Experiences of newly qualified critical care nurses caring for post-cardiothoracic surgery paediatric patients in a private hospital in gauteng

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ARTICLE INFO

Keywords:
Critical care nurses
Experiences
Caring
Congenital heart disease
Paediatric cardiothoracic intensive care unit

ABSTRACT

Purpose: To gain an understanding of newly qualified critical care nurses’ lived experiences in caring for post-cardiothoracic surgery paediatric patients in a private hospital in Gauteng.

Background: Caring and Ubuntu are often referred to in caring for patients and their family members, yet little is known about how those processes are applied to nurses in the work environment. The researcher’s assumptions about caring were based on definitions from Watson’s theory (Watson, 2008:34). The core principle of this theory evolves from carative factors, the transpersonal caring relationship and caring moment. The researcher viewed a newly qualified critical care nurse as a person offering high-quality nursing to paediatric patients with congenital heart disease who require complex knowledge and advanced nursing skills. Newly qualified critical care nurses need assistance to gain knowledge and skills in this new environment.

Design and methods: A qualitative, exploratory, descriptive and contextual research design was employed using Giorgi’s method of data analysis. Participants were six females with ages ranging from 30 to 34 years, and they were of Black and Indian ethnicity. Data were collected employing in-depth, individual phenomenological interviews.

Results: The results revealed the newly qualified critical care nurses experienced an overwhelmingly stressful environment, uncaring relationships, the participants experienced the nursing to be entirely different from nursing adult cardiac patients, and they experienced a great need for supervision and training. Participants shared their compassion, Ubuntu and transpersonal caring with patients and parents.

Conclusions: Newly qualified critical care nurses need knowledge, skills and Ubuntu to offer holistic care to paediatric patients with congenital heart diseases. Nurses need to be nurtured, respected and assisted in the new environment to promote their caring consciousness. Given the clear knowledge and expertise needed in caring for paediatric patients with congenital heart disease, additional education and mentorship are needed.

1. Introduction and background

Globally, 15 million children under five die each year, with congenital heart disease (CHD) substantially contributing to this high mortality rate (Musa et al., 2017:52-58)). It is also asserted by Ellesøe et al. (2018-2) that congenital heart defects affect up to 8 of 1000 newborns, making heart defects the most common congenital malformations. The defects comprise an assortment of structural malformations, ranging from insignificant defects to complex life-threatening malformations, which require highly specialised medical care. The worldwide prevalence of CHD is estimated at 1.35 million annually (Ni, Lv, Ding, & Yao, 2019:1). In Africa, approximately 500 000 children are born with CHD (Jivanji, Lubega, Reel, & Qureshi, 2019:1). Moreover, in South Africa, an estimated 11 000 (resulting in 0.6–0.8/1 000) children are born with CHD annually, and the majority of these children do not receive appropriate care (Murni & Musa, 2018:1).

Corrective surgery for paediatric patients with CHD is considered high risk, and appropriate postoperative care knowledge is crucial (Ni et al., 2019:1). Knowledge is needed for the newly qualified critical care nurses working in the paediatric cardiothoracic intensive care (PCCU) to prevent possible complications. Providing care in an intensive care unit (ICU) is a holistic process that requires nurses to be vigilant regarding all aspects of patients’ needs; at the same time, nurses are expected to be competent experts in working with advanced technical tools (Bagherian, Mirzaei, Sabzevari, & Ravari, 2016:17–77). There are limited paediatric cardiac health resources in Africa, resulting in a severe challenge in caring for paediatric patients with CHD. There are also only two paediatric cardiac centres in South Africa, namely the

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https://doi.org/10.1016/j.ijans.2020.100213
Received 22 September 2019; Received in revised form 3 May 2020; Accepted 16 May 2020
Available online 24 May 2020
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Maboneng Heart and Lung Institution in a private hospital in Gauteng Province, and the Red Cross Memorial War Children’s Hospital, a state hospital in Cape Town (Bronicki et al., 2017:8).

Sinclair et al. (2016:437) state that teaching nurses about compassion is essential when caring for paediatric cardiac patients. Such training is said to enhance the key facets of empathy, while adding distinct features of being motivated by love and acts of kindness. Watson’s curative factors endeavour to honour the human dimensions of nurses’ work and the inner life world and subjective experiences of the people they serve (Watson, 1997:50). In the context of South Africa, we consider practices of nurturing a variant of humanism called ‘Ubuntu’, meaning a human being is a human being through the otherness of other human beings (Johnson, Sanchez, & Zheng, 2015:5). Metz (2017:2) explains Ubuntu as per Bishop Desmond Tutu, “a person is a person through other persons”; therefore, Ubuntu entails communal or harmonious relationships, a sense of togetherness, cooperation and helping people out of sympathy.

Bhaskar, Rettiganti, Gossett, and Gupta (2018:120-128) mention that paediatric cardiac intensive care is a relatively new frontier in cardiovascular medicine, and as a subspecialty, this field demands expertise in paediatric cardiology as well as paediatric intensive care. Paediatric care nursing education and certification really matter in paediatric patient outcomes. New nurses need adequate time and guidance to ensure smooth adaptation to their working requirements (Keles & Yalindag Ozturk, 2018:4). However, the additional qualification ‘Medical and Surgical Nursing: Critical Care Nursing’ (Council (SANC), 1993R.212) does not include paediatric cardiac nursing. A qualitative methodology is thus crucial to finding new knowledge on the experiences of these nurses.

The purpose of this study was to gain an understanding of the lived experiences of newly qualified critical care nurses in caring for post-cardiothoracic surgery paediatric patients in a private hospital in Gauteng. Based on the results of their lived experiences, recommendations were formulated to support newly qualified critical care nurses in optimising quality care for post-cardiothoracic surgery paediatric patients.

2. Methods

The researcher followed a qualitative research method in this study. LoBiondo-Wood and Haber (2018) define the research method in qualitative research as a systemic method that guides the process of data collection and data analysis. The researcher explored and described the experiences of the newly qualified critical nurses caring for post-cardiothoracic surgery paediatric patients in a private hospital in Gauteng Province. A description of the conceptualisation process was presented whereby relevant literature were involved. Moreover, recommendations were made to support the newly qualified critical care nurses in caring for the post-cardiothoracic surgery paediatric patients. The researcher used the Consolidated criteria for Reporting Qualitative research (COREQ) guidelines in approaching and reporting on this qualitative study.

2.1. Study design

A qualitative, exploratory, descriptive and contextual research design was used to conduct phenomenological, in-depth, individual interviews. The phenomenological approach is aimed at obtaining a description of an experience as it is lived in order to understand the meaning of that experience for those who have lived it (Creswell & Poth, 2018:17). Giorgi’s method of analysis is used to uncover the meaning of a phenomenon as experienced by a human through the identification of essential themes (see Table 4). The researcher put aside her personal biases, meaning her experiences and preconceived opinions and beliefs that could have influenced what was heard and reported (LoBiondo-Wood & Haber, 2018:576). The researcher focused on the experiences of the newly qualified critical care nurses caring for post-cardiothoracic surgery paediatric patients in a specific paediatric cardiothoracic ICU in Gauteng.

2.2. Settings

The setting in this study was a specific PCICU in Gauteng Province, South Africa. It is the only ICU in Gauteng Province that cares for paediatric patients with complex CHDs pre and post-surgery. This specific unit admits paediatrics and neonates from all over Gauteng and other provinces, as well as from most parts of Africa – Botswana, Swaziland, Nigeria, Ghana and Zimbabwe. This PCICU is a 23-bedded unit with 10 isolation beds; the remaining beds are divided with glass partitions. There are four highly specialised paediatric cardiac surgeons, four paediatric cardiologists, two paediatric intensivists, two dieticians, three physiotherapists and one speech therapist working in the unit.

There were 16 critical care trained registered nurses in the unit, eight critical care nurses who have attended an additional paediatric cardiothoracic course, 18 registered nurses with ICU experience, 12 enrolled nurses, four enrolled nursing assistants regulated by R.2598 (the regulations relating to the scope of practice of persons registered or enrolled under the South African Nursing Act, 1978), one clinical facilitator who works day shift, and one unit manager. All nurses in this PCICU worked shifts (day and night) according to their requests and the operational needs of the unit. The occupancy of this unit is 95%, and the nurse-patient ratio is 1:1. The enrolled nurses work under the direct supervision of the registered nurses as per their scope of practice (SANC, R.2498). The enrolled nursing assistants are not directly involved in patient care, but help with bed bathing, linen changing and carrying out orders from all nurses taking care of the patients. The newly qualified critical care nurses work only day shifts.

2.3. Participants, sample and sampling

A purposive, convenience sample of newly qualified critical care nurses in PCICU (N = 6), employed in a private hospital in Gauteng Province, was recruited for participation. All participants were full-time permanent employees working day shift as it was convenient since they were given time to be interviewed during working hours. Inclusion criteria were nurses who obtained additional qualifications in ‘Medical Surgical: Critical Care Nursing’ (SANC, R.121); and who had worked in this specific PCICU for more than six months but not longer than one year to ensure exposure to the specific phenomenon under investigation. It was anticipated that these participants would provide thick, rich, meaningful data; hence, the rationale for purposive sampling. Moreover, participants had to be able to read and speak English. Exclusion criteria were nurses who worked in the PCICU before the commencement of the critical care course; and qualified critical care nurses who had worked in PCICU for more than a year. It was decided that after a year in the unit, qualified critical care nurses are familiar with the environment and have gained knowledge in caring for paediatric patients’ post-cardiothoracic surgery. Eight nurses met the inclusion criteria; however, one participant resigned after signing written consent, to join the adult ICU in another hospital. Another participant withdrew from participating in the study and took a transfer to the adult ICU. Data were saturated with the sixth interview. Participants were not compensated. The nursing service manager allowed interviews to occur during the participants’ work time, eliminating the need to make arrangements outside these hours. The researcher, who is a nursing unit manager, conducted personal recruitment; however, she was aware of possible coercion due to her position of power, and participation was therefore voluntarily.
2.4. Data collection

The researcher was a part-time graduate nursing student at the time of this investigation. She was also the nursing unit manager at the time the interviews were conducted. The researcher fully explained the purpose of the study to participants prior to obtaining their informed consent, and information letters were given to participants who volunteered. Data collection started on 29 November 2017 and was completed on the 30th of April 2018; the researcher (first author) spent five months collecting the data. The interviews were held individually on different dates at the hospital in the Cardiac-Catherisation Laboratory (CATHLAB) boardroom as it is away from the hospital wards for participants’ privacy and is conducive and noise-free. It is a small boardroom with a nice view outside to promote calmness for the participants. Each interview lasted between 55 and 60 min. Only the participant and the researcher were present, and an audio-recorder was used to capture the data, along with observation and field notes written for non-verbal data. The research question that guided the interviews was: “How is it for you to nurse the paediatric patient post-cardiothoracic surgery?” A pilot study was done with the help of the researcher’s supervisor to test the research question; it was successful and taken as the first participant.

Communication techniques were used to facilitate questioning (Gerrish & Lathlean, 2016), and to gain rich information from the participants. These techniques included (a) listening - maintaining eye contact and being receptive of non-verbal communication; (b) clarifying - to enhance understanding by asking the participant to repeat what she said; (c) paraphrasing - rewording what the participant said; (d) probing - asking questions to help the participant expand on an important statement; (e) summarising - the researcher summarised the individual interview to confirm what the participant said. All interviews were de-identified and transcribed verbatim by the researcher on the day the interviews were conducted. These were also reviewed by the research supervisor, who has extensive knowledge of qualitative research.

2.5. Data analysis

Data were analysed for meaning using Giorgi (2012:3-12) approach which involved the following steps: (a) The researcher first read the complete transcription in order to get a sense of the whole. The researcher, as a nursing unit manager, bracketed her own preconceived knowledge and ideas regarding the phenomenon under study in order to obtain data from the newly qualified critical care nurses’ perspectives. The information was obtained and transcribed from the in-depth individual interviews, the audio-recordings and field notes. (b) The researcher went back to the beginning of the description and reread it. This time, every time she experienced a transition in meaning from within the attitude, she made a mark on the transcription. These parts are called ‘meaning units. (c) The researcher transformed the data – still in the words of the subject – into expressions that were more directly revelatory of what the participant said. (d) The direct and psychologically more sensitive expressions were then reviewed and, with the help of free imaginative variation, an essential structure of the experience was formed. (e) The essential structure was then used to help clarify and interpret the raw data of the research. The researcher compiled, reanalysed and interpreted the results of the study.

2.6. Description of raw data coding

The researcher manually coded the data with the use of coloured pens to categorise the data, identifying significant patterns in all the interviews, and finally drawing meaning. All negative experiences and emotions were grouped together and given a name. Inadequate knowledge and the need for training were put together and a meaning unit was formulated. All positive experiences and emotions shared by the participants were grouped together. A discussion was held with the independent coder in May 2018. The independent coder holds a PhD and is an Advanced Psychiatric Nurse Specialist. She has been an independent coder for more than 40 Master’s and PhD studies. Agreement was reached regarding the themes and subthemes that emerged; differences only related to terminology and phrasing of sentences by the researcher and the independent coder. The researcher went back to the participants to confirm if the analysis of the data was a true reflection of what they meant. None of the participants requested changes to be made in the themes/subthemes.

2.7. Trustworthiness

Lincoln and Guba (1985) method was used in establishing the trustworthiness of the study, adopting the following strategies: 1. Credibility: a) Prolonged engagement was adhered to as data collection started on the 29th of November 2017 and was completed on the 30th of April 2018. b) Triangulation was done by the researcher using multiple sources of data collection c) Use of peer debriefing with her supervisor who have extensive knowledge in qualitative research. d) Member checking: Collected data were verified. 2. Transferability: Entailed the dense description of the process. 3. Dependability was heightened in the discussion of the results. 4. Confirmability: This was enhanced through triangulation. See Table 1 for further detail.

3. Results

Six participants were interviewed, and data saturation was achieved. The participants were nurses who ranged in age from 30 to 34 years and of Black and Indian ethnicity. All participants had been employed in the unit for 6–12 months, and had post-basic diplomas in Medical Surgical: Critical Care Nursing (Council (SANC), 1993:R.212). Their nursing experience in adult critical care ranged from two to four years. A summary of participants’ demographics is presented in Table 2.

3.1. Participants experienced the PCICU as an overwhelming and stressful environment

3.1.1. Feeling worthless, scared and anxious

The participants had difficulty in adapting to the new environment, and they experienced uncaring and poor interprofessional relationships among senior nurses and mistrust from physicians. Thus resulted in a lack of trust and confidence in themselves, and doubting their own competencies.

Stressful experiences were mentioned by the participants in terms of adapting to the new environment, the medications, nursing paediatric patients and being part of the paediatric cardiac team. They relayed:

“I have knowledge and experience of working in the ICU, Huh (taking a deep breath) paediatric cardiac is a challenge, it is a field that it is so intense, so much responsibility, so much of learning, so many things to adapt to.” (Participant 2, female, 34 yrs).

Other participants explained:

“it is overwhelming, challenging, depressive, and stressful for someone who is ICU trained and never worked with paediatric cardiac patients (sad face): we need effective team in this unit, seniors with knowledge and good interprofessional relationship but most of the senior nurses can belittle you, make you a failure (shaking her head)” (Participant 1, female 30 yrs).

“Emotional and scary, 3.3 kg baby with all invasive lines, peritoneal dialysis, endotracheal tube and chest drains; small baby, you don’t know where to touch the baby. Most of them with open chest, Extracorporeal Membranous Oxygenation (ECMO) and Left Ventricle Assist Device (LVAD)” (Participant 3, female, 32yrs).
3.1.2. Lost trust and confidence in their own knowledge, skills and capabilities

The participants described the PCICU as a scary environment. They said they relied heavily on senior staff members. This is evident in the following statements:

“One end up having fear and anxiety of what if I am not doing the right thing, questioning your competency. (Her fingers tapping on a table). When you are at home after work, when eating your supper, you start thinking about these children. You start asking yourself about your handover to the night staff; did you tell them everything about this child?” (Shaking her head) (Participant 2, female, 34 yrs).

“I am ICU trained but now I am relying on the shift leaders full time” (Participant 3, female, 32 yrs).

3.1.3. Uncaring interpersonal relationships among staff members

The participants shared feelings of not being part of the team as they were belittled, humiliated and isolated by the senior staff members. The participants expressed there was no helping, trusting, caring relationships among the senior staff members and the newly qualified critical care nurses; instead, they experienced social isolation. Insensitivity from the senior staff members towards the newly qualified critical care nurses was also mentioned. The participants stated that senior staff members did not recognise and understand their feelings. The participants said:

“It is so emotional to nurse these babies with congenital cardiac diseases. We need effective team in this unit, seniors with knowledge and good interpersonal relationship; and most of the senior nurses can belittle you, make you a failure.” (Participant 2, female, 34 yrs).

“Yes, this is really creating a barrier between new nurses and the gurus of the unit. You show them the blood gas, so that you can discuss together, instead they will be so rude to you for example, before you can say anything about the blood gas, she will look at you and say... What now? (With a high tone voice) It is really bad.” (Participant 5, female, 34 yrs).

3.1.4. Mistrust from physicians

The participants mentioned that they experienced mistrust from the physicians, along with feelings of not being wanted, and a feeling of not being respected by the physicians:

“You hesitate to ask clarity from the physicians, one got fear to talk to the physicians because they can just bark on you. Because you are still new in the unit, they just don’t like you.” (Participant 1, female, 30 yrs).

“They do not trust you when you are new, instead of giving you orders about your patient, they give orders to the nurses who had been there for a long time (Silent) you feel offended, disappointed, you feel like you do not worth anything.” (With an angry face). (Participant 5, female, 34 yrs).

3.2. Participants experienced nursing paediatric cardiac patients to be entirely different from nursing adult cardiac patients

3.2.1. Different physiological structures, compared to adult patients

The participants acknowledged that they had no experience in paediatric cardiac nursing as it was not included in their training (SANC, R.212). As a result, there were significant challenges in delivering comprehensive care to paediatric patients post-cardiothoracic surgery. The participants mentioned that paediatric cardiac patients are more complex compared to adult cardiac patients in terms of their physiological structures, their diagnosis and specific operations, calculations of tiny doses of medications, as well as specific equipment. The participants mentioned:

“with children the weight counts (shaking her head), with each surgery there is a specific nursing care plan, and there are many types of congenital heart diseases; children got specific oxygen saturation needed, heart rate and mean arterial blood pressure according to their ages and weight, as well as specific operation done.” (Participant 5, female, 34 yrs).

“Normal heart rate for the adult is 60–100 bpm, but not with paediatric
patients, there are different heart rate parameters, blood pressure for the neonate and the paediatric patients” (Participant 3, female 32 yrs).

3.2.2. Different equipment compare to adult equipment

The techniques of some procedures for the paediatric critically ill patients were perceived as a challenge by the participants. The need to learn about paediatric equipment was also mentioned. The participants said they were experiencing challenges in delivering nursing care with unfamiliar equipment, as they did not want to cause harm to the patients. The quotes from the participants follow:

“Different brand of equipment same as different brand of ventilators, different syringe pumps, different bridge for monitoring central line pressure and arterial blood pressure.” (Participant 2, female, 34 yrs).

“They small ET-tubes are uncuffed. It is scary, there is a high risk of accidental extubation whereas with adult patients the ET-tubes are cuffed, and it is not easy to come out accidentally.” (Participant 1, female, 30 yrs).

“Ventilators are not same. The type of adult ventilator is not the same like the one we were using in this unit, it is scary.” (Participant 3, female, 32 yrs).

3.2.3. Interpersonally they had to deal with the babies and families

Participants explained that they needed to give holistic care to critically ill babies and counsel the family members as well. They found it difficult, as they did not know how to explain what to expect to parents or possible complications after specific operations. The participants mentioned that it is frustrating as the family can be difficult at times. They said families blame them if their children experience complications. Some of the participants’ expressions follow:

“And you as a nurse you have to comfort her, while taking care of their critically ill child, nursing the child and the mother.” (Participant 5, female, 34 yrs).

“It will be a fulfilling emotionally to have theoretical knowledge in caring for these children, able to nurse them holistically and be able to care for their parents as well.” (Participant 2, female, 34 yrs).

“Parents are emotionally affected, and sometimes very rude because of the conditions of their children, they are very angry and in denial as well. You have to deal with angry parents, taking care of the whole family.” (Participant 4, female 32 yrs).

3.3. Participants experienced a great need for supervision and training, and a need to be part of the team

3.3.1. Need for mentoring and clinical facilitation

The participants mentioned that the unit is very busy, and there is no time for teaching. Lack of mentorship was also mentioned by the participants; they expressed difficulties in completing workbooks by themselves. Participants shared:

“Orientation period is too short to cover too much knowledge needed to nurse this paediatric patient post-cardiothoracic surgery.” (Participant 2, female, 34 yrs).

“Too it is a very busy unit, the first two weeks they pair you with someone, it is really not enough because even though you are working with somebody, she does not have time to teach you because these kids are critically ill.” (Participant 5, female, 34 yrs).

“I mean in any new environment, everyone needs orientation for at least some few weeks until you get to see how things are done, so it is very challenging.” (Participant 6, female, 33 yrs).

“When you start in this unit, there are procedures to be done with the help of the shifthead, protocols and hospital policies, but the unit is very busy there is no teachable moment.” (Participant 3, female, 32 yrs).

“No teaching in the unit at all. No mentorship. There is shortage of staff and the unit is always busy, always running around, discharge quickly, to admit another sick baby.” (Participant 6, female, 33 yrs).

The participants showed eagerness to learning and achieving professional growth and caring for the family members as well. The participants acknowledged that they had inadequate knowledge, skills and were lacking in terms of highly advanced technology; the need to attend a paediatric cardiac course was mentioned as an urgent matter. One of the participants said:

“I read in the newspapers that the first paediatric Left Ventricle Assist Device (LVAD) in South Africa was done in this institution, I need to know about these congenital cardiac diseases, I need to learn, I need to do paediatric cardiac course.” (Smiling) (Participant 6, female 33 yrs).

3.3.2. Positive attitude to be part of the team

Regardless of the stress they were experiencing, participants were happy to be part of the paediatric cardiac team. The participants expressed their joy at seeing the children doing well. The participants also showed eagerness in learning and achieving professional growth. Participants explained:

“It is kind of blessings to be part of the hands in caring for this paediatric cardiac patients. It is fulfilling to be part of nurses that bring the company’s name up, as well as the name of nurse up” (smiling) (Participant 2, female, 34 yrs).

“It is so nice when after six months the parents bring a healthy child to say thank you for looking after my child.” (Giggling) (Participant 5, female, 34 yrs).

3.3.3. Transpersonal caring and Ubuntu

The participants shared their compassion, transpersonal caring and Ubuntu as follows:

“There is attachment to parents emotionally, we end up exchanging contact numbers with the parents to do the follow up of the children after they had been discharged, being a woman, a mother and a nurse is difficult not to bond with them” (Participant 2, female 34 yrs).

“Very emotional and stressful to us and to parents as well, you need to support them during this stressful time.” (Participant 3, female 32 yrs).

4. Discussion

The identified themes and subthemes in this research study were derived from the participants’ quotes and supported by relevant literature (See Table 3). Field notes from observations were incorporated into the findings. As mentioned in the background section, the researcher’s based her assumptions on Watson’s Theory of Caring. According to Watson (2008:34), a person has three dimensions of mind, body and soul; a person is a being whose wholeness is valuable and deserves respect, assistance and care. The researcher viewed the newly qualified critical care nurse as an individual who deserves to be respected, assisted and cared for in the new environment. The results are in line with some earlier research showing that ICUs are challenging and stressful environments for new nurses. Moreover, caring for paediatric patients with CHD demands highly knowledgeable nurses due to its complexity. The participants shared their negative experiences in caring for paediatric post-cardiothoracic surgery patients as being overwhelming, stressful and scary. The ICU is an environment that is stressful for patients, caregivers, as well as family members as it is a fast-paced setting. It was also asserted by Coats et al. (2018:52–58) that the medical complexity and seriousness of a child’s illness can be overwhelming for patients’ families and healthcare providers. Nagel, Towell, Nel, and Foxall (2016:67) agree that professional nurses starting in critical care regularly experience feelings of anxiety regarding their performance. Anxiety is related to the intensity of patient care, insufficient knowledge, extreme workload, role uncertainty,
feelings of being unsafe, making mistakes, having to work with new technology, as well as social acceptance in critical care with its unique working culture (Hussein, Everett, Ramjan, Hu, & Salamonson, 2017:1-5). Hussein et al. (2017:1-5) further mention that new graduate nurses’ experiences in the first year of practice are often described as overwhelming and stressful as they strive to apply newly acquired skills, deliver quality patient care and ‘fit in’.

The participants had challenges in caring for paediatric post-cardiothoracic surgery patients; therefore, their affective responses included losing trust and confidence in their own knowledge, skills and capabilities. McNeill, Douglas, Koro-Ljungberg, Therriault, and Krause (2016:20) discovered that newly qualified nurses often have little trust in their own capabilities and experience, and lack confidence which manifests in behaviours such as doubting their level of performance. Confidence is an element of self-efficacy, and self-efficacy is the personal belief of how well an individual is able to perform in a stressful and new environment. To acquire nursing competency, nurses must possess the skills and personal traits necessary to effectively perform their duties while integrating multiple elements, including knowledge, techniques, attitude, thinking ability and values that are required in specific contexts (Fukada, 2018:1-7). According to Ally, Nel, and Jacobs (2016:122), nursing competency is a complex integration of knowledge, including professional judgment skills, values and attitude, and it is an ability acquired through experience and learning.

The participants experienced uncaring behaviour, poor interprofessional relationships and belittling from the senior staff. Zachariadou, Zannetos, Chira, Gregoriou, and Pavlakis (2018:1-8) state that uncivil behaviours in the workplace are threatening and a leading risk to the health of nurses and patients in clinical environments. They further explain humiliation as uncivil behaviour that signifies belittling and disrespecting others. Ally et al. (2016:122) found that the participants in her study experienced a lack of caring as the absence of empathy and not caring about what the participants were going through. Zachariadou et al. (2018:1-8) describe hostile and unethical communication as workplace bullying, psychological terror and psychological harassment.

The participants experienced mistrust, feelings of not being wanted, and a feeling of not being respected by the physicians. In collaboration, problem-solving is a mutual effort in which no superiority is present in the relationship between physicians and nurses; traditionally, physicians view nurses as subordinates to whom they give orders for implementation (Elsous, Radwan, & Mohsen, 2017:1-7). Lee and Doran (2017:75-93) confirmed that patient safety is compromised by medical errors and adverse events related to miscommunications among healthcare providers; communication among healthcare providers is affected by human factors, such as interpersonal relations. Hammoudi, Ismaile, and Abu Yahya (2017:1-15) found that the primary cause of medication errors is poor nurse-physician communication.

The differences between paediatric and adult cardiac patients were stated as a challenge for the newly qualified critical care nurses. They also mentioned the physiological structures, calculations of tiny doses of medications, complexity and specific nursing care of post-cardiothoracic paediatric patients, as well as working with unfamiliar equipment. “Children are not just little adults”, but often have different diseases, developmental issues and possibly differential responses to therapies compared with adult patients; hence, paediatric specialists require certain expertise and skillsets that non-paediatric physicians may lack (Czaja, 2016:178-180). There are significant barriers in applying adult data to children because of developmental factors, and age variation from birth to adolescence. Rajaean and Masoudi Alivi (2018:32) mention that ventilators, infusion pumps, monitors and dialysis machines make health care in an intensive care setting more complex, and technology is not only the equipment itself but also the knowledge of how to use it. There is a difference in the tidal volume of paediatric patients compared to adult patients, and calculations are based on their weight to avoid high airway pressures in the lungs (Joseph, Khan, & Balendram, 2018:1-23). According to Gupta and Rosen (2016:422-426), caring for ventilated paediatric patients require an extensive understanding of respiratory mechanics and pathophysiology of cardiopulmonary disease. The risk for endotracheal tube (ETT) obstruction is inversely correlated to gestational age due to the smaller ETT size (Bruschettini, Zappettini, Moja, & Calevo, 2016:1-18).

The participants reported that they care for critically ill paediatric patients and have to deal with their families as well. Paediatric intensive care nurses have tremendous influence and impact in addressing some challenges faced by family members due to their children’s critical illness. Pinheiro (2018:1-5) stated that the disease and hospitalisation of children promote intense emotional destabilisation in the life of mothers, and in the case of CHD, prolonged and continuous monitoring and multiple interventions and surgeries are needed, aggravating the situation. These challenges worsened when the prognosis was uncertain or the child’s health rapidly deteriorated. It is stated in the study by Kolaitis, Meenteken, and Utens (2017:1-5) that in the period surrounding a child’s cardiac surgery, parents are at elevated risk for developing mainly traumatic reactions, anxiety and depressive symptom; there is also psychological distress following cardiac surgery. Hambly and Cockett (2018:22) state that parents of children with CHD struggle to cope, and after their child’s diagnosis, parents express signs of depression. Parents can feel unsupported when health professionals only focus on their children. Through caring and active communication with the family members, there will be reduced anxiety in parents, resulting in dignity and trust.

According to the participants in this study, the culture of quality care is the main factor causing their eagerness to learn and achieve professional growth. The speciality of paediatric cardiac intensive care is believed to require a composition of highly trained and experienced personnel to achieve optimal patient outcomes. Sacco and Copel (2017:76-83) found that without formal paediatric critical care training, curriculum, or certification processes, there is a wide variation in understanding what skills and care are required. Despite many difficulties, the participants were happy to be part of the paediatric cardiac team. Sacco and Copel (2017:83) further mention that nurses

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### Table 3

**Description of main themes and subthemes.**

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<td>3.1.1 Feeling worthless, scared and anxious.</td>
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<tr>
<td>3.1.1 Feeling worthless, scared and anxious.</td>
<td>3.1.2 Lost trust and confidence in their own knowledge, skills and capabilities.</td>
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<td>3.1.2 Lost trust and confidence in their own knowledge, skills and capabilities.</td>
<td>3.1.3 Uncaring interpersonal relationships among staff members.</td>
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<td>3.2 Participants experienced nursing paediatric cardiac patients to be entirely different from nursing adult cardiac patients</td>
<td>3.2.1 Different physiological structures, compared to adult patients.</td>
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<td>3.3.3 Transpersonal caring and Ubuntu.</td>
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experience an intrinsic sense of fulfilment derived from their work in caring for other people, and in order to provide high-quality care, nurses practice with both empathy and compassion. Nurses’ motivation to remain at the patient’s bedside is related to the positive feelings derived from caregiving and the desire to help others. According to Sinclair et al. (2016:437), compassion satisfaction is about the pleasure you derive from being able to do your work well. Compassion enhances the key facets of empathy while adding distinct features of being motivated by love and acts of kindness. Taylor and Aldridge (2017:16) participants also shared that getting it right for children is a strong motivator and reward. Professional nurses have the drive to learn, and compassion for their patients encourages them to achieve their optimal level of performance in all aspects of care.

The participants stated that caring for the critically ill paediatric patients involve caring for the family as well. The participants verbalised that they need to help and support the family in caring for paediatric cardiac patients. The critical illness of a patient was seen as a shared responsibility between the nurses and the family members, and not an experience that family members had to face by themselves (DeBeer, Brysiewicz, & Bhengu, 2017:1-7). Ubuntu is an African view that grounds societies that embrace communal ways of living. This means that one is not considered a human being unless one is concerned about the well-being of other people (Ngubane-Mokiwa, 2018:7). A nurse is considered an external factor that can offer assistance and care to a person through love, empathy, trust, teaching and learning experiences (Watson, 2008:34). The researcher viewed a newly qualified critical care nurse as a person who needs assistance in order gain knowledge and skills in the new environment.

5. Strengths and limitations

The researcher used a qualitative research design which enabled exploration and description of participant experiences and was the strength of this study. The phenomenological research method and multiplicity of realities were used during data collection. Since the participants had been working in this specific PICICU for more than six months but less than one year, there was a possibility of missed information from newly qualified critical care nurses working in the unit less than six months or more than one year. There were also no male participants. The participants were recruited by the researcher, who was also the nursing unit manager, which may have influenced study participation and responses; however, the participants ensured voluntary participation to avoid possible coercion. Moreover, bracketing was ensured throughout data collection and analysis.

6. Conclusions

The study findings illuminated the extensive negative feelings and challenges experienced by newly qualified critical care nurses in the PICICU. The participants experienced uncaring relationships and a lack of respect from the senior staff members and doctors. However, the newly qualified critical care nurses were found to be interested in learning. Participants also displayed caring and Ubuntu to the family members.

This study makes a valuable contribution to the understanding that newly qualified critical care nurses do not only need nursing knowledge and skills to care for paediatric cardiac patients; holistic care and Ubuntu are also essential in delivering quality patient care. Through caring moment, one learns to recognise oneself in others, and the intersubjectivity of the caring occasion keeps one’s common humanity alive and avoids reducing the human being to an object (Watson, 2007:347). In future, newly employed staff members should be nurtured and respected, and caring relationships are of the utmost importance. Organisational support and interprofessional relationships are also crucial in creating a harmonious environment in delivering quality patient care. A healthy caring environment is one that offers assistance to maintain a healthy mental status (Watson, 1997:50).

7. Relevance to clinical practice

Clinical supervision and a buddy system should be implemented and monitored to enhance learning and promote teamwork. It is asserted by Chaghari, Saffari, Ebadi, and Ameryoun (2017:26) that in-service training for nurses was found to be indispensable in improving the quality of patient care, and a need to enhance the effectiveness of in-service training for nurses is an essential requirement. Nurses’ ward rounds should be encouraged, along with bedside learning. Clinical facilitators should be available at all times to assist new staff members. The unit manager should encourage a harmonious working environment for learning to occur by attending to any conflict among the staff as it happens. Changes in nursing practice regarding mentoring programmes, and the need for a follow-up study of such mentees, as well as recruitment/retention rates, are recommended.

8. Recommendations for future research

A study that assesses the new SANC post-graduate programme for critical care is recommended in order to determine if issues arising from this study are addressed in the new programme. A quantitative study, using the findings of this study, should be conducted to generate a questionnaire and then roll it out to public and private hospitals; it could even include a comparative section. A study on the experiences of senior staff members working with newly qualified critical care nurses in PICICUs is recommended.

9. Ethical approval details

The study commenced after approval was received from the Academics Ethics Committee (REC-01-108-2017), the Higher Degrees Committee (HDC-01-65-2017) and the private hospital in Gauteng, where the study was conducted (UNIV-2017-0051). Ethical considerations were discussed using the principles of the Belmont Report, including the principle of autonomy and respect for persons, the principle of non-maleficence and benefits, as well as principle of justice (Dhai & McQuoid-Mason, 2011).

Funding source declaration

The research study was financially supported by the researcher and the partial funding of Supervisor bursaries as awarded by the University of Johannesburg.

Ethical approval details (if applicable), under these headings

The research was approved by the Research Ethics Committee (REC-01-08-2017) and the Higher Degrees Committee (HDC-01-65-2017) of the University of Johannesburg

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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