framework of patient satisfaction needs to be developed; one that clearly defines the facets of patient satisfaction, and that incorporates what the term means and the process by which patients determine whether they are satisfied or dissatisfied.

During the last decade the measuring of patient satisfaction has come to be regarded as the method of choice for obtaining patients' views about their care. Considerable research has documented the importance of the role that patient satisfaction can play. Patient

satisfaction in turn influences the quality of care rendered, that is from the patient's point of view if he/she is satisfied then the nursing care rendered was of a "good" quality. This point is based on two main principles according to Donabedian (1992:247-251): patients are an essential source of data about how the service functions, and patients have a right to have their views taken into account.

### **1.5.3 Quality nursing care**

Kitson states "Quality of care begins and ends with a patient's experience of the service" (1990:1). Kitson's starting point for the development of a "theoretical framework for quality" was to match patient expectations of nursing care with the care actually received. Donabedian (1992:248) stated, "obtaining information about consumer satisfaction or dissatisfaction, is a necessary component of any quality assurance enterprise, it is their expectations that should set the standard for what is accessible, convenient, comfortable or timely". There is a need to continually improve the quality of our nursing care as a service to the patients; therefore it is important to me as a nurse manager to be able to describe what a patient means when he/she says he/she is satisfied or dissatisfied. "After all it is they who tell us to what extent they have been listened to and express their personal preferences" (Donabedian 1992:247).

Patient expressions are regularly considered to be biased in that patients may wish to please staff, they may have restricted knowledge of the services and low expectations (Bond, Thomas 1992:56). This study asserts that patient satisfaction is thus a relative measure dependent upon expectation and concurs with Redfern, Norman (1990:1261) who state that ultimately high quality nursing care is influenced predominately by social values. The views and experiences of patients are vital indicators of patient satisfaction with nursing care. Parasuraman, Zeithaml, Berry (1985:41-50) state that when a service provider [in this case a hospital] knows how the service is going to be evaluated by the consumer [patient], then the service provider will know how to alter it. Walsh, Walsh (1999:307-315) state, "Quality is a very subjective phenomenon when seen through the eyes of patients' measurement". This is particularly true as there is a lack of patient information relating to socio-demographic status, acuity, and health status. This then raises the question as to whether patients can make objective judgements about the quality of

nursing care. As Donabedian (1992:247) states, "There is reason to believe that consumers are not that ignorant of the processes, when their situation is familiar and particularly if prior experiences of good and bad care have adequately prepared the patient." Good care [nursing practices] is defined not by what has been done but rather by what has been completed in terms of influencing patient outcomes; how the patient feels, whether able to return to his/her normal daily living and how the event of their illness has resulted in adapted strategies that now form a part of their coping mechanism and has given meaning to their lives both now and in the future (Shindul-Rothschild, Long-Middleton, Berry 1997:43 and Fife 1994:309).

There is a need to continually improve the quality of our nursing care as a service to the patients; therefore it is important to me as a nurse manager to be able to understand and identify what the patient means when he/she says he/she is satisfied or dissatisfied.

#### **1.6 Purpose of this research from the researcher's point of view**

The purpose of the research was to:

- Understand the aspects of nursing care most important to patients.
- To understand what makes them satisfied/dissatisfied with that care.
- To interpret satisfaction and dissatisfaction of nursing care in order to determine the quality of nursing.

The study centres upon the concept of "patient satisfaction" in order to continually improve the quality of the nursing service. By studying patients who are being nursed in this setting, which is either surgical or medical, it was envisaged that the data collection would preserve the spontaneity of the participants by using open and semi-structured questions in an interview.

#### **1.7 The rationale for the research**

There is currently no standardised patient satisfaction survey available for use in the South African setting of private hospitals. There is currently not a consistency in how patient satisfaction has been viewed.

### **1.8 Methodological, ontological and epistemological levels on which this research is based**

Learning the skills of Interpretive Phenomenology becomes much easier once the ontologic (what is the nature of the reality?) concerns are recovered and the researcher is able to sift the data and question “why” and “how” some things (experiences) constitute our knowing (ontology). The process of learning is to create, understand and interpret texts for meanings and to extend everyday experiences through narratives to interpretive research. Learning about the skills of interpretative hermeneutics comes from the researchers ability to shift from questions about *what* it is to know [epistemology] to questions about *why* we “know” some things and not others, and, *what* constitutes our knowing [ontology] (Benner 1994:102) [writers italics].

The search for the understanding of how patients (participants) perceive and experience satisfaction of care is based on the assumption that what happens between them influences the phenomenon. This is how I got interested in the study; my assumptions are that patients are the best ones to identify what is good or bad nursing care. The best way to do this is by interviewing patients and identifying the nuances. This means that when patients are dependent on nursing care, they experience multiple meanings dependent on the caring interactions of the nurses. The approach in this study was to seek understanding, formulate meanings and identify themes around the different patients to discover new explanations and understandings of the text.

### **1.9 Preview of the study**

Chapter Two details the qualitative methodology, using a phenomenological approach. In positioning interpretative phenomenology in qualitative research, Ricoeur’s hermeneutic arc has been applied. The first stage of interpretation moves from understanding to explanation and from explanation to comprehension which Ricoeur calls “interpretation proper” (Van Veuren 1993:136). This leads not just to the research question but in particular uses the theory of interpretative phenomenology. This research design and methodology will be discussed in detail in this section. Chapter Three sets the scene for the study setting, the research participants are introduced and the data is analysed with the aid

of a computerised qualitative data analysis tool [Nud.ist 4] is explained in the definition of terms. In Chapter Four the findings are presented and the meaning of the core finding “caring” and more specifically, the phenomenon “patient satisfaction” will be explained and defined.

Chapter Five discusses the meanings of patient satisfaction, as satisfiers and dissatisfiers of care. A graphic framework of patient satisfaction was developed and is discussed in Chapter Six. Chapter Seven presents the summary and recommendations.

### **1.10 Conclusion**

The purpose of this research is to gain an understanding of the phenomenon “patient satisfaction” because the significance of “patient satisfaction” underlines the caring and the knowing, as described by Levinas (1981 cited in Van Manen 1990:6). Nursing care is having the insight of connection and involvement with our patients, which meets the demands of “caring and knowing” especially when a person is at his/her most vulnerable or weakest. In the same way that a child calls innocently for help, so do our patients. Levinas (1981 in van Manen 1990:6) describes caring as a loving responsibility, in the same way that a parent cares for a child, as a moral claim in a way that leaves one no choice but to respond or care.

## **Chapter Two: Research Design**

*"He who seeks may use all means; that which has been found, however, must withstand critical tests"*                      *Wiener Kreis in Van Veuren (1993:140).*

### **2.1 Introduction and the theory behind interpretive hermeneutics**

The nature of the research question in this study led me to a qualitative approach.

Qualitative research is pluralistic, consisting of a variety of paradigms. The one I chose was phenomenology. This too is pluralistic and one finds authors of phenomenological research methods (such as Moustakas 1994) taking their own stance in order to draw out an artistic mode that emphasises the meaningfulness of the research text. In qualitative research the inquiry processes in the human and social sciences are based on words containing detailed perceptions and lived experiences of interviewees. This is indeed is what transpired when using the research transcripts. Moustakas (1994:9) refers to this as: "the art of reading a text so that the intention and meaning behind appearances [would] be fully understood".

My question was "How would one interpret such text?" This led to deciding that interpretative phenomenology would do justice to participant's discourses or text.

### **2.2 Introduction to research design**

The graphic overview given by Tesch (cited in Miles, Huberman 1994:7) (Figure 2.1), areas of which I have highlighted, shows how, in situating hermeneutic phenomenology, twenty types of qualitative research can be identified. Tesch (cited in Miles, Huberman 1994:7) categorised them into characteristics of meaning, language, discovery of regularities and the comprehension of meaning and reflection. His diagram reveals that his research interest was in interpretative phenomenology and he tracks how interpretation and reflection are part of the hermeneutic family tree (or line of enquiry).

The use of interpretive phenomenology as the method of choice was based on my pilot study.

Graphic Overview of Qualitative Research Types (Tesch,1990:7)

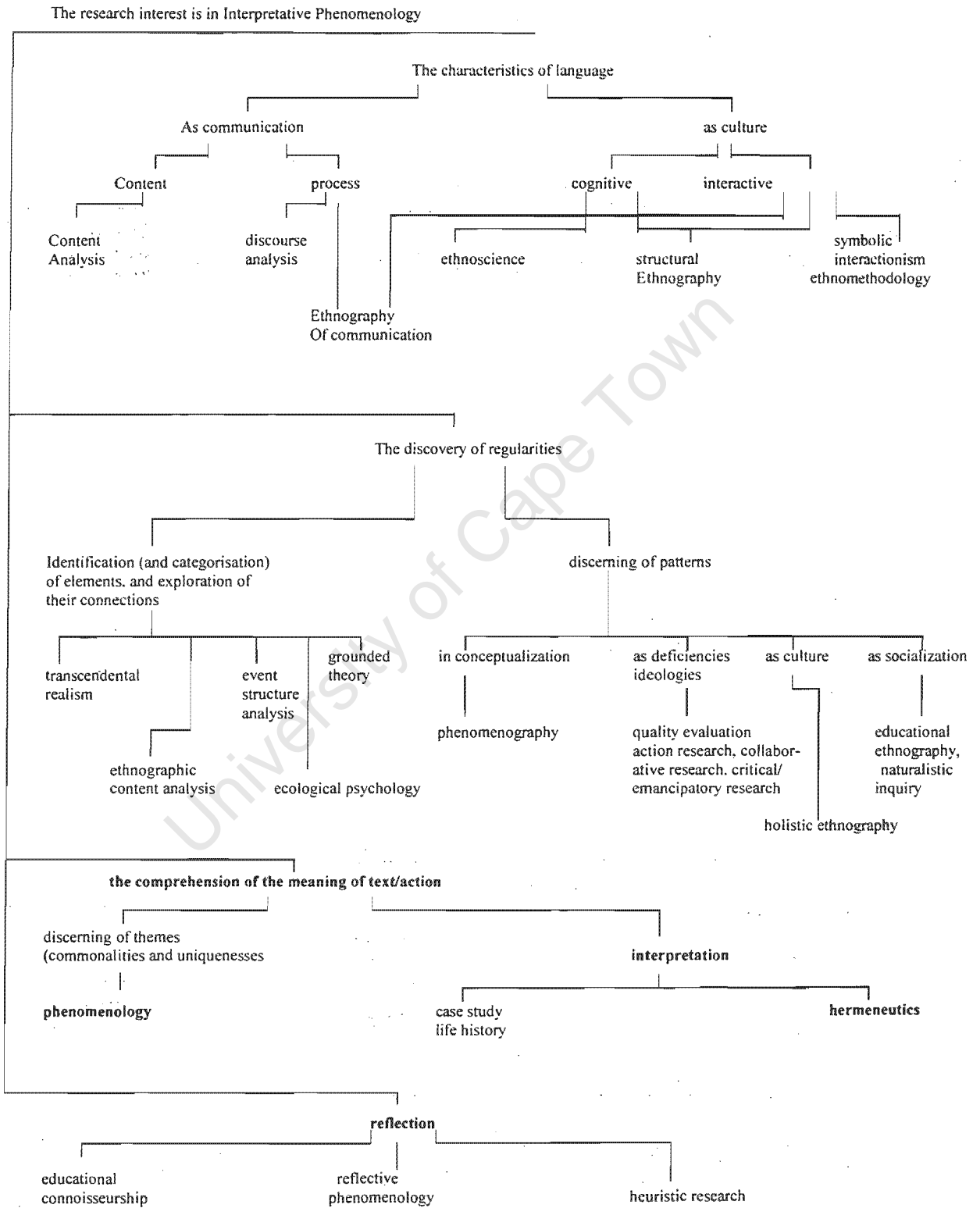


Figure 2.1

### 2.3 Pilot study

A pilot study using three participants subsequent to their discharge was carried out. All three were classified as “major surgical patients” who had been admitted to the Intensive Care Unit at a private care hospital. They were subsequently transferred to high care/wards. All three patients had previously experienced inpatient hospital care.

They met the criteria for the selection of participants. These criteria were:

- An “experienced” patient. This is defined by Staniszewska, Ahmed (1999:370), who described an experienced patient as someone that is hospitalised for more than three days.
- A patient who has had an inpatient episode previously (not necessarily at the two hospitals, A or B, in this study).
- A patient aged 18 years and over (18 years and over is viewed as an adult patient).
- A patient who has experienced a medical or surgical ward and either high care or intensive care facilities during the period of hospitalisation (Walsh, Walsh 1999:309).
- A person who is able to communicate in English and has the ability to verbalise feelings, thoughts and experiences.

The pilot study clarified the questions and criteria for admission to the study and was one of my motivations for continuing to use a qualitative method and in particular interpretive phenomenology. The pilot study assisted me in gaining experience in the interview technique of using open and semi-structured questioning and avoidance of closed questions. It enabled me to ensure that important information was collected and clarified, while ensuring that patients comfortably narrated their feelings and thoughts. The open-ended questions in the pilot study brought out more critical views of how patients perceived their care and enquired into patients’ experiences in broad terms, and asked them to clarify and reflect on what was said. This meant that rather than limiting patients to a series of questions it allowed a patient to make his or her judgement about how good their care was. The pilot study assisted in identifying the appropriate selection of the questions and the method of collecting, transcribing and analysing patient narrative information.

The questions that were piloted in these interviews were as follows:

1. Can you tell me about the aspects of nursing care you received during your stay in hospital?
2. Which aspects of your care were the most important to you?
3. Did you regard them as good or bad nursing care?
4. Did you experience any good or bad surprises in the way nursing care was delivered during your stay? [A question asked by Nelson, Larsen (1993:89-84)]
5. Did you have any previous expectations of the way care was delivered?
6. How did this reflect on your previous hospital stay?

As a result of the pilot study and my gaining experience of interviewing, I changed the questions to:

1. I would like you to tell me, can you tell me about how you have experienced care during your stay at this hospital [Hospital A or B], namely how you experienced nursing care, from the ward – to ICU – High Care – describing if you can, night and day care and the thoughts and experiences that have stayed in your mind.
2. What did you think of the nursing care you received – was it good or bad? Did you experience any surprises – were they good or bad?

This phenomenological method involves the collection and analysis of the narrative information given to the researcher by individual patients using a semi-structured and open interviewing technique. The primary aim was to analyze the narratives sufficiently in order to identify problems in my questioning techniques, which could have resulted in missing important information. Brown (1992:47) describes three “primary components” for the collection, analysis of data and writing up and presenting the findings.

Transcription and analysis of pilot study interviews:

- The accumulation of life experience material – that is, from interviews, observations, etc. It is the gathering of descriptions given by interviewees using everyday language to describe specific experiences [that relate to a patient being satisfied or not satisfied by their hospital experience].
- Examining these life world descriptions for their structural elements, that is, searching the descriptions for language clues that signal deeper conceptual

structures of meaning [interpretations or hermeneutics], which are associated and consistent with these experiences.

- Calls for the recommendations and practical applications that can be derived from a deeper understanding of the experience/s studied (Brown (1992:47).

Oiler (1982:178) describes four steps of the phenomenological method, bracketing and intuiting of which the last two concepts described below relates to analysis:

- **Analysing.** “As descriptions are compared and contrasted, recurring elements are noticed. This allows identification of the ingredients of the phenomenon and the way the ingredients relate to one another” (Oiler 1982:180). Themes and categories of care with similar meanings and patterns will be identified through semi-structured and open interviews and continual listening to tapes and reading transcripts.
- **Describing.** A description of what has been seen, observed, felt, as well as ideas contained in these themes, in which findings are taken back to the participant as validation, so that the researcher can add to the data what has been omitted. “A successful description directs the listener to his own experience of the phenomenon” (Oiler 1982:180).

Information obtained from one interview in the pilot study included the interviewee’s disease process, numerous hospital episodes throughout South Africa, financial and work-related problems, marital and family problems linked to the disease process, and accounts of doctor’s performance [both good and bad]. Although descriptive, much of the narrative discussed medical terminology, and going from outpatient doctor to doctor; and although there were many prior inpatient episodes little of the material could be used to compare and reflect on what nurses did and how nursing dimensions of care could positively or negatively enhance this patient’s satisfaction outcomes.

The transcripts were analysed and the themes of caring, nursing skills, communication, personal attention, and information relating to the diagnosis and progress of care evolved.

This pilot study made me realise that interpretive phenomenology was the method of choice for this study because the goals of interpretative approach are:

- To understand everyday skills and practices,
- To find meaning in skills, practices and embodied experiences

- To find exemplars and paradigm cases in understanding the significance of the person in the situation whilst preserving meaning and context.

According to Ricoeur (cited in Van Veuren 1993:136) felt that understanding discourses is not sufficient. Understanding requires explanation to complete the task of understanding. Explanation is not sufficient and requires interpretation to complete the task of understanding. Exemplar cases are used to describe the interpretive analysis of the text described in 4.4 and 4.5.

A hermeneutic interpretive research method was chosen for this purpose. I felt that this method would best examine patient's experiences and perceptions of their satisfaction with the nursing care they received. This method will be discussed in detail later.

#### **2.4 Hermeneutics as methodology**

Hermeneutics is derived from the Greek word for interpretation. The following philosophers [in date order] have shaped hermeneutics as a methodology for research:

Schleiermacher, Friedrich (1814-33)

Heidegger, Martin (1927/62)

Dilthey, Wilhelm (1893-69)

Gadamer, Hans-Georg (1900-82)

Ricoeur, Paul (1913-2005)

Rorty, Richard (1931-2007)

The focus of this philosophy is the question "How is understanding of [narrative] texts possible?" That is, how is making sense of textual or oral communication possible? Understanding is rendered explicit by interpretation. Interpretation is using language: "its main task is to explicate the ways people in particular settings come to understand, account for, take action and otherwise manage their day to day situations" through the use of words (Miles, Huberman 1994:7). Language, according to Heidegger is a mode of human being that discloses what it is to "be" through communication (Rather 1992:48). Hermeneutics is philosophical in that it asks the general question: "How is understanding of the text possible?" (Van Veuren 1993:113-115). The reflective nature of this question was an important departure from the traditional view of meaning [as merely contextual explanation and interpretation], and the understanding of the text [with a more socio-historical understanding]. The method by which interpretation [the traditional interpretation] proceeds enables the interpreter to reconstruct the author's [or interviewee's

in this research] meaning of “how is understanding of the text possible”? (Van Veuren 1993:115).

Heidegger held that our foundational mode of existing as persons is in interpretation and understanding hermeneutics. It consists also in making individuals' lived experiences meaningful [i.e. what is said (text or discourse) is interpreted and clarified]. Philosophers have had problems with epistemological words or concepts such as explanation, interpretation and understanding [of communication].

For Schleiermacher (1985 cited in Van Veuren 1993:115-119) a text was the result of a free, creative human being activity. Dilthey (1985 cited in Van Veuren 1993:123-124) saw text as an expression of life and hermeneutics as interpreting these expressions of the inner life of human beings.

Dilthey did not develop a hermeneutics [a particular way of interpreting] as such (Van Veuren, 1993:119). Much of Dilthey's work is unfinished, but he formulated an epistemological foundation for hermeneutics, which centres on the problems and concerns of developing a methodology, and differentiates between the human sciences and the natural sciences. By this is meant, perceptions of where the researcher stands between the human sciences in relation to the reality of the world (de Vos 1998:240). Human activity was seen as “text – as a collection of symbols expressing layers of meaning” (Miles, Huberman, 1994:8).

The philosophers Schleiermacher, Dilthey and Gadamer extended the scope of hermeneutics beyond the mere theoretical account of the interpretation of texts to the study of understanding itself (Van Veuren 1993:115-132). This led to a tension between, or opposition to, the concepts of explanation, interpretation and understanding. For Gadamer, one way to overcome the “opposition” between understanding and explanation and interpretation and explanation in the social sciences was by giving reasons for an action instead of pointing to causes. In this way the action was construed to mean this or that: giving a plurality of meanings. Nevertheless, the paradigm case of interpretation is the interpretation of speech or texts as the lived experience of the subject (Van Veuren 1993:115). Paradigm cases are instances of particular patterns of meanings.

The goal of hermeneutics and its application for Benner and other nurses is to understand everyday skills, practices, and experiences; and to find exemplars or paradigm cases that

embody the meanings of everyday practices (Benner 1985:5). Therefore hermeneutics should make misunderstandings clear, draw understanding close to individuals, make the familiar new, and reduce the tension between what is often taken as strange and that which is taken for granted (Van Veuren 1993:150).

Interpretation is the basic structure of experience. Therefore central to hermeneutics is a focus on individual consciousness and experience. As Rather (1992:48) states, “The hermeneutic researcher seeks commonalities in meanings, practices, and bodily experiences in the depiction of the [individual’s] lived experience”. In this she concurs with Ricoeur’s concept of hermeneutic analysis having a “potentiality for multiple interpretations” (Van Veuren 1993:137,141).

Van Veuren (1993:120) shows that Dilthey’s contribution to the discussion on hermeneutics is chiefly the interrelationship of science, art and history. This is at the heart of hermeneutic design and methodology. Van Veuren moves his reader to the work of Ricoeur (van Veuren 1993:133-137). Ricoeur sought to establish a relationship between understanding and explanation on two levels: that of guess and validation, and that of structural explanation and interpretation, which he sought to complement. What he meant was that human action leaves “traces” on social life when it contributes to the emergence of social patterns or structures. In this process the meaning of an action [for example, a caring practice] is detached from the event of the action and becomes something “objective”. Thus social patterns and structures can be seen as “documents of human action which can be interpreted”. Thus by breaking down the text into meaningful analogous concepts, reading and repeatedly rereading the transcripts form the first level of analysis and overcomes the opposition between understanding and explanation (Van Veuren 1993:138).

Returning time and again to the data checks the meanings and correct understandings. The interrelationship of science, art and history that accounts for the experience [of each interviewee] is found (Van Veuren 1993:137).

Human activity in hermeneutics is seen as “text”. That is, the human being’s activity is a collection of symbols that express layers of meaning communicated through the continual reading of the “text” And by this word “text” is meant the human experiences or narratives of the research participants [in this instance]. This text captures the “essence” of what is

constant and therefore meaningful in the participant's life. The experience of care [or non-care] described by the participants has been remembered, reflected upon, explained and interpreted. The 'text' becomes the data that the researcher can use. A methodology of text interpretation, according to Ricoeur (Van Veuren 1993:134-137) can serve as a paradigm case for interpretation in the field of the human sciences [e.g. nursing].

Ricoeur's hermeneutic theory moves from a basic theory of texts to a methodological clarification of the operations of understanding to explanation in the human sciences – thus Ricoeur reinstates themes like: scientific-objectivity and explanation as proper concerns of hermeneutic theory. Ricoeur's theory establishes the "objectivity" of texts and the nature of texts. This is, according to Ricoeur's phenomenological description of the nature of texts, that written discourse that is distinguished from spoken discourse, in the change from spoken to written discourse. The meaning of the discourse becomes independent, this is the "rupture" or "distancing" between a text and its interpreter that has no connection to "method", but is associated with the text itself as a written document. By this he means that the "sense" of a text, what is [being] said and its reference consists in the extra linguistic reality "about which" a text says what it says.

Therefore to understand a text according to Ricoeur is to follow the movement of its meaning from sense to reference (Van Veuren 1993:134-135) and this is used to assist in the engagement with the phenomena under investigation, to show up meanings that arise out of the lived experience of the persons involved and to create new possibilities for understanding (Leonard cited in Benner 1994:58).

## **2.5 Ricoeur presents interpretation as a movement along a hermeneutic 'arc'**

In the next step Ricoeur presents interpretation as a movement along a hermeneutic 'arc'. This arc has been diagrammed in the bookmark and will now be discussed (see Figure 2.2).

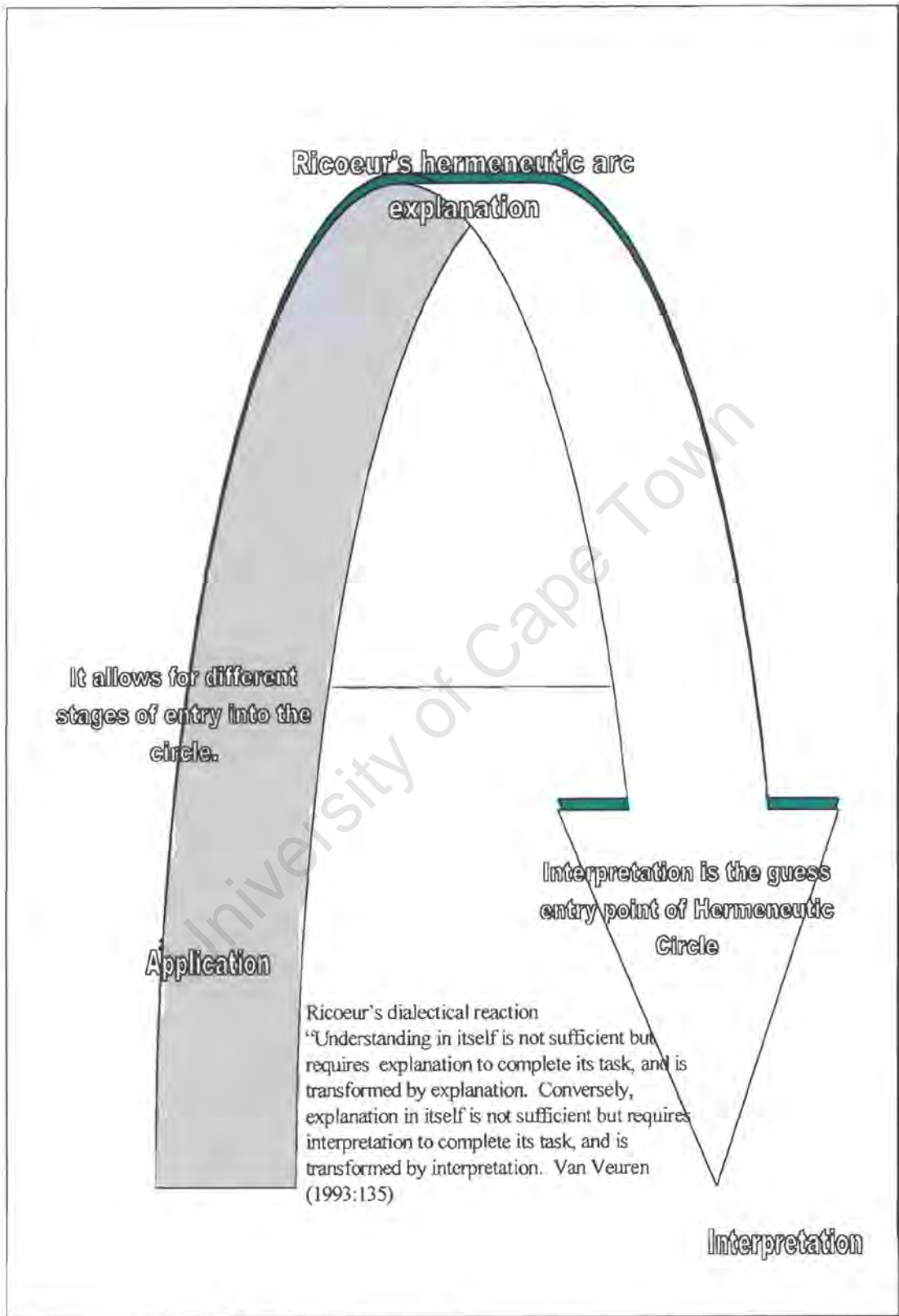


Figure 2.2. Ricoeur's arc.

The four “movements along the arc” described in 4.5.2 have been linked into the diagram [figure 2.2] Ricoeur’s arc. The “arc” leads to a circle, which Moustakas (1994:10) describes. Point 1 (Application) making a guess as to the meaning; Point 2 (Application) remains the same [different stages of entry, or multiple different guesses]; Point 3 (Explanation) a trajectory off the arc is those explanations [or multiple meanings] arising from the guesses or application; and Point 4 (Interpretation) is the interpretation which leads to the circle described on fig 2.2.

Ricoeur’s arc requires analysis or application in order to derive correct understanding of the text. It is fair to say that in hermeneutics the words understanding, explanation and interpretation are all affected and need explication. According to Van Veuren, Ricoeur showed, through the hermeneutic arc, a dialectical relationship to the concepts. He felt that understanding, as a task in itself was insufficient. Understanding required explanation for completion and was transformed by the explanation given. Conversely, he also felt that explanation was also insufficient and that it required interpretation to complete its task. In this case explanation was transformed by interpretation. A trajectory off this arc is application. Further Van Veuren points out that an entry into [what is called] the circle of hermeneutics is “the guess”. This is a guess as to the meaning of text. Previously Van Veuren had written that when there is spoken discourse, the following happen: firstly that a “rupture” occurs between the meaning of the text and the intention of the author; secondly when the spoken discourse is changed to a written document, meaning frees itself from the cultural context in which the author’s words originated; lastly the meaning of text becomes independent, addressed to anyone who can read (Van Veuren 1993:134-135).

In the next section I demonstrate how these concepts [the arc and circle] are used in this study.

In my reading of hermeneutics in Moustakas (1994:10) and Van Veuren (1993:134-135) I have sought to clarify a possible dilemma. Moustakas discusses and explains a “hermeneutic circle” as a process that he itemises. Van Veuren also discusses a hermeneutic circle but does not explain it. Van Veuren does however elaborate on a hermeneutic “arc”.

This idea of a hermeneutic circle, according to Van Veuren, was mooted by Schleiermacher and refined by Gadamer. Gadamer did this in order to explain the

conditions under which understanding took place. Understanding was seen as a part of the coming into being of meaning. The hermeneutic circle is the relation between the part and the whole. It is a moving back and forth between word and sentence, sentence and passage, text and its cultural context (Van Veuren 1993:131).

The hermeneutic circle is “seen” by Moustakas (1994:10) as consisting of

- The text [interview protocols] that provides descriptions of conscious experience
- Hermeneutic [scientific] understanding [or meaning] occurs
- Prejudices [biases] are corrected or set aside [bracketed]. One “listens” only to what the text says
- Prejudgements are corrected in view of the text
- Understanding leads to new judgments
- New pre-understandings are constantly being formed.

This circle requires analysis or application in order to derive correct understanding of the text. In this section the use of the hermeneutic ‘circle’ in the research will be indicated.

The method, the research strategy, how the data was acquired and how the data was analysed will be discussed.

As previously mentioned the term interpretative phenomenology is in apposition to hermeneutic phenomenology. The two terms interpretive phenomenology and hermeneutics have been used interchangeably, but I want to distinguish between the two. Hermeneutics is associated with biblical interpretation. As it acquired contextual meaning to everyday narratives, interpretation using the biblical hermeneutic principles was adapted by Van Veuren who used the ideas of philosophers Schleiermacher, Heidegger, Dilthey, Gadamer, Ricoeur and Rorty. These philosophers contributed to the conception of the theory and enlarged on the history. My preference is towards Benner’s methodology whose research is based on interpretative phenomenology. Benner’s approach will be discussed later (Benner 1994:99-127).

## **2.6 Hermeneutics as a method**

I will discuss the method in logical order. Firstly theoretical preamble, secondly the data collection and thirdly I apply Dilthey’s, Ricoeur’s and Benner’s analysis (Van Veuren 1993: 133).

### **2.6.1 The theory behind the actual method**

Hermeneutics continues to be shaped as a method by phenomenological researchers: e.g. Van Veuren (1993), Moustakas (1994), and nurse philosophers/researchers: Allen, Benner, Dickelmann (1986), Rather (1992), Leonard (1994) and Chesla (1994).

Moustakas, in his description of phenomenological research methods identifies hermeneutics as providing an important description of conscious experience. These “protocols” as he calls the interviews “call for interpretation analogous to the interpretation of a text” (Moustakas 1994:10). The following is a composite of the methods of Moustakas, Rather and Leonard for data collection and the initial stage of analysis.

In order to describe the hermeneutic method I have attempted to amalgamate the ideas of the above-mentioned. The following is the result and has been broken into stages that parallel the research process. This process will now be described.

### **2.6.2 Data collection and the initial stage of analysis according to Moustakas, Rather and Leonard**

Given these alternative approaches or critical practices, which are used across different qualitative research types, there are common features when it comes to analysis. Miles and Huberman (1994:9) discuss these commonalities in a set of analytic moves, which they arrange in sequence:

- Affixing codes to a set of field notes drawn from observations or interviews.
- Noting reflections or other remarks in the margins.
- Sorting and sifting through these materials to identify similar phrases, relationships between variables, patterns, themes, distinct differences between subgroups, and common sequences.
- Isolating these patterns and processes, commonalities and differences, and taking them out to the field in the next wave of data collection – these are particular patterns of meaning.
- Gradually elaborating a small set of generalisations that cover the consistencies discerned in the database.
- Confronting those generalisations with a formalised body of knowledge in the form of constructs or theories.

By using whole paradigm cases (the application of this strategy is fully described under point 2.7.3) the interpreter engages in the practical world of the participants and comes close to their lived experiences, their understandings as they unfold. These will be augmented by exemplars and thematic analysis in this dissertation to identify a pattern of meaning.

According to Rather (1992:47-55) who uses a “Seven step method” described by Diekmann, Allen, and Tanner (1989), step seven incorporates all the contributions of all the interviewees in order to “refine understanding of the phenomenon” described in Chapter Four (Rather 1992:47-55). She states that the goal of hermeneutic analysis is to discover meanings and achieve understanding, not to extract theoretical terms or concepts at a higher level of abstraction, such as in grounded theory methodology.

Interpretation on the graphic overview of qualitative research types given by Tesch (cited in Miles, Huberman 1994:7) is located above hermeneutics, as illustrated in Figure 1.

What is important to interpretive social scientists is how people understand their worlds and how they create and share meanings about their lives. Social research is not about categorising and classifying, but figuring out what events mean, how people adapt, and how they view what has happened to them and around them. Interpretive social researchers emphasise the complexity of human life. Time and context are important and social life is seen as constantly changing (Rubin, Rubin 1995:34-36).

The interpretive approach argues that not everything that is important can be measured with precision and that trying to do so is a distracting and inappropriate task. Similarly searching for universally applicable social laws can distract from learning what people know and how they understand their lives. There is not one reality to be measured (values and views differ from place to place and group to group and person to person). Different people understand objects and events differently, and these perceptions are the reality – reality that is the focus in social science.

Interpretive researchers try to elicit interviewees’ views of their worlds, their work, and the events they have experienced or observed. To reconstruct and understand the interviewees’ experiences and interpretations, interpretive researchers seek thick and rich descriptions of the cultural and topical arenas they are studying and try to develop an empathetic understanding of the world of others. Clarifying questions and probes, paraphrases and

follow-up on previous topics from prior interviews are used to empower the participant to tell the story in his /her own words.

- The interpretive project is approached with some pre-understanding.
- The research question is viewed from a particular interpretive lens that orientates as a bigger picture toward the phenomenon “patient satisfaction” in a particular way that is critically relevant to the study.

Interview protocols are formulated from the primary research question. The formulation (verbal or written) questions provide the descriptions of conscious experience of the phenomenon. The transcribed interviews are then used as text for interpretive analysis. The data obtained is analysed for the language used, including silences or emotions felt, facial expressions and gestures displayed during the interview process.

- The data were analysed with the aid of a computerised qualitative data analysis programme [Nud.ist 4]. Further coding details have been put into the Definition of terms, described under point 6.
- Multiple common meanings are sorted into tentative themes. One obtains a plurality of descriptions that is analysed further. As Moustakas asserts citing Dilthey (1976), [One's] “horizon of experience widens: at first it only seems to tell us about our own inner states but in knowing oneself one also comes to know about the external world and other people” (Moustakas 1994:10).
- Hermeneutic understanding [or meaning] occurs as one reads and re-reads text [transcripts] and repeatedly hears the interviews as one transcribes them.
- A written summary of the implicit and explicit meanings in the transcripts is analysed. Dialogue centres on the summaries and constitutive patterns.
- Prejudices [biases] are set aside [bracketed] and areas of disagreement are corrected during the analysis. One “listens” purely to what the text says. The researcher writes a composite analysis of each text.
- Prejudgements are corrected in view of the text
- As understanding is sought, new prejudgments are developed as constitutive patterns expressing the relationship between the parts and the whole.

- New pre-understandings are constantly being formed as one discusses similarities and differences “uncovering what fundamentally underlies them or goes beyond them” (Moustakas 1994:10; Rather 1992:48; Leonard 1994:58).

Learning the skills of interpretive phenomenology comes much more easily once the ontological concerns are uncovered and the researcher questions why and how we know some things and not others, and what engineers our knowing. This is identified within the text and serves to articulate understandings by the process of reading and rereading the text Taylor (1991,1992 cited in Benner 1994:113 - 115).

### **2.6.3 Data analysis at the level of reflection and interpretation**

#### **2.6.3.1 Analysis using Dilthey's concern to relate understanding to meaning.**

Van Veuren refers to Dilthey (1958) whose analysis is expressed as objectifying the lived experiences of human life. These experiences bear the imprint of the inner life of man. They form the content that is organised into coherent totalities that give the value, meaning and purpose of these experiences and include all cultural manifestations. Thus to get at the real meaning of an experience Dilthey felt that life interpreted life. Therefore nothing could be present in the objectifications of life that was not also present in the mental life of the interpreter. This relates well to Ricoeur's stages of interpretation (see below). Dilthey posited that those objectifications that were common to all people provided the interpreter with fixed expressions that could be constantly revisited.

Moustakas (1994:11) discusses the process of analysing texts using Ricoeur's four criteria [to which has been added Van Veuren's (1993:134-141) interpretation of Ricoeur].

#### **2.6.4 Analysis using Ricoeur's stages of interpretation**

1. *A fixation on meaning.* The first stage moves from understanding to explanation. Ricoeur sees a “dialectical relation” between the two concepts. There are arguments amongst those dealing with the natural sciences as opposed to human sciences about words like understanding and explanation. In social science one explains. In human sciences there is a relation between lived experience and expression therefore the term understanding is the more appropriate in this context. Human action acquires autonomy by surpassing its

momentary, situational character and by becoming “fixed” in enduring social structures (Van Veuren 1993:137).

Human action leaves “traces” on social life when it contributes to the emergence of social patterns or structures. In this process the *meaning* of an action is detached from the *event* of the action and becomes something “objective”. Social patterns and structures become “documents” of human action that can be interpreted. The *importance* of a meaningful action can transcend the *relevance* it had in the context in which it occurred (Van Veuren 1993:134-141).

2. *Dissociation at some point from the mental intention of the subject* [the author of the text or discourse]. The hermeneutic science involves the art of reading a text so that the intention and meaning behind appearances are fully understood. A “guess” at the meaning of the text as a whole is initially necessitated because of the “rupture” between the mental intention of the author and the verbal meaning of the text.

Unlike Schleiermacher's and Dilthey's hermeneutics there is no recourse in Ricoeur's mind as to the “authorial meaning” of the text. This “guess” is the entry point in the hermeneutic circle [this circle presupposed a whole that was implied in the recognition of the details]. Reciprocally, the whole is construed by explicating the details (Van Veuren 1993:134-141).

3. *The necessity to interpret the protocols [text] as a whole*, a gestalt of interconnected meanings. Importance is ascribed to any one of a diversity of topics in the text. All text is not seen as equally important.

4. *Their universal range of address*, i.e. their potentiality for multiple interpretations. Complex texts have an inherent “plurivocity” (Van Veuren 1993:135). This signals the inadequacy of “naïve” interpretation. One adjudicates between the pluralities of which construes the meaning of a text. “Naïve” or first-stage interpretation thus calls for a kind of explanation, a confirmation according to intersubjective rules. This amounts to validation, one possible interpretation is more probable in the light of available knowledge than another: an interpretation can be confronted with other interpretations, arbitration between them is possible, and agreement can be sought, even if it is not reached immediately (Van Veuren 1993:135).

From this four-fold analysis one obtains “interpretation proper” [a reconstruction of the structure - a structural analysis]. This move is from explanation to comprehension, an enriched form of understanding. Titelman (1979) cited in Moustakas (1994:11) “The hermeneutical task is to find justifiable modes through which my experience and comprehension of the phenomenon being researched can serve as a bridge or access for elucidating and interpreting the meaning of the phenomenon”.

(Van Veuren 1993:136) takes those four stages further. In applying rigor to research he adds two further stages: validation and structural analysis. These will be discussed under the section titled issues of reliability in 2.9.

### **2.7 Benner’s approach to interpretive phenomenology (as she calls hermeneutics).**

Benner’s research expertise is in hermeneutic interpretation. In Benner’s (1994:112-118) approach to interpretive phenomenology she describes three narrative strategies to provide the basis for entering the practical worlds and understanding of socially rooted knowledge.

Here I want to show how the strategies are applied. These strategies include the use of:

- **Thematic analysis**
- **Exemplars**
- **Paradigm cases.**

In Nud.ist 4 the process describing the first level of analysis is to break down the text into words and phrases. This process of analysis of the nodes to categories is lengthy. These words and phrases form an index system, to which are attached references from the text. This process of analysis of the nodes to categories is lengthy. The nodes define how the researcher has organised and managed the ideas, which are given a title or node address. As ideas and meanings develop, one can start drawing together, linking and grouping the nodes. Conceptualising data involves breaking data down and comparing phrases, ideas and associated meanings, which become a category. A category contains related data, which further distils, develops and clarifies the meaning associated with that category, this the researcher brings through interpretation. These related categories are grouped together with similar meanings, and form an emerging theme or themes. A theme is a cluster of categories conveying similar meanings. Much movement of the data, as Benner (1994:127) describes in her interpretation of thematic analysis, occurs when her interpreter moves

back and forth between portions of the texts and analyses [from themes and situations] and questions the participants' words.

For the application of these strategies, I will now turn specifically to Benner to apply her three narrative strategies to interpretive phenomenology.

### **2.7.1 Benner's thematic analysis comprises:**

Thematic analysis may be done to support the process of a coding procedure [as described in the definition of terms number six]:

- To clarify distinctions and similarities.
- Meaningful patterns of concerns are considered, rather than words or phrases.
- The interpreter moves back and forth between portions of texts and analyses (from themes and situations) and questions the participants' words.
- The interpretive researcher engages in cycles of understanding, interpretation critique, imaginatively dwelling in the world of the participant and distancing and questioning the participant's world as other (Benner 1994:115-116).

The researcher identifies themes and patterns through listening to and reading transcripts over and over again.

Most qualitative approaches include some form of thematic analysis because researchers are searching for themes. Although the term is mainly associated with phenomenology, it involves searching the data for related categories with similar meanings. These are then grouped together and themes inferred and generated from data.

Each case is read frequently. Lines of inquiry are identified from the theory that grounds the study and the emerging themes. This analysis terminates in the identification of general categories. These form the foundation of the study's findings.

### **2.7.2 Exemplars**

Exemplars are both interpretation and presentation strategies. Exemplars convey aspects of a paradigm or a thematic analysis. They are like paradigms; they are shorter stories or vignettes. They capture meaning in objectively different contexts. One is used to illustrate the experiences of "touch" as described later in this dissertation in 4.5.3. This serves as an example of a component of caring, taken from the seven transcripts making up the research

study. The transcript identified patterns of meaning from the individual textual descriptions to make a composite whole. Such exemplars are used in order to recognise distinctions in practice differences, caring patterns and meanings of caring. From this exemplar another was developed to examine the questions asked by the researcher to create basis for similarities and differences in interpretation between the cases, so that the researcher's practical reasoning in the textual evidence put forward can be challenged.

Features of exemplars include:

- They convey aspects of a paradigm case or a thematic analysis.
- They demonstrate intents and concerns within contexts and situations in which the objective attributes of the situation may be quite different, i.e. change in the nurse's role as the patients' advocate.
- The goal is to develop a range of exemplars to recognise the distinctions the interpretive researcher is making in practice.
- Exemplars can become teaching and curriculum documents that give the clinician (such as nurse, physician and teacher) concrete examples of distinctions in practice (Benner 1994:118).

Once the interpretive researcher has identified a pattern of meaning, common situations or embodied experience, exemplars may be extracted from the text to demonstrate the similarity or contrast.

With the use of exemplars, a pattern of care is recognised without presenting a narrow, objectified account of this form or mode of engagement. This allows the researcher to train his/her own pattern of thoughts. The researcher is developing his/her practical reasoning and understanding in exemplars, using qualitative distinctions, e.g. working with the patient, understanding her illness, pain, anxiety, and social emotions was an aspect of the healing relationship.

### **2.7.2.1 Analysis of exemplars**

This is the analysis of incidents and the interviewee's response to the situation and episode. These are taken together and analysed. From this come exemplars: instances of a particularly meaningful transaction, intention or capacity (Benner 1985:10).

Paradigm cases and exemplars are strong instances of a particular pattern of meaning; they are effective strategies for depicting the person in the situation and for preserving meaning and context (Benner 1994:117).

The aim of interpretive phenomenology is dependent on the narrative. The narrative process, states Haegert (1999:1-5; 25) begins as a story, or as a question leading to such stories. These narratives are used to interpret the themes meaningfully and should reveal aspects about the person/s. These narratives form the discourse material of this dissertation and relate to the phenomena of patient satisfaction, to uncover naturally occurring concerns and meanings together with the facts and experiences. The focus is on finding multiple occurring common meanings. Thus the emphasis is on listening to the conversation: to ask for further clarification on the subject by asking, "Am I correct in understanding...", to enable further descriptions of the subject, by discussing transcripts and interviews for better explanation [understanding].

### **2.7.3 Paradigm cases**

The search for paradigm cases (Benner 1994:113-115) involves the following:

- The whole interview is read for understanding of issues, concerns, and events.
- Observe how the interviewee moves from one topic to another.
- Look at reasoning and associations given by the interviewee.
- Check for incongruities, puzzles and repeated concerns.
- Understand the language used.
- The text is meaningful in that it flows from multiple traditions, in a particular language, and from a socially organised set of practices and a variety of experiences.

This is the identification of strong instances of particular patterns of meaning. These embody the rich descriptive information necessary for understanding how an individual's actions and understandings emerge from the situational context: their concerns, practices and background meanings. They are recognised as "family resemblances" between a paradigm case and a particular clinical situation that one is trying to understand and explain (Chesla 1988 cited in Benner (1994:59).

## 2.8 Value clarification / bracketing

The process of challenging the researcher's value clarification is also the process of bracketing. The researcher's value clarification is of the images and ideas of what [in this study] good nursing care is, of what is acceptable to the person [the researcher], of what the meaningful world is and the meaningful distinctions that good nursing care encompasses (Benner, Wrubel 1989:1). It is a removal of researcher biases or prejudices. Koch (1994:977) refers to "prejudices" as conditions by which we encounter the world as we experience something. Therefore we take value positions with us into the research process. This in turn can make research meaningful. Subjectivity can remain. Bracketing does not emulate perspective, it brings it into view. The participant becomes the originator of data. The subjective meanings of the participants and the subjective meanings of the researcher are integrated with each other.

The hermeneutic experience includes the perspective of the interpreter and the "historical" conditions that are brought into the interviews (Gadamer 1976 cited in Koch 1994:977). An example illustrates this. My frame of reference of the participant Mrs Magg is a picture of loneliness; this is how I see her in the hospital setting (room) and in her home (described in Chapter Three). For Mrs Magg the picture of loneliness is one of being widowed, being without relatives or friends to care for her. Her personal self and past events in her life compared with the adapted diagram "The process of reconstructing a meaningful response to life threatening illness" (Fife 1994:311) is illustrated in Figure 4.1. This diagram illustrated that nurse caring-behaviours were regarded by Mrs Magg as the principle components of patient satisfaction. This depended on the warmth, the touch (hugs), the empathy, "*if they are kind to me*" shown by the nursing staff.

In my understanding of bracketing or subjectivity I have used the work of Rose, Beeby and Parker (1995:1125) who cited the example of Jayne, where the researcher went through an in-depth values clarification of what "caring" meant to her, as she had some very clear and strong views of what caring was. The researcher had to move herself out of the practice role and see caring from a different perspective [that of patients].

This role refers to being a Nurse Manager at hospitals A and B. As a nurse manager I am seldom in a clinical role working with patients. However I had to put aside what I knew

and what I would have expected [I would expect nurses to be kind and compassionate and to involve patients in their care]; how my perceptions of care differ from what I found. But as Marcel (1981 cited in Riemen 1986:35) states in writing about knowing and caring, the researcher becomes and reveals herself as “present”, that is to say she is “one” with the patient. What I did do was reflect as a nurse and as a close relative on the views and examples from my father's experiences. At this time I had not wanted to be known as a nurse or even to interfere in the regimens of his care.

As Jayne (cited in Rose *et al.* 1995:1125) went through a ritual of clearing her mind prior to interviews, so did I. I tried to relax for ten minutes in my office, often putting my hands over my face and head inward onto the desk, trying to clear my thoughts of the day and put myself in the seat of the patient, as much as I could. I am a very observant person, so I feel that many of the observations patients made, which were not picked up, changed or challenged by nursing staff, I could see through patient's eyes. Thus elimination of bracketing could not be avoided because of my own value system and care standards. This is in essence a part of my own value system of how I like things to be done, not just at work but in my own life.

I always negotiated for a time and a place suitable to the participants, never expecting them to fit in with me. I wanted them to be at ease with me. Strong (1979 cited in Reid 1991:549) commented that wards are public places and that the presence of the researcher may influence the content of what the participants say. I as the researcher and nurse manager took this into consideration. The participants often needed to speak to me prior to the interview. They wanted to be reassured that their information would be meaningful to me. For example Mrs Ray asked, [almost embarrassed], "*I hope you can make something of this*". She wanted to go over the questions again prior to taping the actual interview. I felt that the participants wanted to do and say the right things to be helpful and was surprised by how much the participants wanted to please; this is echoed in Bradney (1988 cited in Reid 1991:545). I was also aware that my so-called position of power [my position as a nurse manager in the two hospitals surveyed] could unduly influence the nature of the participants' responses. In anticipation of this I used a co-coder consistently, used the bracketing method and consulted with my two supervisors to minimise this risk.

A common criticism of qualitative research is that the researcher is the sole instrument and therefore bias can be high. From the participants' view of research Hammersley, Atkinson (1983 cited in Reid 1991:549) stated that there is an issue with patients wanting to tell you what you want to hear. We have no way of knowing what people "really think" and therefore we must rely on what they tell us.

The consent, prior to the interview, was read and explained. The initial meetings I had with each participant were relaxed enough for them to tell their stories and to feel that the information was confidential, especially as names and in-depth descriptions were relived. I felt patients were safe in the environment that I had created. Some descriptions brought tears to the eyes of both parties. Often long comfortable silences were experienced. The vulnerability that the participants may experience in giving information was handled in a sensitive manner, described by Webb (1989 cited in Reid 1991:546) as being a "sympathetic listener".

I became really close to my chosen participants in trying to observe them in their setting in a way that would provide understanding to their conditions and the experiences they were conveying in their stories.

As mentioned above, because of my position as a Nurse Manager and the possible power status over patients, it was felt that I would need to involve the assistance of a co-coder in order to establish trustworthiness. This I arranged when analysing data. It was noted in the interview with Mrs Rank, that the patient appreciated the time and took pains to describe her experiences. She sat facing me with an envelope bearing her notes. She explained she had jotted down notes to help her keep focused on the questions. This conveyed to me Mrs Rank's willingness to participate in the research. I went over the consent forms and took pains to explain the confidentiality and the fact that individual names would not be used; they would be linked by a coded reference.

I had to be very aware of my own preconceived ideas of what caring means, and not to adjust or manipulate the data with ideas and assumptions that are important to me.

I had my own preconceived idea of the patients' views of their care. This is based on patients' opinions, expectations, perceptions of their nursing care and from my own experience of assessing and evaluating actual care in different settings over the years. Patients come into hospital with their own agenda, based on previous experiences, new

fears and concerns for their future care coupled with the need to adapt to and cope with changes in their health status. When discussing the implications of the validity of this research, an issue arises with patients wanting to tell you what you want to hear. What patients were telling me about their care could be organised around the components of nursing care important to them, that were focused in the literature (Chang 1997:28-28). This is where intentionality comes in. I had to acknowledge what caring meant to me [as a nurse manager] and “bracket” it out. This is where the purposive subjective dialogue explains their feelings about the topic “patient satisfaction”. I have to bracket out my feelings of the topic and put aside what I knew as a nurse manager. Understanding of the participants perspective came from rephrasing questions and listening to them in such a manner that I give their subjective explanations, feelings, expressions and behaviours due justice and interpret their dialogues in such a manner.

### **2.8.1 Summary of value clarification / bracketing**

The idea of bracketing stated by Boyd (1989 cited in Rose *et al.* 1995:1126) is not to deny its relevance to experience but to make experience explicit, to maintain open listening and to hear without bias and prejudice what the participants describe as their experience of the phenomenon patient satisfaction.

Thus far the methodology and strategies used have been discussed. The question of verification or validation (to use Van Veuren’s words 1993:136) will be described, together with confronting the ethical issues.

## **2.9 Issues of reliability, validity, trustworthiness, dependability, confirmability, transferability and auditability**

Concepts of reliability and validity are expressed in different ways in qualitative methodology. Holloway (1997:160) argues that issues concerning validity and reliability are different in quantitative research and suggests that researchers do not use these terms in qualitative research. The following terms are used in qualitative research.

The term **credibility** corresponds to internal validity in quantitative research (Krefting (1991:214). The term **trustworthiness** is also used instead of validity Guba, Lincoln (1981:75-91), Lincoln, Guba (1985 cited in Holloway 1997:160). Ensuring trustworthiness

involves the achievement of the following: credibility, transferability, dependability and confirmability.

According to Ricoeur (Van Veuren 1993:136):

- He sees validation as the weighing and evaluation of evidence and not as verification. It is valued as an argumentative discipline, logic of uncertainty and of qualitative probability comparable to juridical procedures like those used in legal interpretations. But the process of validation changes from guesswork to scientific knowledge. Using validation and the logic of probability it can be shown that one possible interpretation is more probable in the light of available knowledge [evidence] than another: for example an interpretation can be confronted with other interpretations, settlement between them is possible, and agreement can be sought, even though it may not be reached immediately (Van Veuren 1993:134-141). I will use the example of participant Mrs Rank whom I would have expected, having knowledge of her diagnosis, and her prior admission, to discuss death or dying in her interview. Instead she spoke of her privacy and dignity, her personal space and that of her family, and how the specialised gastro-intestinal unit fulfilled many of her needs in the way she experienced care. This I interpreted as the coping mechanism, which the unit inspired in her.
- Structural analysis (Van Veuren 1993:138) in Ricoeur's usage treats a text as an encapsulated whole and thereby abstracts from it the meaning it may have for us. These structural relations themselves have a semantic function. In the movement of interpretation, structural analysis is the stage of "depth semantics" that discloses the reference of the text. The meaning [as reference] of the text is a disclosure and Van Veuren (1993:134-141) requires that the interpreter understands the meaningful patterns the text has to have as a "personal commitment" to make the "depth semantics of a text his own".

The findings showed the true interpretation/validation as experienced by those participants under study. Sandelowski (1986:30) stated that a qualitative study is credible when it presents such accurate descriptions or interpretations of human experience that people who have had that experience recognise it from the descriptions or interpretations as their own.

**Dependability** Guba's (1981 cited by Krefting 1991:216) concept of dependability implies trackable variability, that is variability that can be ascribed to identified sources. Variability is expected in qualitative research and consistency is defined in terms of dependability. It is consistent and the variability can be ascribed to identify sources [and is explainable] and the process follows accepted standards. Qualitative research looks at the range of experience rather than average experience, so that different or non-normative situations are important to be included in the findings [the criteria for selection of patients was important in that patients had been previously hospitalised, not necessarily at hospitals A or B, whose current stay had been more than three days and who had experienced a high care or intensive care ward during that period].

**Confirmability** is ensured when the reader is able to assess the adequacy of the research process and judge whether the findings come directly from the data (Holloway1997:161). If the study shows truth and transferability of data, then the data is accurate.

These strategies were important in my qualitative research to assess the value of my findings. They tested and increased the "rigour" of this piece of qualitative research.

**Transferability** is the commonality of experience in a similar setting, for example in a State hospital, or in other settings or to another context. To ensure transferability, studies would need to be done at other private hospitals *and* State hospitals in South Africa, to reflect and ensure a range of patient's views. This research was done in two private hospitals, which could be said to limit transferability. However I strongly believe that the in-depth research could be useful to another private hospital context although patients would be different and such is the nature of qualitative research that the narratives would be different.

**Auditability** is to facilitate answering the problem statement, in a way that justifies and is achieved by a description, explanation or justification of:

- How the researcher became interested in the study matter
- How the researcher views the subject matter
- The purpose of the study
- How certain information came to be included in the study for clarification and how subjects were approached
- The impact the subjects and researcher had on each other

- How the data was collected. (Sandelowski 1986:34-35).

This has been described in Chapter Three, which sets the scene for the main body of the dissertation, and Chapter Four contains the interpretations of the findings. It is to interpret the kind of care patients received and to understand how they perceived and experienced and sought to understand how patients experience what they perceived as good [or bad] nursing care, or, as satisfiers or dissatisfiers. Auditability is to check that there are no errors or omissions and that the subject matter is relevant to the research question and the problem statement. The context of the research should justify and achieve auditability.

Throughout I sought to *understand the language used in order to make the text meaningful*.

I, as the interpreter, sought to:

- Articulate aspects of the text
- Identify naturally occurring questions and dialogue within the text
- Communicate understanding, which is created by the process of reading the text.

The aim of this interpretative phenomenology was to focus on participant's language (narratives) to uncover, to understand, develop and discover naturally occurring agreements and meanings. This process allows the researchers to understand the text in their own terms and promotes the rigour of the research process (Taylor 1991,1992 cited in Benner 1994:114).

## **2.10 Ethical concerns**

### **2.10.1 Informed consent**

Ethics in research relates to moral standards in the way research is carried out, which involves human subjects. The researcher must apply ethical principles, ensure trust and protect the participants. Informed consent is often difficult to explain to the participant, as qualitative research is partly unpredictable because ideas emerge and are not fully formed at the beginning of the research. The participants' role in this study was not to gain direct benefit, and my role was merely to record their findings; however some of the issues and concerns of unsafe practice had to be dealt with sensitively, immediately and with confidentiality and reported to the unit manager (Reid 1991:545-546). The researcher's intentions of the need to observe body language, an explanation of the questions which were asked and the structure of the interview with a brief outline of the research was

explained, as well as the need to tape-record the interview. Disclosure of all personal information would be kept confidential.

### **2.10.2 Issues of sensitivity**

I was exploring feelings and experiences, and was acting with sensitivity and diplomacy, with respect to patients, particularly as I am recognisable as a representative of hospitals A and B (Cowles 1988:163-179). Participants may become fearful of intimidation should this information be taken back to the nursing staff concerned (Holloway 1997:56-58). I was aware that the manner in which I handled the interviews and the data collection activities might create vulnerability among the participants and the need for support. The timing of when an interview was done entirely with the co-operation of the participants so as not to be intrusive. I was very wary of the participation in research involving sensitive information, personal experiences [with their disease process] and an intrusion into the lives of the participants, which can stimulate emotional responses during [and after] the need to record their findings (Cowles 1988:167). The in-depth relationships with my participants and the taping of interviews could have created discontentment amongst the nursing staff. This is because patients often tell you what you want to hear (Reid 1991:545-546). Fortunately this was not an issue I had to overcome.

Potential issues of sensitivity were attended to by the building of trust at the initial meeting, participants' willingness to participate, the relative ease with which the interview technique was used to overcome nervousness, and returning the transcripts to them and entering into further discussion. The participants wanted to be of assistance to the process and to assist with the improvement of nursing care in the future (Cowles 1988:173-177).

### **2.10.3 Confidentiality**

All interviews were tape recorded for the purpose of the study; certain quotes and words were required to be used with the consent of the participant. Patients were identified by means of a code. Only the co-coder and I had access to the tape recordings. My notes were used and treated in the same manner as audio and written data.

Signed consent forms were obtained from each participant after the above information had been disclosed and discussed. The right to withdraw from the study at any time was

assured (consent form Appendix 1) without prejudicing treatment and care. Permission to return to the participant, in person or by telephone to clarify interpretations and to feed back was requested at the initial interview (Reid 1991:549).

Participation was voluntary and patients were informed of the purpose, aim and the objectives of the research. Respect for autonomy means that the participants in the research must make a free, independent and informed choice without coercion (Holloway 1997:57-58; Holloway, Wheeler 1997:39).

### **2.11 Strengths and limitations**

This study was conducted in two private hospitals with a small number of patients (seven). Although representative of the specialties of these two hospitals, it may not represent the socio-economic populace of Cape Town. There can be no evidence of transferability of the experience of patients to other hospitals. However I strongly believe that the research findings could be transferred to another private hospital, although patients would be different and such is the nature of qualitative research that the narratives would be different. Therefore the findings do provide insights and resemblances to the concepts discovered in my own research.

To ensure transferability, studies would need to be done at other private hospitals [and public hospitals] in South Africa, to reflect and ensure a range of patient's views.

In the next chapter I will be discussing the study participants, the interviews, how the data was collected and the interview technique.

### **2.12 In summary**

The aim of the research was to gain an understanding of the phenomenon "patient satisfaction" because the significance of "patient satisfaction" underlines the caring, and the knowing, as Levinas (1981 cited in van Manen 1990:6) described.

## **Chapter Three: The research approach**

### **3.1 Introduction**

This chapter describes the study setting and sets the scene for introducing the participants. Each participant is introduced in this chapter by her/his coded name. The interviews take place in the participant's ward. This was the setting in which the participants were interviewed. This chapter describes how data were actually collected, the interview technique used, the participants and the sample size. The initial stage of analysis will also be described.

### **3.2 The study setting**

The study is based in Cape Town at two private hospitals [Hospitals A and B], which together have a total capacity of 234 beds. The two hospitals have different surgical and medical disciplines, but operate under a combined Management Team. These two hospitals have been chosen as they are the researcher's domain of work. The approach taken by the researcher was one that would capture the holistic experience of the participants in both the ward and specialised areas.

### **3.3 Study subjects, determining the sample size and criteria for selection**

According to Morse (2000:3-5), estimating the number of participants required in a study in order to reach saturation point depends on a number of factors.

- The quality of data
- The scope of study
- The nature of the topic
- The amount of useful information obtained from each participant
- The number of interviews per participant
- The qualitative method and study design used.

Sample size is limited by the size of the text that will be generated (Benner 1994:107). The researcher uses an unstructured approach using a broad opening question and asking questions in conversational or natural language, "Can you tell me about...?" This allows people to talk out or deny their feelings in ordinary language, to give the interviewer, as much detail about as many events, situations, feelings and actions as they are able, which

in turn stimulates narratives. Subsequent questions are more focused as they are guided by the responses to the broad question (Polit and Hungler 1999:332).

A purposive convenient sampling method was employed to obtain participants. A study population of seven participants [excluding the three pilot study participants] were taken from two private hospitals in Cape Town.

The following criteria for selection were used [refined during the pilot study]:

- The patient had previously been hospitalised [not necessarily at Hospital A or B].
- The patient's current stay in the hospital has been for three days or more. [Staniszewska and Ahmed (1999:365) feel that an experienced patient is someone who has been hospitalised for more than three days.]
- Aged 18 years and over [18 years and over is viewed as an adult patient].
- Someone who has experienced a medical or surgical ward and either high care or intensive care facilities during that period (Walsh, Walsh 1999:309).
- A person who is able to communicate comfortably and willingly in English. Where a patient preferred to speak in his/her own language the researcher facilitated this and arranged for the appropriate translation [or the use of a translator] to be made if required. The co-coder is fluent in Afrikaans and Zulu.

All patients were asked to read and if they agreed, to sign the "informed consent form" [see Appendix 1] in order for the interview to take place according to the agreed times set with each participant. Participants' names have been changed and a coding system has been used to ensure confidentiality and anonymity.

Allowing persons who are already hospitalised to describe their experiences ensures that the data collection preserves the experiences they have had and reveals aspects of the situation within the setting of the hospital or the ward situation, as referred to by Staniszewska, Ahmed (1999:365,367) and Aharony, Strasser (1992:56).

### **3.4 The interviews**

The researcher interviewed medical and surgical patients using structured and semi-structured techniques [interpretive phenomenology being dependent on the use of narratives, or interviewees' stories, as data]. These narratives are used to interpret data and

should reveal meaningful aspects about the storytellers [(participants)] and their stories. Haegert (1999:1-5) declared that the process beginning as a story, or, as answers to questions leading to such stories, is an art.

Narratives consist of discourses from participants. These were transcribed from the tape recordings verbatim and formed the content for this study. An example of one full interview [Mrs Rank] is given in Appendix 2. The transcripts relate to the discovery and understanding of the phenomenon of "patient satisfaction". They uncover naturally occurring concerns and meanings together with the experiences of the participants. The focus is on listening to the discourses, to ask further questions [which suggest themselves from these narratives], and to enable further clarification on the subject by asking oneself, "Am I correct in understanding...?" This allows for further descriptions or story telling of the subject, and leads to better comprehension of the phenomenon being studied.

Hermeneutic understanding [or meaning] occurs as one reads and rereads the text [narratives] and /or repeatedly hears the interviews as one transcribes them. This repetition enabled the researcher to identify themes and patterns of meaning [Themes and categories with similar meanings and patterns were identified through semi-structured and open interviews. This was achieved by the listening and reading process of transcribing outlined above.]

The actual patient experiences raised were pertinent to the care experienced, as evaluated by them in terms of their expectations and perceptions of the care they had received. During the interview they were able to differentiate the positive aspects of care from the non-positive aspects, defined as dissatisfiers. The researcher questioned, when analysing, how some patients knew some things about patient satisfaction which was understood by the participants as the type of nursing care they received and not others; and, what engendered their knowing. Vuori (1991:183-189) stated that "patient satisfaction with care depends on two factors: expectations concerning the care they will get and perceptions about the care they receive".

Leading from patient experiences of their care and their care needs, therefore, the questions are: what makes patients satisfied or dissatisfied with the nursing care they receive? And is good nursing intuitive to the trained practitioner and does it develop understanding of the care and coping skills that lead to patient satisfaction? These questions of human being

[like becoming satisfied] and skills [like caring and coping] are fundamental to the methodology of hermeneutic phenomenology. The answers to these questions were identified within the text and are described in the “framework of patient satisfaction” diagram [Figure 6.1] explained in the findings in Chapter Six.

The three narrative strategies of Benner (1994:112-118) that provide the basis for entering practical worlds and understanding socially rooted knowledge have been previously described: thematic analysis, exemplars and paradigm cases in the research design. They will be exemplified by the use of narratives to understand meanings and the interpretation of the discourses in chapter four. Heidegger (1926-1962 cited in Benner, Tanner and Chesla 1996:45-47) asserted that care consisted of monitoring possibilities and inhabiting a shared world.

### **3.5 The interview technique**

One basic broad question was formulated and subsequent semi-structured questions were used. The aim was to:

- Determine from patients the aspects of nursing care most important to them
- Understand what it was like to receive this nursing care.

The researcher asked questions relating to:

- How patients experienced their nursing care
- What they liked most about this nursing care, and the converse, what they liked least about it
- How patients experienced and viewed their care in order for them to define satisfaction with nursing care from their perspective: their views, experiences and opinions.

Subsequent questions emerged during the interviews, in response to the original question. This approach served my research goal, to understand patient’s experience of nursing care and to identify whether or not they were satisfied or dissatisfied with that care.

The patients’ perspective allowed the health care provider [the hospital] to evaluate good and poor service:

- To know what patients mean when they say they are satisfied, and
- How they arrived at that view, how they evaluated the care received.

Nelson and Larson (1993:90) believe that patients' opinions of their care are influenced by their perceptions of the relationship between satisfaction and the quality of nursing care that they receive.

In the next section I am going to introduce each of the participants in their ward setting from the first meeting of introduction to subsequent meetings. Parts of the actual interview and in some cases the conversation and interaction that took place between the participants and the researcher when their transcripts were returned to them are reported. Participants are introduced by their coded names with their age and actual diagnosis disclosed.

### **3.6 A picture of participants in their ward settings**

#### **3.6.1 Mrs Windy**

Mrs Windy was admitted to the hospital to have a below-knee amputation for a painful, cold right leg.

Mrs Windy is a 42-year-old woman. She has a 9-year-old child and a difficult marital arrangement. Mrs Windy's main problem pre-operatively was pain control. She was visibly in pain and spent much time rubbing her leg to obtain relief. Numerous different medications were used to little effect. Finally she was referred to a pain control specialist and an epidural infusion was administered with good effect 24 hours prior to her operation and for 72 hours postoperatively.

At the initial meeting, after her operation, I requested permission to interview Mrs Windy. We talked about the informed consent and the interview technique, whereby I explained the ethical issues of the structured and semi-structured interviewing technique, the taping of the interview and the informed consent. She agreed to be interviewed the following morning, which was suitable to her.

We commenced the interview, Mrs Windy faced me but was fidgety and not at ease initially. She kept moving her stump up and down and stroking her affected knee. I enquired if her affected leg was painful. She replied, "No just a dull ache, more when I hang my leg down for long periods". I assisted Mrs Windy to gain a comfortable position using the chair for extra support.

I encouraged Mrs Windy using my body language and facial expressions at times, in order to help her describe certain events. No tears or emotion were seen throughout [which I

would have expected in the light of her relatively young age and the psychological effect of having an amputation with a 9-year-old child and husband].

I moved closer to engage more participation and to listen very closely to her as she continued to rub and massage her knee. The room was hot. There was no air conditioner although Mrs Windy did not appear to be bothered by this.

As the interview progressed she became more relaxed and spoke about the incidents and events of nursing care relating to her stay and how she experienced different attitudes of care from nurses, non-nursing and medical staff. She became more assertive and emphasised certain key words when describing the poor, or the lack of, treatment.

### **3.6.2 Mr Van**

Mr Van, a 22-year-old single gentleman, was admitted from London for a skin graft and free flap from abdominal rectus to left heel. He lives in London with a friend having spent two years in the army. He found it difficult to find permanent employment in South Africa so he relocated to London [his mother is English] and found a job as a courier. He loves London, which he describes as “the vibes and the buzz”, but finds the amount of people overwhelming. He still misses Africa. He described the wide-open spaces of his home near Somerset West affectionately.

Mr Van returned to South Africa because of the need to have micro vascular surgery to his foot, which apparently could not be performed overseas. His parents are paying for the procedure to be done at Hospital B. A previous foot injury when he was 16 years old has resulted in numerous hospital visits.

He was sitting in a vacant semi-private room, staring out of the window and listening to music with his foot elevated on the bed. He is a shy young man, but agreed to have an interview, saying, “There is not much I can tell you”.

### **3.6.3 Mrs Magg**

Mrs Magg is 77 years old, a widow with one son (estranged). She is an ex-nurse. She told me that her daughter had died on the same day (not the same year) as her husband’s death 16 years ago. Mrs Magg was interviewed in her semi-private ward on Saturday 5<sup>th</sup> May 2001 at 14h30. She was admitted with a painful abdomen, following surgery for a bowel

obstruction. She was lying down. She spoke softly, at times turning her head away from the researcher. From time to time she reflected on nursing: e.g. "Where did you train?" She discussed both the lack of training and routines of nursing. Her perception of professional nurses then and the nurses of today was often quite negative.

Mrs Magg appeared to me to be a picture of loneliness. Occasionally when communicating she stretched to look out of the window whereupon she described the lovely view. Perhaps this was her view of life. She pointed to an expression of kindness and caring that was special: namely her "mobile walker". Cindy, the physiotherapist, had made a flag on top that holds her intravenous drip stand and named it "M's mobile". She spoke fondly of Cindy and glanced often at the flag on the mobile walker. She seemed proud and excited that someone had taken the time to do this and was making a fuss of her. She beamed from ear to ear and gave a little laugh when I noticed the mobile walker.

At the initial interview to gain permission, I asked Mrs Magg which setting would be the most comfortable for her interview. She spoke about the Charge Sister who wanted to move her to a general ward. She had wanted to stay in her room alone, and hoped that the sister would not move her. She liked her own company, she said, and the lovely scenery out of the window. She had moved from Gauteng to Cape Town to look after her ailing sister who had subsequently died 18 months later.

She was about to move into a new flat, following her discharge, which she had not seen. "I did not even have time to pack my things," she said, "what a state to be in, but I am too tired to care where all my things are." She looked sad and helpless, but clearly there was nothing she could do but rely on her distant family for assistance.

Her medical aid was limited and did not cover for home care. She had to finance 24 hour nursing care through a nursing agency. She hoped that her brother-in-law would bring her meals and do shopping, if "meals on wheels" could not be organised.

Unfortunately the after care she required in a frail care was not part of the expenses covered by her medical aid. Mrs. Magg did not have the finances to go into a frail care facility, so she said, "I just have to manage on my own".

#### **3.6.4 Mr Mentor**

The staff of Ward Two approached me regarding the discharge of Mr Mentor, who had recently spent many episodes in hospital as a result of his diagnosis of cancer of the larynx. He is a 55-year-old primary school teacher from the Eastern Cape, who had recently undergone a period of chemotherapy in Port Elizabeth. Mr Mentor was obviously very well liked by the nursing staff, as judged by the number of the nurses who were around his bed and kept coming in and enquiring about his well-being. He greeted them all warmly as he did me and appeared very happy to be able to assist me. He turned in bed to face me. I moved closer to him as his voice, as a result of the surgery, had reduced the audibility and enunciation of his speech.

I arrived at Mr Mentor's bedside on the morning of 16 May 2001. He was pale and rather sleepy looking. He again greeted me warmly and invited me to sit down. I enquired if he was feeling up to the interview to which he replied immediately, "Yes, I want to help you and I am so happy here; it is like a family." I positioned myself with the tape recorder very close to Mr Mentor and proceeded to interview him.

On the 25 May I visited Mr Mentor to re-interview him, because of the poor recording and difficulty in understanding the transcript. I had pre-arranged our interview on the 24 May informing him of the problem and requesting his permission for a further interview. He again agreed, so I met with him in the ward at 15h30. We walked together to a vacant ward so that we would not be affected by the background noise as had happened previously.

Mr Mentor unfortunately had to stay longer in hospital because of an infection of his wound site hence this enabled me to re-interview him. He was to be discharged on the 26 May to a relative in Cape Town and thereafter to his home in the Eastern Cape.

#### **3.6.5 Mrs Rank**

Mrs Rank is a 32-year-old woman, married without children and previously medically diagnosed with a primary cancer of the cervix, which had been surgically removed one year before. She had apparently been misdiagnosed at this time and she now had a reoccurrence of cancer in her large bowel. She was admitted to Hospital A for a total colectomy and formation of a temporary ileostomy.

Mrs Rank is a human resource executive. She was feeling very tired, suffering from an excessive workload. She had taken a sabbatical for one year to, in her words, "Find myself and recharge my batteries." Mrs Rank explained that she had always paid attention to her body and done everything right. "I always made sure that I drank eight glasses of water, ate lots of roughage, and I try and get enough exercise and sleep".

Mrs Rank agreed to participate in the interview. She has a Masters in Business Science and verbalised that she was pleased to be able to assist me. The time was negotiated: that being mornings when she was less tired and following her colonic washout procedure.

She is a very precise woman, always very neat with her hair in a bun. I noticed her often walking the corridors of the hospital engaging in conversation with the staff. The time was ten minutes to eleven (as I got to know Mrs Rank, the telephone call reminder to my office prior to the interview taking place became a usual event). The ward staff also told me that Mrs Rank was waiting for me.

On my arrival to the ward, she was in the toilet and so I waited outside to be called. I was invited to sit on the bed, as the chair was more comfortable for her. The charge sister was with me in the room. Mrs Rank asked us about how we coped with our jobs and our coping mechanisms. She replied that she was impressed with the manner and humour in which we carried out our work. "There is so much humour here," she said.

I closed the door and explained the procedure of taping our interview and the discussion began. We sat face to face, she on the chair and I faced her from the bed. Mrs Rank had prepared her discussion [narrative] by way of written points on a large envelope. These she said, was what she "particularly wanted to get across." As we began, Mrs Rank read from the written paper sitting upright and staring into my eyes, occasionally looking up to the ceiling when engaged in a pensive thought process. During the interview, the colostomy was working; Mrs Rank put her hand on her side and laughed in acceptance. She smiled warmly in her peppermint green dressing gown, but I felt the smile was hiding much sadness.

She referred to the ward as being "her" family, to the skills of the nursing staff, to the safeness of the unit. She described this as a special place and wished she had known this one year ago, how wonderful it was that she was being treated at Hospital A.

### 3.6.6 Mr Stone

Mr Stone is a 20-year-old man who suffers from chronic cystic fibrosis.

He greeted me warmly. Mr Stone wanted to meet in the afternoon, as the mornings were very difficult for him, a 16h00 interview was arranged following visiting hours. He was waiting for me, having asked the charge sister to telephone me as his visitors had left early. As I arrived he sat paging through his hard-covered notebook on the cardiac table. Our previous conversation had been to gain his consent for an interview, but Mr Stone also used this to explain how disappointed and indeed how unhappy he was at the care he had received at Hospital B. This was Mr. Stone's third admission to this hospital in three weeks.

He required six-hourly intravenous antibiotics again. The reduction to antibiotics three times a day on discharge previously had been insufficient to reduce the chronic lung infections. He was readmitted with abnormally high carbon dioxide levels, poor perfusion and requiring pulmonary ventilation. He had sustained a pulmonary bleed at home as a result of the incorrect use of the "Bipacp" machine [The Bipacp gets rid of carbon dioxide and aids ventilation and perfusion to the lungs]. No humidification had been used [this was not Mr Stone's fault, as the instructions as to the use of the machine had not been properly explained].

Mr Stone was seemingly pleased to be back if only to have the use of the IVAC Pump [this monitors and infuses the intravenous drugs] again. Now he did not have to control the intravenous drugs to time [at home he did not have the benefit of the IVAC Pump].

Mr Stone's mother talked about the need to get Mr. Stone to a specialist center for a heart and lung transplant. She was desperate to keep her son alive.

Mr Stone was readmitted three weeks later, this allowed me the opportunity of speaking to him again. I was able to hand him the typed transcript and to listen to his feedback and to give his approval of what he had verbalised in the tape recording.

We arranged to meet the next afternoon at 16h30; Mr Stone had his hard-covered notebook, which he was paging through as he checked with the transcript. He compared the treatment with his previous admission to me, and explained how the nurses were much more aware of "how" drugs were to be given now, so much so that he was able to rest and let the nursing staff take over the drug regimens.

### **3.6.7 Mrs. Ray**

Mrs Ray is a widow whose husband had died one year earlier [at Hospital A]. Mrs Ray expressed how unhappy she was at some of the care her husband received; she was visibly tearful when she mentioned her husband.

When I approached Mrs Ray, a very independent 82-year-old, she openly told me that she had had many hospital visits but that she was very pleased with the care at Hospital B. She would always come to Hospital B. “The care was personal and friendly,” she said.

Mrs Ray said, “I’m not sure I can tell you very much my dear, I don’t have very much to say.”

I reassured her that just in the short while in hospital there would be some very valuable experiences that she could share with me. I arranged a time and date with Mrs Ray and left the informed consent form with her. On my next arrival Mrs Ray was in bed with the consent form on the bed, awaiting the interview.

She again reiterated, “I don’t know that I can tell you very much,” and immediately leapt into telling me all about the care, the staff and how “it is very important to have your leg positioned correctly by these big buxom friendly nurses”. She was intent on saying the correct things, and stated, “Now, what do you actually want here?”

I contacted Mrs Ray on the 20 June to ask if she would look over the transcript and make any comments. I would then contact her telephonically to discuss it with her.

I again contacted her on the 26 June for her comments. Mrs Ray’s reply was, “Its fine my dear, I am glad I can help you, perhaps it will assist you with some of those non-caring nurses who quick, quick just want to move you quickly in and out and not take care that you have had a joint or bone operation.” She confirmed her love of Hospital B and that she would not go anywhere else. We said our goodbyes, as there appeared to be no further comments to be made.

### **3.6.8. Combined information on participants**

These are the seven interviewees whose narratives will be discussed in the next chapter. The seven patients interviewed consisted of four females between the ages of 32 years and 82 years and three males between the ages of 20 years and 55 years. The female interviewees were all surgical patients although two patients were initially admitted as

acute medical admissions prior to surgery. All four patients had previously experienced medical care. The male interviewees consisted of one medical and two surgical patients. All three had previously been medical admissions, prior to this interview. The seven interviewees represented the following cultures: a Xhosa male, and two white males [one English-speaking and one Afrikaans-speaking], three white females and one coloured female. The pilot study consisted of an Indian male from Durban, one Coloured female from the Eastern Cape and a white male also from Durban.

### **3.7 In summary**

This concludes how the data was collected and how the data was analysed. The criteria for determining the sample and its size have been discussed. The personal introduction of the research participants has been made. This now leads to the discussions of the next chapter and is the main body of the research. It sets out to understand what patients sought from their nursing care and their understandings and meaning of their care.

**Biographical Information of Interviewees - A qualitative Table**

Group	Previously at Hospital A or B	Other Hospitals	patients stay more than 3 days	Aged 18 years and over	Experienced High care and Intensive Care	Able to communicate in English (Home language)	Age	Race / Gender	Medical or Surgical Care
Participant 1 - Windy		x	x	x	x	x	42	White / Female	Surgical
Participant 2 - Van		x	x	x	x	x (Afrikaans)	22	White / Male	Medical
Participant 3 - Magg		x	x	x	x	x	77	Coloured / Female	Surgical
Participant 4 - Mentor		x	x	x	x	x (Xhosa)	55	Black / Male	Medical
Participant 5 - Rank	x		x	x	x	x	32	White / Female	Surgical
Participant 6 - Stone	x		x	x	x	x	20	White / Male	Medical
Participant 7 - Ray	x		x	x	x	x	82	White / Female	Surgical

Figure 3.1

## **Chapter Four: The Findings**

### **Section One: Satisfiers of caring**

#### **4.1 Introduction and chapter overview**

This study sets out to understand from participants' perspectives:

- To understand the aspects of nursing care most important to patients.
- To understand what makes them satisfied/dissatisfied with that care.
- To interpret satisfaction and dissatisfaction of nursing care in order to determine the quality of

The researcher's core finding was how participants experienced "caring" as recognised by patients as a satisfier or as a dissatisfier of care (what happened to them or around them). The participants discussed how caring as understood by them and how their perceptions of being cared for satisfied or dissatisfied them. This involved acts of care and an in-depth concern for them as patients by their caregivers. "Caregivers" refers to nurses of whatever category. The definition of the terms "care" and "caring" are synonymous. I am aware that "to care" is a verb and caring is an adverb and that there can be other grammatical uses. However participants do not differentiate between the two therefore I will use the terms care and caring synonymously.

This chapter seeks to illuminate the author's understanding, explanation and interpretation of these satisfiers/dissatisfiers using interpretive phenomenology.

Ricoeur (cited in Van Veuren 1993:138) felt, that understanding discourses [like transcripts] was not sufficient. Understanding required explanation to complete the task [of understanding]. Explanation [of such transcripts] was also not sufficient, and interpretation is required to complete the task of understanding. The findings to be discussed now are the researcher's attempt to demonstrate the application, explanation and interpretation as given in Ricoeur's hermeneutic arc [described in Chapter Two].

How patients experience meaning in their lives is not easily understood nor recognised by healthcare workers (O'Connor, Wicker, Germino 1990:168) who said that professional nurses must be prepared to assist families not just in coping with illness and suffering, but in finding meaning in these experiences. Most patients believe that the important aspects of their medical care include receiving personal care and attention. They describe this as

“personal touch”. Touch becomes a descriptive and expressive concept, illustrated as an exemplar [this concept: “touch” will be dealt with later].

This study shows that patients value qualities when a nurse displays sensitivity to their own feelings and emotions. The participants describe these qualities as: receiving empathetic care; or, as one participant Mr Van described it, a “caring attitude”. It is possessing or not possessing this “caring attitude” that is displayed in what nurses do and how they carry out their care for patients. Patients have their own interpretation as to what they “see” and as to how they “feel” care should be delivered.

## **4.2 The theme caring and the components of caring**

### **4.2.1 The theme caring**

Caring, in its different manifestations, was identified in the seven transcripts. Patients equated “*satisfaction*” with the “*care*” they had received when asked by the researcher, “Can you tell me about the nursing care you experienced?” They seemed to have a “tip of the tongue” response straight into the aspects or dimensions of care most important to them. How they felt they were cared for, what they experienced, is the substance of this caring theme. It is so important because it influenced how they coped with their illness and stay in hospital.

The theme of caring includes: individual care, emotional care, personal care, practical care and supportive care. This is not a new finding as Benner (1994) defined the essence of nursing practice as a caring practice in the midst of health, pain, loss, fear and death. Benner stated, “Caring is central to human expertise, to curing and to healing. Nursing is viewed as a valuing of the other with a positive attitude towards the patient together with a desire and a commitment to ‘care’ ” Benner, Wrubel (1989:1-2). “After all it is [the patients] who tell us to what extent they have been listened to, informed, allowed to decide, and been treated with respect,” states Donabedian (1992: 247).

Caring, in the sense of its meaning far more than physical or instrumental nursing care, became the central theme or outcome of the study. My research findings concur with those of Williams (1998:19), in that the research confirmed that patients’ meanings and their experience of caring is linked with, and related to, positive satisfaction with nursing care. Being positively satisfied with their care improved patients’ perceptions of well-being and

overall functioning. Caring for the patient involves tasks that maintain health [for example: learning to walk unaided, gaining independence sufficient to care for ones self again] and facilitate survival, but caring also assists in the coping with and adaption of how to overcome illness. Loss of control of patients' bodily functions or a loss of independence due to weakness may not be readily perceived by nursing staff. Yet there may well be a number of nursing interventions/nursing acts as discussed by the participants in the seven transcripts (narratives) that assisted them to overcome their fears. By simply getting to know the patient, being with the patient is in itself a form of healing. To Mrs Magg who said "she had time for me" and the expression of touch (the hugs or just coming back to her) gave her the feeling of safeness and being taken care of and in effect gave her the confidence to overcome the loneliness of her situation and take the next step to home coming.

#### **4.2.2 Components of caring**

These properties or components of caring are interpreted from the interviewees' text and named as:

- Individual care
- Emotional care
- Personal care
- Practical care
- Supportive care, etc. [the etceteras refer to the diagram "Components of caring emerging as satisfiers or dissatisfiers" [see Figure 4.2] that have evolved from this study.

Words, phrases and events have been inserted and merged by me, as my understanding of that category or "components" of care changed. For example, the definition of individual care as interpreted by me changed as coding progressed. Individual care formed part of the meaning of interpersonal care, emotional and supportive care. The participants interviewed were influenced by different components of care and by the caring actions they received. It was found that patients made a distinction between caring that is perceived as an individual, emotional and supportive response and care received, and caring as a series of

nurturing responses involving activities or tasks. These were described as practical care, personal care, knowledge and insight, and skills in caring.

Thus the diagram “components of care emerging as satisfiers or dissatisfiers” illustrates and expands the theme. This relates to the research question: What makes patients satisfied with the nursing care they received? It seeks to understand how patients perceive and experience what is good or [bad] nursing care as satisfiers/dissatisfiers.

#### **4.2.3. Caring as relationships**

Caring involves a relationship. For example, a vital aspect for Mrs Ray [see below] was the relationship that the nurse felt for her. The patient may not describe it as an ethic, but, as Thomasma states, “The essence of nursing ethics is not what the patients do or what nurses do to the patient, it is the way the dynamic of the healing relationship unfolds not just in hospital but also back in their home environment” (Thomasma in Benner, 1994:94). Relationships, the most elusive of all realities, are so important to human beings. Astrom, Norberg, Hallberg (1995: 110-118), Cohen, Strater (1992: 1481-1486), and Swanson-Kauffman (1986: 37-46) show in their research this same intensity of emotion, this loving care, in their description of the relational caring of their interviewees (nurses). Partly this love was dependent upon their nursing situations: the type of patients they nursed (terminally ill persons); partly it came from their experience and maturity and partly it was the meaning caring had for them (for those interviewees) (Astrom, Norberg, Hallberg, Jansson, 1993:183-193).

The researcher interprets relationship as individual care and emotional caring in Figure 4.2. It is relevant to the main components of caring (as described in the analysis using Ricoeur’s stages of interpretation described in Chapter Two). My findings are supported by relevant quotes taken from the text of the transcripts.

#### **4.2.4. The way forward**

The components of caring that satisfied/dissatisfied patients will be described in more detail and are illustrated in Figure 4.2 “Components of caring emerging as satisfiers or dissatisfiers of care”.



The plan is to apply the hermeneutic circle and Ricoeur's arc. Dilthey (cited in Moustakas 1994:8) relates experiences to the belief that they are dependent on historical groundings like participants' past hospital experiences and their associated meanings and descriptions. It is their story-telling [captured in interview] that brings together the explanation, understanding and interpretation of the hermeneutic circle.

Let me explain this diagram further in terms of the caring components: the possible multiple meanings that emerged. The research participants reflected, and then described concepts involving nurses' personal qualities [amongst other things]. These nurses displayed personal qualities [for example, gentleness, dedication] that gave the patients nursing care that satisfied them. Other factors were the interactions and expressive care that nurses were involved in. Others, again, were outside these personal qualities of the nurse and were more esoteric – yet they were inside the nurses' control. The three groups of "caring" factors: a. personal qualities; b. interactions and expressive acts of caring, (including intensity of caring) and c. ward organisation, have been summarised in Table 4.1. They are the words, phrases and statements made by participants that really express their meaning of satisfiers.

**Table 4.1 Caring factors**

**a. Factors involving the personal qualities of nurses**

Gentleness
Dedication
Secure and trusting: "She was my guardian angel"
Knowledge and insight
Kindness
Feelings, "I feel that I am looked after"
Time, "time for him", "she makes time to come here".
Confident care
Friendly
Personally made an effort
Bending the rules a bit
Appreciates the needs of patients

a. The nurse who satisfies patients rejects, as Carper (1978: 19) asserts, approaching the patient as an object. She or he strives instead to actualise a personal relationship between two persons. Being truly a presence with the patient is how Marcel (cited in Riemen 1986: 35), describes care. The list taken from participants' transcripts reveals "presencing" such as Marcel describes.

**b. Factors involving interactions and expressive acts of caring by nurses**

Touch, even rubs your feet  
Hugs, she put her arms around me  
Positioning of limbs, confident and comfortable care  
Came back last thing at night  
"You would want to latch yourself to someone who is really gentle and dedicated, go the extra mile"

b. Distinction is being made between the nurse merely being physically present, and, being "truly a presence", as a way to develop caring. This was described by Marcel (cited in Riemen 1986: 30-36). Then lastly, I expound in more detail the discovery of the participants' concepts of caring as satisfiers. These concepts formed not only components of care and caring that patients had used (in terms of their being satisfied) but interactions which expressed the care that nurses engaged in and which gave meaning to patients' coping capacities enabling them to take control of their own health episodes.

**c. The factors of ward organisation**

"Its peacefulness"  
Safe and secure  
Friendly  
It's more like family care [a homely environment]  
Specialised care  
Consistent care

c. The ward organization is very important as it sets the scene to show how patients feel cared for in an environment.

To expand on and summarise the above, the insight and meaning that participants have of their own experiences became their descriptions of satisfiers in their understanding of care and the delivery of caring practices. This is the researcher's use of Ricoeur's "guess" [Van Veuren 1993:135] [Figure 2.2]. This illustration shows how the nodes were formed from the text [transcripts]. They were organised according to the similarities in words, phrases and events. This formation developed the researcher's understanding and interpretation of the transcripts. These nodes were then joined together as multiple meanings emerged. "Multiple meanings" encompass the author's understanding of the whole hermeneutic process as derived from the theory given in Chapter Two. One such multiple meaning was the theme "caring". To make these multiple meanings more cogent I will now discuss how patients turned practical aspects of their care into satisfiers or dissatisfiers.

### 4.3 Patients' concepts of care as satisfiers

#### 4.3.1. Practical aspects

Mrs Ray explained how one nurse always came back to check on her last thing at night to make sure she was comfortable. This was interpreted by the patient as the right way to do things and for her showed good caring and a good expression of caring. Line 77-84:

*She has got the knack and I was in hospital here on one occasion for, uhm a skin graft and there was one particular nurse who used to come back last thing before she went off and she would ask, "What have they done for you tonight"? Because she hadn't been around. And she would, uhm get my back in a position and to sleep. I didn't move. Those are the sort of things that are few and far between. You might get another nurse like the other, um, quick, quick, and I wanted to go to the loo [toilet] and I wanted to stand and wash while I was there. So she didn't help me, but quick, quick I must move myself. So, she hasn't got the practice of how to get me to the loo.*

[Knack in this context = the practice required to correctly position and place the limbs]

What satisfies this lady, I ask? It is the fact that the nurse had a “knack” and that she bothered to “come back”.

#### **4.3.2. Sensitive personal touch as a component of caring**

This component does not refer to just any touch. What I am trying to do is describe touch as the satisfier it was to the participants. There is physical touch or the touch that both provides comfort in the form of healing and builds trust. The meaning for patients lies in the nurses’ sensitivity to them as human persons. Figure 4.2 illustrates that touch is intertwined with emotional, supportive, practical and individual care. In fact, the way it can be interpreted touches each of the boxes. This is why they are illustrated as interlinked. Sensitive, patient-satisfying touch is an attitude that shows that one is culturally aware. Thus one needs to recognise distinctions in different nurses’ caring practices of the meaning of “touch”. It is a powerful caring tool. To understand it is necessary to look at patients’ perceptions as part of their experience of “patient satisfaction”.

Touch becomes a descriptive and expressive concept. It is part of the emotional, practical and individual caring component. It consists of highly personal care, which was discovered, understood and interpreted as part of the findings. For example, personal touch is walking the extra mile for the patient, and shows kindness, which touches patients’ emotions and feelings. These caring actions are performed with sensitivity and involve a valuing of the person.

“Touch” to the seven participants was a combination of all these factors. It involved the personal qualities of nurses, interactions, expressive care; ward organisation and setting the scene for care to take place. In interpreting these meanings of touch, the participants’ examples are given in the following texts to show the multiple meanings:

Mrs Magg described Line 129-131:

*Just by them coming and going and putting their arms around you.*

*She, the professional nurse, has just got that way with her [that feeling of touch].*

*That’s what is lovely, what a nurse should have to care about your patient.*

*Feeling of gentleness and dedication*

In analysing a practical activity like “touch”, the objective is to clarify and understand what the participants mean by feeling touch. These are the empathetic feelings and

understandings that make up personal characteristics and actions by the nurse. Most patients believed in the important aspects of their care, such as receiving care and attention. They described this as the “personal touch” [this concept: “touch” will be dealt with later when the exemplar is described].

Nurses in this study displayed how the power of touch, in the personal, compassionate and emotional care, motivated patients to feel special and made a difference because patients felt that, to these nurses, patients matter. Patients recognised that emotional and personal care is a significant factor in being satisfied.

Having expounded touch as an emerging component of caring, one that is concrete and practical, I will now describe a more cognitive element, that is, knowledge and insight skills. These are also described by Benner (1994) as competence. However, patients expressly used these terms, as will be seen, therefore I have retained them.

#### **4.3.3 Safety, knowledge and insight skills into the care and caring**

Participants were able to distinguish and describe different patterns and understandings of the concept “safety, knowledge and insight”. They saw it as something that nurses need; in order for them [the patients] to feel satisfied with the care they received. For example, Mrs Rank described the knowledge and skills of the nursing staff. Line 291-293:

*And then the other thing I just want to say was the major skills level, I think, of the hand picked staff here [in the GIT unit] is fantastic*

*The knowledge and skills level there was just fantastic to me. I’m working well [going through all the stages of illness and recovery].*

Line 301-306:

*I’m being treated by people who are experienced and they’ve got the skills and they know what they’re doing and there is a confidence and because of that I’ve been treated properly and I’m feeling good and I am feeling happy here. Safe.*

Line 352-354:

*So, I am very impressed with that, you people here are pro-active and on the ball. It’s again why I say this hospital is in a league of its own*

Line 79-83:

*I mean just the way you know I was treated. I was sore, I was uncomfortable and it was just amazing. She had a positive attitude. She was gentle with me, dedicated. I felt safe and secure and I also believe that speeded up for me, you know, made me feel uhm good, speeded up my healing.*

Although knowledge and skills are not specifically mentioned in the last quote they are inferred. This interpretation is of the nurse being able to move the patient from discomfort to comfort and healing. Benner refers to this as the intuitive domain where the expert practitioner resides (Benner, Tanner, Chesla 1996:142-169).

Mr Mentor stated. Line 303-304:

*The nurses took care of me*

*They encourage me*

*Nurse made me not afraid of swallowing. I loved it*

(it was the interpersonal nature of individualised nursing care and attention that overcame Mr Mentor's fears of swallowing though this quote could just as easily reflect the intuitive "knowledge and skills" that nurses show).

Caring about the patient creates an environment, in which the patient felt very secure. Approaches to care that enhance positive identity are important. This ability to presence oneself, to be with a patient in a way that acknowledges your shared humanity, is the fundamental base of nursing in a caring practice and is reflected by Simons (cited in Benner, Wrubel 1989: 13). This reflects being in tune with each other and being aware of the uniqueness of the individual person. The findings acknowledged that the participants experienced that relationships are a two way process, which requires commitment on the part of the patient, to value the interaction that patients consider meaningful and which lead to the establishment of a positive relationship. This has been described in the text as:

*"she went the extra mile", and in "[she had] time for me".*

The reassurance of the nursing staff in giving information and communication was described as their ability to put Mrs Rank at ease and made her feel that she was in safe hands. She linked organisational care [the safeness and security] and the ethic of caring [attitude, gentleness and dedication] to the difference between the efficiency and

effectiveness of the care and the nursing and medical staff at the two hospitals in her experience. Line 41-42:

*Yes definitely I have had one experience at Hospital C a year ago where I had a big op and um it is definitely chalk and cheese*

The comparison was the difference in the way the staff approached her, cared for her family and the experience of feeling the dedication and competency amongst the staff during her previous encounter. Line 61-65:

*“They knew what was happening [in Hospital A]”. “The feeling that you are “really being cared for”, and the relaxed atmosphere of being in a “family”. Finally the desensitisation of what happens to you, “burping, letting out wind” – you are not made to feel embarrassed. It is all very open and quite normal to what is happening here.”*

*Uhm, in the ICU definitely um but just in terms of the privacy where I had my previous ICU experience, uhm Rob was also there, but on a permanent basis but uhm there wasn't the privacy and there wasn't the sensitivity to other members of the family.*

She stated how important it was to her to have the correct information and care and knowing that there was continuity of care. These constituted skills.

Mrs Rank Line 178-179:

*Are they skilled, are they caring enough, are they monitoring you? Uhm, so ja, there was definitely that kind of fear there. Uhm, Just the other thing that has been important to my experience here has been the information and care that I received here. It has been wonderful, just the amount of information, you know, just all my questions have been answered. The staff has been wonderful about telling me about the operation and incredibly humorous about what's going on so there is a wonderful openness in communication. So that has been a great experience which is also different from what I had at Hospital C.*

It is the intuitive perspective of the nurse to perceive and interpret the subjective experiences of others and to ingeniously plan for effective nursing actions. If a nurse has not the insight to intuitively perceive the patient's needs then he/she will only see the

patient's illness as just another event in the patient's life. This intuitive process involves having continuity of contact with the same patients.

One component of care emerging as satisfiers or dissatisfiers [as it relates to Figure 4.2] is individual care.

#### 4.3.4 Individual care

This is caring to maintain the individuality of the patient. It involves the personal care aspects of the individual whether nurse or patient.

Definitions of patient satisfaction include elements and interactions of care. These definitions are unique to patients' expectations of care. These definitions were of care experienced either by them, their spouses, or their close relatives, in this admission [or previous admissions]. They describe their perceptions of care as and when [or if] they received care. It needs to be recognised that care has neither a positive or negative meaning. It is context and attitude that gives meaning.

Thus individual care has multiple meanings and expressions.

Patients know when a nurse is caring. Line 425:

*"[She's] just got that way with her",* said Mrs Magg.

Conversely, nurses are criticised for their lack of care. Nurses spend much more time with patients than doctors do. This reflects greater contact and therefore allows for more complaints.

Mrs Magg expressed the caring qualities that were most important to her Line 301-307:

*"And she puts her arms around me, gives me a hug; that sort of thing goes a long way. Then you feel they are caring and they do worry what happens to you. Some of them have just got this don't care attitude and it's off putting – so, I mean if they are nice to me and I feel they are caring and that helps me in myself to get well and then if they are horrid like some of these night staff they just push me back".*

Another participant, Mrs Ray said Line 422-423:

*"I just feel that, you know, I just had care, everything was in its place for me."*

Patients are reassured by the positive way they are cared for and in the knowing that this care met their expectations.

Thus patients look for certain qualities that a nurse portrays, particularly when their conditions are of long standing as with the three elderly participants (all over the age of seventy). All had difficulty with movement and were looking for nurses who ensured that they were moved appropriately.

Patients' expressions of satisfaction and dissatisfaction may relate to aspects other than those stated, namely, loneliness and how they are going to cope with their frailty and generally care for themselves. This was found to be particularly relevant in this research and has been discussed by Bond, Thomas (1992: 56) who feel that patients characteristics of age, gender and previous hospital experience, their general state of mind, which they may not be able to differentiate, reflect these satisfiers and dissatisfiers.

Mrs Windy reflected this in the appreciation of dedicated and individual care she received:  
Line 73-74:

*One thing I really, really appreciated was uhm, when I was in such extreme pain, they took a nurse and dedicated her to me for the morning...*

She reflected and repeated again, almost in surprise that this sort of care was made available to her. Line 75:

*I mean she was dedicated to me. And it was very nice [my emphasis].*

The element of surprise in this particular act of nursing care confirms Nelson, Larson (1993: 89-94) exploration of patient satisfaction. Good or bad surprises were defined, in that there were specific events associated with patients defining "patient satisfaction".

Other participants also spoke about acts of individualised care, e.g. having "time" for "me". Three patients used the word "time", in terms of the time taken with "me" the patient, in relation to the individualised nursing care given and received. This *giving* and *receiving* is important. This is that "dynamic of the healing relationship" that both Montgomery (1991: 91-104) and Thomasma (in Benner 1994: 85-98) discuss.

Mrs Magg reflected, Line 333-335:

*She makes time to come here and do everything in her power to make me comfortable and nice ..... she is exceptional.*

*You know she has put herself out for me*

This encounter expresses the uniqueness of the individual as a person. One feels recognised and valued by the amount of time and effort taken by an individual nurse in the

act of caring. It is necessary for nurses to acquire these skills in order for them to examine their own personal value system and to understand the person and the meaning behind care.

Mrs Ray stated, in respect of the care her late husband received at Hospital B Line 45-46:

*And doing all sorts of things for him. You wondered how they got time for the other people in the ward*

And Mr Mentor [who had undergone head and neck surgery] stated Line 52:

*They (nurses) did not leave me to go on alone...*

Patients consider and focus on the interpersonal characteristics of nurses that relate to what the nurse does for the patient. This is described in the text by the seven participants in their use of words, “for me”, “it was nice to have a nurse dedicated to me”, and “for him” which described each participant’s individual and personal experience of being a satisfied patient. Apart from Mr Stone, the participants describe the way nurses worked positively and how special they felt when care was individualised.

Mrs Magg confirmed Line 321-329:

*...yes there’s sister on the floor here, the one that is so nice you know she has put herself out for me time and time again*

*...In which way?*

*you know if there is something I can’t get right she comes here and helps me you know...*

Mrs Ray said Line 382-384:

*I had kindness and help*

*I do like to feel that I am looked after*

Mrs Ray responded further, Line 388-389:

*That confidence that you are put in a comfortable position...Special attention and the right way to do things.*

This shows an understanding by the patient in that her individual needs of being cared for is dependent on the knowledge and skills of the nurse/s. This is the meaning and intention of an action as described by Ricoeur in 2.4. The participants were easily engaged in the descriptions of how comfortable they felt with their individual caring aspects. The participants in this study presented themselves as “informed respondents”, who showed an

understanding of care, speaking confidently, positively and assured about the personalised and individualised aspects of their care.

#### 4.3.5 Qualities of the nurse

Caring acts involve coming to know the uniqueness of the individual. For example, Mrs Magg perceived both expressive and interventional caring behaviors of nursing action as satisfiers of care, as described Line 129-133, 45-47:

*She was so caring you know and I find that ... patient could get better quicker if ... she sees that the nurse cares for her or there is a caring person there, and I find that I can get on quick... I, myself feel safe and good but when a nurse comes in here full of the sulks and... then I can't get well. (Little [nervous] laugh)*

Patients consider and focus on the interpersonal characteristics of nurses, which relate to what the nurse does for the patient, how pain is experienced and the action that the nursing staff took to enable the patient to cope with the pain for example.

All the transcripts describe the way nurses work with patients, how special the patients felt when care was individualised to them. Mrs Magg described Line 321-329:

*... yes there's sister on the floor here, the one that is so nice you know she has put herself out for me time and time again*

*R: In which way?...you know if there is something I can't get right she comes here and helps me you know...*

Interpersonal care is involved not just in the task of caring but with the concern for, and in the dedication to, them as patients. "Personal knowledge", states Carper (1978: 18) "is concerned with the knowing, encountering, and actualising of the concrete, individual self". This knowing is what incorporates and creates personal relationships between the two persons. Coping strategies often involve personal relationships with nursing staff and other members of the multidisciplinary team. Patients often verbalise their feelings to this effect: "I put my life in your hands (to the doctor) I know that you will do your best for me". Those who provide and shape individuals' perceptions of his or her illness may influence the meaning ascribed to certain interventions of caring in order to provide holistic care. In so doing this may ease the feelings of vulnerability by certain acts of caring (or non-caring actions). This may be aided by a relationship with a nurse from the

family or a particular family member, certain acts of kindness or nursing acts, which assist in overcoming the adaptation and coping mechanism that is needed by the individual [illustrated in Figure 4.1, adapted from Fife (1994: 315)].

Mrs Rank described the need to have her family and specifically her husband around, and Mrs Ray watched over the care given to her husband, when he had been a patient at Hospital A. The concept of caring, and the meaning patients ascribe to caring, which is of a supportive and behavioral nature, enhances positive patient identity to their disease process, and their coping mechanisms which was willingly discussed by the participants. Three participants used the word “secure” in terms of feeling “safe” at Hospital A compared with Hospital C. Describing how happy one participant felt was linked with feeling safe, and with regard to caring and skilled nurses, a feeling of safeness was experienced. This showed that nurses were dedicated to the care of their patients and thus created an atmosphere of safety rather like that of a parent to a child.

University of Cape Town

THE PROCESS OF CONSTRUCTING A MEANINGFUL RESPONSE TO LIFE THREATENING ILLNESS

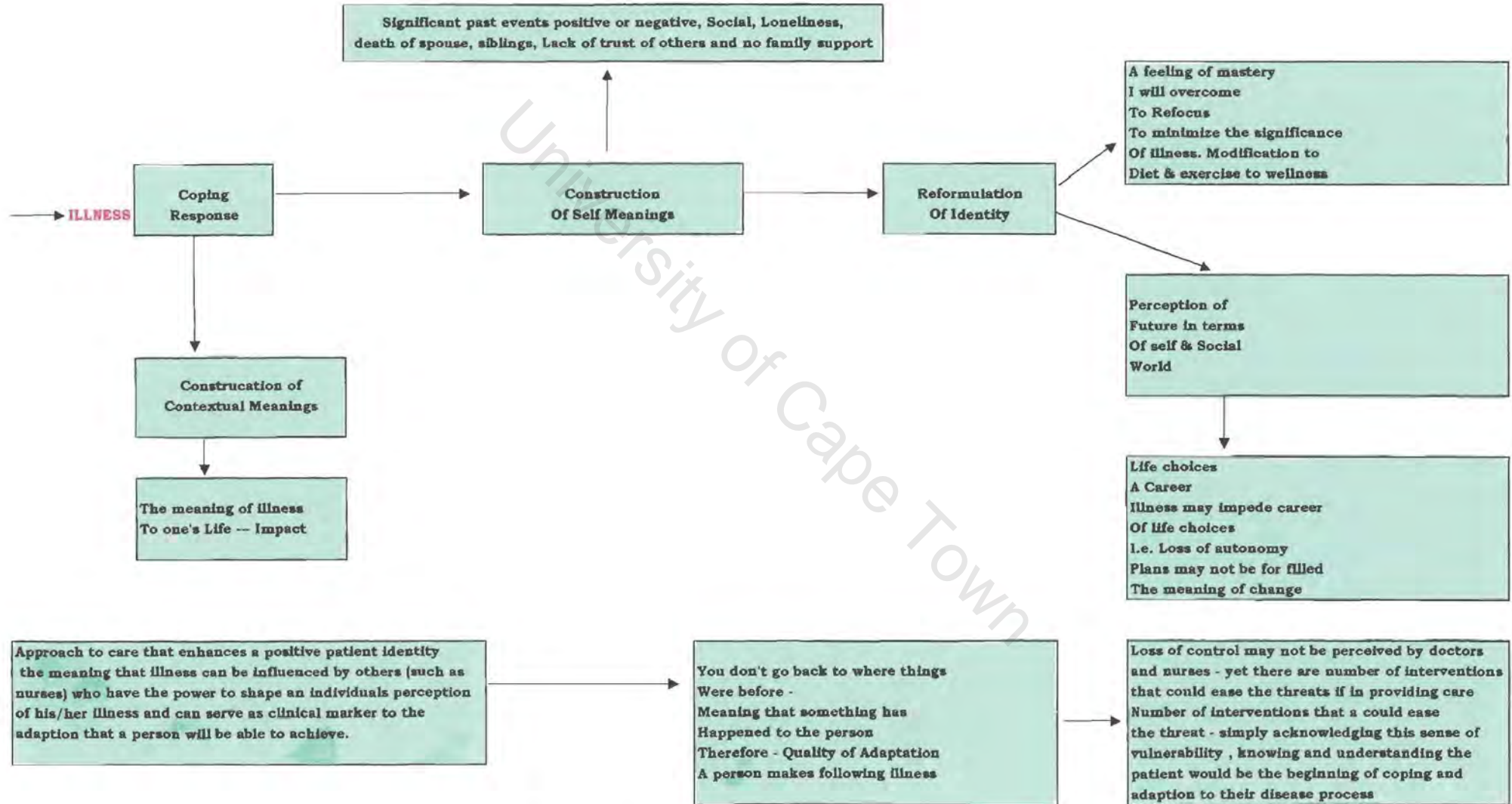


Figure 4.1

ADAPTED FROM (FIFE 1994:311)

#### 4.3.5.1 Security

The word “security” is significant in both meaning and expression. This leads the researcher to the theme of caring to encapsulate the families’ role in security, and safeness both in the surroundings and in encompassing care needs.

Illness brings out the vulnerability, isolation, and suffering created by disease and the need for a wall to be built around the patient, to work “inside” the wall as a nurse is to understand the patients suffering (Fife 1994: 309-316) and (Price 1993:33-41).

As Mrs Ray described Line 382-384:

*... had kindness and help*

*I do like to feel that I am looked after*

And Mr Mentor described Line 72-73, 176, 303-304:

*The nurses took care of me*

*They encourage me*

*Nurse made me not afraid of swallowing*

*I loved it* [the interpersonal nature of individualised nursing care and attention overcame Mr Mentor’s fears].

Caring about the patient creates an environment, in which the patients felt very secure.

#### 4.3.5.2 Identity

Approaches to care that enhance positive identity are important. The relevance of the meaning illness holds for patients must be readily discernable by the researcher through the interview process, states Fife (1994: 316) in order to bring out a discussion of their caring and its relevance to their coping abilities [illustrated in Figure 4.1].

#### 4.3.5.3 Presence

This ability to presence oneself, to be with a patient in a way that acknowledges your shared humanity, is the fundamental base of nursing in a caring practice and is captured by Simons (cited in Benner, Wrubel (1989: 13). Simons has captured this sense of presence that was interpreted by patients as caring. This reflects being in tune with each other and being aware of the uniqueness of the individual person. As previously mentioned, Marcel

also notes presence as a part of caring and distinguishes between being physically present and being truly “a presence”.

The phrase “to presence oneself” comes from Heidegger’s *Being and Time*, in that you are available to understand and be with the person. He was concerned with what *Being* means to us, which requires an understanding in their everyday activities and practices as, *Being – in the world* (Guignon cited in Benner 1994: 74). In contrast to being outside of the “caring situation”, standing aloof or being preoccupied with other thoughts.

Mrs Ray responded Line 388-389:

*That confidence that you are put in a comfortable position...Special attention and the right way to do things.* [This shows an understanding of the patients needs being cared for as an individual].

The participants easily engaged in the descriptions of how comfortable they felt with their individual caring aspects. They presented themselves as informed respondents, with an understanding of care speaking confidently, positively and assuredly about the personalised and individualised aspects of their care.

#### **4.3.6 In summary**

Chang (1997: 26-37) conducted a review of all published instruments used to evaluate “Patient satisfaction of nursing care in the hospital” over a period spanning 18 years. The result of this review was a proposed taxonomy that was based on Donabedian’s structure, process, and outcome framework.

The structure in Donabedian’s terms (1992: 247-251) is the observed physical component of the patient’s immediate surroundings and reflects the nursing management of their patient’s environment.

The process describes how the nurse interacts with the patients in the actions of caring divided into the auditability of the nurse, technical skills, the art of care, explanation of care and the continuity of care.

Patient’s satisfaction as an aspect (effectiveness) of the outcome of care is the perceived nurse/patient interactions in the overall impression of the effectiveness of nursing care and whether their caring needs have been met. The improvement of their health condition is attributed to nursing care (Chang 1997: 26-37).

This research has assisted me to put together the components of care emerging as satisfiers or dissatisfiers [in the future to use as guidelines/framework] as a starting point to define what patients mean when they say they are satisfied/dissatisfied with the nursing care.

## **Section Two: A description of care from theorists**

### **4.4 An exemplar case is used to describe the interpretive analysis**

#### **1 To understand the meaning of “touch” as a “satisfier of care”**

#### **2 The ethics of the care of self**

In this next section the researcher will be taking aspects of the feelings from the participant’s transcripts of what the meaning of care was to them, and, using selective nursing theorists and authors (giving their descriptions of care) to work out and understand the meanings of care to back up these statements using Ricoeur’s four stages (Van Veuren 1993: 134-136):

- A fixation on meaning
- Dissociation at some point from the mental intention of the subject
- The necessity to interpret the protocol [text] as a whole
- Their universal range of address.

### **4.5 An exemplar case, which is used to describe the interpretive analysis**

In chapter 2.7 of this dissertation the strategies, thematic analysis, exemplars and paradigm cases was discussed. This section will now demonstrate an exemplar that has been drawn from the seven transcripts of the research.

An exemplar is used to understand the meaning of “touch” as a “satisfier of care”.

What makes [hospital] patients satisfied or dissatisfied with the nursing care they receive? That is, the research seeks to understand the nature of care patients receive [the skills in practice]. It seeks to understand how patients perceived and experience the type of care that satisfies and dissatisfies patients, or what is considered to be good or bad nursing care.

#### 4.5.1. Introduction

As was said in Chapter One, the role of the health consumer, or patient involvement in the evaluation of nursing care is not new. And here one must repeat that the term care has no ethical meaning. Care becomes defined by the attitude of the person, and the quality with which care is given. In this chapter, I show the research participants in-patients who had had previous lived hospital experiences, evaluating the nursing care they received. From their pronouncements one can identify further as to what for them were satisfiers or dissatisfiers. That is, through the discourses about their experiences the research question is being answered. What this means from a research point of view is: if the researcher gets the questions right the interviewee responds not merely with a clipped answer but with a personal story that embraces emotional feeling reflecting a stored memory [or memories] of something that has happened, to them or their close family. The patient catalogues this mentally as “good” or “bad” and the researcher considers it as a “satisfier” or “dissatisfier”. However, between the patient’s response and cataloging, a process of research analysis takes place.

To show the application of hermeneutics to the research question I will use this chapter to unfold participants’ interpretation and meaning of care. Care, as has been said, was for them more than mere physical contact with nurses doing routine tasks. What emerged was the all-embracing concept “touch” as a category or component of care.

“Touch” constitutes that “composite whole” to which Moustakas (1994:122) referred. Benner (1994:116-117) takes the “whole” further and uses the term “pattern of meaning”. Her term illustrates different aspects of meaning for the participants through the caring action they receive.

Initially patterns of meaning were identified from the embodied experiences of participants. Then, from this source, exemplars that convey thematic analysis were extracted. These became operational definitions of specific terms like satisfiers. The concept “touch” will be described using the three emerging components of caring previously identified as emotional, individual and practical care.

Firstly, I will summarise the methodological theory behind these exemplars. Secondly, I will describe the practical application of this theory in relation to the exemplar “touch”.

#### 4.5.2 The theory

Moustakas (1994:10) described the process of doing hermeneutics [or Benner's interpretive phenomenology] as a circle. Van Veuren (1993:135) described the process through the use of an arc attributed to Ricoeur. Both of these have been explained in Chapters Two and Three. Ricoeur's application of this process [his four stages] presented interpretation as a movement. This "movement along the arc" is taken to involve the following:

1. Making a guess as to the meaning of the text by the interpreter. This necessitates what Van Veuren names:
2. The rupture or that dissociation or break between the mental intention of the author and the verbal meaning of the text [each becomes independent]. This forms
3. A trajectory off this arc and this is the application of the participant's meaning [multiple meanings] and the final stage is
4. Interpreting these first three as a "gestalt of interconnected meanings".

Now these two processes [that of circle and arc] may seem contradictory. Van Veuren sees them as dialectic or, one can say, the art of investigating the truth of opinions (*Readers Digest Complete Word Finder* 1993). The key to all this is that making a "guess" as to what the text [transcript] means is the "entry point into the hermeneutic circle" Figure 2.2 illustrated on page 24. It presupposes, with a concept like care, a certain kind of whole implied in the recognition of parts. The whole, Van Veuren felt, is formed by mutually construing the details.

Thus the researcher, with the participants, takes a concept like care and makes a guess as to the meaning of the participant's experience of being cared for in relation to the meaning of being satisfied. By the researcher's reading, and rereading, by asking the participants also to read through what they had said, and clarifying the concepts, the "rupture" given by Van Veuren occurred. The trajectory off the arc of being satisfied with care became "touch". To explain further: the "entry point" is seen to be care as a whole entity with different trajectories. One takes the parts of care as given in the emerging components and the hermeneutic circle is completed (given application as one describes their meanings and the essences of the participants' experiences). Participants' satisfiers are then described through a rich textural-structural description, which are now given below.

#### **4.5.3 Aspects of touch: an exemplar - using participant Mrs Rank**

What is “touch”? Thomasma (in Benner 1994:92) describes an expanded meaning of “touch”. For her, the importance of “touch” is that it conveys trust and comfort. It gives information. It conveys the understanding an illness has for a person in a unique and personal way. It interprets suffering [in a person] in a way that is the beginning of “knowing” that person. Thus the whole reason for nursing theory and practice and the learning of tasks is to care [ethically] for patients. This is described by Pellegrino and Thomasma (cited in Benner 1994: 93-94) as the hierarchy of values that is formed in each clinical encounter. There are at least four operative levels in the relationships between human beings: in this case the healer [nurse, doctor, caregiver]; the plan - medical, therapeutic or the life plan; and the ultimate value. These show the complexity of caring for patients.

I concentrate in this section on Mrs Rank but the component of “touch” emerges from the seven participants. It is a combination of the following factors:

- How I have interpreted touch phenomenologically;
- The meaningful lived experience of the participants; and,
- The personal qualities of nurses’ interactions and expressive care combined with the ward organisation and setting the scene for care.

When questioned, most patients believed they had received quality care and attention. They valued [nurse] qualities such as being sensitive to their feelings and emotions, they described these qualities as “receiving empathetic care”, or as one participant Mr Van declared, “caring attitudes” were displayed by what nurses did and how they carried out their care for patients.

Patients had their own answers as to how they saw and as to how they felt care should be delivered. These were those important aspects of their care that satisfied and as such described what I called “personal touch”. It intertwines all three of the components mentioned above.

Touch, like caring, does not have one definition and a singular meaning. Rather “touch” has multiple meanings. The task of the researcher is to reach a description of “touch”

through the seven transcripts, to make a composite whole through explication that is both theoretically and conceptually adequate (Gaut 1983: 316-317).

Patients related the importance of “touch” to their individualised care in that they felt special when nurses showed care, as Mrs Magg stated Line 128-129

***“ Just by them coming and putting their arms around you”***

And in the reassurance gained from nurses, as Mrs Windy stated Line 150-151

***“there was always someone coming in or holding your hand or patting your shoulder”***

The expressions of touch are the “little things, like even rubbing your feet”. Mrs Rank expressed surprise at the care received: “[the nurse] does not have to massage your feet, you know”. The genuineness of the carers’ dedication and the willingness to focus on patients as individuals conveyed a feeling of trust to patients. “The simple act of touching,” described by Benner *et al.* (1996:318) shows how important that act was for connecting to patients.

To Mrs Rank it was the combination of the personal attributes of the nurse, such as being knowledgeable, her skills, experience [including life experiences], values and personality traits, which enhanced or inhibited caring and trust. The intense closeness to the patient displayed the positive effects of their caring (Montgomery 1991: 99). As Montgomery infers throughout her work, the time nurses spent with patients was seen as comforting and the time taken was viewed as building up a relationship in assisting individuals in the accomplishment of their health outcomes.

This is confirmed by the powerful statement made by Mrs Rank when she describes Line 133-135:

***“It’s the peacefulness, it is a great sense of peace, you are the patient and we are the caregivers. Which for me has been marvellous that I know I’m really being taken care of”***

For Mrs Magg it is a relationship as well as a presence Line 333-335:

***“she makes time to come here to do everything in her power”***

Mrs Ray reiterated Line 388-389:

***“And the special things nurses have done”***

*“You felt so secure and [she was] so dedicated”*

This ability to presence oneself has been discussed previously [page 74]. By connecting with the meaning of the illness, the nurse makes illness interpretable and approachable. Touch reflects being in tune with each other [the patient and the nurse] and being aware of the uniqueness of the person. Touch is a way for the patient to feel the dedication that comes from the nurse. It is a warm and “fuzzy” feeling: one through which trust is built. Communication [whether verbal or non-verbal as in touch] leads to healing. It is part of the care-giving relationship, whether paradoxical and/or having transcendent aspects. Caregivers have always lived with the paradox that they are supposed to care deeply about their clients, but not get too involved. In addition, caring itself has been viewed as dangerous for the one caring, such that caregivers are urged not to care too much, for fear of burnout (Maslach cited in Montgomery 1991:91).

Not all patients experienced the power of touch in the same way. For instance the two elderly participants Mrs Magg and Mrs Rank describe touch as acts of kindness or hugs, as when a nurse puts her arms around you. Mrs Rank describes touch in the therapeutic way that Carper (1979:1411) describes it, for example, to be concerned with the “whole person” and to practise caring with consideration and sensitivity. For the integrity of the human self is basically an ethical injunction, owing to the fragmentation of care received and the various teams involved in care. However, “rubbing of the feet”, as described by Mrs Rank in the Intensive Care Unit, is an act of touch and is symbolised as a concern for comfort and compassion by the nurse despite the restraints of an ICU environment (Hofhuis, Bakker, Lukas 1998:114).

Three participants used the word “secure” and this showed that nurses were dedicated to the care of their patients. This created an atmosphere of safety rather like that of a parent to a child.

Mrs Rank said Line 62-83:

*I had my previous ICU experience, um Rob [husband] was also there, but, and on a permanent basis. But um there wasn't the privacy and there wasn't the sensitivity to other members of the family coming in and that makes a huge difference, when you are in ICU because you are, you know you are really needing a lot of care. uhm...[you]... may be not consciously but unconsciously, you may not, you know*

*come around fully or whatever but just the presence of loved ones around gives you that security and I think it speeds up the healing and I always believed in that so the fact that she was flexible enough to do that for me was impressive [i.e. a charge sister].*

Mrs Rank said this of a nurse. Perhaps, because of the feeling of fragility Mrs Rank wants to be encushioned by loved ones, certainly in relation to wanting her family to be with her.

For “extra security” somebody else [a nurse] was there to watch over her. Her family watching over her was of the utmost importance to Mrs Rank. Otherwise she was left feeling vulnerable, and frightened of dying. Her fear was communicated to the researcher at the second admission following the return of the transcript. The researcher had the opportunity to explore the use of certain phrases and categories and to ask questions relating to these feelings and emotions; and to the amount of control and vulnerability that was verbalised in the initial interview.

This participant was trying to overcome the effects of this recent illness, supported by her husband and immediate family. She had modified her diet and had improved her lifestyle a year previously following the last threat to her health. She had taken a year off work in order to “heal her body”. This was a period in her life that was described as “her time”.

Mrs Rank discussed these thoughts with me during her second admission. All her working life had been given to her career and the advancement of her career. The shock and horror of finding that she had cancer sent “shockwaves” through her system. The thought of leaving those so close had made her decide to take a year’s sabbatical. Being in touch with herself and in touch with life enabled her to confront the cancer for the second time knowing that those around her would be her comfort, and her support [at first it was her husband and family]. She felt surrounded by the “care” she received from the GIT unit, which she described like family care. Valuing relationships was perceived by Mrs Rank as the respect she had for individual nurses in the information, communication and supportive care she received from them which in turn aided and speeded up her healing.

Fife (1994: 311) describes the meaningful response to life-threatening illness, as “you don’t go back to where things were before”, there has to be an adaptation that a person makes in their life following their illness. Mrs Rank’s illness had an effect on how she constructed meanings in that she describes: confidence in care, comfort of care, assurance

and information. Her own mental stability during this time had “blocked” out touch from others apart from her husband and family.

#### **4.5.4 The dimensions of caring**

There are different dimensions of caring in relation to touch and these should be used in appropriate settings to provide actions or interactions which meet the person’s needs. Only by knowing the person would these different approaches to nursing care delivery be made available to patients. It is described by Gaut (1983: 317) as “What nurses do when they care”. For example Mrs Ray states Line 389-391:

*...and that confidence that you’re put in a comfortable position and they look after you at night so that ... that matters. It’s the positioning of your body that matters.*

And in relation to the care that her husband received Line 40-46:

*...but my husband died here in January, not January, November, and when he was in ICU here, there was a sister on then and she was watching him, caring for him and, and doing all sorts of things for him. So, so dedicated and uhm you know you wondered how they got time for the other people in the ward uhm, just caring for him. She had time for him [her husband].*

Mrs Rank describes caring and dedication in relation to the feeling of trust and comfort, Line 80-88

*The other thing is that I, I’m sticking to ICU because that’s in that area for now but just the very uhm the genuine gentleness and dedication of, of some of the staff and of particular uhm I think it was Lynn or Lynette [not real name] fantastic I mean just the way, you know, I was treated. I was sore, I was uncomfortable and she was just amazing, she had a positive attitude she was gentle with me dedicated, I felt safe and secure and I also believe that speeded up for me you know made me feel umh good, speeded up my healing.*

#### **4.5.5 In summary**

In analysing a practical activity like “touch”, the objective is to clarify and understand what participants mean by feeling touch: the empathetic feelings and understandings that secure personal characteristics and actions by the nurse/s.

#### **4.6 The second exemplar - The ethics of care of self**

To explain this concept, I take my cue from Mrs Rank [the research participant] and the methodology I am using, where I can interpret her discourse in the manner already discussed. In her discourse Mrs Rank said Line 105-106:

*“There is definitely an ethical difference in terms of dedication and care.”*

What did she mean? As has already been mentioned this participant is a young successful businesswoman who has terminal cancer. As she is a professional in human resource management and an academic, I feel she knows what she means when she talks about ethics in terms of dedication and care. But, she goes further than just these two words. She lists the attributes of an ethic of the care of self. In her own way she is an authority on the subject for she has had several hospital admissions, two of which were in ICU units when she was very ill. I believe she knows that she is dying, that she has accepted it, but it's not a subject she discusses. She is a private person and a private [paying] patient. So she pays for the service she receives whether she is satisfied or not. Yet, even in such a place, she knows what it is like to be vulnerable, to be fearful of the very people who are being paid to nurse her in her condition.

##### **4.6.1 Mrs Rank's meaning**

To answer the question about her statement regarding the ethical difference in care one has to look at this discourse more thoroughly and in its context. The context in which Mrs Rank talked about the ethic of the care of self was twofold [my interpretation]. Firstly, it was in the context of her feeling fear and “uncomfortable” with some nurses, particularly agency nurses. Mrs Rank perceived that they as a group did not share the same values and sense of meaning about the patients and the hospital. This Mrs Rank reiterated to me on several occasions. She would discuss why she felt so strongly about the nurses' sense of belonging to a team and ownership of the unit, and the uneven quality of work, which she was able to distinguish in the nursing practices directly relating to herself. She further comments on what she sees as some nurses not caring for themselves. She felt they could not care sufficiently for patients to satisfy them. Part of this being satisfied with the care

received was negative. This implies that satisfaction lay in nurses not causing patients to feel vulnerable or afraid.

In positive terms it lay in:

- Diminishing patient's vulnerability
- Nurses' accountability to patients,
- Nurses caring for themselves ethically
- Nurses' "touch".

These are to be discussed in this section using Mrs Rank's discourse. Line 94-106:

*Did you feel the difference in the care with other members of staff there?*

*Yes, I did, I mean there was certainly some members in ICU that I was very afraid of, did not want them near me (laugh) and at night I mean if we talk specific day and night I mean I think the night staff are not as good as the day staff, I just, that's just a general thing. I think there is more agency staff at night and there is more of a core permanent staff during the day and there is definitely an ethic uhm difference in terms of dedication and care. And um ja the other members of the unit that I wasn't very comfortable with I can't remember names I just know there wasn't that feel.*

#### 4.6.1.1 Diminishing patients' vulnerability

Mrs Rank expressed her feelings of vulnerability. Line 599-607:

*Well there was one particular person I felt a little bit uncomfortable with and I just continued to just sort myself out a little bit [with the lack of caring and support]. She was quite rough and, you know, and quite um uhm anxious, has to get stuff done and I could just see she wasn't quite there and then you obviously wonder what is she doing, is her mind with the job, you know, is she thinking about what she is doing and so uhm ja there was one person*

How fearful was she of "some" nurses? The discomfort she felt with them was contrasted with the feeling of dedication and gentleness with which others treated her. Mrs Ray and Mrs Magg had also described the rough handling, or the "quick, quick" attitude of rushing patients and the sulky disposition of some nurses. Patients perceived different levels of patient satisfaction. This is their interpretation of nursing care. Therefore the words "a bit uncomfortable with" and "she was quite rough" indicate degrees of vulnerability. Their

words were central to this concept of vulnerability and affected their coping mechanisms: in that their feeling vulnerable related to the severity of their illness and their psychosocial states. This is where the expanded meaning of “touch” is recognised, as given by Thomasma (cited in Benner 1994:92). There were other aspects of vulnerability felt by patients. This was increased when nurses were unfamiliar with their environment [as in having agency nurses looking after them]. If nurses did not have a balanced disposition they were perceived as not able to give of themselves. In fact these nurses often took from patients in that they spoke about their own problems. This was perceived as putting an extra burden on the coping abilities of patients.

Mrs Rank’s increased vulnerability, fear, anxiety, frustration and the control she felt she needed to exercise in order to cope and be consistent came from the feeling that nurses lacked dependability. Their minds were not focussed on the job, and she perceived that a nurse was not thinking about what she was doing.

#### **4.6.1.2. Nurses’ accountability to patients**

Were nurses accountable to patients? Mrs Rank thought so. Line 122-125:

*...to think about accountability, just think you are not quite sure how accountable an agency nurse would be for maintaining the standards and ethics in an environment which they are not permanently part of uhm ...*

This showed in that she thought nurses should maintain the standards and ethics of a unit. Mrs Rank felt that standards rubbed off on patients. Weil (1968: 153-159) discusses giving “ethical attention towards another”. What she means is not merely gazing at another in sympathy, nor is it simply looking at another in conversational manner. Rather, it is a strong, positive disposition whereby one ethically attends to another person’s being in an “unselfing” manner.

Murdoch (1970) developed a concept of “unselfing”. This strange word is derived from this author’s reflection on self or selfishness. She interprets it as being so absorbed with the other person [in a caring relationship] that you become unaware of, or lose consciousness of, yourself. If one reflects on this, this can and does happen to one in nursing. It is not personal effacement, disempowerment or submissiveness. On the contrary it is empowering and leads to spiritual and emotional growth partly because positive caring can

define you as a person, and partly because caring ethically has healing properties. You center onto the person for their own sake, not for anything you can get out of the situation or person. His or her need takes up your entire concentration in an all-absorbing manner. You are totally focused on the person and their being. This is an aesthetic aspect, for you unconsciously see the possibility of a beautiful caring relationship. It is spiritual too, as two beings unite in personhood. If there is a consciousness of anything it is that one is self-possessed and one is using all one's being [intellect, volition, spirituality and emotion] towards the other for their [holistic] health and well-being.

“Unselfing” implies a relationship where one consents to give ethical attention to another's personhood: a personhood that has perhaps been shaped out of vulnerability but also constructed out of a subconscious indomitable spirit that expects to cope with an intangible illness in relationship with caring beings. Bowden (1998:59) asserted that the characteristics of caring attention were wrapped up in what she felt could only be “moral feelings or impressions: both of which can be ambiguous or vague”. But the quality of attentiveness enabled the sorting through of relationships with people in respect of the situatedness of their lives.

The total contrast to “unselfing” is the nurse who is unsure of his/her environment and who dissipates uncertainty and incompetence. When a nurse comes from an agency the participants were aware of the differences between a permanent member of the nursing staff and a temporary nurse. Agency nurses themselves often say, “I'm an agency nurse! I don't know how to do that”. Or, “I don't normally work here”. Statements such as these provoke uneasiness amongst patients especially those who are informed and acknowledgeable about their care and who are trying to recover from their illness through the expertise and competence of nurses assisting them in this process (Haegert 2001:28-30).

*“As patient you would want to latch yourself to a person who is really gentle and dedicated and goes the extra mile”.*

Such was the positive attitude, gentleness, dedication, safety and security experienced that this participant believed that it speeded up her healing. This is a profound statement: to say that rendering ethical care leads to healing is a giant satisfier for someone like Mrs Rank. In practical terms Mrs Rank described this Line 79-86:

*...and dedication of, of some of the staff and of particular um I think it was Lynn or Lynette fantastic. I mean just the way, you know, I was treated. I was sore, I was uncomfortable and she was just amazing she had a positive attitude she was gentle with me, so dedicated, I felt safe and secure and I also believe that speeded up for me, you know, made me feel uh good, speeded up my healing.*

Moving to such satisfiers as having one's vulnerability diminished [a definition of caring] and a positive disposition from nurses, leads into the next point (Benner, Wrubel 1989:1).

#### 4.6.1.3 Nurses caring for themselves ethically

As has been said, this arises from Mrs Rank's discourse Line 558-578:

*Ja, just to maybe cover a comment of uhm just staff in general. You have to distinguish between staff who you could see take care of themselves holistically. So they have a friendly disposition and they are quite relaxed and they are very balanced and they can give 100%. Then you've got the other half who you can see are not taking care of themselves, who are not balanced who don't have such a friendly attitude and who can't really give of themselves and who might be taking a little bit from you because they need some support. I think, something just to think about. Uhm you can encourage them to also look after themselves. To be able to give to other people you have got to be able to take good care of yourself and there is a nice balance here. I mean the majority of the people fall into looking after and having some balance, but the other 25% are not doing that. I think that is not just a bad advertisement for the hospital, in that uhm we can see what you are promoting in terms of health and wellness it also could be value for the patient.*

Here she makes a distinction between staff who:

- Take care of themselves holistically
- Have a friendly disposition
- Are quite relaxed
- Are balanced
- Can give [of themselves] 100%.

In contrast are those who:

- Are not taking care of themselves

- Are not balanced
- Do not have such a friendly attitude
- Cannot give of themselves
- Take a little bit from you because they need some support.

In summary, rough-hand care, a term I used to describe patients' dissatisfaction, was shown by Mrs Rank to produce negative consequences, which increased patients' vulnerability instead of reducing it.

The analysis of the data reveals that according to Gaut (1983:315) the general family of meanings are all related to the notion of caring in three senses:

- Giving attention to or having concern for
- Being responsible for or providing for
- Having regard, fondness, or attachment.

Therefore the concept of caring can only be enriched by strong nursing practices and by those who have strong ethical dimensions of caring practices. What must be questioned is how much understanding nurses have of the ethical component of caring, and whether reducing the number of agency staff will increase the caring ethic that is felt by patients.

Is it the caring for patients in unfamiliar surroundings which adds to the tension of nursing highly specialised patients, coupled with patients' demands, that leads to the compromised care or the components of rough-hand care?

When agency nurses were assigned patients for a shift the accountability for the quality of care rested with that nurse. Did quality care diminish as a result of the agency staff? The two hospitals studied had an agency nurse protocol, which included a short orientation to the ward, workload, changing of all intravenous and controlled drugs by permanent staff and all checking of documentation prior to the end of the shift. As a result of this protocol, because of the placement of less experienced and less competent staff, permanent staff [professional nurses] had increased responsibilities or more patients assigned to them. The use of agency nurses was a contribution to the dissatisfaction with care which patients experienced in this study. It requires supervision and action in the future to ensure that patients with higher levels of vulnerability [and acuity] were not compromised by "ad hoc" nursing staff. This will be discussed as a recommendation in Chapter seven.

Gaut (1983: 313-324) sought to use particular terms of theoretical caring in relation to what nurses do. She wanted to understand the meaning of caring to them, to gain the importance derived from the “valuing of persons” in society and amongst individuals. The goal of her analysis was to identify the need for care and the need to implement an “action” programme based on that knowledge so as to bring about positive change directly related to the need for care. Practically she felt that these conditions would bring about good caring actions and positive outcomes in a specific nursing context.

If Gaut’s model is to succeed in nursing then the notion of caring related to the ordinary action of feeling, touching and talking to patients lies in identifying the need for care and implementing action based on the improvement that would be experienced by doing these things. The importance of knowing and understanding the patient, her condition, and family is really a key concept here and is interpreted as the ethic of caring (nursing) by Mrs Rank Line 94-106:

*P: ...Yes I did, I mean there was certainly some members in ICU that I was very afraid of, did not want them near me (laugh). And at night, I mean if we talk specific day and night, I mean, I think the night staff are not as good as the day staff. I just think that’s just a general thing. I think there are more agency staff at night and there is more of a core permanent staff during the day and there is definitely an ethical uhm difference in terms of dedication and care. And uhm ja the other members of the unit that I wasn’t very comfortable with [I can’t remember] names I just know there wasn’t that feel.*

Mrs Rank described the differences between day and night staff, with regard to their care values. As did Mr Stone, she questioned how nurses, especially the agency nurses went about their work.

The researcher, for validation of the differences between night and day staff and in the ethical difference [as described by Mrs Rank] between the permanent staff and agency staff, clarified the understanding and the meanings by examining the literature. Mahone (2001: 1-2) states that there is no inherent difference in the quality of care given by temporary staff compared with that provided by those permanently employed, but the way in which temporary staff are managed is crucial in the National Health Service. Temporary staff is allocated in an “ad hoc” way and they often have to care for patients in unfamiliar

situations. They may not be shown where vital equipment is kept. They may be unfamiliar with practical aspects and procedures where they are placed. This unfamiliarity with both the patients' conditions and the situation leads to the difference in care, which is interpreted as poor caring practices by patients. Riemen (1986:35) in her example of patients feeling dehumanised, devalued and fearful felt that patients perceived nursing as more than just a job [task to be done].

A patient like Mrs Rank makes this assumption on the basis of her own socialisation and her experience of previous care [at Hospital C and in the medical ward at Hospital A].

Thus there is a need to support patients and care givers, especially those working in specialised units since the relationship of the nurse to the patient was identified as important in that nurses' [caregivers] ethical behaviour is central to what patients interpreted as the satisfaction of nursing care received in this study.

The use of relational ethics is a way to further illuminate patients' experiences of these compromised situations. It is very important for patients to feel safe and supported during these times of difficult care and trying to cope [in order for patients to feel cared for and to be able to overcome the insecurity]. Care needs to be continually supervised especially at night when unfamiliar nurses are working in complex and highly specialised units.

Astrom, Norberg, Hallberg and Jansson (1993: 183-193) pointed out, and it has been recognised and identified in this study, both in the wards, specialised units and the ICU and HCU) that caring knowledge requires nurses to communicate and to receive support from one another in a group in which to share their thoughts and feelings. Being able to care for the fragile, inarticulate or silent patient requires that any experientially gained knowledge is preserved and passed on to all nurses in the care of patients so that continuity of care is practised at all times. This social interaction of nursing should be communicated to the incoming nurses, particularly when a permanent member of staff is handing over to an agency nurse. Extra time may be needed for in-depth explanation during handover to ensure that little idiosyncrasies in the form of a narrative about the patient is passed on.

The lack of attention spent in the time teaching agency personnel in the use of equipment is very evident in these descriptions of non-caring behaviours. The safeness of how a patient feels lies also in the assessment of how nurses work [assessed by patients in his/her presence].

Aspects of care identified as gentleness and dedication are described as patient satisfiers of care. They were all part of the multiple meanings of components of relational caring:

- Using personal touch. This enhanced the physical and psychological comfort of Mrs Rank
- Being there providing safeness, security, dedication, and being trustworthy to carry out care. This involved being there when needed and informing the patient. The knowledge and skills level of the staff and the confidence of being treated well in order to show that the patient was *in good hands*.
- Demonstrating empathy and compassion for patients being able to appreciate and understand the patients' situation or feelings was needed by nurses in order to show compassion.
- Appropriate laughter and humour enhances the positive experience and meaning of being a patient.

The core practice in providing ethical care is that nurses must spend time with their patients in order to walk the extra mile, attend to activities and tasks in order to provide continuity of care. Staffing levels, the levels of experience and having the right mix of staff is critical to the nurse-patient relationship and continuity of good caring practices together with good leadership and management and organization of the unit.

#### **4.6.1.4. In Summary**

The necessary skills, knowledge and experience of nursing staff are essential for the continuity of care between day and night staff, permanent staff and agency staff to enable nurses to become involved and committed in providing the best nursing care appropriate to patient needs.

### **Section Three: Dissatisfiers of care**

#### **4.7.1 Introduction**

The focus has been on good nursing care rather than on bad in the emergent sense of caring. The difference in staff competencies, the use of agency staff, the difference between night and day staff and the corresponding continuity of care patients received are

intertwined with different caring attitudes. Examples of poor care, and dissatisfiers of care, will now be described.

#### **4.7.2 Dissatisfiers of care**

This section will describe poor attitudes and poor caring practices and leads on from the second exemplar to discuss the caring practice differences of some nursing staff whose intent appears to be something other than promoting healing supportive actions.

Participants were able to distinguish the different standards of nursing care they received because of the criteria that had been used in selecting them, i.e. they were experienced hospital patients who had had at least three days in hospital and a previous admission/s. Such experienced patients expect nurses to be knowledgeable about their care, so it was important that nurses knew them as individuals and knew about their treatment. All the participants were concerned about the effect of how care was delivered. This is the nature of caring from the perspective of maintaining the individuality of the patient. It involves the personal care aspects of the individual. Definitions of patient satisfaction include elements and interactions of care. These are unique to patients' expectations of care. In the examples given in this section the participants' understanding of dissatisfiers of care are described.

Nurses need to provide the right caring environment for the needs of families and patients. They need to understand the patient as an individual, a social being who is part of a wider family. They need to be aware of the concealment or acknowledgement of communication with sensitivity around the care of the patient with a chronic illness.

What actually dissatisfies patients [participants] is the nature of the caring, the caring communication, and the caring attitudes described below. This list is by no means an exhaustive account of every fundamental aspect of dissatisfiers of care, but it represents those elements identified by patients as contributing to the dissatisfaction of a patient's experience. The dissatisfiers are:

- Poor attitudes to patients
- Poor care and poor caring practices
- Lack of nurse's discretion in the carrying out of routine care, or adhering too rigidly to rule-bound or regimental care

- Long handovers [which resulted in Mrs Windy not receiving medications as requested]
- Patients' difficulty in receiving normal over-the-counter medications [as patients perceive it] which are not readily available
- Time taken to give medication and the lack of caring attention given during this time
- Nurses rushing patients [when mobilising them]: "quick, quick"

#### 4.7.2.1 Poor attitudes

Patients believe that aspects of their care, such as receiving attention, and nurses being sensitive to them as individuals, are important. Mr Van stated Line 556-600:

*"They did not pull the curtain when I was eating breakfast, when someone was putting something down someone's throat"* [Nurses were suctioning a tracheostomy patient.]

A few patients reported negative feelings or experiences of nursing care received from both agency and permanent staff. Such criticisms were directed at the poor interpersonal skills of nursing staff. One participant [Mr Stone] felt that the reason nurses were short-tempered and had attitude problems was because of the lack of facilities and resources at the government hospitals. Line 456-457

*"They have a reason to feel like that, but I don't think they should take it out on a patient,"* he said.

Patients spoke about being disregarded and ignored.

Mrs Magg described Line 625-626:

*"sulky, moody nurses who take it out on patients."*

Comments such as these arise from a sense of being devalued and the idea that nurses take their frustrations out on patients.

Mrs Magg commented in her transcript Line 99-101:

*"if the nurses are caring then the patients get better quicker".*

Patients observed the personal qualities of nurses themselves as important, certain nurses stood out and were described as satisfiers or dissatisfiers. These findings highlight the importance of respecting individuals and are described by Montgomery (1991:93) as the

“nature of the connection”. Care is described as the quality of caregiver’s engagement, and involvement with patients, which leads to growth and “healing through communication”.

Two patients, Mrs Magg and Mrs Ray, in their responses compared the training and caring attitudes of nurses years ago. Mrs Magg had been a nurse, so she compared how she had nursed with nursing she experienced today. She said the old saying one often hears from elderly folk, “nursing is a vocation”, might suggest that patients are looking for the nurse of a bygone age. This implied that nursing had been more hands-on and nurses had been more empathetic in their care, and, as old pictures showed, nurses were continually seen around the patient’s bedside.

Mrs Magg described Line 224-254:

*“You know, it used to be so strict; with nursing today they are so lackadaisical you know. The nurses don’t seem to care. They’ve got a job and that is that. They don’t take up nursing to care”.*

She continued Line 358-365:

*“I mean it was so strict and like... After visiting hours they used to ... if anybody wanted a pan (bedpan) and then ... they would rub our bottoms (patients) and but they don’t do those sort of things today”. Today, like when I am on my own they don’t worry about me anymore... I am there, not even a patient anymore as far as they are concerned... “You’ve got to tell them”. “And I don’t know how you are going to get that into nursing” [looking directly at the researcher, shrugging her shoulders].*

Mrs Magg went further, in her knowing and informed way Line 245-246, 287-291:

*“She (the professional nurse) has just got that way with her. You know, that’s what it is, love, a nurse should care about, about her patients. They were so much stricter with us; I’m afraid all the good professional nurses have gone overseas. You know the lot that trained with me have all gone over”.*

For Mrs Magg, a 77-year-old ex-nurse who lives alone, it was important to question the whole nature of caring because she had experienced what it was to be a nurse and continually compared the old tradition of nursing with what nursing is today. Her words “I am there” show that she felt that she was not even being recognised as a patient. She was physically there but she felt a distinct lack of being cared for.

She explains Line 94-99:

*“Where did you do your training, because there is no caring in your training? Learning [nursing] is to care for your patients.”*

Mrs Ray and Mrs Magg questioned the caring attitudes of nurses and whether the nurses they described as uncaring were “properly trained”, saying,

*“there is no caring in your training.”*

Mrs Ray explained Line 132-137:

*You don't do it because you get money at the end of the day but because you want to see your patient get well enough – there is too much of the other. You've got to tell them to put your bed right, put your food in the right position, you have to ring your bell and say, “I can't do this”.*

Mrs Ray felt that the care and the interpersonal contact she had from some nurses was cold and uncaring. This made her feel helpless. It was as though she was an inconvenience to them. Patients' expectations of receiving routine care were identified by the need to receive proper care. Patients were concerned that some basic nursing tasks were being left out. Thus in caring, the practice of giving nursing care is related very much to the experienced or the involved nurse and how the concept of “time” affected the organisation and how care was being carried out (Benner *et al.* 1996:47).

Mrs Magg stated Line 226-236 and 358-365:

*They [nurses] just don't seem to care; they've got a job, and that is that. They don't take up nursing to care. I mean these that aren't trained.... [meaning enrolled nurses and enrolled nurse auxiliaries]. If they come into nursing because they are caring or they like people or they want to help people ... that's different... And then there is such a big difference between the trained sisters. She is normally the professional nurse... there is totally a different training coming out... that you can see!*

What these patients say compares with the study by Riemen (1986:35) who sees nursing as more than just a job and patients as more than just objects. Marcel, the French existential philosopher cited in Riemen (1986:35) explained that one way to develop a caring attitude was the difference between “physically being present” and “being truly a presence”. He uses this example: if a person (patient) is in pain, there are some people who “reveal” themselves as “present” in that they are there because they want to be there

and hence their actions are befitting the needs of patients. Then one feels their presence in a special way. There are others who do *not* give this feeling, however [well] they may come across. One senses whether the person is truly giving of her/himself, because “presence” reveals itself immediately in body language and facial expression: by a smile, a nod, a look or a handshake.

Mrs Ray commented on the “rough treatment”, the lack of involvement of nurses, together with the lack of skills that she experienced when being mobilised. She describes Line 65 – 71:

*Nurses who [are] quick, quick. [They] want to mobilise patients and are not equipped or competent to care for specialised patients.*

This hurried and uncaring approach to patients by some nurses is perceived as the lack of potential “time” that nurses could spend with patients and the effect this had on their care.

#### 4.7.2.2 Poor practices

Five patients reported specific incidences of poor care. Mrs Windy, for example, referred to the lack of catheter care and the resultant infection. Line 423-445:

*Mrs Windy: When I was in High Care I had a catheter and I think I picked up a bit of an infection because of it, which I wasn't happy about. But now my doctor has prescribed something. I mean he looked at the sister and said, “I'm not a gynaecologist”, you know, what do I say, what do I do? I feel for the doctor because he did not know, he never deals with that part of the body, so it's a situation one expects in a provincial hospital where there is always doctors available, but not in a private hospital. There should be a GP available in a private hospital that could give you something off the shelf and deal with it.*

*R: So you did say that you were a bit unhappy about the fact that you got an infection?*

*Mrs Windy: Ja*

*R: Can you tell me a bit more about that?*

*Mrs Windy: Well, a catheter is necessary when you have the op [operation] on .... Its just that I, while I was in High Care I had a smell which was not supposed to be there and a bit of a discharge which was also not supposed to be there either and I asked*

*about it and they [nursing staff] said it was normal... and uhm.. I don't think that I got a hell of a quick reaction to this one either and it was only once I was back in the ward and I said to them you know this is what happened. I was not being sorted out and ... you can't get away from this; the surgeon should have sorted it out, because they obviously don't know what you are talking about.*

The participant recognised the problem she encountered as the lack of competent and knowledgeable nursing staff, which culminated in the non-caring attitude and lack of attention to detail of the nursing staff in the high care ward.

#### **4.7.2.3 Participants described the lack of nurses' discretion in the carrying out of routine care, or adhering to rule-bound or regimental care**

Patients felt that they would have liked nursing staff to use their discretion when working with patients early in the morning, for washing purposes especially, as patients were washed very regularly. For example, in the ICU attention to sleep was not seen as a priority, and was being taken over by routine.

Mr Stone described Line 174-178:

*Not being able to go to the bathroom and washing at various times of the day [were problems]. Often, a couple of times, they would wake me at 04h00 in the morning to wash me and to change my linen. If they had to and uhm, I would have liked the night nurses to have used a bit more discretion. It is a lot better here [at Hospital B] obviously, because I am not in such a critical condition.*

Mrs Windy asked Line 30-49:

*Mrs Windy: Who wants to bath at 05h00 in the morning (laughing)? And have clean sheets put on. You know, I mean, please, ...try again!*

*R: You find the hospital routine a bit difficult?*

*Mrs Windy: The 05h00 in the morning. Yes, a routine is required, yes, but at 05h00 in the morning, I never ever could dream up a reason why they wake you up and make you get up so that they can make the bed and ...*

*R: Is there anything about that 05h00 and the way the nurse came to you that you can remember?*

*Mrs Windy: Ah, very regimental. You know, come on, wakey, wakey. 05h00. Get the usual thermometer, here is the bowl of water, have a wash. Get up let's make your bed. Uhm, I suppose that is the only way they get people moving, at 05h00 in the morning anyway.*

#### 4.7.2.4 Long handovers

Mrs Windy discussed the long nursing handovers, which she found inflexible even to the point of not receiving pain relief medication when requested. As a result of the inflexibility of the nursing staff she describes what she did to overcome her problem Line 119-124:

*Yes, there are times at 07.00 and again at 19.00 hours for handovers and then its Visiting hours, and yes if you then seriously want a pain tablet you're going to have a bit of a problem getting one. It's understandable. So what I eventually did is tell the staff that I want my pain tablets at 18h30 and I'll keep it, if I need it during visiting time, which was fine.*

The lack of caring attention and the experiences participants described became evident if patients had been hospitalised for a long period of time. The lack of attention given by doctors was mentioned as well. The expectation by nursing staff was that patients should be caring for themselves or at least trying to gain their independence. One patient interpreted this lack of care as being due to laziness and not wanting to assist her. Mrs Magg who had spent more than 40 days in the ward, commented negatively Line 424-432:

*"Well for instance I need a hair wash badly and I have been asking and asking and nobody wants to wash my hair and the doctor said I could bath as long as I ... nobody wants to help. ...(laughing) I'm frightened I might fall over or something.*

Mrs Magg Line 363-365:

*Today, like when I am on my own they don't worry about me anymore. I am there, not even a patient anymore as far as they are concerned.*

She defended herself in that gaining independence is one thing, but the nurses' unwillingness to help her, when she is not yet strong enough to help herself, is another. Line 379-380:

*I am very independent and I like doing things [for myself]. No matter how much you want to do them, you just can't.*

She was also critical of instances involving doctors. Line 438-443:

*Even the doctors, once you've recovered from their side of the deal, they don't bother about you, you know, while you are ill they are very... But otherwise... if you're used to being in a place for so long you become part of the furniture.*

*So I try and battle here; to do for myself... But you can't always get comfortable trying to manoeuvre on your own.*

The experience Mrs Magg described is that the nurses expected her to help herself. This was done in part to prepare the patient for discharge; however, Mrs Magg perceived this lack of care and attention as an attitudinal problem amongst nursing staff of today. This is interpreted as a dissatisfier of care. Mrs Magg compared the lack of care and attention to feeling she is just part of the furniture.

#### 4.7.2.5 Difficulty in receiving normal over-the-counter medications

Mrs Windy questioned the inflexibility and availability of the hospital and the staff to provide what she described as over-the-counter medication for a sore throat.

Line 387-404:

*Mrs Windy: Ja, the one thing I found strange in a private hospital, which was a bit of a surprise for me, is if you in the middle of the night think " my throat is actually sore", there is nothing they can do for you. They have to get a doctors' script to give you Cepacol [throat lozenge] to suck, I mean.*

*R: And you find that a bit strange?*

*Mrs Windy: Ja, that is a bit mind-boggling. You know, things like Cepacol and Band aid or a ...*

*R: Simple medication?*

*Mrs Windy: Elixir [cough mixture], like first aid kit kind of stuff I would of expected them to have it available to use. And tomorrow replace it. But it is in the middle of the night so while my throat is sore they say, "Well, we are sorry we are a bit busy...wait until tomorrow", it is very strange.*

The experience Mrs Windy discusses shows that she expected the nurses to help her, irrespective of the time of day or night.

Line 75-86:

*And it was just the way she [the night nurse] came in, you know, with a face like thunder and banging things around you know ... that sort of thing and then there was another sister um she was, she is on duty today, she was on night duty ... and you know my tummy, I had the runs and there was just nothing, you know, I could do about it and I used to have to ring the bell about every five minutes and she came in and she told me, "you ring the bell about every five minutes". And she said " you can't go every five minutes you are not helping yourself "... And things like that you know ... insulting me.*

#### **4.7.3 In summary**

The manner of the nursing staff was interpreted by Mrs Magg as insulting and non-caring. To Mrs Magg the meaning of care and caring began with Florence Nightingale [researcher's interpretation] whom she perceived as providing compassionate care and comfort in human skills in order to perform "careful nursing", putting the patient in the best circumstances for nature to heal him/her, to her this was the "art of nursing" (Benner 1994:30).

Many patients feel that nurses should continue to give care [despite being able to care for themselves], even as they approach the time for discharge home. This is consistent with patients' expectations of private health care as seen as a right by the patient [to receive care despite the fact that the patient can care for him/herself]. Patients are regularly heard to say "We pay for the service." Therefore it is an expectation that they should continue to be nursed with all nursing care and activities until discharge, irrespective of the actual level of care they require. The same expectations of care from private patients often apply even for relatively minor operations.

Learning self-care measures, while being provided with independence and control over one's situation, may induce feelings of dissatisfaction. Eriksen (1987:31-35) describes this as a goal that is learnt. The patients' perception of their ability to take control of their care may be in opposition to the nursing goals. Learning to care for one's self differently may be a result of the illness. A patient may need to learn coping skills and responsibilities of care in order to alter his/her lifestyle and to move out of the comfort zone of the hospital. They are no longer in the "sick role", states Eriksen (1987:34). Often patients want to

continue to have help and assistance from nurses well into their recovery phase. The nursing staff felt that Mrs Magg should be able to care for herself. This is where long hospitalisation (more than 45 days in Mrs Magg's case) becomes difficult for both nursing staff and patient. The nursing staff are often seen as being "cruel to be kind" especially when a patient is reluctant to regain their independence. This is often the case with patients like Mrs Magg who live alone. Another problem involves the difference between nursing staff abilities [insight and knowledge and their intuitive skills to knowingly care for a patient], the abilities and responsibility of agency staff and the difference between night and day staff in that the continuity of care received is compromised.

Overall all participants had a negative view of the agency nurses in the Intensive Care and High Care Units and in the wards, especially on night duty. Mrs Rank stated in relation to care values Lines 118-129:

*"I think there are more agency staff at night - and there is a more of a core permanent staff during the day. there was some permanent nurses as well who just weren't as skilled or as dedicated and there are those differences..."*

How people went about their work was different, although as she remarked, it was not always the agency nurses who lacked commitment and competency. She was encouraged to explain the reason behind her feelings.

Mrs Rank questioned the accountability of agency nurses in maintaining standards and ethics in an environment of which they are not permanently a part. Mrs Rank's expectations of nursing staff were that they should be balanced in order to care for patients, especially to work on the GIT unit. Staff who don't care for themselves and speak about their problems with patients would affect how the patient refocuses and understands the significance of their illness and adaption [Figure 4.1, page 73](Fife 1994:311).

Mrs Ray felt that Line 557-558:

*...in order to care for others the nurse must take care of herself to be whole.*

She continued Line 150-153:

*Sometimes they (nurses) come in and they are not interested in you, as nursing is a skill, not just a job. They put your food here whether you are in a position or not... its here and you've got to ring and sort of say, I can't do this like this, either I need to go up or I need something close.*

Mrs Magg Line 134-137:

*I find it more with the agency staff they are like that you know and uhm... they come and make their own rules and tell you to get up and I can hardly walk.*

These incidences reflect that patients' feel they have to tell nurses what they need, nurses don't see the problems or have insight into the patient's predicament. Mrs Magg reiterates this further Line 388-392:

*"I've got to tell them every night please close the blinds, please turn off the lights, and again in the morning please open the blinds and sometimes you ask them to lift you up because I can't breathe properly if I am lying down and they say, 'we are coming we are busy, there is other patients besides yourself' and this is how it goes you know... so I try and battle here to do for myself.*

#### **4.8 Agency nurses and nurse shortages, described by participants as dissatisfiers of care**

The next section discusses the problems and concerns patients had with the use of agency staff and the lack of caring attitudes and responsibilities these staff displayed. An overview of the current literature that is available on agency staffing has been discussed (Aiken *et al* 2001:43-53); (Mahone 2001:10-11).

That hospitals are facing serious nursing shortages has been recognised and discussed by the participants in this study. Their experience is a microcosm of what is happening worldwide in health care and in nursing generally. In particular the use of agency staff to fill these gaps is in some areas having severe consequences on patient quality care. The inconsistency and the unknown quantity of agency nurses place an unfair burden on the already overstressed unit manager each time she books an agency staff member. To fill a nursing vacancy is becoming more and more difficult and detrimental to permanent members of loyal staff and to the retention of those remaining. Job dissatisfaction, burnout and the intent to leave are becoming a reality as current shortages and soaring vacancy levels in the hospitals increase. This problem is further exacerbated by the belief that task nursing and delegation of patient care to lower categories of staff, due in part to the decreasing numbers of professional nurses staying in the profession [as is the case in South Africa], is spiralling (Aiken *et al*. 2001:43-53). This results in a lower staff-to-patient

ratio, which in turn increases the responsibility and accountability of caring for patients. In the hospitals in which this research was conducted the professional nurses now have to take responsibility for nursing a higher number of patients and supervising a greater number of non-professional staff who assist them in the care of patients' basic needs. Prior to this shift in care the professional nurse would have nursed a smaller number of patients and been responsible for their total care needs.

As a consequence of this, patients such as Mrs Magg, Mrs Rank and Mr Stone are fearful, anxious and worried about the skills level of nursing staff, and they specially mention agency nurses. Patients perceive the lack of care being provided and see this lack of commitment to patients as a reflection on nursing ethics. It is clear that emphasis on the role of ethical nursing is not being provided by the nursing agencies, and the nurses' failure to recognise this themselves is compromising patient care. This is in direct conflict with the existential skills of involvement that are part of nursing as a profession (Thomasma in Benner 1994:90-91);(Searle 1987:237).

The licence to practise as a nurse is not permission to act and practise poorly. It presupposes an obligation to practise well and safely with the protection of the patient as an aim. Practising professionals need to internalise this philosophy of "no harm to patients" and to act toward individuals as they would act towards themselves Searle (1987:237).

#### **4.8.1 In summary**

The transcripts highlighted the central and pivotal role that patients expected nursing staff to have in their hospital experience and the "core" caring role.

The participants were aware of the difference between the care "values" of permanent staff and those of agency nursing staff. How nurses went about their work was seen as the difference - between professional care [which was given in most cases by permanent staff] and the uncaring inconsistent care given by agency nurses. Being rough with patients and displaying non-caring attitudes increases the patients' vulnerability. Patients' perceptions of non-caring behaviours have been identified and described by Redfern (1996:22-33) and matched the properties of caring discovered in this study. The categories identified were:

- Psychological care of patients

- Positive attitudes of nurses
- Nurses spending time with patients, talking to them, using humour, laughter, being cheerful, and bringing out their own personality to establish a rapport was valued
- High standards of professional nursing service
- A pleasing and well equipped clinical environment.

The next section illustrates how a paradigm case emerged from the findings.

#### **4.9 A paradigm case to show the description and effect of poor nursing practices as perceived by Mr Stone as an example of a “dissatisfier” of care**

This section describes the experiences of Mr Stone who was suffering from cystic fibrosis. Mr Stone has lived with his disease for 20 years. He lives around his disease but it controls his life. He feels he is entirely responsible for the control of his drug regimens. His treatment revolves around the chemo port, a permanent intravenous line. Mr Stone has modified his lifestyle to accommodate his illness: he sleeps late in the day. This is in order to have fewer waking hours in the day because of the pounding headaches he gets as a result of the build-up of carbon dioxide every morning.

In this case the lack of caring practices of nursing has provided a paradigm case that illustrates the poor skills and the lack of attention, which cause acute dissatisfaction. A paradigm case is used to formulate particular patterns of meaning. These patterns of meaning are necessary to teach and coach; particularly caring actions in a nursing context. Through this paradigm one could learn to recognise symptoms, to listen to, and to work with, the patient so as to improve the outcomes of care. Instead, it shows how little attention nurses paid to the caring and specialised needs of Mr Stone, both in the Intensive Care Unit and in the ward at the two hospitals.

The interviews had to be done late in the afternoon, when as Mr Stone said, “I am at my most perky”. He certainly did not come across as “perky” as he struggled to breathe. He was greyish in colour and had an agonised look. He was conscious of the time throughout. He was constantly aware of the medications due and his nebulisers, together with the intake of food required to reduce the gastric symptoms. Mr Stone’s life is centred around his complex treatment regimen. The value in this example is that it shows in a significant way what satisfiers an informed and even an expert patient needs in order to have a better

quality of life. This patient has learnt to cope with his disease, which he fully understands. He painstakingly keeps a diary of events. He logs all medication given. It shows [in the researcher's opinion] "He is a nurse, who cares for himself."

This paradigm case describes how Mr Stone recognised poor nursing practices and the lack of skills, and how nurses failed to listen to him. According to him, a patient can be punished when he intervenes in his care and can be threatened verbally. This was true in Mr Stone's experience. Other examples given by patients illustrate that nurses could have listened and responded to the cues of understanding how a patient was feeling. Nurses just did not listen. Power over a patient is often apparent. The attitude of the nurse is often, "I know better".

Nurses can benefit from experienced nurse coaching, but they can also learn from experienced patients. The patient has learned these aspects from knowing his or her illness thoroughly. This can benefit, and contribute to, the nurse's education about the disease process and alert him/her to changing patient outcomes if he/she is willing to learn from this source.

Mr Stone related an experience line 149-164:

**R: *Was this in the ICU?***

**Mr Stone: *That was in the ICU at Hospital C, because my blood sugar had been high and it was coming down but they still applied the sliding scale and gave me twice the dose. Then I would [emphasis] have been in big trouble. As it was I had already had a big dose and I had to eat something two hours later. I then got bombed out about it [shouted at] because I wasn't sleeping and I was eating in the middle of the night. Then the next night I had a big fall out with [a] nurse who was a very short prickly gay man who obviously had some issue about being a male nurse. Uhm, I got into a big fight with him, but eventually it was all sorted out with the doctors and he was reported to the matron. But, uhm... Once I eventually got to know all the nurses and they got to know me, it wasn't really a problem.***

Mr Stone described his understanding of how he recognised nursing care or non-care. He described the poor nursing practices, and the lack of insight into his condition, a result of the nurses' inattention to the patients' reactions to illness. This shows a lack of overall competency, knowledge and insight among the nurses at both Hospitals A and G. This

example also shows how badly the nurses failed, or chose to ignore the patient. They did not listen to his explanation of how he cared for his “chemo port” [long-term intravenous entry]. It is vital to Mr Stone that this permanent line remains patent in order to support the many intravenous medications he receives on a 6-hourly basis. Good aseptic technique is essential to maintain the intravenous line and keep him free from infection.

Mr Stone is articulate and aware of what is entailed in these procedures, so much so that he is better in the technique than many of the nurses who care for him. (The researcher evaluated this so as to authenticate this statement.) Much of his agitation, loss of temper and anger at times were sheer frustration caused by the lack of care and attention shown by many of the nurses with whom he had come into contact. The contribution through patients’ narratives of their “lived experiences” is particularly valuable, according to Ingham (2001:43) in planning enquiry-based learning methods.

The following narrative paradigm illustrates how the nurses in High Care failed to respond to Mr Stone, in understanding his disease, and the signs and symptoms.

Mr Stone judged the nurses by his own standards. They almost all fell short.

He described line 498-503:

*And I got on very well with the doctors up there because I could discuss my condition and my situation, go through my folder and have students interviewing me every day and ...hat's sort of replaced by the friendly nurses here. They are my replacement for the friendly doctors over there (laughing.*

*Because I had breathing difficulty but uhm the nurses in the High Care Unit uhm... during the day when I first arrived they were fine but uhm when I was in distress in the evening they actually got short with me and I did not really have any energy to sort of, you know, get into an argument with any of them, but uhm I was actually struggling to breathe and they just said you know, they told me just to suck in and to calm down and I actually could not breathe properly so, I was quite worried. I managed to calm down eventually and got to sleep about 03h00 in the morning.*

Mr Stone is not an easy person to speak to, or to get to know initially, especially if one comes across a little vague about his treatment regimen, or shows a lack of insight and knowledge with regard to the care of his intravenous chemo port. This can and does put nurses off. As he described, the nurses often got annoyed with him and “did their own

thing as opposed to listening” [to Mr Stone], or helping the situation by trying to understand his care, or, going to find out the correct treatment. Mr Stone only wanted the best treatment. Is that too much to ask? This substantiates the point Mitchell (cited in Carper 1978:18) makes about the growing evidence that the quality of interpersonal contacts has an influence on a person’s becoming ill, coping with illness and becoming well.

Just because he knew more in most cases than the nurses about his treatment (even more than the ICU nurses and much more than the ward nurses), he questions whether that is any reason for his treatment to be compromised, or nurses’ attitudinal problems to arise against him.

A further example below illustrates how the nurses portrayed little knowledge about the patient’s disease and a lack of insight into his condition. The nursing staff showed themselves up very badly in failing to gain expert knowledge or contact the doctor; this led to a compromised outcome for the patient. Line 197-207:

*I felt, although they were equipped, obviously it was because, because they did not have the ventilator to start with, which okay, that is explainable I mean the only place that had one was Hospital C. But the way they did treat me, big a big problem because they put me on 40% oxygen mask because I felt that I could not get enough oxygen, but the sats [oxygen saturation levels] showed that I wasn’t getting enough oxygen on the nasal speck. So then they put me on a 40% mask, and then Professor said hang on there is too much oxygen, that is part of the problem. Put him on a 28% mask. So they cut that down. Once that dropped a bit lower. I then panicked and the nurses panicked and they put me back on the 40% mask without [asking] the Professor. So when he eventually came round 10h00 in the morning I was back on the 40% mask and he was very, very angry that they put me up on this mask, and actually it’s you know it seems like the right thing to do if you get the sats right, but it actually did more damage than good.*

*R: ... for your disease?*

*P: Ja, so he was very, very angry with that. Uhm, and they put me back on the 28% and then I went...*

Price (1993:31-41) calls this action “the nurse repelling concept” in the process of expressing verbal or non-verbal actions by the nurse and has been labelled “conflict”. This represents what parents and nurses perceive as important to meet their goals of the meaning of quality nursing care.

This concept represents the nurse moving away from the patient, telling the patient what to do, not asking patients if they want or need anything, and serves to move the patient away from the nurse. Price describes the “nurse repelling concept” as representing the move away from the parent or child. I have used this example and the “process of knowing” as the comparison in the case of Mr Stone.

This amounts to conflict, and indifference to treatment, and a failure to respond to the needs or the expressed wishes of the patient, as is the case with Mr Stone. The patient has to get into a “fight” situation as he describes it in order to receive what he so rightly deserves.

The concept of nurse technology as discussed by Price (1993:38) describes a force opposed to a movement into the stage of the “process of knowing”. Price describes this stage as “manoeuvring”, which is the first stage in the process of quality nursing care. Patient satisfaction of nursing care has been described as an indicator of patient’s perceived nursing care quality (Chang 1997:26). If nurses do not listen to patients, or have time for patients, then the next process as described by Price is the process of knowing, i.e. getting to know the patient or not getting to know the patient. The latter is going to impede patient outcomes.

The concept of time is fundamental to the process of knowing, as is the process of caring. The importance of how a nurse interacts with a patient would in the case of Mr Stone have improved his care in the basic insight and knowledge of cystic fibrosis, which would then have resulted in not over-oxygenating him. The mere presence, states Price, of a technically focused nurse would result in more time spent with the patient. Mr Stone saw the error in the fact that Hospital B was not equipped or the nurses did not have the “know-how”, which he described later in the transcript when asked about nurses that were not up to his standard. Line 485-503:

*Ideally, if I could have the facilities that I have here and the selection of the nurses, selection of nurses, just three or four nurses from the ICU at Hospital G, one or two*

*here that would be fine, and then also having all the doctors around me. That is one thing that is also a problem. There is, there aren't enough doctors around. All the doctors are, at least most of them are, at private practice and they only come in at very odd hours sometimes to see their own patients whereas at Hospital G, uhm there are physios and doctors swarming all over the place. And I got on very well with the doctors up there because I could discuss my condition and my situation, go through my folder and have students interviewing me every day and ... that's sort of replaced by the friendly nurses here. They are my replacement for the friendly doctors over there (laughing).*

The establishment of this positive relationship with the nurse and the patient is a necessary foundation for receiving quality nursing care (Price 1993:39) and would probably mean that Mr Stone would not have had to be transferred from Hospital B to Hospital G because of the lack of knowledge and insight of nursing staff.

This narrative portrays an intrinsic attitude of a person (Mr Stone) who understood his care and was able to explain and describe the competent and the not so competent nursing staff. Mr Stone, who experienced care in the Intensive Care and High Care Unit, described mixed experiences of caring, technical care and nurse competency levels. Patients were asked to explain how they experienced their current care at Hospitals A and B and how they experienced care at other hospitals. Understanding their previous expectations of care or their knowledge and insight into their diagnosis may help place their evaluation of care in context. Patient satisfaction, states Linder-Pelz (1982:577-582), is believed to be related to various health and illness behaviours, i.e. a satisfied patient will comply with physician's instructions and keep future appointments.

Mr Stone explained Line 197-207:

*"I had breathing difficulty but uhm the nurses in the High Care Unit was not during the day when I first arrived they were fine, but uhm when I was in distress in the evening they actually got short with me and I did not really have any energy to sort of you know get into an argument with any of them, but uhm I was actually struggling to breath and they just said you know, they told me just to suck in and to calm down and I actually could not breath properly, so, I was quite worried. I managed to calm down eventually and got to sleep about 03h00 in the morning".*

Avis, Bond and Arthur (1994 cited in Avis, Bond and Arthur (1995:316-322) found that many patients reviewed their current experience in the light of previous episodes of care, which were of poor practice. [For example, if patients had been wrongly identified previously, then they cited examples of bad practices]. Patients can see what is going on around them, and how things go wrong. Often they can identify in some cases the root causes of the problem namely, staff do not listen to patients carefully enough. Patients can discern or pick up the differences in different wards, in the quality of care and treatment.

#### **4.9.1 Discussion**

Why did I choose Mr Stone as a paradigm case? Primarily this example illustrates how Mr Stone understands his disease. He has control over his disease process [cystic fibrosis]. He has accepted his illness; to him it is neither passive resignation nor an enthusiastic embracing of the demands of illness. This is primarily due to the complicated medication and treatment regimens Mr Stone has had to learn because there is no one else able to really show enough understanding or informed enough to take on this responsibility. Even the nursing staff, as has been shown, do not take the responsibility to learn about the many different drug regimens. He has become adept at adapting his lifestyle.

He records everything in his neat hardcover book: names, what happens, drugs and treatments given, almost like evidence about the events and almost like nursing or medical progress notes. His experiential learning is to overcome many or some of the symptoms to enable him to achieve a level of acceptance of living with a chronic illness. Mr Stone recognises the need for experienced nursing and medical care in order to fight his cystic fibrosis. He analyses the care, people, food and friendliness, in fact all aspects of his care. He enjoys discussing his condition with the doctors at Hospital G and gains comfort from having them around.

For a patient to accept the way he/she feels frees that patient from feeling defensive. Then the patient feels free to follow suggestions and guidelines. In a way patients such as Mr Stone can feel patronised. It is the "the nurse knows better" attitude that has a belittling effect of devaluing the patient's knowledge, expertise and experience of his disease. He does not accept poor practices. Only when he feels that the nurses know how the drug and

treatment regimens work is he then satisfied, despite often feeling very ill and very tired. Despite all these circumstances he continues to cope. He cares for himself.

#### **4.9.2 In summary**

Nurses need to provide the right caring environment for the needs of families and patients. They need to understand the patient as an individual, as a part of a wider family, a social being, and to acknowledge the sensitivity around certain diseases, especially cancers and preterminal conditions like that of Mr Stone. Concerned caring leads to patient satisfaction. Concerned caring identifies what matters to a person and also sets up what options are available for coping. Caring creates ethical possibilities for all parties Benner (1994: 3).

Mr Stone's narrative has revealed a meaningful response to a life-threatening illness. The researcher has adapted Fife's work, the "process of constructing a meaningful response to life threatening illness" and recognised the process in the way Mr Stone [and others] cope with their life-threatening illnesses, illustrated in Figure 4.1, (Fife 1994:311).

We can compare how Mr Stone copes by seeking out information about his chronic illness. He wants to know and understand how to cope and in effect is attempting to make himself better. He wants to keep up high standards, to maintain the chemo port, to sleep late because all these affect his quality of life.

"Time creates a story," stated Heidegger (cited in Benner, Wrubel 1989:64). The story we get from Mr Stone gives us different time perspectives and vantage points from which to learn about his need to have the best care. Time is of the essence because he is in a preterminal state. He cannot afford to lose time because of poor nursing practices or nurses making mistakes in caring for him. This story includes the need to be informed about his condition. If Gaut's theory of conditions of caring (1983:318) are used in the context of Mr Stone's experience, then the nurses at both Hospitals B and G failed to be involved in the need for care, directly and indirectly. It was apparent that certain things could be done to improve the situation, but instead his story showed a distinct lack of insight and understanding. Nurses failed to care and show insight. Despite his having been in Intensive Care with seemingly advanced or expert practitioners, their failure resulted in his transfer to Hospital G. Mr Stone fights for better care in his involvement and intervention in his own care. To improve his quality of life he takes the lead in his care.

He described Line 246-248:

*Ja, and uhm you know, things like them forgetting to give me treatment at a certain time: and I have to ring the bell and say, "I need a drip now", and stuff like that.*

And continued Line 254-262:

*The drips are okay, but things like nebulisers and stuff tend to get mixed and then forgotten and then I realise like 3 hours later [when] somebody comes to look and the charge sister ask "did you have your 12h00 nebuliser?" and I'm like "No! It's mixed up there but nobody's given it to me or turned it on". Uhm, the nurses have come, when I have called them, they come very, very quickly, that hasn't been a problem and they have generally been very friendly, Uhm.*

The ability of a nurse to care for a patient like Mr Stone using Gaut's formula (1983:318) must be more than just awareness. It also involves various kinds of knowing and a conscious focusing of attention in an effort to do or to improve care, and by so doing the nurse respects the patient as a person with values and choices.

When nurses take the risk of getting involved with their patients from a position of caring "we expand our consciousness", such that our notion of self includes another and consequently all others. Macy (cited in Montgomery 1991:102) feels that when nurses are willing to expand themselves to include their patients they become part of another. We "become more of our self". Caring becomes a self-enhancing way of being. Our clients [patients] become a part of our hearts and in so doing help to heal themselves and our hearts as well.

Referring to Gaut's (1983: 313-324) formula and criteria, the meaning of care as used by in the "conditions of caring" [an explicative analysis] revealed that Mr Stone showed an awareness of his condition, which was not part of the caring ethic displayed by many of the nursing staff he described. He was at a different level of expertise [from the nurses]. He liked particularly to be in the centre of the doctors' rounds so that he could discuss his folder, and have students interview him. He saw himself at their level, not at the nurses level; he had moved beyond being just a patient to being an expert patient, an "expert" carer [to use the term Benner uses of nurses loosely].

On reflection after interviewing and seeing Mr Stone on many occasions and speaking to him following his discharge, I questioned how nursing could overcome these gaps in care,

which should not exist in practice. There should be sufficient encounters in nursing practice to coach and help learners and all staff to overcome these dilemmas so that patients do not feel that a non-caring ethic exists, and that we as nurse managers are not placing staff in situations such as these without the resources to overcome the gap between clinical and theoretical knowledge or both. This will allow for a patient perception of dissatisfaction with care to be reversed, if one has a better understanding of what the patient expects.

#### **4.10 In conclusion**

To achieve the purpose of this study, interpreting phenomena appearing in the text inspired by Ricoeur's hermeneutic arc was used. The method sought to uncover the process of interpretation as a series of steps to obtain patterns and meaning of patients understanding through their narrative descriptions.

It is Ricoeur's claim that the methodology of text interpretation can serve as a paradigm case for interpretation in the field of human sciences. This is based on the assumption that human action is meaningful and this action can be treated as a parallel to text. Human action leaves "traces" on social life when it contributes to the emergence of social patterns or structures (Van Veuren 1993:137). I have used Mr Stone as a paradigm case to interpret "meaningful human action". The "traces" it leaves is the message in this text: that nurses need to learn from those patients who have lived with their illnesses, or who have gained experience from being frequently hospitalised. This would make for patient satisfaction. Patients concerns can only be understood by engaging in meaningful dialogue with them. This is a powerful process of involving patients in their care. In letting patients advise the professionals in terms of what is important to them and to better meet their needs in the future. The "inner circle of care" or framework of patient satisfaction described in Chapter Six captured those ingredients of essential care that facilitated patient understanding of satisfaction with nursing care.

## **Chapter Five: Findings and discussion: Understanding the participants' meaning of patient satisfaction**

### **5.1 Overview**

Benner, Wrubel (1989:1) state that “caring sets up the condition that something or someone outside the person matters and creates personal concerns because caring sets up what matters to a person, it also sets up what counts as stress and what options are available for coping”. I have interpreted the patients’ understanding of satisfaction or dissatisfaction of their nursing care received, as the experience of the relationship created between the nurse and the patient. What emerged as a satisfier of care was the presence of a caring relationship by nursing staff that demonstrated involvement, commitment to patients and concern. These factors were emphasised by the participants in this study. Caring for patients does not just reside in a set of procedures and practices but in a thinking-feeling relationship involving nursing interventions and practical solving care that facilitates the healing (Astrom *et al.* 1995:110-111). Fife (1994:309-316) describes the responses of the “social world”. These are the interventions and approaches to care, knowing and understanding the patient. The nursing care they received has made a positive impact on their lives and enabled them to cope and in some instances to adapt to their disease process (Fife 1994:309-316).

It is the nature of the care that is provided and the interpersonal aspects of caring that emerged significantly in my study, as well as the approaches to care. Caring is what matters to patients; the “components of caring emerging as satisfiers or dissatisfiers” described in Figure 4.2 enabled me to discern what patients wanted from their care and what mattered to them. Part of what patients expect in their role as consumers of health care and in the involvement that they need to play in their care, is described by Kitson (1990:1) as the “patient experience of the service; quality of care begins and ends with the patient’s experience of the service”. My findings show that when patients feel that they matter in the caring process, in an environment that encompasses personal caring and dignity, that respects and values them as individuals, they identify these components as patient satisfiers of nursing care.

## 5.2 Introduction

The research was undertaken to discover and understand the participants' experience and meanings in relation to the concept of satisfiers and dissatisfiers of nursing care. Indeed Benner's work (1994:34) rests heavily on the assumption that good nursing practice is readily apparent if one provides the event and its context. The literature review revealed that patient satisfaction has rarely been described or defined. What is known is that patient satisfaction is integral to the assessment of the quality of nursing care (Chang 1997:26-37) and can play a role in influencing the quality of care rendered (Aharony, Strasser 1992:50-51). Bond, Thomas (1991:1492-1502) discuss the effect of the usefulness of nursing. They question whether nursing makes a difference and to what extent patients seek (expect) the same or different things in their nursing care.

In attempting to answer some of the questions/dilemmas raised in the literature, my research study interpreted the meaning of the following:

- Identifying patient satisfiers and dissatisfiers
- How patients perceive nursing care in terms of being satisfied or dissatisfied and what makes these satisfiers and dissatisfiers more cogent and more practical.

What it is that makes patients satisfied with nursing care is interpreted from the discourses as the caring attitudes of nurses. This has been described as emotional and supportive care performed by experienced, competent and caring nurses. That which makes patients dissatisfied with the nursing care is interpreted as poor attitudes. From the discourses it emerged that poor interpersonal skills and lack of routine caring tasks were interpreted as cold and uncaring attitudes. Patients were able to differentiate between nurses' levels of involvement in their care. This was demonstrated in the level of commitment nurses showed in their caring practices and in the amount of time they gave to the nursing care of patients. Patients were able to evaluate the care they received, and it emerged that they believed that nursing is not just a job and patients are not just objects. This can be compared with a study by Rieman (1986:35) that described nursing as a "presence" making a difference to patient care, because they (nurses) want to be there supporting and focusing on patient care. Patients perceive caring as having a sense of value, which is a part of this quality of care, felt by the consumer (the patient) and interpreted as important to the healing relationship: the relationship between the patient and the nurse. Basic

nursing practice reveals one of the most important care concepts to patients in evaluating nursing care.

In contrast to the patients' perceptions of caring are the non-caring behaviours and attitudes. Riemen (1986:30-36) asks the question, "What is it that nurses can and must do in order for patients to perceive themselves as being of value?" This question can be answered from the descriptions of non-caring interactions and poor clinical practices, which are detailed very specifically in this study. The caring acts are so simple and are described as "*I just had care, I know they care*". "*I think it all depends on who is on duty,*" said Mrs Maggs. Patients feel uncared for and undervalued if the care is in conflict with what they perceive as important. These actions have an effect on patients and are a combination of attitudinal and behavioural interactions. Why is it then that some nurses perceive these feelings and walk the extra mile while others display an apparent lack of care towards patients? The patients in this study who had been nursed in public hospitals recognised the shortage of nurses and commented on the declining state of the health care services. Despite their recognition of the increased workload, the dissatisfaction of care related to the way patients were communicated with, their being left without basic routine care being done and being nursed by nurses lacking experience, competency and the skills to care. It is evident that more research needs to be done in South African hospitals, both private and public, to develop this concept of what makes patients satisfied or dissatisfied with care and a need for a standardised instrument. This concept of caring in nursing puts the patient in the centre of everything that nurses do. I have further illustrated the importance of this in the "framework of patient satisfaction" diagram in Figure 6.1. Understanding what patients mean when they say they are satisfied or dissatisfied with the nursing care depends on two factors:

- Expectations of the care they will get
- Perceptions about the care they receive.

The most commonly studied dimensions of satisfaction with care are humaneness, informativeness, overall quality and competence (Staniszewska, Ahmed 1999:364-372). The literature concurs that most studies on satisfaction have been consistent, indicating that most patients were generally satisfied with the care they received. Patient satisfaction surveys tend to produce little variation in reporting high levels of satisfaction experienced

by patients. Although they claim to measure how patients feel, in reality most studies lack the clarity of representing the feelings and experiences of patients (Thomas, Bond 1996:747-756). The aim is rather to ask simple questions about how patients feel about the care they have received.

My analysis of the transcripts revealed the participants' understanding of what constitute caring practices and fulfilled the research question. From descriptions of the caring interactions it emerged that nothing is more important to the patient than the nurse. This is hermeneutic understanding whereby themes and categories with similar meanings emerged when seen through the eyes of patients. The participants were able to distinguish between different staff in respect of the kindness, emotional and supportive care they gave. Participants described how the nurse/s focused on them and spent time with them, which relates to insight into the approaches to care. They described both getting to know the nurse/s as well as the nurses getting to know them. The interpersonal skills and the relationships that were developed between the patient and the nurse/s together with the importance of nurses' clinical skills and competence were interpreted as the most important aspects of their care. Patients' perceptions of how care was delivered are described as the aspects of care most important to the outcomes of their care, which constitutes patient satisfaction and is illustrated in the framework of patient satisfaction in Figure 6.1. It is important in this type of research to include patients who have previously experienced nursing care, as all of the participants were able to evaluate their expectations of care over time and critically assess what they liked and did not like about their care.

The participants' ability to cope with serious illness and the meaning that had been constructed within the reality of their diagnosis, or to the change and adaption to [in] their lifestyle (Fife 1994:309-316) contributed to patients' feelings of hope, comfort, confidence, assurance and wellness. From this emerged the theme of caring from the patients' perspective. The nature of the care provided was linked to nurses' professional competence, behaviour, and the knowledge and skills in how care was delivered. Care was characterised by the nature and quality of the nurse-patient relationship linked to how information was communicated through the presence of a caring relationship. This was demonstrated by staff who showed commitment and responded to patients' needs. Several factors affected this understanding and meaning, which was the extent to which patients

perceived how they were able to control their situation (vulnerability) and how illness affected their ability to function. Nurse caring attitudes (a positive attitude) in recognising patients' needs were characterised by helping and assisting them and involved a concern for and a valuing of them as patients. All the participants recognised this as the personalising of nursing care. They perceived this as: focusing on them as patients, going the extra mile, doing something extra, i.e. *“she makes time to come here, [does] everything in her power to make me comfortable and [has] time for me”*. This is associated with the expressive nature of care [friendliness, the touch, the hugs, for example] and the intensity of care described by participants as the knowledge and the skills to know about them as individuals and to know their treatment.

The participants voiced that individualising of care assisted in their healing. This concurs with Brown's (1986:58) study in which the participants perceived that the nursing care was personalised to them as individuals and was not routine. The patient is seen as a person for whom all aspects of care are crucial, including basic care and skilled technical tasks/procedures. Thus “nursing helps people to feel better as well as get better, an outcome enhanced by the nurses' therapeutic use of self” (Salvage 1990:42). Patients' perception of non-caring behaviour and attitudes was evident in how one patient (Mrs Magg) described the sulky nurses who banged things around, with faces like thunder. Patients are dependent on nursing staff. They are vulnerable. Mrs Rank described, *“Some members in ICU I was afraid of. I did not want them near me and you sort of had to fight for something.”* These descriptions detail specific behaviours and attitudes of the nurses and the effects of these remarks or actions had made the patient feel the nurse(s) did not care for her as a person.

These concepts emerged and were defined as the “components of care emerging as satisfiers and dissatisfiers” in Figure 4.1, interpreting phenomena appearing in the text using Ricoeur's hermeneutic arc. As has already been explained, Ricoeur's application of this process (his four stages) presented interpretation as a movement. This ‘movement along the arc’ is taken to involve the following:

- A fixation on meaning
- Dissociation at some point from the mental intention of the subject
- The necessity to interpret the protocol [text] as a whole

- Their universal range of address.

The method uncovered the meaning and experiences through the interpretation of the participants' descriptions and has reflected how patients perceive and experience understanding and meaning of patient satisfaction with nursing care, interpreted as the satisfiers and dissatisfiers of care.

In the interpretation of the text I can see how the reflection of the patients' descriptions of what happened when they experienced caring made a difference. This interpretation that they felt cared for fits into Ricoeur's hermeneutic arc. The search for an understanding of the meaning of what makes patients satisfied or dissatisfied is based on the assumption that being satisfied with the nursing care implies a relationship between the patient and the nurse. Interpretation of a text involves dialectical movement between understanding and explanation. The meaning of caring can be transferred through interpretation of narratives between the whole and parts of the text (narratives). As the meaning of the text becomes appropriated, a deeper understanding is created. Through interpretation of the narratives patients' reflections and descriptions of the experiences of good nursing care were interpreted as the "*knowingness*" of the nurse who can respond to their needs, others have called it "a presence". Marcel in Rieman (1986:35) stated, "In a caring interaction in which the nurse is truly present this sense of value is felt not only by the patient but by the nurse as well." Patients recognise that positive *knowingness* and caring is linked to patient satisfaction. Caring is always about patient understanding. Patients do not use the term satisfied [or the opposite, dissatisfied] frequently. Therefore the main question centred on: Can you tell me about how you have experienced the nursing care you received? To understand the aspects of nursing care most important to patients and to interpret good and bad nursing care in order to determine quality is the culmination of the research process based on Ricoeur's hermeneutic arc. The relationship between application, explanation and interpretation involves the analysis of specific episodes or incidents. From this analysis came the use of paradigm cases and exemplars that capture why particular cases [or the aspects] of caring had been followed throughout this interpretive phenomenology research analysis (Benner 1994:59).

From this I developed the "framework of patient satisfaction" [Figure 6.1]. This framework describes the nurse as truly a part of the patient as Marcel (cited in Rieman

1986:35) describes. The framework places the nurse and patient together in the “inner circle” of caring because they are both intimately involved in the presence of caring. Caring is always about patient understanding and the expressive acts of caring. This is further discussed in Chapter Six.

The patients’ emphasis was their perspective on the type of care [positive/negative] that they had [or had not] received. In the interviews they concentrated on the positive aspects of care. As already mentioned, the words satisfaction/dissatisfaction did not occur frequently. It would seem that these words are not in vogue. What emerged is more descriptive, it is a picture of “emerging care”, and based on the participants’ own opinion and evaluation of the “care” they received. This then became the central theme of the dissertation.

### **5.3 The relationship of caring and meaning**

From the patients’ descriptions it became clear that nurses “affective” behaviour and their activities in response to “knowing” are part of an intuitive experience. As patients tell their stories, experienced nurses interpret “the knowing” response to the understanding of a caring action which improves and deepens the experience that a patient has of caring. These experiences and the meanings that patients have described about their care and caring are interpreted as patients’ experience of “patient satisfaction” and are described as satisfiers and dissatisfiers of care. These interpretations disclose the meaning of knowingness of the nurse who can respond to patients’ needs. Good care was characterised as individual patient-focused care through the presence of a caring relationship by staff who were involved and reflected a body of knowledge and skills that they bring to each patient interaction. They must have an awareness of the patients’ illness and the meaning patients associate with their illness. Mrs Rank described this as “*being surrounded by the care*” which she regarded as being similar to family care.

The goal of health care and healing is not life preservation, but assisting individuals in the accomplishment of their life goals (Walter cited in Thomasma 1994:95). Gaut identifies the consideration of caring as a practical activity and the identification for change in the patients’ conditions as necessary to determine the need for care (cited in Haegert 1999:61).

There are varying opinions in the literature of a patient's skill to assess the technical skills and abilities of nurses. I have used the "experienced patient" (Staniszewska, Ahmed 1999:365). The subjective experience of the patient who has previously experienced health care allows the patient to distinguish between good and bad practices, which affected him/her. For example, Mr Stone described in his transcript how he gained the knowledge of what to do from these experiences [of previous hospitalisation]. This equipped him to be informed and critical of the care he received. The lack of caring behaviour as perceived by patients impacted negatively on the patients' sense of well-being, feeling cared for and ultimately on the progress towards healing.

Benner (1994:96) concludes that the theory underlying nurse practice suggests that the proper ethic should be a relational ethic, one that targets the problems patients have with their disease, with family, with disruptions in their social and work structure and in relation to their values, including their ultimate value. Benner also states that much more needs to be done in the theory of care to ensure that caring is central to the nursing role, which should be taught as part of the nursing curriculum to ensure standards of practice and to uphold the belief in patient involvement in their care. Nurses need to work with the principles of customer care and satisfaction (Ingham 2001:42-43).

### **5.3.1 The relationship of caring**

A relationship is the most elusive of all realities, yet the most important to all human beings. A relationship between the nurse and the patient was found to be the most important satisfier in his/her care. It is the dynamic of the healing relationship. Thomasma (in Benner 1994:94-96) describes healing as that step beyond curing that seeks to restore the ability of the persons to develop and nurture their relationships. It was Jameton (cited in Benner 1994:95) who pointed out that caring is a labour-intensive form of helping persons, that is often undervalued when compared with highly technical interventions. Since skill in caring is labour-intensive and has little economic value to investors, the carers do not receive the rewards and respect awarded to those with more technologically orientated skills, yet it is the most powerful form of relationship that exists between the nurse and patient and assists in restoring a person back to health and back to the societal obligations of a breadwinner. This disputes the lack of economic value to society.

As discussed in Chapter Four, caring attitudes were important as shown in the responses from two elderly patients who compared current standards of nursing with those of previous years. They looked for certain qualities that nurses exemplify: when they receive hugs, acts of kindness, or when their care is received with a personal touch. This highlights the importance of therapeutics as an aspect, which may be lost in the learning of nursing tasks during professional training (Benner 1994:92).

Benner (1994:94) states that the nurse should be the expert who attends to the relations of persons [who are syntheses of the relation of the body and spirit], to their support groups at home, work and in society. The very complex nature of relationships is in the approach to care that lies in the interrelationships that unfold, and is in the dynamic of the nurse herself.

This is what patients experience from their illness and in their own coping mechanisms as described by Fife (1994:309) as the meanings which emerge as a result of the circumstances of their illness, which may influence future behaviour and reaction [to interpersonal relations, namely close family members and health care professionals]. Caring is about valuing patients positively, which improves patient outcomes. Caring enhances a patient's dignity, health and well-being and offers a sense of personal worth. It improves the patients' coping skills and overall functioning, if they receive encouragement, motivation, concern and support (Fife 1994:309-316).

Mrs Magg said: "*she has put herself out for me time and time again.*"

The meaning placed on the preservation of positive identity can influence the power nurses [and other caregivers] have over patients in shaping individual perceptions of their illnesses and can change possibilities and their future coping skills (Fife 1994:309-316; Benner, Wrubel 1989:114). Therefore approaches to care that enhance a positive outcome and a respect for patient identity serve as "positive patient involvement" in their care. This highlights what patients observed and perceived as good or bad about their treatments. They were able to identify problem areas and possible solutions to improve the quality of their care. Involving patients and the coming together of initiatives that seek to identify the things that matter to patients may serve as a foundation for a framework for patient satisfaction in the future. This has been described in the work of Gillam *et al.* (2001:119-131), to integrate the views and experiences of patients in an effort to bring about an

improvement in patient care and quality. The input of patients, communities and users of the health care services by means of the “patients as teachers model” was positive and has led to further projects being undertaken.

### 5.3.2 Seeking meaning in caring

Patients only feel cared for properly when nurses have the right attitude. This has been identified in the descriptions in the transcripts. It is the notion of caring, feeling cared for, having time for, the personal touch, the concept of touch, practical care, and competent, knowledgeable care. To understand what patients derive from the meaning in caring requires the identification of the essence of care. This has been interpreted from the transcripts as “being cared for as individuals”.

The essence of being cared for is the art of nursing which according to Carper (1978:13-16) is the aesthetic pattern of knowing in nursing; she states that the more skilled the nurse becomes in perceiving and empathising with the lives of others the more knowledge and understanding will be gained. Benner takes this art of knowing and understanding further in her description of “novice to expert practitioner” and clarifies insight and knowing as vital components of caring, which comes with experience and expert practices.

Gaut (1983:313-324) states that “caring is the fundamental basis of nursing care to patients”. This concept has a very special place in nursing discourse. Nursing is concerned traditionally with the “caring needs” of people and also the “value of caring” as a principle for nursing action or as a positive nursing outcome. The negative “not to care” gives the notion of disregard for, the lack of attention to, or indifference to patients. This was interpreted in the transcripts as an attitudinal problem. Patients described dissatisfiers as the lack of care; for instance, in the failure to care for their pain, the lack of supportive care when patients are having difficulty in breathing, “*they [nurses] actually got short with me*”, and in the inconsistent care when moving patients or attending to basic needs.

The “components of caring emerging as satisfiers or dissatisfiers” as illustrated in Figure 4.2 describes practical activities relating to a task, which encompasses the practice of nursing care, as described by Gaut (1983:317). The notion of “individual care” has been described in the findings and is intertwined in the theme of caring, interpreted as a valuing of how patients feel about the care and the nursing component of care. “*I’m really being*

*taken care of;*” said one participant. Although there are many themes within the components of caring, such as touch, trust, attentiveness, secure care, knowing [“in the art of care or in the action of caring”], the expanded meaning of these components reflects the importance of patient satisfaction. The participants, in their descriptions of care as to what satisfies and dissatisfies them, are insightful in the disclosure of their experiences and their understanding of patient satisfaction. This has been described and illustrated in the framework of care diagram [Figure 6.1].

Numerous nurse scholars according to Brown (1986:57) have examined the concept of care and have asked nurses and patients to identify specific actions and or attributes of nurses that indicate how care was carried out. It was Leininger (cited in Brown 1986:57) who identified care as the core of nursing that distinguishes it from other professional endeavours.

Does anyone have the potential for learning to care within nursing practice, or can one just be a proficient, competent but uncaring nurse? Haegert (1998:5) stated that any person has the potential for learning to care: “Let caring be the ‘heart’ of nursing.” It is clear that nursing without its heart is only charts, observations that can be recorded, bed-pans (or other material things) being given without words spoken, whereas caring should be the very hub of nursing. (It was Mrs Magg who described that there was no caring in present-day nursing). Thus, the kind of person the nurse is/becomes has direct influence on the therapeutic, interpersonal relationship.

#### **5.4 Summary of findings and discussion**

Caring for the patient is to “see” the patient’s struggle and to face one’s own limitations, in that curing is not always achieved. As Henderson (cited in Searle 1987:60) describes, the healing goal of health care “is to ensure patients reach a peaceful death.” Healing can only take place when there is an interactive knowing relationship between nurses and patients (Thomasma in Benner 1994:94-95). The essence of nursing ethics is not what the nurse does for or to the patient; it is the dynamic of the healing relationship, that is a positive nursing outcome.

Nurses in this study displayed how the power of touch and concern for the personal, compassionate and emotional care allowed patients to feel special and made a difference to

them. The patient matters to them. Patients recognised that emotional and personal care is a significant factor in patient satisfaction.

The fulfilment of the expectations of nursing care both from the patients' perspective and from that of the hospital represents a significant proportion of the health care budget. Nursing will as a result continue to experience increasing pressure to deliver high-quality nursing care and a cost-effective service (Price 1993:33-41). The increase in consumerism and competitiveness within the health care market highlights the need to listen to our patients more. These are some of the reasons behind the need for understanding our patients' reactions to care, so that improvements can be made in order to let patients take more control of their own health (problems). What is the best way to care for our patients and understand patient satisfaction of nursing care? Recent literature describes a number of initiatives that identify the things that matter to patients. There has been a change in the culture of care, toward a more patient-orientated service, involving patients in their care Gilliam *et al.* (2001:119-131; O'Rourke 2001:1-5). Gilliam *et al.* (2001:119-131) describe the model "patients as teachers" which has led to improvements in service delivery in particular at a number of NHS health care trusts in the UK. This is because patient information and feedback from the patients' perspective has been used. Patient groups and consumer interest in these projects have stimulated the health care professionals to look at how they are practising. The key here is a partnership and an all-round improved environment for both patients and staff. Ultimately the challenge to nursing is to combine competency and skills with the personal touch. Improved information and communication, pre-admission clinics, support groups and specialised units can only lead to better patient outcomes. The belief in patient involvement in their care is central to the work of Gilliam *et al.* (2001:119-131) who invited focus groups drawn from previous patients with the aim of improved patient participation and explored patient's perspectives on how care can be improved in the future. Staying close to the consumer is most important. To assist in the understanding of the nursing shortages of the future, nurses and patients need to come together with a common understanding to ensure that the increased stresses will be highlighted (Aiken *et al.* 2001:43-53). This will enable nurses to perform with a maximum level of skill and compassion. Three patients in this study were able to compare nursing practices and caring at state institutions highlighted these shortages. These could be

compared with concerns about the shortages, the organisational structures that ignore nurses, their increasing and overburdened work overload and the underpaying in relation to other less responsible professions (Benner, Wrubel 1989:369). It is still an attitudinal problem; ultimately nurses are responsible for providing effective and satisfying care. Patients understand the qualities necessary for effective and empathetic care. As one patient, Mr Stone, described, attitudinal problems he encountered with nurses were in essence due to the poor conditions they worked under and the lack of resources (an example being that there were insufficient sheets to make beds). The agency nurses "*who come and go*" contribute to a lack of involvement and responsibility to care. The agency nurse staffing practice was described as being detrimental to care specifically with regard to their limited knowledge and lack of commitment to caring.

Although some criticisms can be linked to the changes in the health care services of South Africa, patients were still concerned about the direct effect on the care and continuity of care and adequacy of care to themselves.

Thus the building blocks of "patient satisfaction" were personalised focused care because the "personal touch", from a technically competent and efficient team of nurses (and extended medical team) who communicated with the patient clearly, and timeously, satisfied patients. Only one patient, Mr Stone, had an overall negative view of his care and felt it was due to the public and private facilities providing inexperienced nurses, which resulted in attitudinal problems. This was, he felt, as a result of the nursing shortages.

In contrast to this perception of care and caring, Mrs Rank makes this profound statement, previously discussed as an exemplar case in the meaning of touch, in response to feeling safe and confident with the care at Hospital A, which is in direct contrast to the care she received at the previous hospital where she felt the roles had been reversed.

***"You are the patient, we are the caregivers"***

Nurses need to care for themselves in order for them to care. This shows how much we can learn from our patients. The research has demonstrated that patients place values on the meaning of their care; and has given new insights into how nurses need to care for themselves if they are to care for patients and add meaningfully to the healing process through communication.

It is important for the nurse manager to understand the changing needs of patients and to understand the role of the patient as a consumer. She needs to make nurses show a deeper understanding of how patients experience care and how nursing issues relate to patient perceptions. These perceptions influence directly or indirectly how patients interpret satisfaction and dissatisfaction of care. This information is needed to form part of an in-service education development programme. To promote patients' understanding, needs and choices in their care will facilitate the strong advocacy role assumed by nurses. In exemplar one, Mrs Rank was in charge of her care in that she and her family were well informed. This was in stark contrast to her previous experiences where she felt she had to lead the care and remind [especially the nurses] of the care that she required.

In doing this dissertation I have learnt personally and as a manager. This research has brought me closer to patients as I sought to interpret patient satisfaction. Patients' valued qualities, which they described as "caring attitudes". They appreciated it when nurses were sensitive to their feelings, they wanted to feel cared for, and that they mattered [felt special]. This study has culminated in the overall understanding of patient satisfaction of nursing care [quality], and in the effectiveness of nursing care they received.

## **5.5 Conclusion**

In this interpretive study, understanding patient satisfaction from the patient's perspective was interpreted as the involvements of the nurse/s in caring practices.

The importance of touch, the concern for others, the words used, showed the meanings patients identified and emphasised. These meanings formed an expression of caring which revealed a relational ethic, described as a professional closeness by Peplau (cited in Pearson, Vaughan 1986:144). Professional closeness is learned through the interpersonal nature, the technical side and the nature of nursing (Pearson, Vaughan 1986:144). Thomasma (cited in Benner 1994:92) states that professional training is but one aspect of nursing the patient, through which the process of learning tasks and procedures is taught.

## **Chapter Six: The framework of patient satisfaction**

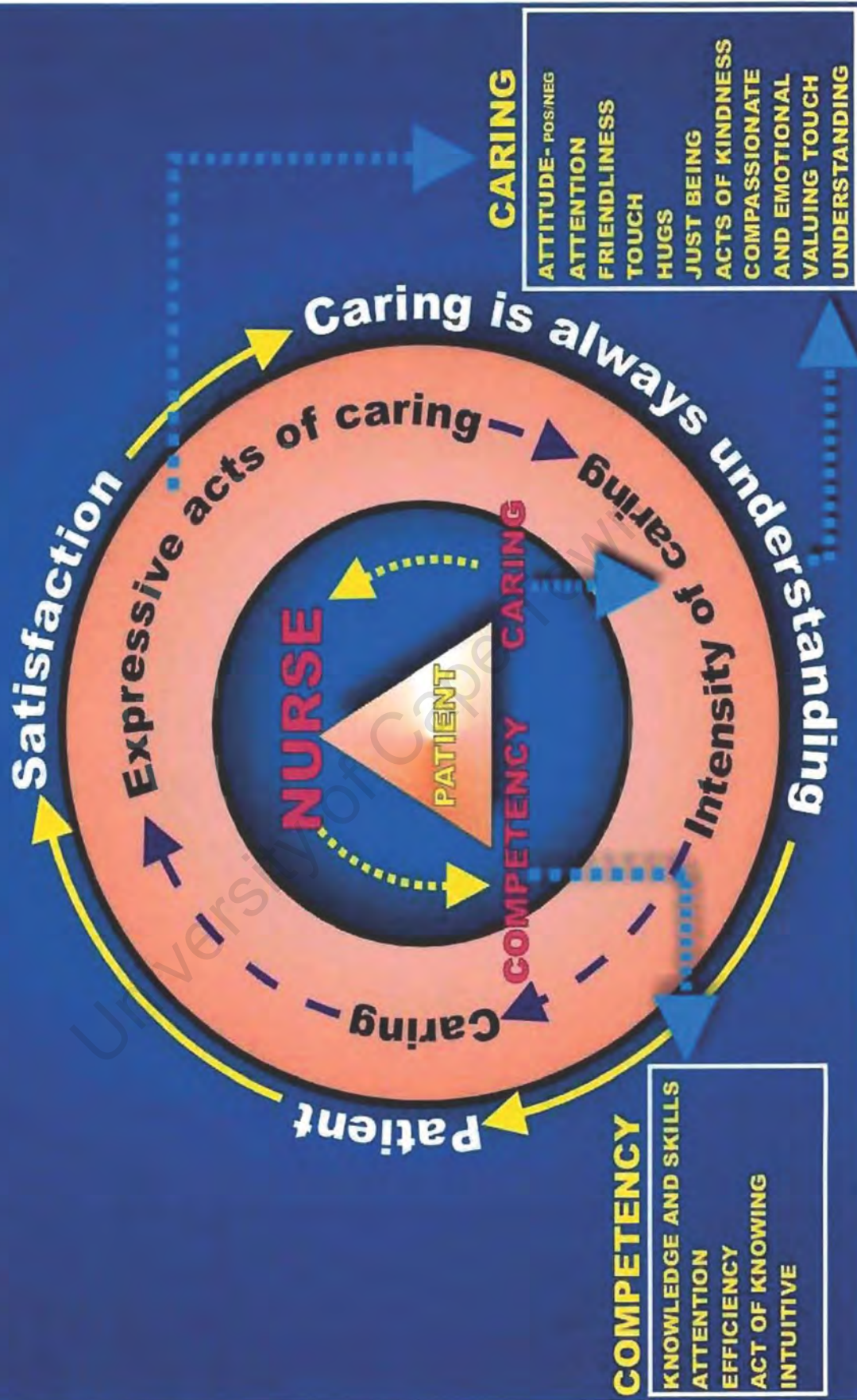
### **6.1 The proposed framework of patient satisfaction**

This dissertation aims to develop a proposal for a framework of patient satisfaction. Though the research participants did not mention the terms satisfaction or dissatisfaction, as previously explained, yet they knew what they wanted in terms of nursing care. As stated in the literature review, patients have expectations and the larger the gap between these and the actual nursing care, the greater the dissatisfaction (Cleary, Edgman-Levitan, McMullen, Delbanco 1992:53-59; Linder-Pelz 1982:175-183; Bond, Thomas 1992:52-63; Staniszewska, Ahmed 1999:364-372). The converse is also true.

To treat patients is to enter into their world, to do this with care and dignity; the nurse experiences the “whole person” and can see through their eyes what it is to experience care from their perspective (Gaut 1983:318-319 and Riemen 1986:31). To both capture and illustrate the inherent concepts of nursing care that satisfies, I have drawn what I call an ‘inner circle of care’ or framework of patient satisfaction [Figure 6.1]. I could have used the term “model” but that term does not do justice to interpretive phenomenology. The research method chosen was not selected in order to generate a caring theory. Authors such as Swanson, Chapman (1991:66-223) have done this expertly.

In the centre of the circle (named by me the “inner circle of care”) is the triangle; this illustrates that the patient is the very essence of the nurse’s endeavour. The inner circle represents the care described and understood by patients as essential to their well-being and healing. Each point of the triangle embodies the elements of care unique to what the patients in this study felt was integral to the activities and the practices of the relationship of caring. The “inner circle of care” was so named in order to encompass those ingredients of nursing care that made the research participants feel that they could cope with their condition or disease. The elements within this framework were also those, which hold the intention of facilitating the healing process. They may be unique for each patient. I could say it is part of their suffering and part of their healing process. Rather this “inner circle of care” or framework is the culmination of the research process, or the amalgam of the application, explanation and interpretation that has been followed throughout this interpretive phenomenology research analysis.

# FRAMEWORK : PATIENT SATISFACTION



The framework can be seen from two perspectives, both those of the patient-participants. The first is captured in the insightful words of Mrs Rank when she said: *“You are the patient, we are the caregivers”* Mrs Rank’s statement was in the context of nurses not being competent; of them wanting patients to “nurse” them. Mrs Rank discussed this as an “ethic of self-care” [which has previously been discussed in 4.6]. This involves instances where nurses did not realise just how much they burdened a patient when they did not have the necessary knowledge, when they were neither caringly attentive nor efficient. Instead of expressive overt acts of caring like touch, understanding, unselfing, presencing and compassion, they were rough, thoughtless, “not there”, even unethical towards themselves, and gave merely instrumental care.

The second perspective relates to the fact that patients want nurses to understand and deliver care congruent with their perceptions of what satisfies or dissatisfies them. These descriptors are consistent with the theorists’ descriptions of the meaning of care.

This inner circle portrays what patients needed if the care they received was to be satisfying. To re-emphasise this, they needed caring always to be expressive and intense [in a positive sense]; they appreciated nurses “just being there”, to understand patients’ unexpressed needs and with sufficient knowledge and skills to make patients feel that they were intuitively competent, even proficient and expert (as described by Benner 1994:34).

As previously described and illustrated, patient satisfaction was interpreted in this study as a component of a variety of types of care, from personal care, through emotional care, to practical hands-on care [as shown in Figure 6.1]. Patient satisfaction is about focusing on what patients want and not on what nurses think they want. This study uncovered some of the issues, such as ensuring that nurses in specialist units are considered competent and knowledgeable, and the need to help patients to cope and adapt to their illnesses and diagnosis. For elderly patients caring meant feeling “cared for” and nurses going the extra mile. These aspects made them feel special.

From these aspects of care the “framework of patient satisfaction” [Figure 6.1] was developed. This framework will now be discussed in greater detail:

1. This framework describes the nurse as truly a part of the patient as described by Marcel (cited in Rieman 1986:35). The diagram places the nurse and patient together because they are intimately involved in the presence of caring, in this inner circle of caring.

2. Caring is always about patient understanding. To understand and perceive what patients mean when they say, "I know that I have been really cared for", shows intensity of caring. It comes out of participants' explanations of differentiating between caring and non-caring attitudes and actions. Patients should experience care in an environment that encompasses individualised nursing care and personal relationships. Nurse-patient communication takes place in such a manner that patients should feel respected and understood.

Nelson, Larson (1993: 89) maintained that individualising care delighted patients and that they were expressed as "surprises". These "surprise" experiences were important in determining patient satisfaction: patients who were pleasantly surprised gave higher ratings to overall patient satisfaction than those patients who had bad surprises. Factors that facilitated this individual care according to Nelson and Larson were:

- the personal qualities of the nurses themselves
- a shared understanding of the patient and his/her illness
- what constituted good nursing practice for patient
- the difference between night and day staffing and the environment, and
- the agency staffing.

These compared with the actions were interpreted as satisfiers and dissatisfiers of care.

Donabedian (1992:247-251) noted that in defining desirable or undesirable care it is the expectations of the patients that should set the standard for what is accessible, convenient, comfortable or timely in care. It is they [the patients] who tell us to what extent they have been listened to, informed, allowed to decide and treated with respect. Gillam *et al.* (2001:119-131), in their study involving patients, felt that it was the quality of health care embodying patient's expectations and perceptions; and, the multidisciplinary team that had helped to bring about improvements in patient care and changed professional behaviour. The provision of knowledge and understanding empowers individuals to make choices and enables patients to take control of their lives.

3. The data analysis carried out through the use of thematic analysis, exemplars and paradigm cases showed that the researcher (interpreter) engaged in the practical world of the participants and came close to their lived experiences and their understandings as they unfolded through patients' narratives. "The goal [of exemplars and paradigms]," says Benner (1985:60), "is to discover meaning and to achieve understanding". The first

exemplar discussed the power of touch as personal, expressive, focused, supportive and intuitive. This was not any kind of touch but caring touch under girded by knowledge and insight [described by one participant as the “knack” of knowing]. Touch, to the participants, represented the most effective level of individual patient care that benefits both patients and nurses in the process of caring and in caring relationships.

The researcher has answered the question “How can nurses inform and communicate better [to patients] to improve patient satisfaction where there is such a caring expectation?”

## **6.2 In summary**

Caring for patients involves an intense understanding and an involvement in the caring needs of patients.

The aim of the dissertation was to interpret the understanding of “patient satisfaction”. Listening to patients and understanding their needs is becoming more and more urgent as patients’ perception of care has become an important component of patient satisfaction and adds a different dimension to the understanding of patient care. This is dependent on the caring attitudes of nurses as perceived by patients - whether a nurse is expressive, competent, and knowledgeable and cares with insight. Caring is about relationships; having the insight, we can learn more about the needs of a patient and knowing the patient [what Marcel (cited in Rieman 1986:35) describes as being “present” with the patient]. Patients recognised that positive knowingness and caring is linked to patient satisfaction. In order for a patient to regain or to be restored to health, care must be felt. Through touching the patient [as discussed in the exemplar “touch”] trust is built and comfort is offered Benner (1994:92). Touch therefore has an expanded meaning through which trust is built and comfort is a part of the healing. Caring has an impact on the illness, as coping and adaptation [resulting from confidence and trust in the relationship built between a patient and nurse and/or the multidisciplinary team] become a part of the healing. In the transcripts, patients described their reliance on specific nurses who made a difference to their care and were an essential component of their healing.

An understanding of what it is to “know” is embedded in both the clinical skilled nurse practices and in the experiences of helping patients, and denotes both caring acts and attitudes. The findings of this study show that it is evident that more research needs to be

done in South African hospitals, both public and private, to develop this concept of what makes patients satisfied or dissatisfied with care.

There is a need to work closer with our patients to enable them to be more informed and understanding of the future changes to health care. As patients become more involved in the process of change they become more informed about and supportive of changes in the health care arena. They [patients] can then act as participative agents of this change process.

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## **Chapter Seven Summary of dissertation and recommendations**

### **7.1 Summary of dissertation**

The researcher set out to answer the question, what makes patients satisfied or dissatisfied with the nursing care they received? That is, the research sought to understand the nature of care patients receive [the skills in practice] and to understand how patients perceived and experienced what was good or bad nursing care.

The research study sought to understand how patients perceive and experience what is good or [bad] nursing care as satisfiers/dissatisfiers. An interpretive phenomenological approach was used for the research methodology. The philosophers Gadamer, Heidegger, Ricoeur, Dilthey, Schleiermacher and Rorty shaped this approach. Understanding is in itself not sufficient; it requires interpretation, using language to make sense of the text. Central to interpretive phenomenology is a focus on individual consciousness and experience, where the researcher seeks commonalities in meanings and patterns of meanings, practices and bodily experiences in the depiction of the [individuals'] lived experience (Rather 1992:48). By using whole exemplar and paradigm cases the researcher [interpreter] engaged in the practical, emotional and individual interpretations of the participants, to unfold the meanings and understandings of how care was experienced. The importance of "touch" was used as an exemplar to show that touch is much deeper than putting a hand on another. It is a part of developing a relationship of caring, in which a nurse is "truly a presence". A caring interaction takes place. The participants described the use of touch as the "value added" benefit of receiving individual care; they liked to be recognised.

#### **" What makes patients satisfied or dissatisfied with the nursing they received?"**

This has been interpreted in this study to be what matters to the patients, using the process of the hermeneutic arc as discussed by Ricoeur. From this came the rich descriptions of care interpreted in the "components of caring emerging as satisfiers or dissatisfiers of care" illustrated in Figure 4.2, from which I developed a framework of patient satisfaction. In this I used the circular hermeneutic process, described by Moustakas (1994:10), which is further explained by Van Veuren (1993:134-135) as a hermeneutic arc. As I have shown, Ricoeur presents interpretation as a movement along a "hermeneutic arc" which allows for different stages of interpretation, explanation and application during which a text says what

it says. I have used Benner's methodology whose research is based on interpretive phenomenology [as she calls hermeneutics] to give a theoretical account of the "interpretation" of the "meaning" of texts in seeking commonalities in meanings and patterns of meanings, practices and bodily experiences in the depiction of the [individuals] lived experience (Benner 1994:xiv-xix, 99-106; Rather 1992: 48).

Patient expectations and perceptions of what constitutes a good nursing service have been identified from an understanding and interpretation of the text as the theme of caring and from what caring consists of discovered in the text as the "components of caring emerging as satisfiers or dissatisfiers of care" [Figure 4.2] that mostly satisfied patients. The satisfiers of care have been described as emotional care, individual care, supportive care knowledge and skills, personal care, practical care, caring attitudes and organisational care and the non satisfiers of care as the differences between night and day care, bad caring attitudes and agency nurses who don't care.

## **7.2 The way forward in nursing practice**

In addition to qualitative work, which has produced a broader and deeper understanding, the researcher recommends from the findings of this study that, in order to continue to evaluate patients' expectations, perceived needs and actual care received, the framework "patient satisfaction" could be tested in further studies. There is a need for more research in the expression of caring that leads to patient satisfaction in different settings e.g. acute versus terminal/long term care, to further elucidate the understanding of patients' needs.

Further integration of the knowledge and understanding gained from the use of both qualitative and quantitative studies such as (Rather 1992:47-55) and (Rieman 1986:30-36) describe, for example: "The Newcastle Satisfaction with Nursing Scales" - an instrument for quality assessments of nursing care (Thomas *et al* 1996:67-72) and the proposed taxonomy as described by Chang (1997:29). This taxonomy, together with the actual dimensions and indicators of patient satisfaction of nursing care using a standardised instrument, should reflect a wider dimension of patients' needs and perceived needs in the future. To address the relationship between adequate staffing levels, patient outcomes and support the delivery of quality patient care. Further integration will enable nurses to have a

more comprehensive understanding of patient satisfaction with nursing care within a managed health care system in South Africa.

This would also facilitate nurses being able to honour the rights of patients in their care (Department of Health, Patients Rights Charter. On line, undated).

Patients' concerns can only be understood by engaging in meaningful dialogue with them. This approach has identified in this study, that there is a need to work closer with our patients to enable them to be more informed and to understand the effectiveness of the nursing care they received in meeting their needs. The use of focus groups consisting of patients and the multidisciplinary team could better provide the knowledge and experience to address problems of care and caring in a holistic manner. Therapeutic nursing practice has been defined by Astrom *et al.* (1995:111) as practice through which the nurse makes a possible difference to a patient's health state and where the nurse is aware of how and why this positive difference has occurred.

In adopting a holistic, humanistic approach to care, Newman (1993:553-554) states that patients will report fewer physical problems and have enhanced well-being. This enables the patient to participate fully in their care. The nurse needs to understand the meaning of the experience from a patient's viewpoint.

Recent literature from 2000 to date has emphasised the need to involve patients in their care. This is being done specifically in the USA and in the UK (Walker, Gilbert 2001:33-34; Oermann, Templin 2000:167-172; Attree 2001:456-466; Tranmer 2000:25-29) through the conducting of focus groups with recently hospitalised patients. Involving patients in the treatment decisions and hospital services aims to improve quality of care delivered to them. This is achieved in a variety of responsive ways: to include the consumer (the patient) to ensure cost-efficient and effective services, to meet the demands of patients, to improve outcomes of clinical care and enable nursing staff (especially) to do a better job, to understand the demands of patient care, to promote mutual trust and to enhance the nurse-patient relationship Walker, Gilbert (2001:33-34); Oermann, Templin (2000:167-172).

There is a move from conceptualising and measuring patient satisfaction with nursing care to the attention given to consumer's opinions on the important attributes of nursing care quality and health care quality. The important indicators were the presence of caring

relationships by staff who demonstrated commitment, involvement and concern for patients; Patients are being cared for by nurses who are up to date, well informed and have sufficient time to communicate with them about their illness (Attree 2001: 456-466; Tranmer 2000:25-29).

The increase in qualitative studies to examine and understand the differences in defining and the experiences of hospitalised patients perception of needs and the impact of nursing care was evident from recent studies from 2000 onwards.

From the South African perspective one study was found describing the management of a quality nursing service in South Africa; this was in accordance with the National Standards Programme (Muller 2000:63-69). This was purely a nursing service study relating to hospitals' compliance with the standards evaluated. This demonstrates the need for further research in this area.

### **7.3 In conclusion**

This research has contributed to my own growth in nursing in a way that has brought me closer to my patients, closer to myself. It has taught me to never give up on my staunch beliefs in good caring practices. Families entrust their loved ones to nurses at a time when they are in the most need of care and commitment.

Patient satisfaction, interpreted as quality care described in the literature, does not necessarily mean high quality care; it means a predictable degree of uniformity and dependability at a low cost, with quality suited to the market (Bruwer 1986;Thomasma in Benner 1994:94-96). What matters is what caring **means** to patients. It is as Benner (1989:1) says, "caring sets up the condition that something or someone outside the person matters and creates personal concerns". Caring becomes understood in the context of each of the discourses, whether in the expressive acts of caring, in the technical actions of care or in the communication of caring.

While the findings in this study have been described in "components of caring emerging as satisfiers and dissatisfiers of care" [Figure 4.2] and the "framework of patient satisfaction" [Figure 6.1], it is recommended that these findings need to be tested in other hospital settings with the standard instruments measuring patient satisfaction (Thomas *et al.* 1996:67-72). It is only as further research is conducted in the South African health services

that we will be able to work towards developing an understanding of what our patients experience as the satisfiers and dissatisfiers of care.

This dissertation is dedicated to those patients who have given me the opportunity to hear their reflections on care, interpret their meanings and have inspired me to work towards the goal of delivering patient satisfaction and improved patient care.

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## Appendix i

### DISSERTATION/PROJECT TITLE:

# **UNDERSTANDING THE SATISFACTION WITH NURSING CARE FROM PATIENTS PERSPECTIVE IN A PRIVATE HOSPITAL SETTING IN SOUTH AFRICA.**

### RESEARCHER

Heather Blackwell

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### PLACE OF RESEARCH

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### **PURPOSE OF STUDY**

To understand the needs of our patients, in order to understand how patients evaluate good and poor nursing care. To improve the quality of nursing care.

### **VOLUNTARY PARTICIPATION**

You have been selected to participate in this study, which is intended to contribute to the improvement of nursing care at this hospital and to improve the nursing staffs understanding of on-going needs of our patients. The information gained from this interview will be used towards a masters Degree in nursing Science at the University of Cape Town.

As you have been a patient for more than 3 days and have experienced Healthcare previously I would appreciate your assistance in a personal interview to ascertain your experience of the nursing care quality you have received while a patient at this hospital.



## Appendix ii

### Mrs Rank's transcript

#### The full transcript of Mrs Rank's interview

\* Interview - 09 May 11h30

\* Interviewer - Heather Blackwell

\* Date - 09/05/2001

R Mrs Rank, I am going to ask you two questions with regards to patient satisfaction. The first one will be:

1. I would like you to tell me about how you have experienced care during your stay at Hospital A, namely how you experienced nursing care from the ward - to ICU – High care – describing if you can night and day care, and any thoughts and experiences that have stayed in your mind.

2. What did you think of the nursing care you received, was it was good or bad? Did you experience any surprises were they good or bad during your stay, and that could either be in the ward day or night, it could be ICU or High Care?

P Okay.

R Okay and I am going to start recording you during this time. So Mrs Rank, Can you tell me about how you have experienced care during your stay at Hospital A, namely how you experienced nursing care from the ICU – High care – describing if you can night and day care, and any thoughts and experiences that might have stayed in your mind during that time?

P. The experience of care at Hospital A specifically?

R. Yes

P. Uhm for me has been just in a league of it own uhm ... I have been very impressed generally with just most of what I have experienced and I am going to get quite specific about some of the things I have been impressed with,

R Can I just interrupt here, when you said it has been in a league of its own I am assuming then that you are comparing it with other situations in other hospitals?

P. Yes definitely I have had one experience at hospital C year ago where I had a big op and uhm it is definitely chalk and cheese ... uhm and there is many reasons for it which I will tell you now, why I believe this hospital is in a league of it own. Uhm first of all just the flexibility uhm ... You know we chatted to the ICU asked if units before I came in and my husband could be around and available, I was feeling insecure and fearful and Sue (charge sister) was very kind enough to accommodate. Whatever we were feeling fearful and insecure, having a specific room on the side, was good allowing that situation to continue. So I was incredibly impressed with that, it wasn't just an autocratic bureaucratic decision that you know policy can't be broken it just was thought through and she (Sue – charge sister) personally made an effort to come and see me and just allayed my fears and that was good.

R You were quite surprised that you were allowed that type of visitation before hand?

P Uhm in the ICU definitely uhm but just in terms of the privacy I had my previous ICU experience, uhm Rob (husband) was also there, but, and on a permanent basis. But uhm there wasn't the privacy and there wasn't the sensitivity to other members of the family coming in and that makes a huge difference, when you are in ICU because you are, you know you really needing a lot of care uhm ...(you).. Maybe not consciously but unconsciously you may not you know or come around fully or what ever but just the presence of loved ones around give you that security. And I think it speeds up the healing and I always believed in that so the fact that she was flexible enough to do that for me was impressive (i.e. Charge sister).

You know, that there wasn't a big issue around that. The other thing is that I, that's ...in that area for now but just very uhm the genuine gentleness and dedication of, of some of the staff and of particular uhm I think it was Lynn or Lynette fantastic. I mean just the way you know I was treated, I was sore, I was uncomfortable and she was just amazing she had a positive attitude she was gentle with me, so dedicated, I felt safe and secure and I also believe that speeded up for me you know made me feel uh good, speeded up my healing.

- R So did you feel she went the extra mile with your care?
- P Definitely, there is no doubt about it she did little things like even rub your feet, I mean, she does not have to do that, she does not have to massage your feet you know.
- R Did you feel the difference in the care with other members of staff there?
- P Yes, I did, I mean there was certainly some members in ICU that I was very afraid of, did not want them near me (laugh) and at night I mean if we talk specific day and night I mean I think the night staff are not as good as the day staff. I just that's just, a general thing. I think there is more agency staff at night and there is more of core permanent staff during the day and there is definitely an ethic uhm difference in terms of dedication and care. And uhm ja the other members of the unit that I wasn't very comfortable with I can't remember names I just know there wasn't that feel for gentleness and dedication there but I remember her specifically, I could have had her permanently I would have really felt really happy (Lynn – ICU sister).
- R So it's quite strikingly different from the day to the night with regards to the care values and how people went about their work, particularly with the agency nurses although there shouldn't really have been a difference when you think they are all professional nurses?
- P Yes
- R but you found that?
- P I found that, I just you know, I think, would be for maintaining the standards and ethics in an environment in which they are not permanently part of. uhm And I am not just saying with the agency I am sure there was some permanent nurses as well who just weren't as skilled or as dedicated and there are those differences you could be just getting everything you need and you are feeling so good and you're recovering.
- R Was there an examples at night that you felt, uhm particularly that you were left on your own or that your requests were not sort of answered in the same way or they might have been left entirely uhm, you might have been ignored was there any of that?

P There was just a there was a little sort of altercation in terms of whether I was allowed ice or not.

R Okay

P Which to me was a very uhm it was an important thing to have some liquid around the lips and there was some ice decision I am not allowed to have some ice and that to me was just ridiculous (Confusion over decision making, Patient lost out re receiving care, lack of continuity of decision-making).

R

P and I already had ice during the day and there hadn't been an issue with it and I had to sort of say but its you know its been allowed you know why is it now an issue. So ja you sort of had to fight for something that you should not have to fight for.

R Uhm

P I don't think it was a big issue.

R You, also used the word fear as well, fear at night?

P Ja you get a little fearful at night because you are not sure uhm you're, you're, my husband wasn't around and my family weren't around that always gave me that extra security that somebody else was there watching and being with me. Just observing generally at things running smoothly, uhm at night they were not there so you were entirely.

R On your own?

P On my own and in the hand of whoever was looking after you so that's a scary thing sometime because you are not sure, especially if it is someone like who you are not feeling safe with you're not sure are they doing their job are they skilled, are they caring enough, are they monitoring you, uhm so ja there was definitely that kind of fear there. Uhm Just the other thing that has been important to my experience here has been the information and care that I received here. It has been wonderful, just the amount of information you know just all my questions have been answered the staff has been wonderful about telling me about the operation and incredibly humorous about what's going so there is a wonderful openness in communication so that has been a great experience. Which is also

different from what I had at hospital C, you know there at hospital C there was a kind of closed, uhm less open in communicative style and much more serious (laugh) you know... uhm and you know I am linking them, but the ... important thing is the information. In being open and honest and saying this is what is going on and what's happening to you so that you can be a participant in your own process and there is nothing being hidden and there is nothing, you are the patient and [quietly intense], we are the caregivers and we know what's really happening with you uhm and on that level to I mean everyone is informed of what is happening to you which is fantastic. I found the hand overs here are amazing this now coming back to the wards.

R Yes, yes

P Coming back to the wards everybody knows what is going on and they are very informed and you don't have to repeat yourself, and go through the third degree of what is going on and there is less mistakes being made in terms of what is going on with your treatment, your care plan and that sort of thing. So that has been fantastic you can ... concentrate on your self and healing.

R Yes, because you know the communication and instructions have gone through the line.

P It's happening and going on and everybody knows what is happening and you can just relax. With before in my experience and again my experience was before I had to be constantly aware or are you aware that I had to have this and I had this and I haven't had this and you know I had to sort of keep.

R You were leading the treatment?

P I was leading the treatment, which was very stressful and could not really focus on your own healing.

R So would you say that you work very much as a team here? That includes nurses, doctors?

P Definitely

R Both day and night?

P Definitely, in fact when I say that you are in a league of your own [hospital A], I think that is the winning combination.

R Okay

P There is a tremendous team here, a multi disciplinary team and everybody knows that everybody has a role and uhm they all work together in an amazing way and there are definitely good relationships. I am sure there are times when there aren't which is just normal, but ja it is wonderful.

R But you are not aware of those poor or bad relationships?

P No, no I'm not aware of that. No, no not at all I am just aware that there is a wonderful rapport going and there is wonderful referrals going on constantly you know sort of comments made, we have this physio for you or we have the psychologist to have a chat ... if you want and we can get this one in to see you. Uhm So there is this constant resourcefulness, uhm as well you know of who is out there to assist you, which is wonderful.

R. This all probably, also helps that you mentioned being lonely and needing support of your husband, perhaps it is you're not actually alone in what's happened to you?

P Oh no, I feel a lot, I feel a lot more safe then I did at hospital C, and it's been a wonderful feeling it not the safety factor I think it's the peacefulness it is a great sense of peace, you are the patient we are the caregivers. Which for me has been marvellous that I just know I'm really being taken care of. Uhm and people are really looking after me and I am going to be okay. And its fine if Rob's not here, you know so you know I am feeling there is also uhm just a tremendous rapport. I think with everybody which is fantastic, we feel uhm that its not just the care its more like a family here. There is definitely the extra mile here and of course it's just not only my experience, but all my friends and family who walked in here. I have had a lot of visitors at this time and they have all commented on the atmosphere the ambiance the friendly attitude, uhm they all seem just so wonderful and their flexibility was there as well. There isn't uhm I don't know there is no air of aloofness.

R Overly professional?

- P yes, just very relaxed it is a family, kind of a family atmosphere and people have noticed that and I have felt that which is important. Ja. You feel at home I feel really at home.
- R You mentioned humour but I presume you are mentioning humour, as been appropriate humour?
- P Yes
- R Appropriate, professional
- P Appropriately I think maybe humour I should say laughter even, you know you get the laughter going and you get a couple of jokes being made that is, they are appropriate I don't think it is picking on people and issues you know that happening, ja, ja. Its appropriate ja. And then the other thing I just want to say was the major skills level I think, of the hand picked staff here (in the GIT Unit) are fantastic, uhm you know I. Again, I must just go through the ward. I have been incredibly impressed with you know Jerome, Marianne, Lynn, Michelle and Lynn in ICU again uhm Cindy has been fantastic and she's been amazing.. And I was even impressed with you washing the patients hair the other day. I thought matron's coming in on a Saturday washing patients hair, I mean I've never heard of this. You know, so I ...okay that's going off the subject. The knowledge and skills level there was just fantastic to me. I'm working well I'm been treated by people who are experienced and they've got the skills and they know what they doing and there is a confidence and because of that I've been treated properly and I'm feeling good and I am feeling happy here. Safe.
- R Have you got examples of those skills? Could it be in a dressing technique or something that is changing of lines or anything in ICU. Just to clarify, I know you said you feel they have knowledge and skills?
- R Well the changing of lines in the ICU by Lynn was fantastic. It was never a problem. She was just incredibly amazing uhm here in the ward it just depended on who was doing it if it was your core staff Jerome, they knew what was happening if it was one of the agency staff there was an issue with the lines and battle by not exactly not knowing how to
- R So there was ...

P there was definitely that. Ja your core permanent people who are here during the day again, I think there is a difference between day and night staff generally although in this ward they've got two core people at night

R That's right?

P And so for me the different between day and night here hasn't been a give issue, it was more of an issue in ICU. Uhm ...ja ...its just about the case management. I think the other wonderful experience here is being the fact that there is this team there is an established team who talk to you about uhm. Who are managing everything that needs to happen to me and pro-actively and preventatively, I mean I was very impressed with the fact that you know. Cultures, like blood cultures are being sent just in case there is an infection. It did not have to happen but you know the decision was made for us to just check that and it is just wonderful because it is the kind of thing that I would have asked around for about. And uhm the team just know they that need to be preventative and pro-active and I just loved it about what is going on here, you know people are forward thinking and sort of don't wait for things to happen and then deal with them.

R Are you using an example from your previous hospital?

P Yes, yes, ja, ja where you sort of you know you sort of treat it when its there you don't pro-actively preventatively given to stop things from happening. So, I am very impressed with that, you people here are pro-active and on the ball. It's that again why I say this hospital is in a league of its own, definitely and there is just the last thing my experience have been the response time you know, it has been wonderful if you ask for something there is a reaction, the cleaning staff needed to come in and clean my bathroom and they were here within minutes, and very happy to do their job, very friendly, they do a good job cleaning the bathrooms. The TV was you know, faulty, the man came in, two minutes fixed all of that you know, uhm. The food, the food is an issue I think, (laughing) I am not sure, uhm, its not an issue choosing a variety of choices, there is wonderful variety of choices and its depends very much on how you are feeling as a patient nothing else. Its always a tricky area with food, but I don't think they are as vigilant in terms of the standards, like you would often get your egg without toast or you would get two peppers and

not a salt and pepper or like you would get half your meal and not the other. And then you would then have to wait for that and they are not on time, you need to really know when they come in you know, that is the one thing which is not. But not, not a big issue, but not a problem compared to my previous ... experiences.

R and the food is edible,

P Oh yes, ja, the food itself is edible. I do worry about and I must say ... probably just from a healthcare prospective, I do worry about the preservatives that are in some of the foods that you get you know. I mean one of the examples is the yogurt, I think yogurt is important because of the antibiotics you get and yet we get yogurt here and yogurts have preservatives.

I have to say no to that and ask my folks to bring in natural ones without preservatives. Just to make sure that I am taking that little bit of extra care with the antibiotics and I just think that something tiny but something that maybe could be looked at for people who are health conscious.

R And also with regards to the amounts of antibiotics been used that you've got your own autoimmune system clicking in and that's where the foods and non-preservatives and fresh produce.

P Yes, definitely uhm ...

R Have you got a dietician who is working with you?

P She is coming to see me tomorrow to just give me some guidelines in terms of what to be eating uhm when I go home. At the moment I think its just been a carte blanche thing choose what you like or what you feel like, just get into a pattern of eating, but there hasn't been any guidelines, no. And maybe there should have or could have been I don't know before hand to say look don't choose the mince and bolognaise for now choose this and this and this. Because you got the choices, which is lovely, but sometimes you look and maybe you make the wrong choice for yourself and you don't know. Although uhm ja, I think it is a question of just as long as you are eating (Laughing). Ja, that is what the important thing is, I am not sure, but it might have been, it might be wise to have a chat before hand and then influence choice on the menu beforehand.

R So this has been an area that you haven't felt quite as happy with, as in the areas of nursing care which you feel has been sorted out pro-actively or completely?

P And then the ward now when I came in for the dilation. I had little experience in the ward and uhm because it's a friendly but that again the value of duties or the nursing duties certainly.

Wasn't up to the standards of this particular ward,

R You talking about the medical ward?

P The medical ward, ja, lots of little things she [professional nurse] they wasn't quite sure of what they had to do and they were there to look after me. It felt like that ward was not organized to me, there was a lot disorganization going on and uhm things like I am trying to think. I was on the bed and I had to have an enema I think and uhm I suggested that she puts one of these little plastic things on the bed because I am going to mess on the sheets and she did not kind of hear that. And I ended up messing up the sheets and we had to change the sheets

That was just a tiny kind of experience of medical ward, which not really relevant but just you asked about the whole experience.

R You are aware that this ward is for people with upper GIT and lower GIT problems?

P yes,

R which would you, say then would has made a difference as to how you've been treated?

P Yes definitely in fact I am going to go out and tell the world that there is this specialized unit because I think it makes a huge difference. I mean little things, not little things, but like you know the normalization of what happens with your operation and the aftercare with your washout and that sort of thing its normalized in a unit like this. In a medical unit it would not be and people know what is going on here and they specialized to deal with that. And uhm

R It's been quite scary has it with regards to all?

P Ja, because I mean it is not stuff that you...

R Procedures that you've required?

P Very much, ja, very much, they are new, quite evasive, its stuff that people don't talk about, you know, you keep it very private and closed and there is this whole de-

sensitization that happens here, which is just normal and you are burping and you know you are letting off wind that's actually expected, well done and (laughing) its fantastic.

R Ja

P Where elsewhere people will be saying, "Did you hear what she did"? So apart from that I also think the knowledge base here is fantastic, they know so much more about what happens with these types of ops and I'm surprised there aren't more units like this. Its fantastic and uhm, I am so pleased I am in the right place you know. In the right hands because its just been wonderful. And the knowledge base is here and because of that the care is here the level of care

R And obviously the enthusiasm and the expertise has remained within the unit because the people actually want to work here.

P Yes

R That comes across does it?

P Definitely, I mean there is no judgmental stuff going on you know, oh we have to leave this now, they like to work in this unit, they know what's happening, Ja, you are quite right, they the expertise is definitely, ja, makes a huge difference.

R So, Mrs. Rank the care then that you have received overall was very good, good?

P I would like to say outstanding, outstanding, I really think you know I would be very happy to come back, and I would be happy to refer anybody and everybody (laughing) ja, I am very, very pleased and you know normally people choose a hospital that's convenient to where they live well we have chosen a hospital which is not convenient to where we live and we will continue just to come back because it's the level of care here, ja.

R And when you chose the hospital you chose it on what you heard about it or that you were particularly referred to a doctor or?

P I was referred to Doctor T and just delighted that, that has happened for me, I did not know anything about hospital A beforehand. uhm Because I don't live in the area maybe, I don't know, because I have not been ill enough to know what is out there uhm, I'm not sure you know I did not know that it existed you know I knew about the hospital but did not know that there was a dedicated unit. And had I

know that a year ago I would have been here a year ago, definitely. But ja I was referred to Doctor L and he just obviously took all the leadership into organizing for the team to manage me here, and that has been a brilliant exercise. Ja,

R So, has there been any surprises apart from what you mentioned about in the ICU and your husband staying has there been any other surprises or equally bad surprises that you've come across during your stay?

P The good surprises is the ethic here I mean it has been wonderful the people really care and to take it a step further there is a medical profession, a medical team that really care because there is just so much out there and I was very critical of the medical profession for many, many years because of the lack of real care and commitment. And just anybody getting busy and being a money making business, I felt very different here, I felt that there really is a genuineness, there is a dedication and a willingness to really focus on a person and the patient and to put them first. Whereas elsewhere people focus on the doctors to put them first and not inconvenience their lives or the bureaucracy gets put first or hospital procedure gets put first or you know money, if its too costly you want to look for something similar. And uhm, and uhm, I haven't felt that here, I have felt that the people have gone an extra mile for the patient and that the patient has been the focus of their attention and that is just unique, just been wonderful (laughing) Ja, the main thing.

R Is there anything else that you feel that has been relevant to your stay good, bad, anything about people's attitude that you have not perhaps already covered?

P Ja, just to maybe cover a comment of uhm just staff in general. You have to distinguish between staff who you could see take care of themselves holistically. So they have a fairly disposition and they are quite relaxed and they are very balanced and they can give 100%. Then you've got the other half who you can see are not taking care of themselves, who are not balanced who don't have such a friendly attitude and who can't really give of themselves and who might be taking a little bit from you because they need some support. I think, something just to think about uhm you can encourage them to also look after themselves. To be able to give to other people you got to be able to take good care of yourself and there is a nice balance here. I mean the majority of the people fall into looking after and having

some balance, but the other 25% are not doing that and I think that is not just a bad advertisement for the hospital, in that uhm we can see what you are promoting in terms of health and wellness its also it could be value for the patient. They talk about the little home problems and this and that and you would end listening (laughter) to the issues you know that sort of thing.

R Is it occurring very frequently? Would you say once a day somebody comes in, that perhaps isn't as professional or needs your help more than?

P Not once a day say once a week you know. I would say once a week that would happen and again one would have to look at who is that permanent or agency staff

R Is it professional, staff or is it enrolled nurses, enrolled nursing assistance?

P I really don't know I think it is a bit of both of both I think there is a bit of both. In fact I do know really there has been individuals from both sides I would not just say one side.

R We have not actually put you off per se. Have you felt uncomfortable?

P Well there was one particular person I felt a little bit uncomfortable with and I just continued to just sort yourself out a little bit. She was quite rough and you know and quite uhm uhm anxious, has to get stuff done and I could just see she wasn't quite there and then you obviously wonder what is she doing, is her mind with the job you know is she thinking about what she is doing and so uhm ja there was one person that I felt a little bit worried about uhm particularly, otherwise not.

R If she was continually looking after you for a time?

P no, no

R Then we might have to do something about it?

P Oh yes, for once she came, definitely, she came in for one session and I didn't pick it up

R If there was a problem with regards to people that were caring for you, you feel able to speak to me or the person in charge?

P Yes, you don't want to be overly judgmental about the situation it could have just been an off day,

R Absolutely

- P You know, so you don't want to say "so and so", but if it continued and that person came back to me looking after me and that was the situation I definitely would, because I feel there is a good relationship, there is so much openness here that it is important to give feedback that is the only way that we could do something about it. Ja, ja, I would, ja
- R It sounds like it has been a time of great relationships, great relationship.
- P Yes, that has been a homecoming because I have had such a bad experience and its just chalk and cheese its just such a difference and it has just been wonderful for me just to know that I have really been cared for.
- R You are using the words home and family
- P Definitely, and I felt very, very comfortable here, very peaceful and just very relaxed and safe and just uhm knowing that I am okay I am going to be fine you know no matter what I have to go through that I got so much support here and there are wonderful people I've developed good relationships with everybody so, ja. It is something that you will treasure
- R Yes, yes.
- P And it will be long term, you know, you know people by first name and its not just sister so and so you know the people, about their slightly relaxed and ja, and you are talking to people just come back and whoever and have treatment.
- R Thank you very much.
- P Pleasure.

## Appendix iii

### NODES TEXT DOCUMENT AND NODES FOR MRS RANK

#### Q.S.R. NUD.IST Power version, revision 4.0.

Licensee: H Blackwell.

#### NODES TEXT DOCUMENT

The following is from one participant: Mrs Rank

PROJECT: Mrs. Rank, User Heather, 12:51 pm, Nov 19, 2001.

The coding was facilitated by the use of a computerised programme. The use of the Nud.ist 4 programme allows the researcher the flexibility to conceptualise the text under broad headings, which form a "node". The nodes were meaningful to the description of "caring", which were made up of words and phrases relating to "caring". The text [narratives] were grouped together [using a category of care, linking categories containing words and phrases with similar meanings] to reflect how the participants described the care that was given to them and the caring actions/practices of care they received and what they liked or disliked, grouped under the headings of care for example: individual care, practical care, emotional care which the patients' experienced. The identification of themes with similar meaning starts to evolve. This is the meaning of "caring" emerging interpreted as those aspects of nursing care, the experience and the understanding of care most important to patients, described as satisfiers and dissatisfiers of care.

(F 1) //Free Nodes/League of its own

P Definitely, in fact when I say that you are in a league of your own I think that is the winning combination

P Yes, yes, ja. ja where you sort of you know you sort of treat it when its there you don't pro-actively preventatively given to stop things from happening. So, I am very impressed with that. you people here are pro-active and on the ball. It's that again why I say this hospital is in a league of its own, definitely and there is just the last thing my experience have been the response time you know, it has been wonderful if you ask for

bathroom and they were here within minutes, and very happy to do their job, very friendly, they do a good job cleaning the bathrooms. The TV was you know, faulty, the man came in, two minutes fixed all of that you know, uhm. The food, the food is an issue I think, (laughing).....I am not sure, um its not an issue choosing a variety of choices, there is wonderful variety of choices and its depends very much on how you are feeling as a patient nothing else. Its always a tricky area with food, but I don't think they are as vigilant in terms of the standards, like you would often get your egg without toast or you would get two peppers and not a salt and pepper or like you would get half your meal and not the other and you would then have to wait for that and they are not on time, you need to really know when they come in you know, that is the one thing which is not

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- (F 1 1) //Free Nodes/League of its own/Chalk and cheese
- (F 2) //Free Nodes/Respect and Privacy with family
- (F 2 1) //Free Nodes/Respect and Privacy with family/Privacy -Bad experience
- (F 2 12) //Free Nodes/Respect and Privacy with family/Family care
- (F 2 12 1) //Free Nodes/Respect and Privacy with family/Family care/friendly care
- (F 2 12 24) //Free Nodes/Respect and Privacy with family/Family care/Its been like a homecoming
- (F 3) //Free Nodes/Caring-gentleness and dedication- Nurses
- (F 3 5) //Free Nodes/Caring-gentleness and dedication- Nurses/patient feeling insecure and fearful
- (F 3 6) //Free Nodes/Caring-gentleness and dedication- Nurses/Sister went the extra mile

- (F 3 6 1) //Free Nodes/Caring-gentleness and dedication- Nurses/Sister went the extra mile/Named nurses' Individual care
- (F 3 7) //Free Nodes/Caring-gentleness and dedication- Nurses/Day and Night differences with nurse caring
- (F 3 7 1) //Free Nodes/Caring-gentleness and dedication- Nurses/Day and Night differences with nurse caring/Agency nurses
- (F 3 11) //Free Nodes/Caring-gentleness and dedication- Nurses/Peacefulness I know I am being cared for
- (F 3 13) //Free Nodes/Caring-gentleness and dedication- Nurses/Flexibility of care

(F 4) //Free Nodes/Accountability

P I found that, I just you know, I think I don't know I want to think about accountability just think you are not quite sure how accountable an agency nurse would be for maintaining the standards and ethics in an environment which they are not permanently part of um and I am not just saying with the agency I am sure there was some permanent nurses as well who just weren't as skilled or as dedicated and there are those differences but obviously as a patient you would want to latch yourself to a person who is really gentle and dedicated and go the extra mile, you could be just getting everything you need and you are feeling so good and you're recovering.

- (F 4 9) //Free Nodes/Accountability/Patient was leading the Treatment
- (F 4 10) //Free Nodes/Accountability/Team approach to care
- (4 10 13) /Accountability/Team approach to care/Flexibility of care
- (F 4 10 23) //Free Nodes/Accountability/Team approach to care/Patient was the focus of the team

P The good surprises is the ethic here I mean it has been wonderful the people really care and to take it a step further there is a medical profession, a medical team that really care because there is just so much out there and I was very critical of the medical profession for many, many years because of the lack of real care and commitment. And just anybody getting busy and being a money making business, I felt very different here, I felt that there really is a genuineness, there is a dedication and a willingness to really focus on a person and the patient and to put them first. Whereas elsewhere people focus

on the doctors to put them first and not inconvenience their lives or the bureaucracy gets put first or hospital procedure gets put first or you know money, if its too costly you want to look for something similar. And um, and um, I haven't felt that here, I have felt that the people have gone an extra mile for the patient and that the patient has been the focus of their attention and that is just unique, just been wonderful (laughing) Ja, the main thing.

(F 4 15) //Free Nodes/Accountability/Competency, knowledge and skills

(F 4 15 16) //Free Nodes/Accountability/Competency, knowledge and skills / Confidence of care

(4 15 17) /Accountability/Competency, knowledge and skills/Impressed with ICU care

(F 4 15 18) //Free Nodes/Accountability/Competency, knowledge and skills/Impressed with ICU care

(F 4 21) //Free Nodes/Accountability/Specialised GIT unit

(F 8) //Free Nodes/Information to patient

(F 8 1) //Free Nodes/Information to patient/Nothing hidden from Patient's

P On my own and in the hand of whoever was looking after you so that's a scary thing sometime because you are not sure, especially if it is someone like who you are not feeling safe with you're not sure are they doing their job are they skilled, are they caring enough, are they monitoring you, um so ja there was definitely that kind of fear there. Umh Just the other thing that has been important to my experience here has been the information and care that I received here. It has been wonderful, just the amount of information you know just all my questions have been answered the staff has been wonderful about telling me about the operation and incredibly humorous about what's going so there is a wonderful openness in communication so that has been a great experience. Which is also different from what I had at Hospital C you know there at Hospital C there was a kind of closed, umh less open in communicative style and much more serious (laugh) you know um and you know I am linking them but the..... important thing is the information..... in being open and honest and saying this is what is going on and what's happening to you so that you can be a participant in your

own process and there is nothing being hidden and there is nothing, you are the patient and (quietly intense) we are the caregivers and we know what's really happening with you um and on that level to I mean everyone is informed of what is happening to you which is fantastic. I found the hand overs here are amazing this now coming back to the wards.

P Coming back to the wards, everybody knows what is going on and they are very informed and you don't have to repeat yourself, and go through the 3<sup>rd</sup> degree of what is going on and there is less mistakes being made in terms of what is going on with your treatment, your care plan and that sort of thing. So that has been fantastic you can concentrate on your self and healing

(F 8 2) //Free Nodes/Information to patient's/Nursing handovers were amazing

(F 8 3) //Free Nodes/Information to patient/You are the patient we are the caregivers

(F 8 4) //Free Nodes/Information to patient/You can concentrate on yourself and healing

(F 14) //Free Nodes/The laughter

(F 20) //Free Nodes/Ward organisation

P The medical ward, ja, lots of little things she wasn't quite sure of and there was to me looked like and felt like that ward was not organised to me, there was a lot dis-organisation going on and um things like I am trying to think, I was on the bed and I had to have an enema I think and um I suggested that she puts one of these little plastic things on the bed because I am going to mess on the sheets and she did not kind of hear that. And I ended up messing up the sheets and we had to change the sheets

(F 20 19) //Free Nodes/Ward organisation/Food not up to standard

(F 22) //Free Nodes/Quality of Medical care-Competency of doctor

(I) //Index Searches

(T) //Text Searches

## Appendix iv

The **NODES TEXT DOCUMENT** illustrates how the Nud.ist 4 programme was used in the process of analysis to engage with the data (narratives). The identification and formulation of categories with similar meanings were grouped together and the interpretation of the theme of “caring” starts to evolve.

### **NODES FOR MRS RANK**

#### **Organisational care**

League of its own  
Chalk and cheese  
Ward organisation  
Food not up to standard

#### **Supportive care**

Respect and privacy with family  
Privacy – bad experience  
Family care  
Friendly care  
It’s been like a homecoming

#### **Individual Care**

Gentleness a dedication – nurses  
Patient feeling insecure and fearful  
Sister went the extra mile  
Named nurses individual care  
Peacefulness I know I was being cared for.

#### **Individual care - Information and communication to patient**

Nothing hidden from patient  
Nursing handovers were amazing  
You are the patient, we are the caregivers  
You can concentrate on yourself and healing.

#### **Emotional Care**

Family care  
Friendly care  
Gentleness  
Peacefulness  
Laughter

#### **Knowledge and insight skills**

Accountability  
Competency, knowledge and skills

Confidence of care  
Impressed with ICU care  
Patient was leading the treatment  
Team approach to care  
Flexible care  
Patient was the focus of the team  
Specialised GIT Unit

**Negative care - day and night differences**  
Day and night difference with nursing care  
Agency nurses

**Quality of medical care**  
Competency of doctor

## UNIVERSITY OF CAPE TOWN



### FACULTY OF HEALTH SCIENCES

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4 April, 2001

Mrs H Blackwell  
8 Strand Street  
MELKBOSSTRAND  
7441

Dear Mrs Blackwell

#### MSc PROPOSAL

Candidate:	Blackwell, H (RCHHEA002)
Qualifications:	Diploma in Nursing (London)
Degree	MSc in Nursing
Title	Understanding the satisfaction with nursing care from patients perspective in a private hospital setting in South Africa
Supervisor	Mrs P Mayers, Dr S Haegert

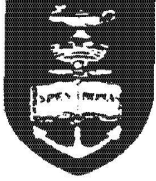
I am pleased to advise that Professor JP van Niekerk, chairperson of the Postgraduate Programmes Committee, has approved your candidature for the above degree on behalf of the Committee. Formal approval will be obtained by publication in the next Dean's Circular (MED02/01).

If you have any further queries, please do not hesitate to contact me.

With best wishes.

Sincerely

**MARILYN DE VRIES**  
**POSTGRADUATE OFFICER**



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Faculty of Health Science  
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31 January 2002

REC REF: 339/2001

Mrs H Blackwell  
Nursing

Dear Mrs Blackwell

**UNDERSTANDING THE SATISFACTION WITH NURSING CARE FROM  
PATIENTS PERSPECTIVE IN A PRIVATE HOSPITAL SETTING IN SOUTH  
AFRICA**

Thank you for your application submitted to the Research Ethics Committee on the 12 November 2001.

*It is a pleasure to inform you that the Committee has **formally approved** the above study 30 January 2002.*

Please quote above REC reference number in all correspondence.

Yours sincerely

**A/PROFESSOR CR SWANEPOEL  
CHAIRPERSON**