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THE EXPERIENCE OF REGISTERED NURSES NURSING IN THE GENERAL ADULT INTENSIVE CARE UNIT.

By

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submitted in partial fulfillment
of the requirements for the degree

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OF JOHANNESBURG

IN THE

FACULTY OF EDUCATION AND NURSING

AT THE

RAND AFRIKAANS UNIVERSITY

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Co-supervisor : Prof M Poggenpoel

November 1996
This study is dedicated to my husband Andy, my son Liam and to my mother and father.
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I give thanks to

- Jesus Christ, the Son of God, the Holy Spirit and the Loving Father for the Hope, Faith, Love and Living Example.
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SUMMARY

The problem of intensive care nurses leaving the profession due to non-conducive working environments and uncompetitive conditions of employment is becoming more alarming and is therefore as relevant as ever. The researcher is concerned about the quality of nurse-awareness nurses create in order to practice quality nurse care. Confusion among nurses about their professional rights and responsibilities adds fuel to the fire. The management of health care services is at times not sensitive to the needs of nurses, and nurses are not always recognized for their inherent professional worth.

In the adult intensive care unit at which the researcher practices as unit manager she perceived her colleagues to be experiencing some sort of emotional and spiritual discomfort in going about their daily activities. As the researcher felt responsible for the well-being of the staff in the unit she decided to investigate the phenomenon via a formal research study.

The objectives of the study were two-fold: Firstly to explore and describe the registered nurse’s experience of nursing in the intensive care unit and then to use the information obtained to describe guidelines for the compilation of a support programme for the nurses nursing in the unit.

The research questions that were generated are: How do registered nurses in the intensive care unit experience nursing there and how can the information be utilised to describe guidelines to support these nurses?

The researcher used an exploratory, descriptive, contextual and phenomenological qualitative design to answer these research questions. Phenomenological interviews were conducted with five interviewees who had been purposively selected. The interviews were conducted by an independent
research interviewer. This was done after obtaining informed consent from the private clinic concerned and all the participating interviewees.

Steps were taken throughout the progression of the study to ensure trustworthiness. All the interviews were transcribed verbatim. Data was analysed following Tesch’s methods and the service of an independent coder was obtained. Saturated themes in the raw data indicated that the registered nurses in the intensive care unit experienced emotional and spiritual distress that was related to their working environment.

Results indicated that job-related stress was experienced due to matters such as impaired communication with management, racial discrimination in the workplace, lack of professional recognition of nurses demonstrated in the inequitable and uncompetitive remuneration, insensitivity to their professional needs, a non-conducive physical environment and emotional and spiritual stress in the working environment.

Guidelines intended to support the intensive care nurses were drawn up based on the themes that emerged from the raw data. These guidelines are strategies to be used in the intensive care unit and are to be submitted to management to create awareness and a collaborative relationship with the members in the intensive care unit.

The possibilities for the application of the results of this study in nursing practice, nursing education and nursing research are discussed.

It is concluded that registered nurses working in the intensive care unit need support from management to promote, maintain and restore their well-being in the workplace as an integral part of health.
OPSOMMING

Dit is inderdaad kommerwekkend dat intensiewesorg verpleegkundiges die beroep verlaat. Die uittog word aan ongunstige werksomstandighede en ontoereikende besoldiging toegeskryf. Die navorser wonder oor die kwaliteit verpleekundige beroepsbewussyn en beroepsorg wat op n daaglikse basis plaasvind.. Sy beweer dat daar baie verwarring onder verpleegkundiges bestaan aangaande hul professionele regte. Die verwarring dra by tot die huidige krisis in die intensiewe verpleegberoep. Die bestuur van talle gesondheidsdienste blyk onsensitief te wees met betrekking tot verskeie behoeftes rakende die professionele praktyk van die intensiewesorg verpleegkundiges.

In die algemene volwasse intensiewe sorgeenheid waar die navorser praktiseer as eenheidsbestuurder, het die navorser n ongemak by haar kollegas in die intensiewe sorgeenheid waargeneem. Die ongemak was teenwoordig in die uitvoer van hul daaglikse verpleegaktiwiteite. Die navorser het verantwoordelikheid vir die beroepswelsyn van haar kollegas aanvaar besluit om die verskynsel te ondersoek deur n formele navorsingsprojek te onderneem.

Die doelstellings van die studie was tweeledig en bifasies van aard : Eerstens is daar gepoog om die belewenis van geregistreerde verpleegkundiges in die intensiewe sorgeenheid te ondersoek en te beskryf en tweedens is gepoog om riglyne te beskryf vir ondersteuning van die verpleegkundiges in die formaat van n ondersteuningsprogram. Die riglyne is gebaseer op die inligting wat in die eerste fase na vore gekom het.

Die volgende navorsingsvrae was gestel: Eerstens, hoe beleef die verpleegkundiges verpleging in die intensiewe sorgeenheid en tweedens , hoe
kan die inligting gebruik word om riglyne vir die ondersteuning van die verpleegkundiges te beskryf?

Die navorser het van n verkennende, beskrywende, kontekstuele en fenomenologiese kwalitatiewe ontwerp gebruik gemaak om die navorsingsvrae te beantwoord.

Fenomenologiese onderhoude is met vyf vrywillige deelnemers gevoer. Hulle is almal doelbewus geselekteer. Die onderhoude is deur n onafhanklike onderhoudvoerder waargeneem. Die onderhoude is gevoer nadat toegeligte instemming van die privaatkliniek en die onderskeie deelnemers verkry is.

Deurgaans is aandag geskenk in die verloop van die studie aan aspekte soos etiese navorsing en strategiee vir geloofwaardigheid. Al die onderhoude is verbatim getranskribeer. Data is volgens Tesch se data analise metode geanaliseer. Vir die doeleine is n onafhanklike kodeerder gebruik. Versadigde temas in die data het aangedui dat intensiewesorg verpleegkundiges emosionele en geestelike ongemak ervaar wat verband hou met hul werksomgewing.

Resultate het getoon dat werksverbonde stres ervaar was. Die redes hiervoor was: onvoldoende kommunikasie met bestuur, rasistiese diskriminasie in die werksomgewing, onensensitiwiteit vir die professionele behoeftes van die verpleegkundiges m.b.t. besoldiging en erkenning, n gedepersonaliseerde werksomgewing en n emosionele en geestelike stresvolle werksomgewing.

Riglyne is beskryf om die verpleegkundiges in die intensiewe sorgeenheid te ondersteun. Die riglyne is gebaseer op die temas wat deur die data analise verkry is. Hierdie riglyne vorm die strategie wat geimplementeer moet word in die werksomgewing. Die strategiee sal in die vorm van indiensopleiding aan die verpleegkundiges gekommunikeer word. Bestuur sal ook n afskrif van die inhoud
van die program ontvang. Die doel hier is om verpleegbewustheid, verpleegsensitiwiteit en verpleegsamewerking te optimaliseer.

Die verskeie moontlikhede vir aanwending van die resultate van die studie in die verpleegpraktyk, verpleegonderrig en verpleegnavorsing word bespreek.

Die gevolgtrekking word gemaak dat verpleegkundiges wat in die intensiewe sorgeenheid werk die ondersteuning van bestuur nodig het om hul werksgesondheid te faciliteer en sodoende hul werksgesondheid te bevorder, instand te hou en te herstel as integrale komponent van gesondheid.
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CHAPTER ONE

1. INTRODUCTION AND RATIONALE

It has always astonished me how much literature and knowledge have accumulated throughout the years concerning mankind. This is especially so in relation to the human sciences and above all to the art and science of nursing. So much has been written about the nurse and her status in the helping relationship. The nurse is a beacon of society always maintaining an openness to the health needs of her fellow man - her patient body. The nurse is voluntarily engaged in many years of training, education and the continuous moral obligation to understand mankind in all its diverse facets. She is always willing to apply the necessary skills to deliver safe, scientific, ethical and quality nursing care. She is forever cultivating cultural sensitivity and political correctness.

In view of this the nurse of today is faced with a complex environment requiring nearly super-human effort. Daily public and professional demands at times appear unrealistic and unobtainable, and commendably the nurse never gives up... or does she?

How much nurse-awareness do we cultivate each day? Do we feel the need to conserve and protect the nurse as an endangered species of great value to our ecosystem... our future? How many skills do we apply in understanding the nurse in her own unique setting? How much time do we spend making the nurse feel safe, of scientific account, respected as an ethical being or as a being who is culturally unique? How do we approach her? Do we apply interpersonal skills and respect her human rights? Do we encourage professional development with constructive feedback? How confidentially do we treat her personal information? Do we respect her position and worth as an individual and as an industrial being in the formal workplace... and how much do we care? These are the questions at the heart of this study.
What follows is a set of strategies that should be employed in the nursing management science to improve job satisfaction and a quality nursing service:

Strategies employed to conserve and protect the nurse are there to ensure stress management in the working environment and to prevent burnout and combat demotivation (Marelli, 1993:211-252 and 67). Fair labour practices should be employed with differential and discriminatory terms of employment eliminated so that equitable conditions of employment can be established (Booyens, 1995:670,402, 28). Nursing staff need to be developed as human resources by means of in-service training and formal education (Booyens, 1995:366-382 and Douglass, 1996: 279-308). It is imperative to enhance the quality of the nurse's work life (Booyens, 1995:671).

Strategies which should be employed to understand the nurse in her own unique setting are the effective and constructive use of communication channels and communication techniques (Douglass, 1996:193-207; Marelli, 1993:64-89 and Booyens, 1995:261-280). The nurse is an ethical cultural being with professional ideals which are influenced by both the negative and positive forces within the scope of intercultural nursing and a culturally diverse working environment. The nurse should be empowered with skills and knowledge to be effective in this type of a working environment and management should respect her human rights. (Douglass, 1996:204-206)

In her doctorate Dr. Elzabe Nel addresses the professional rights of the intensive care nurse (Nel, 1993:181). This doctorate concerns itself with all the functions of the intensive care nurse as perceived by other members of the health team, the scope of nursing practice itself and scientific literature. In the working environment of the intensive care nurse these rights have to be respected and management must be made aware of them.
A strategy which would encourage professional development is the establishment of management programmes to empower nurses by means of fair performance appraisals, staff development, career planning (affirmative action), assertiveness training and conflict management (Booyens, 1995: 366-382). Periodic workshops pertaining to work and profession-related issues should be made available to nurses (Nel in Booyens, 1995: 386-387 and Booyens, 1995: 550). Ethical norms should be taken into account and personal information should be regarded as highly confidential (Douglass, 1996: 327). To develop culture sensitivity in management’s developmental strategies can only improve labour relations between management and workers. Management must also support staff in the process of change in the workplace (Douglass, 1996: 218 and 225).

A strategy that would initiate caring for each other’s well-being in nursing would be to advertise this notion in nursing literature (formal and informal) as an ideal norm for nursing practice. Nurse managers should be made NURSE-AWARE if they are not already so. In nurses’ daily interaction with each other they must be made aware of their commitment not only to patients and the community but to each other as well. Those nurses who are empowered by means of their strategic position (education) and influence should use their position and influence precisely to ensure that nurses needs are heard and addressed.

Nurses need active participation in a nursing body that will be truly representative of nurses organising themselves for the benefit of nurses, and for the advancement of nursing.

If these issues in nursing are ignored a constructive working environment will be impossible to attain.
The International Council of Nurses Code for Nurses (as quoted by Kozier & Erb 1992:195) sees the fundamental responsibility of the nurse as a fourfold construct: to promote health, to prevent illness, to restore health and to alleviate suffering.

The need for nursing is a universal one. Inherent in nursing is: the respect for life, dignity, and the rights of man. This service to mankind is unrestricted by considerations of nationality, race, creed, color, age, sex, politics, or social status. Nurses provide health services to the individual, the family, and the community and coordinate these services with those of related groups.

The Code also mentions the following interrelated aspects: nurses and people, nurses and practice, nurses and society, nurses and co-workers, nurses and the profession (Kozier & Erb, 1992: 196-197).

**Nurses and People:** The nurse has a primary responsibility to those people who require nursing care. In fulfilling this the nurse promotes an environment in which the values, customs, and spiritual beliefs of the individual are respected. The nurse holds in confidence personal information and uses professional judgement in the disclosure thereof. *Nurses are people too, and the same intercultural aspects of values, customs and spiritual beliefs that shape her daily existence are of importance to the study. At times, value conflict and culturally sensitive issues are experienced by the nurse in her day-to-day nursing activities.*

**Nurses and Practice:** The nurse is responsible for nursing practice and maintaining competence by continual learning, education and in-service training. The nurse maintains the highest standards of nursing care within the reality of a specific situation. The nurse uses both judgement and a rating of individual competence when accepting and delegating responsibilities. The nurse must ensure professional conduct and maintain personal standards of behaviour which bestow credit upon the profession (Kozier & Erb, 1992:196). *In the past some nurses have*
undertaken strikes at hospitals and neglected their ethical obligation: the welfare of the patient. This leads to the conviction in some members of the community that there is no dignity in nursing any longer.

**Nurses and Society:** The nurse shares with other citizens the responsibility for initiating and supporting nursing action to meet the health needs of the public (Kozier & Erb, 1992:196). Nurses too are part of society and are influenced by the state of current affairs in South Africa (economic, political, social, spiritual etc.). The South African nursing profession is in a period of TRANSITION (Poggenpoel & Muller, 1996:12-14) and the profession is facing unique challenges. In this period of transition the profession is continually struggling to organize itself into a united and representative body that has freed itself from the apartheid era values and practices. Issues that needed addressing are: deliberations regarding nursing education, improving the image of nursing, clarifying the values of the nursing profession, improving and maintaining the standards of nursing care and, with special reference to the RDP, to stay relevant in the health-care delivery system.

**Nurses and Co-workers:** The nurse should maintain a cooperative relationship with co-workers in nursing and associate health-care providers. The nurse is responsible for ensuring that appropriate action is taken when an individual’s health is jeopardized by a co-worker or any other person (Kozier & Erb, 1992:196). *Nurses are responsible for ensuring that appropriate action is taken when another nurse’s dignity (personal and professional wholeness) is being jeopardized.*

**Nurses and the Profession:** The nurse plays the crucial role in determining and implementing quality care nursing standards in practice as well as nursing education. The nurse is active in developing a greater core of professional knowledge (research). The nurse, acting through the professional organization, participates in establishing and maintaining professional empowerment regarding equitable and realistic social and economic working conditions in
nursing. The American Nurses Association Code for Nurses (Kozier & Erb, 1992: 196) statement 9 proposes: The nurse participates in the profession’s effort to establish and maintain conditions of employment conducive to high quality care.

The Canadian Nurses’ Association Code of Ethics of Nursing (Kozier & Erb, 1992:197) sees the social context of nursing as follows: Conditions of employment should contribute to client care and to the professional satisfaction of nurses. Nurses are obliged to work toward securing and maintaining conditions of employment that satisfy these connected goals. Professional nurses' organizations recognize a responsibility to clarify, secure and sustain ethical nursing conduct (responsibility to the employer rendering a health service with legal implications). The fulfilment of these tasks requires that professional organizations remain responsive to the rights, needs and legitimate interests of clients and nurses.

If we as nurses have to take the responsibility of caring for each other’s well-being in the working environment via organizational channels, what then, on a more tangible level, is our day-to-day responsibility to each other? How we experience our day-to-day nursing activities in our working environment must bear some weight in determining the standard of quality nursing care we provide and to what measure we are sensitive to - and provide support for - each other (Marrelli, 1993: 67).

In the intensive care unit, where I work as unit manager, I have experienced demotivation and low productivity, and this manifested itself in staff absenteeism, negativity and lack of cooperation in daily activities, a high turnover of staff, continual complaints about off-duties and the general functioning of the unit with no suggestion as to how to improve it. This profile, no doubt, had a direct influence on patient care, team work, unit atmosphere and the well-being of
all the nurses in the adult general intensive care unit. Furthermore, there was inter-staff conflict and resistance to organizational change.

The general adult intensive care unit is a seven-bed intensive care unit. Patients require various disciplines in the treatment of their respective diseases: from vascular surgery to plastic and reconstructive surgery to polytrauma (workman's compensation injuries); from myocardial infarctions to neurovascular incidents. A racially integrated body of patients receive care here. There is an ebb and flow of patients depending on the number of trauma cases and theatre cases. At any given time the greatest number of ventilated patients are four out of the seven patients. There are only five registered nurses (excluding the unit manager) on both day and night shift. As patient numbers are unpredictable, agency staff are utilised to make up for shortages of staff. Intensive care and agency staff are composed mainly of black staff. On night duty, intensive-care-trained agency staff are used and because most of the agency staff members have permanent posts as well, there is no continuity in the availability of these trained people. The staff mix applied on night duty are a minimum of three staff members per shift. They consist of an intensive-care-trained nurse, a registered nurse and a enrolled nurse. Depending on the patient acuity levels and numbers, extra agency staff are ordered as required.

There is a casualty officer available on the premises on a twenty-four-hour basis. These doctors are reluctant, however, to take responsibility on behalf of other doctors regarding the treatment and management of the resident doctors' patients. They are available for resuscitation of patients and other emergencies.

I feel that it is my professional obligation to find out what it is that is causing this dis-ease among the staff in the unit. If staff can share their experience of nursing in this intensive care unit with the researcher, insight into the obstructive aspects they experience as barriers to quality nursing care and their professional well-
being can be made, problem areas can be identified and a programme for support can be instituted. The information obtained from this can then be communicated to management as guidelines to support staff in their daily nursing activities.

The attributes of the field of nursing (Botes, 1994) form the point of reference from which the researcher will embark. The unit of assessment is the intensive care nurse as she experiences herself in practice. The nurse is not seen in isolation: she is an active participant in generating the field of attributes as they present themselves in practice. These attributes are functions of nursing actions. The following aspects are noted: The intensive care nurse in his/her relational aspects, where all his/her actions are seen as intentional and interpersonal. The nurse is the central generator of the field of nursing. Thus the nursing actions of an intensive care nurse nursing in the adult general intensive care unit can only be understood with careful attention to factors like cultural sensitivity and dis-ease in an interactional context. The nurse is experiencing some sort of dis-ease that can only be understood in the context of her working environment. The multidimensional character of nursing (a human science) and the actions of the intensive care unit only serve to complicate the aim of consolidating and organising all the factors in nursing. The dynamic character of the intensive care nurse’s actions underlines the provisionality of scientific statements or propositions.

1.2 PROBLEM STATEMENT

Two research questions can be generated from the foregoing discussion:
How do registered nurses experience nursing in the adult general intensive care unit? How can this information be utilized to describe guidelines to support these nurses?
1.3 OBJECTIVES

The objective of this study is twofold: Firstly to explore and describe the registered nurses' experience of nursing in the adult general intensive care unit and then to use the information obtained to describe guidelines for the compilation of a support programme for the nurses working in the adult general intensive care unit.

1.4 CENTRAL STATEMENT

The central statement of this research is that insight obtained into registered nurses' experience of nursing in the adult general intensive care unit will form the basis of describing guidelines for the compilation of a support programme for the nurses in the adult general intensive care unit.

1.5 PARADIGMATIC PERSPECTIVE

The Nursing Department of the Rand Afrikaans University (R.A.U.) supports the Nursing the Whole Patient Theory (NWPT) of the Oral Roberts University: Anna Vaughn School of Nursing (1990: 136-142) which is congruent with both the philosophies of RAU and that of the South African Nursing Council (SANC).

1.5.1. METATHEORETICAL ASSUMPTIONS

One's philosophical position influences knowledge as well as how one views the empirical world (Burns & Grove, 1987:14). The researcher will support and incorporate the NWPT as a paradigmatic perspective for this research. It is a worldview based upon Judeo-Christian philosophy. The central redemptive implication of Christ for man is synonymous with the implication that one must love one's fellow man as man has love for God and love for himself (Matthew 22:
This implies redemption from daily grievances through love. Love in the spiritual sense is therefore not only a feeling but an action. TO LOVE is: to care, to provide a service to mankind, to foster and nurture (to facilitate). It is precisely this nurturing and love that should form the backbone of nursing practice: nurses should love themselves, their colleagues and their nursing mission and philosophy. Nurses are responsible for each other's well-being.

Nursing is therefore a service to mankind in which love and care has been revealed and has a very practical goal in mind: to provide a wholesome environment for man to grow towards wholeness. Metatheoretical assumptions applicable to this research are based on NWPT. The focus is on the whole person: body, mind and spirit. Whole families consist of whole persons. Whole communities consist of whole groups/families. A whole society consists of whole communities. A whole society creates an environment characterised by whole individuals. This is a reciprocal process: man and his environment are in interaction with each other and influence each other's degree of wholeness. This holds true for both the intensive care nurse in her relational aspects as a professional individual, as a member of an intensive care unit and as a member of the intensive care community as well as the Nursing Society at large. The same assumptions are applicable to the patient as an individual, member of a family (group) and the community as a unit of society at large. NWPT identifies parameters of nursing and convictions on the following exist: MAN, HEALTH, ILLNESS AND NURSING.

* PERSON / ICU NURSE

The intensive care nurse is a spiritual being who functions in an integrated biopsychosocial way in his/her quest for wholeness. He/she in all his/her facets as a wholistic being is in interaction with both his/her external and internal environments. In his/her professional capacity the intensive care nurse is the
initiator of a therapeutic environment characterised by quality nursing care. The following statement is central to the purpose of this study: the nurse is influenced in her personal and professional wholeness by the interaction of her internal and external environments.

* HEALTH/WHOLENESS

Health is a condition of spiritual, mental and physical wholeness. Health status (wholeness) is dependent upon the typical (patterned) ways in which man interacts with his internal and external environment. Health is qualitative and can be conceptualised as existing on a continuum of maximum to minimum health. A healthy person retains the potential to become sick. In this research wholeness of the intensive care nurse is addressed and the focus is on the measure of professional wholeness experienced by intensive care nurses (Emotional, volitional and intellectual processes). The intensive care nurses experience dis-ease through the patterned ways in which they interact with their internal and external environments. This dis-ease disrupts the wholeness of the intensive care nurse.

* ILLNESS/ DIS-EASE

According to NWPT, illness is a dynamic condition which reflects stress factors in the patterns of interaction man has with both his internal and external environment. Illness can be conceptualised as occurring on a continuum which ranges from critically ill to minimally ill. For the intensive care nurse, however, illness is not necessary physical illness, but rather a disharmony within a person's inner self. Watson is cited by Riehl-Sisca (1989) as explaining that a troubled inner self can lead to dis-ease, and dis-ease can result in pathology. Illness is subjective turmoil or disharmony within the spheres of the person, these spheres consisting of the mind, body and the soul.
*NURSING*

Nursing is seen as a service directed at helping the individual, family or group and/or community to restore, promote and maintain health (wholeness). Where wholeness as absence of dis-ease cannot be obtained and death and chronic suffering cannot be avoided nursing is a service geared to support and guide individuals (families/communities) for the dignified acceptance of the inevitable and to mobilise resources within these individuals (families / communities) to provide pain-free, prepared and culturally sensitive outcomes.

Intensive care nursing is a specialised branch of nursing which focuses specifically on the care of critically ill patients in life-threatening situations. It is high-tech based nursing art and science directed at the protection, enhancement and preservation of human life and dignity. Although intensive care nursing mainly functions within the Curative Health Care set-up, nursing actions are goal-directed to the restoration, promotion and maintenance of health and are committed to the quality nursing care ideal. In this research the focus will be on identifying barriers that create dis-ease for the intensive care nurse thereby frustrating facilitative processes for promotion of professional and personal health for the intensive care nurse in the quest for quality care.

1.5.2. THEORETICAL STATEMENTS

When conducting fieldwork the researcher will approach the field with no preconceived framework of reference. Theoretical Models used are NWPT (1990), as referred to by the Rand Afrikaans University Nursing Science Department.
NURSING THE WHOLE PATIENT THEORY.

The concepts identified, classified and defined in the conceptual framework are in relation to one another and organised into propositional statements. There are five statements for each of the parameters of nursing care: the individual, the family and the community. The parameters of nursing as a service include the individual, family/group and the community. An interdependency and interrelatedness amongst the three parameters are implied and therefore a parameter can never be seen in isolation.

An individual is a spiritual being who functions in an integrated biopsychosocial way within the family or community. A family (group) is the basic unit of the community, which consists of individuals who evaluate each other according to value and who exist in interaction with each other. (In this research this is applied to the concept of the intensive care unit.)

A community is an identifiable group of people who engage in a common interactive pattern or share a common geographic area. (The intensive care nursing community engage in a common interactive pattern.) Furthermore, environment includes both an external and internal environment. Internal environment includes the bodily, psychological and spiritual aspect whilst the external environment includes physical, social and spiritual aspects. Patterned ways of interaction between internal and external environments determine health status. Wholeness and health are used as synonyms: wholeness of body, mind and spirit. All individuals aim at attaining wholeness.
THE MAIN OBJECTIVE OF NURSING IS TO FACILITATE WHOLENESS OF INDIVIDUALS, FAMILIES AND COMMUNITIES (TO PROVIDE QUALITY NURSING CARE)

• RESEARCHER'S OWN ASSUMPTIONS

The essence of nursing is relational (interpersonal). The role of the intensive care nurse is goal-directed (intentional). The patterns of interaction are the variables that have an influence on the nursing goal. These patterns can also be described as possessing value content/attachment, they are contextual, dynamic and multidimensional. In general, quality nursing care or feelings of professional competence will be enhanced if philosophical and value related barriers can be identified which frustrate the facilitation of therapeutic interactional processes in nursing. One such factor is that the nurse remains ethically bound for the well-being of her patient even if the patient (and/or his family), management and co-workers are insensitive to the cultural dimensions of the nurse as well as her human rights and dignity. (I assume that this will be a prominent issue to address in the intensive care unit as well as on a higher level seeing that the nurses are very much in the transitional state of their empowerment.)

* THEORETICAL DEFINITIONS

Refer to concepts and statements already identified, organised and defined in NWPT.

# FACILITATION

Facilitation is a synonym for the process of making things possible. In nursing, facilitation is a combination of processes and actions which empower nurses to restore, promote and maintain health for individuals, families and communities. The nurse creates a positive, therapeutic climate for the attainment of nursing
goals and objectives. Inclusive in this process is the identification and breaking down of barriers that frustrate the attainment of health. The central purpose of facilitation is to alter human behaviour. Facilitative processes in nursing should instill within humans the desire to attain health and internalize responsibility for health (e.g. communication is a process of facilitation)(Kozier & Erb. 1992:290-291). The relevance of this definition to the study is that all the processes of communication constitute the backbone of all the managerial approaches. Thus there is no facilitation without communication. Support is also a product of communication. The second objective in this study is to describe guidelines to support nurses in the intensive care unit.

# SUPPORT

To support someone is to help that person maintain his strategies for interaction. This interaction ensures coping with the circumstances of his life and includes daily coping mechanisms which respond to the demands of daily adaptation. This includes verbal and non-verbal communication, the mobilization of resources (psychological, social, emotional, information/knowledge, spiritual, financial / instrumental). It ALWAYS remains a temporary measure. Respect for the choices of the individual and his autonomy are ensured. The essence of the relationship is seen as situational, temporary, motivational and reassuring (Kozier & Erb, 1992:289-290). Byrne and Sebastian (1994:33-34) after reviewing the literature for a definition of "support" identify 3 aspects: support as attitude, support as intervention and support as role. Support as attitude includes the following aspects: sharing, accepting, being heard/understood, valuing inherent worth regardless of particular characteristics of an individual and allocation of adequate resources so as to empower care. Guidelines for the support of nurses in the intensive care unit will form the second phase of this research and concern themselves with their day-to-day activities.
Support as intervention includes providing comfort with interpersonal and physical care dimensions. The emphases from a psychiatric point of view are: interventions to reinforce defences, decrease anxiety and enhance self-esteem, to provide reassurance and a sense of being nurtured, to provide an emotional boost, to empower, connect, do something for, and to find meaning. As regards the notion of support as a role, Peplau (1952) describes various roles which occur at specific phases in the nurse-patient relationship with specific emphasis on the mother-surrogate role. Other roles mentioned are: consultant, advocator, educator and resource person.

Thus the Unit Manager as the "mother" of the intensive care unit must through insight into the experiences of the nurses in the unit be equipped with skills to "mother" her staff.

1.5.3. METHODOLOGICAL ASSUMPTIONS

No preference to type of research is stated. Due to the exploratory and descriptive essence of the research the qualitative method of research is employed. The central methodological assumption is based on the functional reasoning approach of Botes (1990:19-22). This implies that research must be applicable to practice and be useful. The major objective is to solve problems as they occur in practice and by doing so improve the service character of nursing: quality care. The utility of research in itself is as a means of providing validity and trustworthiness. Botes (1990:21) discusses the functional reasoning approach which directs the goal of research: to provide action-focused prescriptions for nursing practice. This of course takes place within a specific context for the functional application of knowledge and improvement of nursing care practice. In the context of this study the ultimate nursing care goal is to provide quality nursing care.
Nursing Practice is seen as the primary resource of research themes. This research focuses on the experience of the nurse practitioner in interaction with the external and internal environment in practice. The researcher has a co-responsibility for practice (to communicate findings and advocate change) as the practitioner has a responsibility to apply the knowledge generated by research. Both of these approaches enhance the usefulness of research.

1.6. RESEARCH DESIGN & RESEARCH METHOD

An overview of the research design and research method will be discussed. Chapter 2 of this research study will provide more detailed information.

1.6.1. RESEARCH DESIGN

The design of this study is both explorative and descriptive as determined by the characteristics of the unit of research. The intensive care nurse is a unique subjective individual. A qualitative, phenomenological and contextual study is selected for attributes like experiences of human resources.

TWO major phases will structure the research: Phase I: to explore and describe the experience of adult intensive care nurses. Phase II: to use the results obtained in phase I as the framework for guidelines for the support of intensive care nurses nursing in the adult intensive care unit. Based on the above a qualitative phenomenological approach will be used to explore and describe the experiences of the adult intensive care nurses.
1.6.2 RESEARCH METHOD.

Methods employed must be academically trustworthy and valid and will be guided by frequent literature checks. The following academic references will be discussed in more detail in chapter 2: Guba and Lincoln (1985) on methods to ensure validity and trustworthiness (Keeping field journals, conducting purposive sampling, gaining entree, interviewing and observation, doing peer debriefing, gathering referential adequacy materials, mounting safeguards as well as managing paradigm / contract disjunctions, managing problems in the field, problems of design.) Inductive data analysis is also investigated: concepts like coding, using an independent coder and triangulation for validity are employed.

Ethical considerations will be made based upon the position paper of Ethical Standards for Nurse Researchers as stated by the South African Nurses Association in 1991. Burns and Grove (1987:336-357) also incorporate what is mentioned in the SANA paper. Ethical considerations are obtaining consent from the private hospital management to conduct research in their institution and obtaining willing and informed consent from all participants. Interviews are to be conducted in a non-threatening way in an environment free of both physical and mental harm. Participation will be voluntary and participants will retain the right to withdraw at any time without any pressure of coercion. Participant anonymity will be ensured and human rights will be protected.

Participants will have the right of insight into reason, results and biographical information pertaining to the research and the researcher. This will accompany all interviews. The researcher should be committed to research of a high quality and which has practical implications and acknowledgement should duly be given to contributors for the planning and data analysis of the research.
PHASE 1
THE EXPLORATION AND DESCRIPTION OF THE EXPERIENCE OF ICU NURSES NURSING IN THE ADULT ICU.

Sampling will be purposive (Guba & Lincoln, 1985:200). A pilot study will not be necessary as a psychiatric nurse specialist (D.CUR) candidate will be used to conduct the interviews: the reason for this is that she is well versed in conducting interviews and the methods of qualitative research. Intensive care nurses working in the intensive care unit and adhering to criteria as stipulated on page 29 will be used. These nurses must be willing to participate. Verbal informed consent will be obtained.

Data collection will be via phenomenological interviews (Kvale, 1983:172-173) and observation, as well as field notes taken which will be written into field journals. Auditory tapes will be made that will be transcribed. Data gathering will be via phenomenological interviews with intensive care nurses who are willing to partake in this research. Interviews will be conducted until the data is saturated (the repetition of themes provides evidence of this). These interviews will be taped via auditory tapes after obtaining verbal informed consent.

The data analysis method of choice will be Tesch’s method (1990) as discussed in Cresswell (1994:155). Interviews will be transcribed verbatim and according to Tesch (1990) must be read through to obtain a feel for the content. Ideas coming to mind can also then be jotted down. Thoughts concerning substance and deeper meaning are written in the margin. After reading through all respondents transcriptions, a list of topics is made, and similar topics are clustered together. Topics are coded and categorised. Codes in categories that relate to each other are amalgamated, interrelationships can be drawn amongst categories and interviews are repeated until themes are saturated and no new themes surface. Concepts
used in qualitative research will also be verified through literature in Krefting (1991) and Strauss & Corbin (1990).

Trustworthiness will be ensured by methods as referred to by Guba & Lincoln (1985) with especial reference to independent coder, triangulation and consensus discussions. As information is obtained via this method literature checks will continuously be done to scientifically account for trustworthy data collection and interpretation methods.

**PHASE 2**

**DESCRIPTION OF GUIDELINES FOR A SUPPORT PROGRAMME FOR ICU NURSES NURSING IN THE ADULT INTENSIVE CARE UNIT.**

Descriptions of themes as they surface in phase I will be used as guidelines to support intensive nurses whilst nursing in the general adult intensive care unit. From data obtained in phase I inferences will be generated that can be made and compiled into guidelines for nursing actions. Validity of inferences will be guided by methods described by Copi (1962:381-386) so as to ensure logic. To elaborate: aspects such as relevance, testability, compatibility with previously well-established theoretical statements, explanatory power and simplicity will be addressed. After much discussion with practising intensive care nurses, to assess if phase I is applicable to phase II (and this will include input from a panel of experts), final guidelines will be drawn up.

A conclusion of the above findings will be made where method of research too will be evaluated. Limitations will be discussed, suggestions will be made and according to findings a support and information programme will be compiled based on the guidelines provided and supported by the literature. Implications for nursing care will then be discussed.
Implementation and communication of this study: the researcher will communicate the findings to the adult intensive care unit in the form of a written support programme with suggestions for in-service training. The researcher also anticipates presenting findings to research conferences. The findings and suggestions will be developed into an article for publication. A hardcover copy of the full research (corrected) will be made available to The Rand Afrikaans University and the private clinic where the research was conducted.

1.7 CONTENT

Chapter 1  Rationale and overview of research.

Chapter 2  Research design and method.

Chapter 3  Exploration and description of intensive care nurses' experiences in the adult intensive care unit.

Chapter 4  Description of guidelines to support intensive care nurses in nursing in the adult intensive care unit. Conclusions, limitations and recommendations.

1.8 CONCLUSION

In this chapter, the problem to be researched has been stated, the background, the rationale, the paradigmatic perspective as well as the research design and method broadly discussed. Chapter 1 will be the structural point of reference for the rest of the study. In chapter 2, which follows, the research design and method as well as trustworthiness will be discussed in detail.
CHAPTER 2

RESEARCH DESIGN AND METHOD.

2. INTRODUCTION.

This chapter is concerned with the methodology of the study. The following aspects will be addressed: a description of the rationale, objectives, research design and method of study will be given. Trustworthiness will also be addressed.

The importance of basing research design and method on scientifically accountable principles cannot be over-emphasized. Within the social sciences, qualitative research has emerged as a scientifically relevant method. Nursing is a health-care science and closely related to the social sciences. Qualitative research employs an analytical, systematic set of procedures to discover properties about a said phenomenon which sensitively represents the truth about the qualities of the phenomenon. The explanatory power derived can synthesize problem-focused, behaviour-oriented solutions, or at the very least suggest open-ended pathways for discovering explanation and understanding of human behaviour (Strauss & Corbin, 1990:19). This quest for understanding can add to improved methods of delivering care with emphasis on interactional relationships - for example, nurse-patient, nurse-colleagues, nurse -social organizations.

2.1. RATIONALE

I see the intensive care nurse as an endangered species who has to be well looked after in the nursing service milieu. So many nurses are leaving the profession due to unfavourable nursing environments. Without the nurse there can be no nursing. For the nurse to maintain professional and personal wholeness (integrity
and dignity) and deliver quality nursing care. Obstructive elements in the nursing environments have to be investigated. The nurse’s experience of her working environment is the focus of the research. The research is also contextual: it pertains to a specific unit with its inherent characteristics that uniquely forms the nursing environment. This study intends to resolve the nursing problem identified: that of the difficulties the ICU nurse has in pursuing her profession.

2.2 OBJECTIVES OF THIS RESEARCH

The objectives of this study are two-fold:
Firstly to explore and describe the registered nurses’ experience of nursing in the adult general intensive care unit and then to use the information obtained to describe guidelines for the compilation of a support programme to support the nurses in the general adult intensive care unit.

2.3 RESEARCH DESIGN AND METHOD

In this section, the research design and method guiding the conduct of this study will be described.

2.3.1. RESEARCH DESIGN

The design used in this study will be qualitative, exploratory, descriptive and contextual.

2.3.1.1. QUALITATIVE

This study focuses on exploring the experiences of the concerned intensive care nurses in totality. A reductionistic design can therefore not be used: Qualitative research combines the scientific and artistic natures of nursing to enhance the understanding of the human health experience (Liobondo-Wood & Haber, 1994:254). Boyd (1990:183) as quoted by Liobondo-Wood and Haber states: Qualitative
research involves broadly stated questions about human experiences and realities studied through sustained contact with people in their natural environments, generating rich, descriptive data that help us understand their experiences. It further follows that this type of research embraces the wholeness of human experiences in naturalistic settings - the unique way in which humans attribute meaning to their experiences and that experiences evolve from life-content. The qualitative design is thus suitable as it assumes that subjectivity is essential for the understanding of human experience (Burns and Grove, 1993:28). A phenomenological approach is employed by the concept-experience which needs to be explored and described. Exploring and describing the experiences of nurses in the unit will give insight into understanding the issues related to their working environment.

2.3.1.2. EXPLORATIVE

When a study is explorative Talbot (1994:90), it attempts to uncover relationships and dimensions of a phenomenon. It investigates the manner in which the phenomenon manifests itself to any other related areas. This manifestation generates a new understanding of the phenomenon and thus has the potential to generate statements or hypotheses (Mouton & Marais, 1990:43). This study is concerned with exploring the experience of intensive care nurses in nursing in the adult intensive care unit. The researcher departs from a point of reference of not-knowing. The design is exploratory and thus suitable in gaining insight into the experience of the intensive care nurse in this context.

2.3.1.3. DESCRIPTIVE

When a study is descriptive Talbot (1994:90), it is similar to the explorative type of study but it is more structured. The main purpose is to examine relationships amongst variables. In this study, intensive care nurses' experience of nursing in the adult intensive care unit will be explored and described. The researcher must
at all times aim at accuracy (Mouton & Marais, 1990:44 and Burns & Grove, 1993:29). The saturated themes will provide guidelines intended to support intensive care nurses and will be described.

2.3.1.4. CONTEXTUAL

When a study is contextual is aims to focus on the specific set of properties that pertain to a phenomenon: that is the location of events and incidents pertaining to a phenomenon along a dimensional range. Strauss & Cobin (1990:96) summarize context as the particular set of conditions within which the action / interactional strategies are taken. Talbot (1994:93) argues that context explains why certain attributes of a phenomenon appear when they do and how they are interconnected. This study is contextual in that it deals with intensive care nurses' experiences of nursing in the adult intensive care unit. All the nurses to be interviewed are committed to the nursing philosophy of the unit. The intensive care unit is a seven-bed adult general intensive care unit. This unit is situated in a private hospital in Gauteng. Context implies the conditions and situations of an event. In human science, behaviour can only be understood within the unique boundaries of the context itself. It is important to note that the intensive care nurse's experience in this context is unique and her experience of the same phenomenon in another context may be completely different. In this research the focus is on the dis-ease experienced in an unfavourable nursing environment. There are only 8 permanent staff members. Excluding the unit manager and the two enrolled nurses there are only 5 permanently employed registered nurses. All the 5 registered nurses are black and their ethnic tongues differ: they speak Xhosa, Northern Sotho, and Zulu. Of the 8 staff the unit manager and one enrolled nurse are white. Both the unit manager and enrolled nurse are Afrikaans speaking. English is the main language medium in the intensive care unit.
2.3.2 RESEARCH METHOD

Now a discussion of the research method will follow.

2.3.2.1 ETHICAL CONSIDERATIONS

In conducting the study the following ethical consideration will be pursued. (Ethical considerations arise from a continuous process from the conception of the study until the research findings are communicated.) Being an emergent design ethical issues will be negotiated as they confront the researcher. It remains relevant to take the following into consideration:

- **competence of the researcher**: The researcher has undergone a postgraduate education programme in research methodology and nursing dynamics. Furthermore, the study will be supervised by two doctoral nursing researchers. Both doctoral researchers are actively involved in qualitative research. The respective fields of specialization held by both are: a professor of psychiatric nursing and a doctorate of intensive care nursing. The competence of the researcher will be nurtured and assessed by these nurse research specialists with the view to facilitating a morally just nursing research and social justice (Minichiello et al., 1990: 236-244). Interaction with these nurse specialists will be effected at short periodic intervals.

- **researcher-interviewee relationship**: an external interviewer will be approached to interview the interviewees. The reason for this is that the researcher is in a position of authoritarian relative to the interviewees. The researcher is the unit manager of the adult intensive care unit and this might influence the responses of the interviewees. Interviewees might feel threatened by this situation and not respond honestly. Furthermore, the external interviewer is a black woman and this might reduce the potential for intercultural prejudice. The external interviewer is an independent person
who has nothing to do with the organizational structure of the private clinic and therefore creates a non-threatening atmosphere in which the interviewees can feel safe to respond freely.

- **Informed consent:** Information on all the aspects of the study are disclosed e.g. purpose, method, objectives, potential risks, benefits and the interviewee input. Participation is to be free of force, fraud, duress or any form of constraint or coercion (Burns & Grove, 1993:104) (SANA: 1991). The researcher will obtain informed consent. (See Annexure 1.)

- **Gaining access:** A formal letter (care of the Rand Afrikaans University) will be written to the hospital management of the intensive care unit concerned. A short informational motivation will accompany this letter. Each interviewee will receive a informational letter as well (Burns & Grove, 1993 and SANA,1991).

- **Communication of essential information:** According to Burns and Grove (1993:104-106), the following information must be communicated (SANA 1991). Human rights will at all times be respected and protected. With initial contact with the interviewees the intention to involve them in a research study will be made known to them. A statement of the long-term and short-term benefits will be made available to all the interviewees involved in the research. Expected duration of participation will also be communicated. Interviewees will also be informed that they fulfil the selection requirements, and what these requirements are. All procedures will be explained to the interviewees. The length of the in-depth interview will be stated as well as venues for further follow-up or contact. A place conducive to privacy for the interviews to take place in will be used. A description of the possible risks will be shared with the interviewees: this study is supposed to be non-threatening and pose minimal risks, yet it is of importance to note that interviewees will have time and interest invested in the research. If at any time an interviewee might experience emotional difficulty that requires therapy an external psychiatric nurse specialist will be available for consultation. Benefits will be
explained as the description of guidelines for a support programme for intensive care nurses working in the adult intensive care unit. A practical implication is that an emotional catharsis may be experienced which stems from their satisfaction that their concerns have been heard. Supervisors and coders having access to raw information will be required to sign a confidentiality note: (see Annexure 1). In order to disguise personal information only the transcriptions of the tapes will be made available to the study leaders. The tapes will be disposed of after the study has been graded. Interviewees will be informed about any intention to publish the study as well as to the purpose of the publications (Minichiello et al, 1990:236-244).

2.3.2.2. PHASE ONE: THE EXPLORATION AND DESCRIPTION OF THE EXPERIENCE OF INTENSIVE CARE NURSES NURSING IN THE ADULT INTENSIVE CARE UNIT.

The objective of the first phase of the research is to describe the experience of intensive care nurses nursing in the adult intensive care unit. To adhere to this objective interviewees will be identified to participate in this study, and data will be collected, coded and analysed.

i) POPULATION AND SAMPLING

• population: Population is an identification of a group of persons, agencies, places and other units of interest that can by definition be placed together. For the aims of this study the population is both targeted and accessible (Burns & Grove 1993:236). The registered nurses working in the adult intensive care unit for at least 2 months both adhere to the selection criteria and are accessible as well. There are only 5 registered nurses who fulfil the selection requirements as they are the total staff contingency of the unit as well as the study’s interviewees.
• **Sampling method:** Contextuality is enhanced with purposive sampling. The aim is to select a homogeneous stratum of the population. Guba & Lincoln (1985:200) mention that the more homogeneous the stratum the better the inferences that can be made. This stratification implies that the sub-units are more alike contextually. In the naturalistic design the researcher begins with the core assumption that context is critical and that each context should be dealt with on its own terms.

• **Selection criteria:** (Burns & Grove, 1993: 246). For the purpose of this study registered nurses working in the adult intensive care unit for at least 2 months will be selected. This will ensure that they will have been exposed to the unit as it presents itself at the moment. This will also ensure that they will have been socialised to the philosophy of the unit.

• **Sampling size:** In this study registered nurses in the intensive care unit will be interviewed until the data is saturated as is demonstrated in repeating themes (Tesch, 1990 in Cresswell 1994).

ii) **DATA COLLECTION**

The phenomenological interviews will be conducted to give the registered nurses in the intensive care unit the opportunity to describe their experiences from their own perspective. The method of choice (the phenomenological interview) must give these nurses the freedom to talk (Burns & Grove, 1993:66).

The researcher will use the format of the semi-structured interview (Kvale 1983:171-196). One central question will be asked: **How do you experience nursing in the adult ICU?** All that is then required of the external interviewer is to guide the interview around the research question and encourage the interviewees to talk.

The reason for selecting this method is that it is an interview method that in its purpose gathers descriptions of the life-world of the interviewee and respects the interviewee's interpretation of the meaning of the phenomenon to be described. It
makes it possible for the interviewees to organize their own descriptions emphasizing what they themselves find important in their own life-world - their opinions and actions, in their own words (Kvale, 1983:173). It goes beneath the surface to explore a sense deeper than the common sense. Great emphasis is placed on interviewer sensitivity and creativity.

Validity threats in scheduled semi-structured interviews will be taken into consideration (Hutchinson & Wilson, 1992:117-119). It is of importance that the research interviewer employ the techniques and skills required for effective interviewing and communication (Poggenpoel, 1988: 9-20). It is imperative that a setting conducive to privacy and free of interruption should be used for the interview (The boardroom will be used.)

The following guidelines will be used when conducting the interviews: The informed consent (Annexure 1.) will be given to each interviewee and 5 minutes (or more) will be spent by the researcher on clarifying expectations or any unclear aspects. Interviews are only to be conducted when the interviewee feels she can allow her patient to be handed over to someone else. The atmosphere will be kept informal and relaxed. Confirmation of time of the interview will be established. This will be organized with the independent research interviewer whom the researcher has approached to do the interviews. The reason for the use of an independent research interviewer is that the staff then have complete freedom to talk to a highly competent psychiatric research interviewer with no ties to the private hospital authority structure or hospital group politics. The interviewer also eliminates researcher bias (Kvale, 1983:189-190).

On the day of the interview the interviewer will again reassure the interviewee. One way of doing this is by talking about general issues (e.g. how busy the unit is) and then guiding the conversation towards the central question. Interviews will be conducted in English. Non-directive communication techniques used will
be probing question to elicit information, clarifying unclear information so that the interviewer and the interviewee achieve mutual understanding, paraphrasing (the sounding board effect), minimal verbal response to encourage the interviewee to continue, allowing the interviewee enough time to respond and express herself. Summarization will be used to ensure that the interviewer is understanding the interviewee correctly (Poggenpoel, 1988:19-20).

The interviews will be recorded on audio tapes. Two tape recorders will be used to guard against the unlikely event of mechanical failure (Hutchinson & Wilson, 1992:119). The advantages of recording data is as follows: it provides a unimpeachable data source, it assures completeness. It provides the opportunity to review as often as required. Non-verbal cues can be followed (e.g. significant pauses, raised voices, emotional outbursts) and it provides material for joint interviewer training and reliability checks (Hutchinson & Wilson, 1992:118).

The disadvantages however are: possible mechanical failure, and the fact that non-verbal cues like wringing of hands, gestures etc. remain dependent on the taking of field notes.

Transcribing interviews should be done as soon as possible after the interviews have been conducted since memory, ideas and impressions are fresh and enhance the ability to process the data more comprehensively. For the sake of this study and the time limitations an independent person will be used to transcribe the tapes. If any information is lost through transcription the researcher still has the tapes to back-up informational losses. Any unclear information can also be verified by the independent coder who is also the interviewer for this study. The tapes will be made available to the interviewer/independent coder for this purpose.
The initial interviews, to gather information, will be semi-structured. In the later stages of the follow-up interviews (triangulation and member checking) this will be more structured so as to verify information obtained.

Field notes: Throughout the collection of data the researcher will maintain field notes on the entire process. Field notes will be written during the interview and immediately after an interview by the external interviewer. This will contain a summary of what the interviewee has said in essence and any other impression that may come to mind regarding the interviewee's non-verbal cues (Guba & Lincoln 1985:327). The interviewer will assist the researcher with field notes about the interviews during the consensus discussion (Minichiello et al, 1991:250-254). In chapter 3 detailed field notes will be discussed.

iii) DATA ANALYSIS

The analysis of data will proceed as follows:

• Assembling and organizing data:
The data collected via the audio tapes will be transcribed verbatim and the data collected in the note book will be organised into personal and analytical logs. A personal log contains a descriptive recollection of the interviewee's non-verbal cues, reflective notes on the fieldwork experience and methodological issues. An analytical log contains a detailed examination of questions asked as well as ideas as the study progresses. (Guba & Lincoln 1985:327)

• Method of data analysis
Tesch 1990 in Creswell (1994:155) will be used as method of choice for data analysis. After all the interviews have been transcribed a sense of the whole is obtained by reading through all the transcripts. Tesch recommends the following: Jot down ideas in the margin as they come to mind. Pick the most interesting interview and ask the following questions: what is it about? What is the underlying meaning? Write your thoughts in the margin. Complete this task for all the interviews and make a list of all the topics. Cluster similar topics together.
Form these topics into 3 major columns e.g. major topics, unique topics and leftovers. Take this list and go back to your data and abbreviate the topics as codes. Write the codes next to the appropriate segments of text. Try this preliminary organizing scheme to see if any new categories and codes emerge. Find the most descriptive wording for your topics and turn them into categories. Reduce your total lists of categories by grouping topics that relate together. Draw lines to indicate interrelationships. Make a final decision on the abbreviation of each category. Alphabetize these codes. Assemble the data material belonging to one category in one place and perform a preliminary analysis. If necessary re-code your existing data. Always be on the lookout for unusual or useful quotes that can later be incorporated into the qualitative story. Major and minor themes can also be categorized and another list can then show contrasting themes.

Triangulation of the data will be made by consulting a nurse researcher (independent coder) who will analyze the interviews independently of the researcher. The independent coder is a nurse researcher who is familiar with conducting qualitative data analysis. A protocol describing the method of data analysis will also be provided to the independent coder. This protocol contains no pre-ordained themes or categories and is therefore known as open coding. After the interviews have been analyzed, the researcher and the independent coder will meet for a consensus discussion.

The themes as they have emerged in the interviews and as interpreted by the researcher will be discussed with the interviewees in the follow-up interviews. This is to ensure that information obtained is representative of what the interviewees meant.

After data has been analysed, the themes will be reflected within NWPT (Oral Roberts University: Anna Vaughn School of Nursing, 1990 136-142; Rand Afrikaans University Department of Nursing, 1992:7-9).
• Literature control:

The results of the research will be discussed in the light of relevant literature and information obtained from similar studies. Referential checks enhance the scientific trustworthiness of the study. This is a strategy used to ensure trustworthiness by means of triangulation.

2.3.2.3. PHASE 2

DESCRIPTION OF GUIDELINES FOR A SUPPORT PROGRAMME FOR NURSES NURSING IN THE ADULT INTENSIVE CARE UNIT.

The data gathered from phase I of this study will be used as the basis for describing guidelines for the intensive care nurses so that they can support each other whilst nursing in the adult intensive care unit. The guidelines will be written incorporating the criteria for ensuring trustworthiness Copi (1962:381-386). The criteria mentioned by Copi help to streamline the process of logical inference.

After analysing the results and their implications for nursing actions, a literature review will be used as a tool to help formulate the guidelines. Final guidelines will be drawn up after discussions with intensive care nurses in practice and input from a panel of nursing specialists. This will be presented in the format of advisory strategies to be implemented.

A written report of the findings will be made available to management and all the nurses in the adult intensive care unit. Issues will be further addressed in the form of suggested topics for in-service training (this will be the application of the research in practice).
2.3.2.4. TRUSTWORTHINESS

Throughout the various stages of the research study the researcher will strive to adhere to the principles of trustworthiness. Guba & Lincoln (in Krefting, 1991:215) regard trustworthiness as the method of ensuring rigour in qualitative research. This is done without sacrificing relevance. For the purpose of this study the researcher will adopt Guba’s model (in Krefting, 1991:217). This model identifies four criteria and strategies for ensuring and establishing trustworthiness. (See application of this research in table 2.1. on page 36.)

TRUTH VALUE

Truth value is the first criterion addressed to establish trustworthiness. This criterion is used to assess to what extent the findings of the study are a true representation of the life-world of the interviewees as are described and experienced by them. The strategy for establishing truth value is credibility. Credibility is achieved with the following actions: a prolonged and varied field experience, reflexivity, triangulation, member checking, peer examination, interview technique, establishing authority of the researcher, structural coherence, and referential adequacy (in Krefting, 1991:215-217). (See application of this research as shown in Table 2.1 on page 36.)

APPLICABILITY

The second criterion addressed is called applicability. This term refers to the findings being applied to other contexts and settings or with other groups (Krefting, 1991:216). Transferability is the strategy employed to attain applicability. This is obtained by using a purposive sample, working contextually, time sampling and dense descriptions (Krefting, 1992:216-217). (See application of this research in table 2.1. on page 36.)
TABLE 2.1 - STRATEGIES TO ENSURE TRUSTWORTHINESS

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>CRITERIA</th>
<th>APPLICABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CREDIBILITY</td>
<td>Prolonged Engagement</td>
<td>The D. Cur. Candidate (interviewer) has a prolonged engagement with issues related to the qualitative nursing research literature as well as the field of research. The interviewer will allow enough time to establish rapport and for interviewee to respond &amp; verbalize experiences during the interview.</td>
</tr>
<tr>
<td></td>
<td>Reflexivity</td>
<td>Field notes will be taken by both the researcher and the interviewer.</td>
</tr>
<tr>
<td></td>
<td>Member checking</td>
<td>Follow up interviews will be held with interviewees. Literature control on themes and its impact on guidelines will be discussed.</td>
</tr>
<tr>
<td></td>
<td>Triangulation</td>
<td>2 researchers, interviews and observation to ascertain if truth is reflected.</td>
</tr>
<tr>
<td></td>
<td>Peer examination</td>
<td>Services of a colleague will be required.</td>
</tr>
<tr>
<td></td>
<td>Authority of researcher</td>
<td>The researcher’s two research supervisors both have Doctorates in the nursing field of research. They will nurture and supervise the researcher’s capabilities and ethics.</td>
</tr>
<tr>
<td></td>
<td>Structural coherence</td>
<td>The focus will be on ICU nurses’ experiences. The results will be reflected within nursing for the whole person theory.</td>
</tr>
<tr>
<td>TRANSFERABILITY</td>
<td>Nominated sample</td>
<td>Purposive sampling will be used.</td>
</tr>
<tr>
<td></td>
<td>Dense description</td>
<td>Complete description of design and methodology and accompanying literature control to maintain clarity will be used.</td>
</tr>
<tr>
<td>DEPENDABILITY</td>
<td>Dependability audit</td>
<td>Personal logs and reflexivity notes will be kept.</td>
</tr>
<tr>
<td></td>
<td>Dense description</td>
<td>Research methodology will be fully described.</td>
</tr>
<tr>
<td></td>
<td>Peer examination</td>
<td>Independent checking by a colleague and supervision by experts will be done.</td>
</tr>
<tr>
<td></td>
<td>Code/recode procedure</td>
<td>A consensus discussion between the researcher and the independent coder will be held.</td>
</tr>
<tr>
<td>CONFIRMABILITY</td>
<td>Audit trail</td>
<td>(As discussed).</td>
</tr>
<tr>
<td></td>
<td>Reflexivity</td>
<td>(As discussed).</td>
</tr>
</tbody>
</table>

Adapted (with permission) from a table used by Poggenpoel, Nolte, Dorfling et al. (1994:132)
CONSISTENCY

The third criterion is called consistency. Here it is assessed to what extent the replication of the study with the same subjects or a similar context will lead to the same findings. Dependability is a strategy used to establish consistency. This is achieved by keeping a dependability audit, providing a dense description of research methods, step-wise replication, triangulation, peer examination and code-recode procedure (in Krefting, 1991:216-217). (See application in this research in table 2.1. on page 36)

NEUTRALITY

The fourth criterion suggested for assessing trustworthiness is neutrality. This refers to the extent to which the findings of the study are free from bias. Confirmability is a strategy used to achieve neutrality. This is established by keeping a confirmability audit, triangulation and reflexivity (Krefting, 1991:217-221). (Table 2.1 page 36) will provide an overview of the strategies by Krefting (1991:215-222) applicable to this study.

2.4. CONCLUSIONS AND RECOMMENDATIONS

Conclusions and recommendations will be made on the strength of the research findings. These will be applied to nursing education, nursing research and nursing practice (Botes, 1994).

2.5. CONCLUSION

The research design described in this chapter, together with the research method and strategies to ensure trustworthiness, will reveal the working life-world of the intensive care nurses working in the adult intensive care unit.
CHAPTER 3

DISCUSSION OF THE FINDINGS

3.1. INTRODUCTION

In this chapter analysis of the data will be discussed and the relevant themes will be verified with a literature control. The results will be described in a narrative format and each theme will be supported by relevant quotations from the raw data (original text). After each theme has been verified via original text and the accompanying literature control the identified themes will be placed in relationship with each other. These themes will be used in describing the patterns of interaction which have an effect on the perception of health.

The results showed that the nurses experienced emotional and spiritual distress related to their working environment. In table 3.1, the researcher gives an overview of the results obtained. Five major themes were identified. Sub-categories are included under each theme. The emotional content of the themes are also summarised under the heading internal environment. These feelings (distress) are indicative of the internal environment experienced by the interviewees. Each theme and its sub-categories are linked with NWPT (1990). This link with NWPT (1990) helps to organise the themes into aspects that effect both the internal and external environment of the intensive care nurses as they are experienced by them. Thus the following discussion of the results will be based on table 3.1.

3.2 AN OVERVIEW OF THE THEMES AND CATEGORIES OF THE EXPERIENCE OF REGISTERED NURSES NURSING IN THE GENERAL ADULT ICU. (See table 3.1)
Table 3.1 RESULTS: An overview of themes and categories of the experience of registered nurses in the general Adult I.C.U.

<table>
<thead>
<tr>
<th>THEME</th>
<th>CATEGORIES &amp; SUB-CATEGORIES</th>
<th>EMOTIONAL CONTENT (INTERNAL ENVIRONMENT)</th>
<th>NWPT (1990)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. IMPAIRED COMMUNICATION WITH MANAGEMENT.</td>
<td>INSECURE / UNPREDICTATBLE WORKING PLACE: 1.1 No career advancement opportunities. 1.2 Remuneration. 1.3 Absence of support. 1.4 Absence of feedback. 1.5 No timely feedback.</td>
<td>Unfairness, neglect, betrayal (1.1) (1.2), mistrust, helplessness, confusion, bitterness, resentment (1.3) (1.4), neglect, no professional worth, lack of acknowledgement, insensitive (1.5).</td>
<td>SUPPORT SYSTEM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Financial  • Material  • Conflict resolution</td>
</tr>
<tr>
<td>2. DISCRIMINATION: WHITE ON BLACK RACISM.</td>
<td>LACK OF HUMAN AND PROFESSIONAL DIGNITY 2.1 Management. 2.2 Colleagues outside A.I.C.U. 2.3 Doctors. 2.4 Relatives. 2.5 Patients.</td>
<td>Helpless, neglect, not accepted, defensive mistrust (2.1), aggression, alienation (2.2), humiliation, low self worth, low self esteem, unappreciated, insensitivity, patronised, hurt, frustrated, anger (2.4), disgust, attacked, victimised, prejudice, not confident (2.5).</td>
<td>EMOTIONAL / SPIRITUAL DISTRESS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Values  • Bitterness / blame  • Anxiety / worry  • Anger / annoyance  • Sadness / hurt  • Defeat / helplessness  • Alienation / humiliation</td>
</tr>
<tr>
<td>3. LACK OF FAIR, COMPETITIVE REMUNERATION AND DISREGARD FOR PROFESSIONAL WORTH.</td>
<td>LACK OF PROFESSIONAL WORTH 3.1 Remuneration. 3.2 Recognition. 3.3 Staff development.</td>
<td>Neglected, unobserved, taken advantage of (3.1), disapproved, inequality (3.2), no professional acknowledgement, no professional advancement, distrust (3.3).</td>
<td>MEANING &amp; PURPOSE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Fulfilment  • Professionalism  • Motivation</td>
</tr>
<tr>
<td>4. NON-CONDUCTIVE PHYSICAL ENVIRONMENT.</td>
<td>DEPERSONALISATION 4.1 Lack of privacy. 4.2 Inter-departmental. 4.3 Lack of equipment. 4.4 Lack of infection control. 4.5 Other.</td>
<td>Neglected, depersonalised, not looked after (4.1), frustrated, low self esteem (4.2), frustration, incompetence (4.3), insecurity, personal discomfort (4.4), cognitive dissonance, intrapersonal conflict (4.5).</td>
<td>LIFESTYLE CHANGES</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Job reorganisation  • Accepting less ideal standards of life</td>
</tr>
<tr>
<td>5. STRESSFUL WORKING ENVIRONMENT.</td>
<td>INTERPERSONAL RELATIONSHIPS 5.1 With colleagues. 5.2 With domestic staff. 5.3 With doctors. 5.4 Staff shortage.</td>
<td>Positive, warmth, helpless / same boat principle (5.1), powerless (5.2), conflict, disrespect, patronised, ethical, dissonance, despair, professionally unsafe environment (5.3), fear of unpredictable working environment (5.4).</td>
<td>INTERPERSONAL RELATIONSHIPS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Relationships with others</td>
</tr>
</tbody>
</table>
support: "...and about your feelings, it looks like nobody cares about you and yet you are doing a great job there in that unit...we call them at times but they never appear."

3.2.1.3. LACK OF FEEDBACK BY MANAGEMENT.
A perceived lack of feedback and support from management was experienced. There was no feedback from management: things were not followed up and there was an atmosphere of mistrust in as such that all matters had to be put on paper in order to elicit some valid response. One interviewee said: "... nurses talk, nothing gets done". Management was thus also not actively inspired to support their staff in a timeous fashion. "Another thing here things are not followed up you have to run after people all the time you know...eventually the answer was that I had uhm obviously made a mistake I didn’t make her write it down...it was my word against hers...eventually there is nothing one can do."

3.2.1.4. LACK OF CAREER ADVANCEMENT AND IN-SERVICE TRAINING
A perceived lack of career advancement and in-service training was experienced by the interviewees. Another interviewee also acted in charge for a while and remarked at how she had been kept in the dark on her promotion / career advancement. "...you know when you look at it, where on earth, in which institution does it take them 8 or 12 months to nominate someone to become the sister in charge?" She further commented that management did not have any intentions of developing her. "...and it makes you feel that they have no intentions in developing me to become anything further."

3.2.1.5. LACK OF SUPPORTIVE INTERVENTION BY MANAGEMENT.
A perceived lack of support/intervention by management was experienced by the interviewees regarding sensitive issues. The doctors were experienced as behaving in a problematic way that made nursing difficult. The loyalty of management was rather with the doctors than the nursing staff. Doctors are seen by management as customers which had to be tolerated by the nursing
staff at all cost. The nurses felt helpless in their struggle to be heard by management when conflicting interests developed between nursing staff and the doctors. They felt that their professional status and worth to the hospital were undermined and neglected. The doctors were always right: "...always put your head on the floor..." and "...they (doctors) really do not respect nurses and they know very well what nurses do for them but they just don't seem to realize or acknowledge that or appreciate it. If we were appreciated it would be much better....you know it doesn't mean if you are a doctor you are not wrong, because they think they are always right so, uhm I don't know how to get through to them."

Another interviewee mentioned: "Doctors, even if they do things which you feel is not right we don't feel that there somewhere that we can report and it can be solved."

Another interviewee summarised it as follows: "Here you are told that the doctor brings money and you have to take what they say."

In a study that Cilliers (1991) undertook as to the working conditions of nurses in intensive care and high care units in South Africa it was noted that two thirds of the nurses in his study complained about the lack of promotion / career advancement in the private sector. A great deal dissatisfaction was expressed on allowances especially charge allowances for shift leaders (Cilliers,1991:3). Intensive care nurses in general felt that there is a lack of support from their nursing service managers in both the public and the private sectors (Cilliers,1991:5). The aforementioned is also reflected by Muff, (1982:387). A lot of dissatisfaction was voiced about the lack of in-service training and career planning in the private sector (Cilliers:1991:4). Hingley & Cooper (1986:73) mention that the profession of nursing in the organizational setting has always been neglected in favour of keeping the doctors satisfied with their social status and the feelings of control and power that it generates. Nurses however are locked in a continuous struggle to be taken seriously in the organisational environment.
3.2.2. WHITE ON BLACK RACISM: DISCRIMINATION

A general lack of sensitivity by different groups in the health-care team to the human rights (cultural diversity) and professional dignity of the registered nurses in the intensive care unit was expressed by the interviewees. This resulted in the emergence of negative feelings in the interviewees. These feelings were of: helplessness, neglect, rejection, mistrust, defensiveness, aggression, alienation, humiliation, low self-esteem, low self-worth, unappreciated, being patronised, hurt, frustration, disgust, being victimised and prejudice. Racial discrimination by the following groups will be discussed: management, colleagues, doctors, relatives and patients.

3.2.2.1. MANAGEMENT

When issues relating to the doctors' conduct had been put forward to management, discriminatory issues were not addressed by management: "you can see management by the end but they say, we need him, but we will speak to him and then nothing happens." There was a distrust of the staff's capabilities and as staff felt that they had to prove themselves to management. They selected a white person: "now one started thinking... did this not have a racial connotation?" One of the registered nurses noted that white people retain a prejudice against black nurses. Madi (1993:33) gives a graphic representation of the Corporate Culture in the RSA. (See table 3.2.) This table shows what white South Africans in the integrated working environment perceive the capabilities and qualities of black colleagues to be. On the surface communication is civilised, yet beneath the surface understanding is clouded by preconceived notions about the work ethic of black persons.
TABLE 3.2: CORPORATE CULTURE AS THE BODY OF THE ICEBERG

BASIC ASSUMPTIONS
- Blacks inclined to communism
- Blacks lack assertiveness
- Blacks lack initiative
- Blacks have no work ethic
- Blacks will ruin the company
- Blacks' culture no good for business
- Blacks will lower the standards
- Black graduates have unrealistic expectations
- White education = perfect education
- Black education = chaotic education
3.2.2.2. COLLEAGUES (outside the intensive care unit)
The staff felt that they were being discriminated against by being referred to as being too loud. They justified this by replying that it is their cultural way. Nurse 2 felt that she had to prove herself to her fellow colleagues as to being knowledgeable and competent: “I had a tough time trying to convince people that I know what I’m doing, that is the doctors and the nurses outside ICU, the general people around here, as well as the management...it is not easy for them to understand what I mean what are your capabilities so I have to prove myself here that I know what I’m doing...so it was a bit hard on me and I didn’t really like it, so I had quite a number of fights with them, the doctors and the nurses.”

It was felt that there was no consistency in the way behaviour and performance had been viewed, for example white staff got away with an unacceptable working ethic whilst black staff were reprimanded if they had done the same: “Even if things were not done properly, because it is whites it is fine you know and that really also makes you feel like everybody is attacking you, nobody is with you, everybody is attacking you.”

3.2.2.3. DOCTORS
Nurses commented about certain doctors having racist attitudes and swearing at them. Thus staff had been the victims of preconceived racist attitudes by some of the doctors. Doctors were experienced as being harsh and unco-operative. Another respondent remarked: “...it's more a racial thing than anything else. All the time one is being judged by one’s colour...some of the doctors they still have that kind of problem.”

3.2.2.4. RELATIVES.
Lower category nurses were approached if they were white rather than black registered nurses who were in charge and took responsibility for the shifts: “...they (relatives) will come through the unit. You’re working with a staff nurse lately or a lower category ... they go straight to the white girl, ask her questions and when she doesn’t know what to say, because she is not responsible for
the place, then she shunts them back to you, then they have to come back to you, you know, with their tails between their legs... towards you to ask you in fact, can you tell something about our relative. I don’t know how often I can take this, you know. It is very offensive.” The same interviewee also remarked that relatives addressed the staff inappropriately, at times they made insensitive remarks and they were patronizing. They were also ignorant of the professionalism of the black nurses.”...you are constantly patronized, you know, with little gifts here and there...you have been nice and good to my husband...as if they don’t expect a black nurse to do that...as if a black nurse is not professional, to take care of the needs of their relatives.”

3.2.2.5. PATIENTS

Patients were experienced as being abusive. This was experienced as a severe rejection: that the nurse attending to a patient to whom she is ethically bound for unbiased nursing care preferred to be nursed by a white nurse: “...patients also are racists because they choose to be treated and handled by a white nurse.” To illustrate this point further, one of the interviewees described the following incident: “…there was an incident in our ICU where a white patient was ventilated and it was a car accident. So that night he was being nursed by a black sister. So this person who was actually ventilated but conscious, but he feels he doesn’t have trust in his black sister.” The patient then addressed a white staff nurse writing on a piece of paper: "could you please look after me because I don’t trust this black sister who is looking after me. I really feel she is going to kill me." The interviewee’s perception of this behaviour was: “It was not totally acceptable.” Another interviewee felt she had to prove herself as a competent nurse. “I as a black nurse has to prove all the time around the clock that you can do it.” She also stated that black nurses were sometimes feared by white patients and she identified a need for patients to be educated that discrimination was not necessary. Another interviewee stated that white people lacked confidence in black nurses: “Let me be honest with you we are living in a different world where we are all supposed to be the same (the New South Africa), but somehow that stigma is still planted in some around - especially white people, not all of them, some of them
they were looking beyond you, not at you, get my point, they look through you... only when you exhibited your talent you are knowing to correct this and that... and that saving his life and his life's going on... then he starts realising, oh, this nurse can stay, I like her, but it is not all the patients."

Madi (1993:vi) discovered in his research on affirmative action in corporate culture that South Africans do not know each other well at all and that we are now beginning to do so and that it is a painful experience for everybody. He also mentions that many misconceptions are held by both blacks and whites and that these stem from ignorance rather than malice.

Issues involving social distance and unequal access to basic resources (power, status and wealth) influence work- and non-work-related behaviours. Employment situations are often stratified and inequitable (Kavanagh & Kennedy, 1992:32). Health-care providers and health-care consumers interact. Their cultural baggage interacts with them (Kavanagh & Kennedy, 1992:82) and this interaction can be clouded by preconceived bias.

In interaction among peoples of different cultural or racial origin the perceived interaction has different meaning for the various individuals involved. Racially integrated situations often lead to increased stress and lower self-esteem (Kavanagh & Kennedy, 1992:108). Avoiding dealing with potentially painful situations maintains the power of those who already have it and reinforces the minority status of those without power. Often the pain that is experienced in which insensitive behaviours have occurred is traceable to differences in knowledge about the situation: that is, insensitivity may be the result of limited understanding of the situation rather than the intent to hurt and discriminate. Discrimination duly hurts perceptions of personal integrity (Kavanagh & Kennedy, 1992:106-107). Racism remains a significant factor in social process, social organisation, and culture. Denying the significance of that situation implies that specific experiences of individuals and groups are not important (Kavanagh & Kennedy, 1992:109).
3.2.3. LACK OF FAIR AND COMPETITIVE REMUNERATION AND DISREGARD FOR PROFESSIONAL VALUE.

A disregard for the professional worth of the intensive care nurses was experienced due to perceived poor remuneration, absence of recognition and the lack of staff development. Feelings that were experienced here are feelings of: neglect, being taken advantage of, being unobserved, being disapproved, inequality, distrust, no professional acknowledgement, and no professional advancement.

3.2.3.1. REMUNERATION

Staff acting in charge were never remunerated (as has been discussed under communication with management). One interviewee was to receive a revised salary 3 months after her date of appointment. No feedback on this matter was received. Thus promises made were not kept and the nurse felt that she had been taken advantage of. Another interviewee elaborated on the remuneration versus job dissatisfaction that she experienced. She felt that she was being underpaid for the responsibility and stress-load she was experiencing. One interviewee’s salary had not been revised and remained static for some time because she had experienced no recognition or warmth from her previous unit manager. One interviewee expressed herself as follows: "And then again, coming to money, they don’t pay us well compared to all this difficulty around...permanent staff it is worse, we get less money still and if you sort of take charge...let’s say it is over the weekend or after four when the clinic sister is gone...you don’t feel encouraged to work in there or do something because there is nothing that...nobody is showing you that you are doing anything good or whatever."

The following was also said in relation to remuneration: "On the other hand you’re not paid as you would like to be paid in other clinics... you feel you have been exploited."

Cilliers (1991:9) noted in his study that staff felt that they were being taken advantage of. Dissatisfaction was expressed about hours worked, years of
experience, allowances and performance being taken into consideration to establish a more equitable system of remuneration. He also found that nurses felt underpaid in comparison to the amount of stress they experienced (Cilliers, 1991:30).

3.2.3.2. RECOGNITION
Remuneration is a method of acknowledging staff for certain qualities. Staff felt this was not happening. Staff felt that there was no spontaneous recognition as they had to prove that they were competent registered nurses. The doctors too did not recognise or respect nurses. Doctors have higher status than nurses and this resulted in a boss-servant attitude from some doctors, and they abused this situation. All the respondents remained committed to their patients although certain aspects had hampered their feelings of self-worth and their personal and professional esteem. Professional accomplishments were not recognized by the nursing service manager. The staff felt that they were not appreciated and asked whether they were being approved of. One interviewee related her feelings as: "I am not alone in this place but I feel really not at ease, not at home at all."

Cilliers (1991:30) found that nurses felt that there was no recognition for the importance of their work within the organisation. Recognition was also perceived to be lacking from the nursing service managers and nurses felt they needed more support and acknowledgement (Hingley & Cooper, 1984:52-53).

3.2.3.3. STAFF DEVELOPMENT
One interviewee noted the lack of unit orientation. Four interviewees experienced that in-service training and education was non-existent in the clinic. This also made staff appear stupid and ignorant of the latest technology thus reinforcing the low professional image that some doctors have of nurses: "We find to lack knowledge, you find a doctor maybe coming to
visit, you know, because some of them go for a holiday then they get somebody from outside. Then they ask for something you don’t know and it makes you feel stupid because it is something that has been there and it is something the doctor will say is new.”

One interviewee felt that management was not interested in developing her: “now you ask yourself questions, you know, what is it that they didn’t approve of us?, why didn’t they bring it to our notice? You do that to an employer who you have intentions of developing - you talk to them, you correct them.” She elaborated further on the feeling she was experiencing at the time : “...it has left me somewhat bitter, it has left me somewhat confused ...somewhat taken my trust of the way things are done here...and that you can’t trust them to develop you.”

In his study Cilliers (1991: 3,90) found that the nurses perceived that there was a lack of in-service training especially in the private sector. Nurses expressed the need for formal and informal education programmes to develop staff on a continuous basis.

3.2.4. PHYSICAL ENVIRONMENT
Depersonalisation due to an unfavourable physical environment was experienced by the interviewees. The features of the non-conducive environment were a lack of privacy, interdepartmental differences, lack of stock and equipment, and the lack of infection control measures. The feelings experienced here were feelings of: neglect, not being looked after, frustration, low self-esteem, incompetence, insecurity, personal discomfort, cognitive dissonance and intrapersonal conflict.

3.2.4.1. LACK OF PRIVACY
All five interviewees experienced the lack of privacy due to the physical layout of the unit as non-conducive. They expressed concern at not having a tearoom, general lack of privacy, having very little space, no stockroom or lockers. “We haven’t got a tearoom, nothing ... you cannot say anything to your
friend privately, you've got to say it in front of everybody. You can't go and have a decent lunch, you've got to eat there... if the patient's puking or having diarrhea there...you're making your tea in the middle of the unit, I mean that's really not nice...the unit has been arranged- everything you just do in front of the patient."

The interviewees also expressed concern about being observed by both patients and visitors all the time.

Cilliers (1991:5) noted that nurses felt concerned about the lack of privacy due to the physical layout of many intensive care units. Adequate tearoom facilities and larger stock rooms were desired by his participants. The nurses feel that they are always being subject to the critical scrutiny of patients, visitors and colleagues (Hingley & Cooper, 1986:48).

3.2.4.2. INTERDEPARTMENTAL
Pharmacy does not always issue the correct stock and it makes the nurses appear more incompetent in the eyes of the doctors. Another interviewee noted that they do a lot of running if they wanted to obtain the desired stock. This resulted in time-consuming non-nursing activities which decreases direct patient care time.

Marrelli (1993:215) comments on the incidence of decreased job dissatisfaction when staff are continuously engaged on non-nursing activities, experiencing problems with other departments and running errands.

3.2.4.3. LACK OF EQUIPMENT
One interviewee remarked on the condition of the equipment - that it is substandard: "We lack equipment in our unit, the things we are using are falling apart all the time. So we are told that they are working on those things."

Booyens (1995:289) remarks that it is imperative to provide adequate and technologically advanced equipment in specific nursing environments.
3.2.4.4. LACK OF INFECTION CONTROL
Inadequate and unsure methods of infection control were in existence. This is seen as a workplace safety hazard. Existing uniforms were seen as ineffectual in combating infection control. Changing into theatre-like overalls for infection control purposes was desired.

Adequate and practised methods of infection control must be in order. The absence of this is an occupational safety hazard (Booyens, 1995:348)

3.2.4.5. OTHER: UNHAPPINESS AT WORK VERSUS CONVENIENCE
The hospital is located close to the staff's homes. Staff felt that it was convenient to work at the clinic although they were unhappy with their working conditions.

3.2.5. A STRESSFUL WORKING ENVIRONMENT.
Themes discussed are: interpersonal relationships amongst the staff in the intensive care unit, relationships with the domestic staff, relationships with doctors and the staff shortage. The feelings experienced by staff were that they experienced warmth in their relationships with each other, yet they also shared feelings of helplessness as they were in the same boat. Other relationships generated the following feelings: powerlessness, interpersonal conflict, being patronised, ethical dissonance, despair and general feelings of working in a professionally unsafe and unpredictable working environment.

3.2.5.1. RELATIONSHIPS OF THE COLLEAGUES IN THE AICU
Generally, relationships among the staff in the intensive care unit were viewed as positive. All the nurses felt that they could count on each other to talk to and for support. They also experienced themselves to all be in the "...same boat". Misunderstandings were dealt with by talking about them. One interviewee noted that the staff relationships were fine and that there
was a deeper concern for each other’s well-being. One interviewee that had only recently joined the unit said that the reception of the “girls” there was positive.

3.2.5.2. RELATIONSHIP WITH DOMESTIC STAFF
One interviewee gave special attention to her relationship with domestic staff. She felt that they were not doing their job and that they were undermining the authority of the registered nurses. The night matron also appeared impotent in keeping the domestic staff in check. Once again the nursing staff had to take over the responsibilities of the domestic staff who were not willing to cooperate and who were very unionised. This also caused job dissatisfaction as non-nursing activities allowed for less time being spent on direct patient care. Another interviewee described her relationship with the domestics as being civilised.

3.2.5.3. RELATIONSHIP WITH THE DOCTORS
Staff feel it was difficult to get hold of some of the doctors at times: it is not nice to work with them because you depend on them, they are not reachable, you find it difficult, some of them don’t write things down, you know those minor things... you’re not supposed to challenge doctors.” Doctors were experienced as harsh and unco-operative and this exacerbates mistrust and disrespect in nurses relationships with doctors and vice versa: “…at times you are faced with patient’s lives and you can’t just go on to prove who is wrong and who is right and you always try to do what is best for the patient...and you will not get anywhere...so you try to sort of reassure them (the patients) that the doctor is coming...doctors have their image to protect... he might say she never looked for me...so it is going to be your word against the doctor’s.” The nurses sometimes had to lie on behalf of the doctor when the patient was not visited on a daily basis by his attending doctor: ”You can’t expose them, you go and try and chill them for the sake of the clinic, to try and let the clinic look good because of the simple thing that the doctors are on their posts...you are trying to chill them and tell lies…” The doctors did not recognize the professional capabilities of the nurses.
Another respondent who mainly works night duty experienced working with the doctors at the clinic as constituting unacceptable working conditions. She elaborated that patients were not seen by their attending doctors before being transferred to the ward. There was no assistance from the doctors in emergency procedures, and where emergency treatment was handled telephonically. This absence of the physical presence of the doctor meant that nurses were then pressurized in to making decisions that fall outside their scope of practice. This was seen as an incorrect way of doing things: "...for instance I was involved in one of the patient’s cardiac arrest- we actually had to cardiovert the patient...you know to my surprise we had to defibrilate a patient through a telephone.” One interviewee remarked that some doctors did not adhere to the patient’s right to be informed: "...some of the times they give orders and they never explain to the patient.” There was no support from the doctors for the nurses in negotiation with management. The interviewee felt betrayed by the doctors who should have spoken about their ability to run the intensive care unit. This did not happen and so the staff felt betrayed, neglected, without support and that their competencies had not been approved of by the doctors at the clinic. One interviewee remarked on the personal preferences of the doctors being varied and individual: "There is so many routines. There is certain doctors who like this to be done this way and that to be done that way...”

In Cilliers (1991:30) the study showed that nurses did not experience recognition from the medical doctors. Clochesy et al (1993:103) summarises the following stresses for intensive care nurses: conflicts with physicians, conflicts with hospital or nursing administration, inadequate staff or inadequately licensed staff, moral and ethical dilemmas, personal insecurity, threat of patient morbidity and mortality, inadequate knowledge or skill, physical work environment, lack of rewards and interpersonal conflict. This is also mentioned by Hingley and Cooper (1986:39-83). They explain the
ambiguity in the relationships between doctors and nurses and quote Gunning (1983) who suggests that nursing as a whole suffers from powerlessness due to the fact that the nurse's professional authority is poorly defined and often changes. Nurses spend more time with patients and have more insight into their condition changes, thus the nurse's professional contribution is denied and often credited to another professional. This does not only have a negative influence on self/professional image, it also influences patient care directly. Problems of interpersonal relationships between nurses and doctors can be a source of stress and often seem to centre largely upon questions of professional power and status (Hingley & Cooper, 1986:68). Hingley and Cooper (1986:68-69) identify other stresses as well: nurses feeling caught in the middle, sandwiched between the patient and the doctor; incongruity of orders when there is more than one attending doctor; unavailability of doctors, and nurses feeling thus “abandoned” by the doctor when emergencies arise; doctors who leave nurses to deal with a dying patient’s relatives and not informing nurses of the diagnosis and prognosis of a patient.

3.2.5.4. STAFF SHORTAGE
A shortage of permanent staff was mentioned by four of the interviewees. This shortage led to the excessive use of agency: “...we operate more with agency people. I see you get good people if the clinic pays well- our rates are so down, you are getting useless people, or they don’t know what they are doing and they are like rejects to you.”. The agency rates that the clinic was willing to pay also meant that the not-so-competent agency staff were sent to the clinic. One interviewee said that working with agency staff was like having to work with new faces every day. There was apparent mistrust of agency staff's capabilities. Orientation of the agency staff was needed on a daily basis. ”...so every day of our lives we’re getting new staff on every shift what happens to you is that you orientate every night.” Emergencies were extremely stressful as agency staff did know what to do. The nursing staff had spoken to
management about this issue but no-one wanted to listen to them. "You are not alone as I am working with a staff nurse and I'll have to see that the responsibility lies with me. So you know it is disgusting to see the condition we're working in, it is not nice and I have been complaining for quite a long time." There was low commitment from agency staff. Permanent staff had to take the blame for things that agency staff did wrong.

Patient care was perceived as being compromised due to a lack of continuity of care. "we don't have a great deal of permanent members of staff. Agency staff cause a lot of the majority of problems... they don't have the loyalty which people working in the unit has... many a times the wrongs that they do reflect on the permanent nurses...someone also on night duty who doesn't know the unit, I mean it is a bit risky...patients don't have continuity... I think for a patient to build trust in someone you need to see the person often." Agency staff were not familiar with doctors idiosyncratic methods and regimes. Concern was voiced: the salaries offered by the clinic were not competitive and the two intensive care trained vacant posts on night duty that had been advertised since January 1996 were still vacant.

Cilliers (1991:22) noted that the most dissatisfaction was related to staffing, high amounts of stress in the intensive care, stress related to work and the high amount of responsibility in the intensive care unit. The participants of his study also remarked about the use of agency staff. Permanent staff members in the units he studied expressed mistrust about the capabilities of agency nurses as well as the concern that they did not know what to do in emergencies and that they were not au fait with the policies and doctors' ways of doing things. Chiriboga & Bailey (in Riegel & Ehrenreich,1989:295-318) noted that major findings, despite differences in sample size and methodology, were surprisingly similar. It appears that three categories of stressors affect intensive care nurses the most: interpersonal relationships (especially with regards to physicians), management of the unit (primarily staffing problems and workload), and direct patient care activities (e.g.
severity of the illness and the difficult or dying patient). This is also reflected by Marrelli (1993:25-26)

3.2.6. VISION (HOPE)
All the respondents expressed hope that the situation they were experiencing would improve and that management would start “looking after” them.

3.3. PATTERNS OF INTERACTION
Here a discussion will follow on how the nurses interacted with both their internal and external environments. The patterns of interaction are based on the themes that were generated in the discussion of the findings. The patterns of interaction as they are theoretically reflected in NWPT (1990) are the unique ways in which the nurses interact with their internal and external environments. These patterns of interaction reflect the barriers to their feeling comfortable in the working environment. As one reads through these patterns it becomes clear how many themes are interrelated, this also serves to reflect the integrated complexity and multi-dimensionality of studying a wholistic being.

1. Feelings of helplessness and insecurity due to the lack of managerial support and communication.
2. Job dissatisfaction due to the lack of adequate and fair remuneration, shortage of staff, lack of collaborative doctors, impaired communication with management and racist attitudes of members in the health team.
3. Emotional discomfort (anger, hurt, frustration, bitterness, alienation, disgust) related to discriminatory attitudes and behaviour by management, colleagues, doctors, relatives and patients.
4. Interpersonal conflict due to lack of ethical conduct of doctors: not seeing their patients on a daily basis, nurses having to lie for doctors.
5. Self fulfilment relating to the commitment of nurses to their patients, related to feelings of competence that they are doing a good job here.
6. Decisional conflict: where doctors behave irresponsibly there is no place to report this due to the lack of managerial support and the fact that nurses' decisions carry very little, if no authority, at all. Cognitive dissonance is also present whereby the nursing staff are experiencing less than desirable working conditions, yet continue working there because it is conveniently close to their homes.

7. Lack of personal and professional esteem and recognition due to the lack of professional acknowledgement of nurses in the work organisation based on the disregard of the professional status of the nurses as well as disregard for their staff developmental and career advancement needs.

8. Altered responsibility (job reorganisation) due the inaccessibility of doctors in times of crisis, as well as the continued shortage of staff, the lack of unit-orientated agency staff, the "above the law" attitude of unionised domestic staff, inept equipment and interdepartmental insufficiency pertaining to unavailability of stock.

9. Depersonalisation of staff due to the non-conducive physical layout of the unit, which causes a lack of privacy, as well as insecurity to applying the correct infection control procedures.

10. Hope and vision (spirituality) that conditions relating to their non-conducive working environment will change for the better. Staff are showing some perseverance by "sticking it out". "...time will tell and things will change, and people will tell themselves and say to themselves, oh, these African hands have brought me back to life..."

In chapter 4 the themes will be discussed and used as the basis for logic inference. Thus the themes will serve as point of reference to discuss and describe the guidelines.

3.4. FIELD NOTES.

The field notes will be described according to the chronological progression of the study.
3.4.1. Setting up appointments.

The researcher experienced problems with co-ordinating the timetables of the independent interviewer and the staff in the unit. The major problem was to ensure that the staff allocated for the sessions were on duty on the appropriate pre-organised dates. The researcher and independent interviewer had to change the date of one session and therefore the interviews were done in a period of two weeks, instead of one. The independent interviewer was late for sessions on the second venue due to traffic problems.

3.4.2. The interviews.

All the interviewees were keen to talk about their experiences but were slightly apprehensive as the independent research interviewer was only introduced to them on the day of their interviews. The researcher however invested some time in explaining to the interviewees what the procedure will be. Annexure 1 was given to each interviewee for her own records and contained informed consent. All the interviewees signed a written consent in their own names and surnames which the researcher interpreted as confidently wanting to partake in the study.

The independent interviewer was well received, liked and admired for her professional status and warmth. One of the interviewees who wishes to study further received the independent interviewer's business card and could not stop bragging about the fact that this black professional nurse was a D.Cur. candidate. The independent interviewer suddenly had celebrity status and was much admired and respected as a positive role model for the interviewees. After all the interviews had been conducted the feedback I received from the staff was that it was a positive experience and that they had felt better since they got a few things off their chests.
The interviews were taped, but no back-up tapes were made although two tape recorders had been present for that purpose. The transcriptions were made by an independent Afrikaans-speaking person and this accounted for the lack of precise punctuation and meaning in some of the transcripts. The person communicated to the researcher that all the responses were not always audible. It was thus time-consuming for both the researcher and the independent interviewer/coder to listen to the tapes for accuracy and trustworthiness.

3.4.3. Data Analysis.

The venue for holding a consensus discussion was also difficult to plan with the independent coder due to time considerations and work responsibilities of both the researcher and the independent coder. The consensus discussion was conclusive for both parties and virtually no dissimilarities featured.

3.4.4. Personal feelings of the researcher.

The researcher felt slightly exposed as to her competence as a unit manager. Yet insight into the raw data answered a lot of nagging questions and the reasons for staff behaving in a certain interpersonal way became clear. It has made the researcher become more of a listener, supporter and encourager in her approach to try and establish team work. Insight into the history of the unit made the researcher more sensitive in her approach to issues the staff had felt strongly about. This also explains the empathetic narrative in some parts of the study. Another reason for the empathy was that the researcher had been exposed to the same working environment and at times had experienced similar discomforts.
In this chapter a discussion of the research findings was presented. The themes were reflected within The Nursing the Whole Patient Theory. The guidelines based on these themes will be discussed in Chapter 4. In conclusion, the patterns of interaction reflect the professional and personal work status of the intensive care nurses.
CHAPTER 4

GUIDELINES, PRACTICAL PROBLEMS ENCOUNTERED, CONCLUSIONS AND RECOMMENDATIONS.

4.1. INTRODUCTION

In Chapter 3 the findings were discussed and compared with relevant literature.

In this chapter, guidelines will be formulated to support the registered nurses nursing in the general adult intensive care unit. The practical problems encountered during the conduct and execution of the study will be described. Last, but not least, conclusions and recommendations will be presented.

4.2. GUIDELINES TO SUPPORT THE REGISTERED NURSES NURSING IN THE ADULT INTENSIVE CARE UNIT.

The results of this study show that the registered nurses working in the general adult intensive care unit require support from the formal health-care delivery system. For the purpose of the study the employer is seen as representative of the formal health-care delivery system regarding issues related to the working environment of nurses. The registered nurses in the intensive care also have nursing rights that have been elaborated on by Nel (1993:181). These rights also afford an inherent responsibility: e.g. if it is the nurse’s right that she must negotiate with her employer for progressive education programmes in her field of specialty so it is the employer’s responsibility to provide scope for staff developmental programmes.

It is also the employer’s right to expect that the nurses employed are professionally competent and licensed. In this regard it is then the nurses’
responsibility to ensure that they adhere to the required standards and communicate their educational/ training needs.

The findings discussed in chapter 3 indicated that work related spiritual and emotional distress was experienced by the registered nurses nursing in the intensive care unit. The major themes that emerged were impaired communication between management and the nurses, racial discrimination in the workplace, lack of professional recognition of nurses via lack of equitable and competitive remuneration and insensitivity to their professional needs, a depersonalised physical environment and an emotionally and spiritually stressful working environment.

The guidelines drawn up are based on Copi's (1962:381-386) criteria for ensuring logic which are: relevance, testability, compatibility with previously well established theoretical statements, simplicity and explanatory power. Thus if chapter 3 revealed that there is a lack of communication between the nurses and management it is only logic to infer that strategies to improve communication between management and the nurses would be a relevant guideline. Furthermore there are relevant scientific literature on the aforementioned strategy which contain references to similar studies, testable strategies and a theoretic framework of communication. The relevant literature enhances the trustworthiness and explanatory power of the guidelines.

4.2.1. STRATEGIES

For issues to be attended to they have firstly to be heard (listened to) and then addressed (acted upon). These are the major interactional processes the researcher would like to propagate as the concerted responsibility of both the intensive care nurses and management. The strategies employed for the research will thus be of interactional nature and will aim to activate intensive care nurses
into mobilizing resources in their working environment to promote, maintain and restore their work health as an integral part of health.

The processes of communication, perception and negotiation, and feedback are inherent characteristics of this approach.

In table 4.1. (Page 66) an overview of the rights and responsibilities of intensive care nurses in interaction with management is presented, based on the themes that were discussed in chapter 3. In the working environment of the nurse there is a reciprocal interdependency between the management and the intensive care nurses. They are co-responsible for the corporate climate of the organisation.

4.2.1.1 IMPROVING COMMUNICATION BETWEEN INTENSIVE CARE NURSES AND MANAGEMENT.

(i) Promote a supportive communication climate.

It remains the intensive care nurses' responsibility to communicate their needs and problems to the clinic management. Nurses also have the right to expect that they will receive feedback, guidance, support and empathy from management. Management has the right to expect that intensive care nurses deliver high standards of nursing care and practice a work ethic. To build trust both parties must actively be involved in the processes of effective communication. The effective application of constructive communication patterns will ensure that a defensive climate is eliminated (Booyens, 1995:262). By contrast, the supportive communication climate nurtures acknowledgement of the ideas of many individuals and encourages employees to ask questions and solve the problems. Every employee is free to talk to managers at any level of the organisation without fear of retribution. Opportunities for this are planned
TABLE 4.1 - OVERVIEW OF STRATEGIES

Responsibilities

ICU STAFF

- autonomy
- participation
- problem-solving
- build trust, support, empathy
- use effective advocacy: leadership in nursing
- use correct channels, take action via grievance procedure, no timely feedback

- autonomy
- self actualisation (wholeness) (personal & professional)
- partake in formulatory policy
- partake in affirmative action / changing the climate of the workplace
- use DENOSA: unify our efforts, representation in workplace forums

- autonomy
- professional conduct / status
- nurturance of professional growth - continued education
- ethical conduct
- knowledge
- authority & responsibility
- educate other health professionals about nursing (nurse consciousness)
- form alliances
- self appraisal, worth, acceptance
- reward professional conduct
- acquire power, effort
- recognition systems

- collaborative relationships
- define scope of practice
- health ethics
- assertiveness training
- conflict management
- stress management
- develop healthy systems
- be relevant to large organisations
- efficient utilisation of resources

- make use of systems for relaxation
- facilities provided by company to improve physical environment

COMMUNICATE

Responsibilities

MANAGEMENT

- have faith in employees, encourage independent decision-making
- honesty, fairness
- feedback
- guidance
- support, empathy, trust
- respect of individual employees
- leadership through relationships
- career advancement ladder

- formulating policy that condemns any kind of racism
- supporting / intervening in staff racial matters
- affirmative action policy
- support group (representatives)

- adequate and fair remuneration
- recruitment systems
- standardising remuneration
- competitive salary
- staff development (educational)

- to intervene in unacceptable behaviours
- discipline & counseling
- to encourage collaborative relationships
- define roles within the organisation
- provide counseling for stress and conflict management
- respect scope of practice

- provide safe working environment
- provide facilities
- encourage inter-departmental collaboration
and communicated to all staff members. There is a spontaneous atmosphere in the organisation and experimentation is encouraged. Management by objectives is usually practiced: the employee sets the objectives to be attained with the help of the supervisor (Booyens, 1995:263).

(ii) Employ methods of formal communication in the workplace. Pertaining to lack of feedback: the grievance procedure can be used by employees in which policy states that feedback either verbal or written must be made available within five working days. It is a step-by-step procedure that ensures that someone at management level has to attend to a certain matter. Management should practice disciplinary procedures consistently and fairly and procedural policies must be in order in the workplace. These policies should be formal communication strategies to prevent insecurity and ignorance regarding work-related issues by both management and the intensive care nurses (Booyens, 1995:263). Nurses should use a formal communication tool such as incident reports to strengthen their formal concerns in the workplace e.g. being ill-treated by doctors.

(iii) Promote leadership in nursing. Nurses should actively promote leadership in nursing so that their leaders can actively communicate their rights and professional needs to management and other health team members. These can be integrated into formal staff policies, and formal meetings with other health team members. The difference between management and leadership is that management relies on systems while leaders tend to rely on people (Booyens, 1995:403). Leaders in nursing can practice nurse-care and build trust, engineer support and use effective advocacy for staff in obtaining work-oriented goals.

(iv) Promote problem-solving and decision making in nursing.
Nurses should actively participate in problem-solving and in obtaining the professional goal of autonomy (Booyens, 1995:507). These provide scope for nurses to take up relevant positions in the organisational structure.

(v) Revise existing remuneration, career advancement and staff development systems.
Management should revise existing remuneration, career advancement and staff development systems. This can only be done with input from the intensive care nurses in collaboration with management and head office.

4.2.1.2. ELIMINATE DISCRIMINATION AND RACISM IN THE WORK PLACE.

(i) Improve self-awareness skills of nurses.
To minimize the intrusion of unacknowledged biases when attempting to understand and appreciate someone else, cross-culturally competent health-care personnel have to learn to know themselves well. Clarifying values are seen as a required prerequisite and crucial to having an accepting attitude towards others (Kavanagh & Kennedy, 1992:82). To combat the effect of racism in the work-place the intensive care nurses should be personally and professionally self-actualised.

(ii) Promote sensitivity and awareness by management of incidences of social injustice.
The grievance procedure can be utilised for this goal. Intensive care nurses should actively partake in the formulation of policy regarding this matter. The nurses should empower themselves within the boundaries of affirmative action. Management should intervene where matters cannot resolved with the normal application of conflict management and disciplinary hearings should be made
use of to formally reprimand intentional transgressors. Management is obliged to adhere to the prerequisites set by the government's plans and policies to promote affirmative action in the workplace. The process of collective bargaining through the use of workplace forums can be used to address these matters (Bezuidenhout, in Booyens, 1995:644-676). A prerequisite here is that nurses belong to a unified representative body e.g. such as DENOSA.

(iii) Promote sensitivity and awareness of social injustice by all the health team members.

Nurses should informally support each other. Nursing staff should organise a support group to provide group participants an opportunity to share experiences, discuss common problems and express emotional distress and reduce their feelings of helplessness and victimisation. Nurses should work at educating other health team members about their mission and be change agents in changing the corporate culture to a more culturally diverse tolerant one (Kavanagh & Kennedy, 1992: 36-48).

4.2.1.3 IMPROVE THE PROFESSIONAL STATUS OF THE INTENSIVE CARE NURSES.

Feelings of professional worth by the intensive care nurses can be enhanced if management would redress their current systems of remuneration, recruitment and staff development.

(i) Improve systems of remuneration for intensive care nurses.

A competitive salary was desired by all the participants in this study. It appears that there is a need for standardisation of remuneration without sacrificing competitive salaries. Special attention to the following factors should be given
when a remuneration package is negotiated: years of experience, years of service, education, allowances (charge allowances, shift allowances and unit allowances) and career advancement ladders. Fair labour practices should be employed (Booyens, 1995:671).

(ii) Develop systems of staff development.
This means that the intensive care nurses are to be granted as much autonomy in their work as possible. The work should be made stimulating and interesting by involving the nurses in the planning phases of projects, tasks should be delegated in their entirety. These tasks must require a number of skills. The nurses should be supplied with the necessary information and management perspectives to obtain their work objectives in order for them to recognise their value and position in the workplace. Formal education programmes should be made available. A formal plan for strategic and relevant in-service training should be provided (Booyens, 1995:672).

(iii) Nursing staff should empower each other.
Nurses should motivate and nurture each other to promote their professional growth through continued education and professional conduct. Ethical conduct should be a shared philosophy and mission. Nurses should actively partake in organising and managing their professional organisations and become politically active and influence policy and legislation on health care issues and the organisation of the profession. Nurses should promote nurse-consciousness amongst themselves and other health-care professionals. Nurses should promote the development of recognition systems within nursing and reward each other's professional conduct. Nurses should actively practice self-talk on issues like professional worth, self-appraisal and self-acceptance. Nurses should form helpful and powerful alliances with other health team members and relevant educational, financial and legislative organisations. Only nurses can promote the
quality of nurses within the nursing profession and only nurses can truly advocate nurse-care (Dean in Muff, 1982:323-327).

4.1.2.4. IMPROVE COLLABORATION AMONGST HEALTH TEAM MEMBERS.

(i) Establish collaborative relationships in the workplace.
Collaborative relationships can be established by teaching communication and interpersonal skills to nurses and other health team members such as assertiveness training, conflict management, stress management (Poggenpoel, 1994:54).

(ii) Define roles within the organisation.
Ethical conduct of all health team members is to be respected and facilitated at all times. The absence of ethical conduct leaves the management open to legislative liabilities. Nurses should communicate their scope of practice to management and other health team members and it should be respected by all.

(iii) Employ adequately trained ratios of permanent staff.
To improve team-building a team has to be established. More permanent staff are required to create a more predictable working environment. This will also allow for the fair distribution of workload and responsibilities (Booyens, 1995:202).

4.1.2.5. PROVIDE A PERSONALISED PHYSICAL ENVIRONMENT

Management remains responsible for providing a safe working environment and providing facilities within which intensive care nurses can achieve their working goals. Intensive care nurses do not only need privacy and respect in the
Areas that needed addressing (as evidenced by the emergence of saturated themes in Chapter 3) were: Communication between management and intensive care nurses regarding the rights and responsibilities of both parties engaged in communication with regard to special issues like: collaboration with doctors, remuneration and career advancement of intensive care nursing staff, development of nursing staff, support generated by the nursing services manager, the formulation of policies exterminating discrimination in the workplace and measures to provide a safe working environment.

The purpose of this study is two-fold: Firstly the exploration and description of the experiences of registered nurses in nursing in the adult intensive care unit, and, secondly to describe guidelines to support the intensive care nurse in mobilising resources to promote, maintain and restore their work health as an integral part of health.

The central questions posed for this study are: Firstly, how do registered nurses nursing in the intensive care unit experience their working environment? Secondly, what guidelines can be developed to establish a support programme for these registered nurses in order to mobilise resources to promote, maintain and restore their work health as an integral part of health?

A qualitative, explorative, descriptive and contextual research was carried out to answer these questions. Phenomenological interviews were conducted with the registered nurses nursing in the adult intensive care unit.

The results of the phenomenological interviews and content of the field notes suggest both positive and negative experiences for the interviewees.
Positive experiences were that peer colleagues supported each other in difficult times and that these nurses were proud of their profession and their skills. These positive feelings are negatively affected by their perception of lack of recognition and professional worth in their working environment.

Based on these results, guidelines were developed for the registered nurses in the adult intensive care unit to support them in mobilising resources to promote, maintain and restore their work health as integral part of health.

It can, therefore, be concluded that the research questions have been answered and thus the objectives of this study achieved. The central statement of the study has also been supported.

4.4. PRACTICAL PROBLEMS ENCOUNTERED

The following practical problems which could have led to limitations were encountered: The researcher obtained the services of an external research interviewer. It can be said that the researcher was therefore dependent on the research interviewer for the keeping of field notes during the interviews. Very little field note information was generated by the independent interviewer. The researcher was present before and after the interviews had been concluded and all the interviewees had expressed the interviewing as a positive experience. Yet, the use of the independent interviewer was of practical benefit: this method eliminated researcher bias as well as the authoritarian relationship the researcher has to the interviewees.
Trying to co-ordinate the schedules of the researcher, the interviewees and the independent coder was difficult although everybody participating had been very enthusiastic. This resulted in sessions for interviewing being postponed over a period of two weeks.

The back-up tapes were not taken by the independent research interviewer. Fortunately the same person was employed to do the independent coding. The transcriptions were done by an independent person who is Afrikaans speaking and some meaning and punctuation was lost through this. This also meant that the independent coder had to spend a lot of time listening to the tapes to fill in the informational gaps. In view of this it was a positive aspect that the independent research interviewer and the independent coder were one and the same person.

One of the research interviewees had only recently joined the unit and her experiences were markedly different to the other four. Perhaps the selection criteria of a registered nurse working in the unit for two months had been too short.

A limitation was that there were only five registered nurses in the unit who met the selection criteria. If the themes had not been saturated a focus discussion might have been necessary for further triangulation. Themes had been duly saturated and a focus group was therefore not necessary.

4.5 RECOMMENDATIONS

Recommendations will be made based on the findings of the study. These findings can be applied in the following areas.
4.5.1. INTENSIVE CARE NURSING PRACTICE

The results of this study point to a need for following a holistic approach when supporting registered nurses in the practice of intensive care nursing. The fact that intensive care nurses have professional rights should be made. Intensive care nurses should be made intensive care nurse aware so that they can practice intensive care nurse care.

4.5.2. INTENSIVE CARE NURSING EDUCATION

The guidelines generated from the findings can be considered in designing in-service education programmes and curricula for the training of intensive care nurses at under- and post-graduate level. Intensive care nurse awareness programmes that promote nurse care should be developed and published in formal scientific journals.

4.5.3. NURSING RESEARCH

The description of methods used in this study included an audit trail to ensure that these can be used in other qualitative studies. This is important due to the fact that the methodology of this research does not make generalisation easy.

Further research should be conducted on intercultural dynamics in the workplace. Seeing that perceptions are heavily influenced by culture this can only shed light on communication of diverse cultures in the working environment. Very little information on intercultural dynamics among working peers in nursing was available in literature. This will also become more relevant when the direct impact of affirmative action in the workplace becomes unavoidable.
4.5.4. OTHER HEALTH-CARE PROFESSIONALS
It is anticipated that the findings and research details used in this study may be applied to other professional groups such as industrial counsellors, clinical psychologists, counsellors and therapists in the working environment. Hopefully doctors will also obtain insight into their professional behaviour and become aware of nurses rights and their practice.

4.5.4. POLICY-MAKERS
Affirmative action in the work place will be the social conscience of ignorance regarding work practices that ill-affect human rights. In theory it appears to be a road to industrial salvation for some idealists. It is important to place this process into perspective within the working environment and within nursing. The reality is that affirmative action practiced, based on the origin of emotional content, rather than economic content, can become a volatile grievance (Madi, 1993:119). More attention in hospital and staff policies will have to be given to these matters. In this study it became apparent how the intensive care nurses working at the clinic had been denied their professional rights. This has to be rectified and the researcher will communicate this to management and the hospital group at large.

4.6. CONCLUSION
In conclusion it can be said that the study has shown that registered nurses nursing in the intensive care unit are at risk of developing work-related illness. It is of utmost importance that intensive care nurses should be adamant about their responsibility in supporting each other so that in making intensive care nurses nurse-aware that they can promote, maintain and restore nurse-care.
BIBLIOGRAPHY


Carstenhof Clinic
MIDRAND

Dear Carstenhof Management

REQUEST TO DO RESEARCH AT YOUR CLINIC

I, Eloise Pope, a masters degree student at the Rand Afrikaans University, wishes to conduct a research study at your clinic in the Adult ICU. The research project is fully explained as per annexure A which is attached to this letter.

Thanking you

ELOISE POPE (MRS)
M. CUR. STUDENT

MARIE POGGENPOEL R.N., Ph.D
STUDY LEADER
PROFESSOR : NURSING SCIENCE
ATTENTION: MATRON J A HAYWARD
THIS DOCUMENT HAS 5 PAGES.

ANNEXURE 1

Eloise Pope
C/o Department of Nursing
Rand Afrikaans University

16 September 1996
Management &
The ICU nurses
The Adult Intensive Care Unit
CARSTENHOF HICNIC

Dear ICU nurse/manager/unit manager

Re: REQUEST FOR YOUR PERMISSION TO PARTAKE IN RESEARCH IN YOUR UNIT.

I am a Master's Degree student in general intensive care at the Rand Afrikaans University. It is required of me to conduct a research study to obtain a M.Cur degree. It is for this reason that I request your personal and professional permission to partake in my research project in your unit. The unit concerned will be the adult intensive care unit.

The title of the research is: THE EXPERIENCE OF ICU NURSES IN NURSING IN THE ADULT ICU.

This study will be conducted in two phases. The purpose of the study is twofold. PHASE 1: Firstly to explore and describe ICU nurses experience of nursing in the Adult ICU. PHASE 2: Secondly to describe guidelines for a support programme for ICU nurses based on the information obtained in phase 1.

The rationale for conducting this study is that nursing staff in your unit appear unmotivated and unsatisfied with the nursing conditions in your unit situation. I have noticed that the ICU nurses experience dis-ease whilst nursing in this unit. The researcher would like to know more about what is causing this dis-ease.

The ICU nurse is the major determinant in this situation - her qualities will influence the nursing outcome and per implication quality care nursing. If she is frustrated in her efforts to do so by the nursing situation, her experience of the nursing situation is definitely worth looking in to. Very little is known of how the ICU nurses experience nursing in the adult ICU (AICU) hence the exploratory and descriptive nature of the research.

Selection criteria is that participation will be voluntary and the interviewees must be registered nurses working in the AICU for at least 2 months. One central question will be asked of you: HOW DO YOU EXPERIENCE NURSING IN THE ADULT ICU? All you have to do is then to share your experience in totality. ALL interviewees will receive informed consent.

Ethical standards will be adhered to at all times. This will also be ensured by the study leaders of this project who are the supervisors of the research. Audio tapes will be made of these interviews as they will be transcribed by the researcher. Anonymity and confidentiality will be ensured. Anonymity by only giving the transcriptions of the interviews to the independent coder (the person who will analyse the transcriptions for themes) and supervisors. Confidentiality by all the supervisors, the researcher self and the independent coder will be ensured by a confidentiality note: thus a clause inserted on the informed consent signed by all concerned. All the interviewees (you) will keep a copy of informed consent for their own records.
Interviews will be conducted over a two month period. This includes the follow-up interviews. These follow-up interviews are interviews in which I ask you if the information I obtained and interpreted in the initial interview are a truthful representation of what was meant by you. I cannot stress enough that participation is voluntary and that you retain the right to withdraw at any time.

Duration of the interviews will not be longer than 45-60 minutes. After the information has been gathered the tapes will be disposed of. Interviews will be conducted until a saturation of themes is obtained. Interviews will be conducted in the boardroom. Individual times will be scheduled.

Benefits for partaking in this research is catharsis of feelings. As it is a benefit it can be a risky situation if emotions are encouraged to surface that the interviewee might struggle with. Referrals for professional help will be made as alternative arrangement for those who might need it. Long term benefit will be established by obtaining knowledge of how to support ICU nurses in nursing in the AICU thereby improving the registered nurses' professional and personal wholeness.

The identity of all the researcher-helpers and supervisors will be made available to the interviewees. A contact number will be incorporated into the informed consent format.

ALL publications that might grow from this research will be discussed with participants and a publication clause will also be incorporated into the informed consent letter.

A copy of the final printed research (corrected) will be made available to CARSTENHOF CLINIC.

IF there are any questions please phone me at 011-975-8267 home or cell: 082 414 4665. I can be contacted on the above cellular number and my work number will be 011-310-2300 ask for ICU. Another number will be my parents: 011-975-9172.

Thanking You

Eloise Pope (Lulu)

RAU student number: 84/1906/1
THE CONFIDENTIALITY NOTE

I hereby promise to protect the human rights of all the participants in this research. This includes the anonymity of all the participants. No moral judgement shall be passed on the information generated by the participants and ALL information will be treated with the utmost confidentiality. The Audio tapes will be wiped out and discarded as soon as all the information obtained has been transcribed and the research has been handed in for evaluation. I will strive to adhere to the conditions of ethical research standards.

THE RESEARCHER

NAME: ELOISE POPE

SIGNATURE: __________________________

DATE: __________________________

PLACE: __________________________

THE SUPERVISORS

DR ELZABE NEL (R.A.U.)

SIGNATURE: __________________________

DATE: __________________________

PLACE: __________________________

PROF. MARIE POGGENPOEL (R.A.U.)

SIGNATURE: __________________________

DATE: __________________________

PLACE: __________________________

THE INDEPENDANT CODER AND RESEARCH INTERVIEWER: SHEILA ZWANE (D.CUR. STUDENT)

SIGNATURE: __________________________

DATE: __________________________

PLACE: __________________________

RAU NURSING DEPARTMENT 011-489 - 2580 (TEL) 011- 489 - 2257 (FAX)
CONSENT OF PARTICIPATION

I, (name)__________________________ (first name only / optional)
hereby give my personal and professional consent to partake in the research project
titled: THE EXPERIENCE OF ICU NURSES NURSING IN THE ADULT ICU, as researched by
Eloise Pope at the Rand Afrikaans University.

I understand that the information will be treated with the utmost confidentiality and that my anonymity
will be protected.

I have read through the informational letter which explains the research purpose and selection
requirements short and long term benefits and understand that I have the right to withdraw at any time
without any fear of coercion or emotional blackmail.

I also give consent that the interviews are to be transcribed and that some texts will be published into a
narrative summary for academical publishing. I understand that this will be represented in the forms of
a mini-dissertation and an article for publishing.

I also understand that I have right to insight into all the proceedings of the research and that I can contact
the researcher about anything pertaining to the research.

I will try to share information as truthfully as personally possible.

SIGNATURE: ____________________________________________________________ (interviewee)

DATE: __________________________________________________________________

PLACE: __________________________________________________________________

Please retain one copy for your own purposes.
Dear Sheila,

Please follow the following steps to analyse the data of the transcribed interviews.

Tesch 1990 in Creswell (1994:155) will be used as method of choice for data analysis. After all the interviews have been transcribed a sense of the whole is obtained by reading through all the transcripts. Tesch recommends the following: Jot down ideas in the margin as they come to mind. Pick the most interesting interview and ask the following questions: what is it about? What is the underlying meaning? Write your thoughts in the margin. Complete this task for all the interviews and make a list of all the topics. Cluster similar topics together. Form these topics into 3 major columns e.g. major topics, unique topics and leftovers. Take this list and go back to your data and abbreviate the topics as codes. Write the codes next to the appropriate segments of text. Try this preliminary organizing scheme to see if any new categories and codes emerge. Find the most descriptive wording for your topics and turn them into categories. Reduce your total lists of categories by grouping topics that relate together. Draw lines to indicate interrelationships. Make a final decision on the abbreviation of each category. Alphabetize these codes. Assemble the data material belonging to one category in one place and perform a preliminary analysis. If necessary re-code your existing data. Always be on the lookout for unusual or useful quotes that can later be incorporated into the qualitative story. Major and minor themes can also be categorized and another list can then show contrasting themes.

Thank you,

Lulu.
INTERVIEW 1

R: How are you?

I: I'm fine thank you. I'm not going to use your name and I will not refer to you by name for the purpose of confidentiality and anonymity I will just refer to you as nurse I. I hope you don't mind referring to you as nurse I.

R: No.

I: Thank you very much. I will just request you to speak a little louder for the sake of the tape recorder. Nurse I, the purpose of uh this interview is just to find out from you how you experience working in the Intensive Care Unit in this hospital in your own words, your own storey, how do you experience working in this unit.

R: Should I say it like a uh......how do I like the doctors or management or how do you want me to say....

I: I'll just like you to tell me your storey. I wanted you to tell me your storey if you want to you can start with whatever. I want to know everything about nursing, whether it to be the management, whether be the colleagues, whether it be patients, any thing and in any order, you can tabulise it if you want to, it is your storey, and nobody else's storey.
R: I must say ICU here is a nice place to work and I enjoy it so much all this all this problems we are face with which unfortunately live with us that's how we work but I think hopefully they will fixed it. Number one about the management here we are really not happy when we got problems here they never come to help they would like you to tell them exactly what's your problem and all but you never get the feedback.

I: Is it now personal or work related problems would you like to tell me more...........

R: It is work related problems. I tell you that for instance like myself. They once put me in charge of that unit and I was going to be told after a few months if I am getting that post or not and I worked and after that time I've asked them am I getting the post or not they said they are trying somebody else again and during that time I wasn't getting any money for acting as in charge of that unit yet things were still going smooth, everything was fine and when we wanted to find out from the management after in the second person they didn't give her that job they decided to give it to a White person then they said to me won't you come back to tell us because we didn't know about this and they have lots of excuses they didn't tell us exactly what was happening but they're going to come back to tell us why we are not giving the post and I don't want the post anymore because of the way it was handled and up to now I still didn't get anything and I just wanted things to be done in the proper way and I felt they should have given us something because we kept that unit going never mind who was in charge because I'm sure they've got in their budget some money for the person who was in charge of the unit.

I: What this means in other words that as if you are acting as in charge of a unit does it means now a different rate as what you are presently doing and it affects uhm status and ..............

R: Yes. It is different because you are now responsible for what is going on in there. they phone you at home you've got to the doctors. everybody is talking to you. you must know what is going on. even if you are at home you are responsible because they phone you at home the sisters. and they said there is no staff you get to come back and we got nothing out of that all that we've got we've got a new White sister which we couldn't understand why and what was our problem nobody told us we are not good in this or whatever. I don't mind about myself because I don't want it anymore
but with the second person I don't think we all are so stupid that we all are in the position that we all like I don't know but then you can imagine if you experience that and then the next thing you have to work with that somebody the next time I mean I think she herself feel threatened about us in there as well as us too we feel who is she now what is she better off than us that they feel she can do better things than us you know such things and I think initially our White sister was felt threatened about us because we really had lots of fights I for instance had lots of fights with her and it is not like I say I don't want the post anymore but I think she was threatened because if you would ask her one thing she'll tell you about other things like are you say I go to an example I had a problem with off-duty and I said to her please I did request this one but she didn’t give me but no. she quoted that you always have problems with me if you don't want.............