RESEARCH REPORT

EXPERIENCES AND PRACTICES OF PROFESSIONAL NURSES CARING FOR TERMINALLY ILL CANCER PATIENTS IN PIETERSBURG PROVINCIAL HOSPITAL, CAPRICORN DISTRICT OF THE LIMPOPO PROVINCE

by

KGOSANA A.I

[redacted]

DISSERTATION

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SUPERVISOR: Ms PM Mamogobo

CO-SUPERVISOR: Prof.TM Mothiba

Declaration

"I, Androulla Isabella Kgosana, declare that the dissertation titled "**Experiences and practices of professional nurses caring for terminally ill cancer patients in Pietersburg provincial hospital, Capricorn district of the Limpopo province**" hereby submitted to the University of Limpopo for the degree of Master of Nursing has not previously been submitted by me for a degree at this or any other university or institution that it is my own work in design and in execution, and all material contained therein has been duly acknowledged."

Signed Kgosana ....

Date 20. 02. 2017 ....

Dedication

This study is dedicated to my beloved husband Peter; My son Tagishi and daughter Maishebe; my mother Matshidiso; my sisters Salome, Lehlogonolo and Mapule and my brothers Solly and Ndicca.

Acknowledgements

My acknowledgements are for the first and foremost to God the Father, God the Son and God the Holy Spirit who gave me the wisdom, courage and the strength to endure this study.

I would also like to extend my sincerest gratitude to the following people they deserve a special recognition.

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Abstract

Caring for terminally ill cancer patients is considered stressful and heartbreaking. Oncology nurses often consider leaving the nursing profession because of the high levels of stress experienced by these health care professionals.

The aim of this study was to investigate the experiences and the practices of nurses who care for terminally ill cancer patients in the Pietersburg Provincial Hospital in the Capricorn District of the Limpopo Province. The objectives of this study were to explore and describe the experiences and practices of nurses who care for terminally ill cancer patients and further to describe the relationship between certain demographic variables and nurses' experiences of death. An additional objective was to develop recommendations and strategies that might assist management of the Pietersburg Provincial Hospital with the development of appropriate skills and the implementation of emotional support that could assist nurses who care for dying cancer patients in the oncology wards.

The study followed a phenomenological, descriptive, exploratory and contextual research design, which assisted the researcher to describe and explore the experience and practices of nurses caring for terminally ill cancer patients. Semi-structured interview method was used to collect data, making use of an interview guide, was used because it is a more free-flowing approach, with its structure being limited only by focusing on the research. Field notes were captured during the data collection session by the researcher. A voice recorder was used to capture all the interview sessions. The initial data analysis started with the researcher listening to the recordings and transcribing verbatim all statements made by the participants. Tesch's open coding data analysis method was used by following the proposed eight steps to analyse qualitative data as outlined in Creswell (2013). Ethical standards as set in Babbie (2013) were adhered to by the researcher. The researcher requested permission to conduct the study from the Limpopo Department of Health Ethics Research Committee and informed consent was obtained from the participants before collecting data. Privacy of the participants was ensured as participants were never called by their names. In the study participants shared different views with respect to caring for dying cancer patients. Some participants regarded caring for cancer patients as stressful and heartbreaking. Other oncology nurses blamed the management for not providing them with courses to assist them with caring for dying cancer patient, nor providing debriefing sessions for them. On the other hand, some oncology nurses believed that relocating to other wards was a better solution. The participants suggested the following improvements for caring for dying cancer patients; oncology nurses should be offered short courses to assist them with the challenges that they come across with regard to caring for dying cancer patients. Oncology nurses need support from the management and colleagues in order to cope with the workload. Oncology nurses need psychological assistance to help them with the psychological stressors they experience. Family members and patients need health education on how to deal anticipatory grief.

Keywords

Professional nurse
Caring
Terminally ill
Patients

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ABBREVIATIONS

ACS- American Cancer Association.

AGS- American Genetic Society.

EU- European Union.

WHO- World Health Organization.

DEFINITION OF CONCEPTS

EXPERIENCE:

Experience means the past events, the knowledge and the feelings that make people's life or character or which have an effect on what they feel or think (Longman dictionary of contemporary English, 2003).

In this study experience means the knowledge and feelings that nurses have with regard to their daily activities in an oncology setting.

PROFESSIONAL NURSE

According to the Nursing Act, Act No. 33 of 2005, Section 30(1), a professional nurse is a person who is qualified and competent to independently practise comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice. In this study, a professional nurse refers to a nurse (general, psychiatric, and community) and midwife trained under Regulation No. R 425 and a general nurse trained under Regulation No. R 683 who is registered by the South African Nursing Council to provide nursing care to patients.

In the study a professional nurse means a person who went for a bridging course in nursing, who is accountable for his/her acts and omissions and provides direct care in an oncology setting, that is, in surgical ward, medical oncology and paediatric oncology in the Pietersburg Provincial Hospital.

TERMINAL ILLNESS

Terminal illness is a term for medical illness, popularised in the 20th century, to describe a disease that cannot be cured or adequately treated and that is reasonably expected to result in the death of the patient within a short period of time. (Longman dictionary of contemporary English, 2003)

In the study terminal illness is when a very ill cancer patient is no longer responding to treatment and the patient is gradually deteriorating and, as a result, and might die anytime.

CANCER

Cancer means any type of malignant growth or tumour, caused by abnormal and uncontrolled cell division: it may spread through the lymphatic system or blood stream to other parts of the body (Longman dictionary of contemporary English. (2003).

In the study cancer means a patient is diagnosed cancer affecting any part of the body which does not respond to treatment in a palliative setting.

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Cancer is one of leading causes of death and disability worldwide, according to the World Health Organisation (WHO) (2008), which reported statistics showing that cancer accounted for about 13% of all deaths reported worldwide. De Kock (2011) reported that the Cancer Association of South Africa estimates for 2008 suggested that up to 80 000 people in South Africa were reported to have died from cancer-related diseases in that year. In the past it was thought that cancer was commonly found in elderly people, predominantly from affluent countries. Recently the incidence of cancer is increasing in developing countries and the morbidity and mortality is anticipated to rise as people in developing countries adopt more of a western life style, which predisposes individuals to cancer (De Kock, 2011).

Nurses are health care workers who provide care to terminally ill cancer patients until they die, while doctors consult patients occasionally. According to an American Genetic Society (AGS) report in 2007, providing effective care at the end-of-life means a nurse should have a positive attitude towards the patient and provides emotional support to terminally ill cancer patients. Therefore, some patients regard this as a special moment in their lives where nurses provide care and are also expected to honour their patients' wishes by relieving the symptoms of the disease, while maximising their comfort (Sherman, Matzo, Pitorak, Fenell & Malby, 2005).

Caring is when a nurse shows care and compassion towards terminally ill cancer patients (Wengström and Ekedahl, 2006), which is very challenging for oncology nurses due to the complexity of the care required by patients with cancer (Kendall, 2007). Patients require physical, psychological and social care from these nurses. The impact of caring for patients with cancer, and their families, may prove to be overwhelming if support systems, particularly in the work environment, are not put in place and the nurses are not taken care of (Medland*,* Howard-Ruben & Whitaker, 2004). Nurses believe that their managers play an important role in ensuring care and in the facilitation of healing of patients by creating a healthy and caring management environment (Minnaar, 2003). Minnaar (2003) argues that human dignity of both patients and staff members must be considered when caring for caring for patients with cancer.

Nurses caring for terminally ill cancer patients experience challenges, despite aggressive efforts to reduce high death rates and extend the life of these patients (Frommelt, 2003). Caring for terminally ill cancer patients is, therefore, a complex issue, especially when caring for elderly patients. Because of their age; the elderly are predisposed to complications and this adds to the burden experienced by nurses, making it more difficult for nurses to care for their patients (Press, Thom & Kline, 2009). Furthermore, a nurse should be able to consistently adjust to the different needs of each patient with cancer and the needs of their families (Byock & Corbeil, 2003). The personality of the nurse is crucial when having to care for terminally ill cancer patients; because their personality is related to the comfort experienced by their patients. It therefore requires great skill and understanding on the part of nurses who care for terminally ill cancer patients (Roberta & Rolland, 2009).

The study was undertaken to determine the experiences and practices of nurses working in an oncology setting at the Pietersburg Provincial Hospital, caring for terminally ill cancer patients.

1.2. PROBLEM STATEMENT

The burden of cancer worldwide continues to grow, with an increasing number of new cases and deaths each year (Carlson & Bultz, 2003). In the surgical ward of the Pietersburg Provincial Hospital nurses appeared to experience challenges with clinical practice as they involve the families and friends in the care of dying patients diagnosed with cancer. Family members often become aggressive towards these nurses, while some of the nurses from medical oncology have stated that some of the family members of these patients believe that death is preventable if proper care is given to the patient. The aim of this research was, therefore, to determine the experiences and practices of nurses caring for terminally ill cancer patients working in an oncology setting at Pietersburg Provincial Hospital

1.3. PURPOSE OF THE STUDY

- **The aim of the study was to:**

- To determine the experience and practices of professional nurses caring for terminally ill cancer patients in the Pietersburg Provincial Hospital.

1.4. RESEARCH QUESTIONS

The following research question guided the researcher throughout the study:

What are the experience and practices of professional nurses who caring for terminally ill cancer patients at Pietersburg Provincial Hospital?

1.4.1 Objectives of the study were to:

- To describe the experiences and practices of nurses who care for terminally ill cancer patients in Pietersburg Provincial Hospital.
- To recommend strategies following Watson caring theory that might assist management of Pietersburg Provincial Hospital to provide professional, clinical, physical and emotional support that could enhance the practice and knowledge to nurses who care for terminally ill cancer patients in oncology wards.

1.5. THE THEORATICAL FRAMEWORK

A caring attitude is a skill and a positive attitude that nurses should have to be able to provide humane care to patients. Most people choose a career in nursing because they want to care for the sick. A nurse who demonstrates compassionate care of patients respects human dignity and has a positive attitude towards improving the quality of care that patients deserve to enhance their wellbeing. Caring takes place every time when a nurse comes into contact with a patient. Nurses believe that a good caring relationship with their patients contributes to the speedy recovery of their patients.

The researcher used Watson's theory in Watson (1979) which developed 10 carative factors that contributed to the development of a caring attitude by the nurse, which, in turn, indicates the internalisation of a humanistic value system as a caring attitude.

According to Watson's (1976) theory of caring, a nurse is someone who develops a caring heart from an early age and is able to enter into the patient's world. The oncology nurse should be able to instil hope into the patient. The art of caring is based on the development of a professional friendship between the patient and the nurse.

A nurse's role is important when dealing with terminally ill patients in reducing suffering and improving the quality of life of the patients and their families through the management of physical, social, psychological, spiritual and cultural needs. According to Watson's (1976) theory, the nurse provides a helping hand to ensure that the patient is provided with water, food and the comfort that the patient needs and to ensure that patients die with dignity.

1.6. OVERVIEW OF RESEARCH METHODOLOGY

A qualitative research method with a phenomenological approach was used in the study. The researcher used purposive sampling to select 15 nurses who met the inclusion criteria. The Pietersburg Provincial Hospital, a tertiary hospital complex, was selected as it the only provincial hospital with designated wards specifically for the provision of care to cancer patients. The hospital has designated oncology wards with professionals allocated to provide care to cancer patients. Additional health services include radiation services that provide chemotherapy treatment to outpatients and inpatients. Patients diagnosed with cancer within the Limpopo Province public health services are referred to Pietersburg Provincial Hospital for further clinical management. A semi structured interview with interview guide was used to obtain information from the study participants. Tech's open- coding method assisted the researcher in the analysis of data. Ethical clearance for the study was obtained from the Medunsa Research and Ethics Committee (MREC). Permission to access the hospital was obtained from the Limpopo Province Department of Health. Informed consent was obtained from the individual study participants. Detailed research methodology will be discussed in Chapter 3.

Trustworthiness of the research methodology was ensured through credibility, transferability, dependability and confirmability.

1.7 Conclusion

Chapter 1 provided an overview of the study. The purpose of the study was to describe the practices and experiences of nurses caring for terminally ill cancer patients.

Chapter 2 of the study discussed the literature review

Chapter 3 of the study discussed the research design and methodology

Chapter 4 of the study discussed the research results from the data, which was collected via a semi-structured interview session with professional nurses working in an oncology ward, caring for terminally ill cancer patients.

Chapter 5 of the study gave an account of the formation of a theoretical framework underpinned by Watson’s theory of caring.

Chapter 6 of the study deals with the conclusion, limitations of the study and recommendations

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 1 dealt with an overview of the study and included an introduction and background, preliminary literature review, problem statement and summary of the research methodology that was used.

This chapter presents the literature that has been reviewed in relation to the problem studied. A literature review is the culmination of a process of researching, reading, understanding and developing conclusions from the reading materials and sources about the problem studied (Brink, Van der Walt & Van Rensburg, 2012). The impotence of undertaking a literature review is to gather substantial information in relation to the problem studied to assist the researcher with the perspective and the context of the research project. The literature review made use of Google's scholar, journals, previous studies related to cancer and research books to develop the study on the experience and practices of nurses caring for terminally ill cancer patients.

Cancer is one of leading causes of death and disability worldwide, as reported by World Health Organization (WHO) in 2008, with statistics showing that cancer accounted for about 13% of all deaths reported worldwide. Cancer as compared to other diseases worldwide; Heart diseases 22%, cancer 21%, stroke 6%, Alzheimer's disease, unintended injuries 3,9 and other diseases 10% as reported by (National Vital Statistic Report, 2014). The Cancer Association of South Africa (2008), estimates that up to 80 000 people in South Africa were reported to have died from cancer-related diseases in that year. In the past it was thought that cancer was commonly found in elderly people, predominantly from affluent countries (de Kock, 2011). Recently according to de Kock (2011) the incidence of cancer has been found to be on the increase in developing countries and the morbidity and mortality is anticipated to rise as people in developing countries adopt more of western life style which predispose individual to cancer.

2.2 EXPERIENCES OF NURSES CARING FOR TERMINALLY ILL CANCER PATIENTS

Nurses who care for terminally ill cancer patients experience challenges, despite aggressive efforts to reduce the high death rate and to extend the lives of people living with cancer (Frommelt, 2003). Caring for terminally ill cancer patients is, therefore, a complex issue, especially when the patients are elderly. Because of their age; these patients are predisposed to complications and this adds to the burden experienced by nurses, making it more difficult for nurses to care for them (Press, Thom & Kline, 2009). Furthermore, a nurse should be able to consistently adjust to the different needs of each patient with cancer and to the needs of their families (Byock & Corbeil, 2003). The personality of the nurse is very crucial when caring for terminally ill cancer patients because their personality influences the level of comfort experienced by the patients. Therefore, it requires great skill and understanding on the part of nurses when caring for terminally ill cancer patients (Roberta & Rolland, 2009).

In South Africa, cancer seems to be the leading cause of death. According to Allchin (2006) some nurses reported that they see cancer as a death sentence, resulting in fear amongst oncology nurses. The fact that oncology nurses are emotionally involved with the care of patients who are dying, affects them on daily basis, to the extent that some of these nurses consider these patients as their relatives. The fact that oncology nurses view these patients as their own relatives assists them to care for oncology patients holistically, that is emotionally, psychologically and spiritually (Vassallo, 2001).

The care of dying patients is a challenge for newly appointed nurses in the early years of service (Roman, Sorribes & Ezquerro, 2001). Oncology nurses are exposed to the care of the dying on a daily basis. This experience often gives rise to anxiety and undesired attitudes that may have an impact on the quality of care provided to patients in an oncology setting (Peter, Payne, Connor, McDermott, Hood & Morphet, 2013). In support of the above statement, a study done by Richardson, (2002) found that nurses with a greater fear of death exhibit fewer positive attitudes towards caring for the dying patients. Contact with terminally ill patients is a strong predictor of a nurse's attitude towards those been cared for.

Demographic, experiential characteristics and previous education of nurses can shape and change the attitudes of nurses towards the care for dying patients (Khader, Jarrah & Alasad, 2010). In the study undertaken by Dunn, Otten and Stephens (2005) it was found that nurses with greater exposure to dying patients reported more positive attitudes. According to Feudnter, Santucci, Feinstein, Snyder, Rourke and Kang (2007), nurses with more years of nursing practice, more hours of palliative care and higher levels of hope were more comfortable to provide care to dying children and their families, had less difficulty talking about death and dying and showed increased levels of palliative care competency. The more exposure to death and dying, the more comfortable the nurses were and the less support nurses would need from the institution's management to cope with their daily work (Wiegel, Parker, Fanning, Reyna & Gasbarra, 2007)**.**

2.3 THE ROLE OF ONCOLOGY NURSES IN THE CARE OF TERMINALLY ILL CANCER PATIENTS.

Caring for terminally ill cancer patients and their families can be emotionally demanding and challenging for professional nurses. According to Birkholz, Clement, Cox and Gaume (2004), "death is a personal issue for each nurse, and each nurse's unique perspective can affect each patient who dies under the nurse's care." The International Council of Nurses stresses that the nurse's role is important when dealing with terminally ill patients in reducing suffering and improving the quality of life for patients and their families. This can be achieved through the management of their physical, social, psychological, spiritual and cultural needs. Nurses play an important role in developing a caring and supportive environment that acknowledges death, in order to help family members accept and deal with their grief and the loss of their loved ones (Birkholz et al., 2004).

Oncology nurses are always working hard to provide the best care to terminally ill cancer patients, they provide physical, psychological and social wellbeing (Vassallo, 2001). Patients seem to enjoy the good relationship they have with oncology nurses and the relationship seems to be recognised and valued by the patients and their families (Richardson, 2002). The art of caring in the nursing profession is based on the development of a professional friendship between the nurse, patients and family, encouraging them to be able to share love and hope during this difficult time (Wengstrom & Ekedahl, 2006).

2.4 THE NURSE- PATIENT RELATIONSHIP

Nurses working with cancer patients are expected to provide clinical care to dying patients at their end-of-life stage in the form of physical and emotional care for patients and their families, helping them to cope with the process of dying. Helft, Chamness, Terry and Ulrich, (2011) indicated in their study that professional ability, skills, experience, gender and age may contribute to the ability of nurses to cope positively when providing care to terminally ill patients diagnosed with cancer. It has been found that nurses prefer not to speak about imminent death to the relatives and friends of the dying patients. Some nurses hate giving bad news as they hate seeing relatives cry and because they feel that they have lost too (Helft et al., 2011). Nurses seem to be touched emotionally by individual patients due to the bond which develops during the caring period and this can be personally demanding on nurses. The nurses experience their own grief and sense of loss (Ramfelt, Severinsson & Lutzen, 2002).

Some nurses develop a feeling of success, depending on the relationship they have with each terminally ill cancer patient and this is related to their interest and their willingness to care for patients who are unable to do anything for themselves (Olthuis, Dekkers & Leget, 2006). Caring for a dying cancer patient involves the body, the mind, the emotion, culture and spirit, resulting in an interactive relationship between the patient and the nurse.

2.5 THE RELATIONSHIP BETWEEN NURSES AND PATIENT'S FAMILIES

Nurses are faced with challenges when caring for terminally ill cancer patients in relation to how they need to interact with the patient's family members. Some families believe that death is a preventable phenomenon and occurs due to failure on the part of professional nurses to take good care of their patients (Pavlish & Ceronsky, 2007). Nurses report that people need to be educated and culturally prepared to accept the death of their loved ones, because not accepting death as a natural process will leave both family and nurses affected emotionally, attitudinally or behaviourally, resulting in strained relationships. According to Cincootta (2004) reported that when family members realise that the cancer stage has advanced they become aggressive, become sad and depressed.

2.6 THE NURSE'S ATTITUDE IN THE ONCOLOGY ENVIRONMENT

In a study done by Lange, Thom and Kline (2008), age had a significant influence on the attitude of nurses towards death and dying. They found that younger registered nurses tended to report higher levels of fear than do their older and more experienced collegues (Barrere, Durkin & LaCoursier, 2008). Furthermore, Morita, Fujimoto, Fukumoto, and Itoh (2006) found that attitudes formed during difficult situations were associated with burnout and were also regarded as one of the endpoints of education interventions. Therefore, the experiences and practices of nurses caring for cancer patients could have significant health care consequences for these patients and their feelings relating to their comfort and hope with respect to their condition. Understanding nurses' experiences and practices in a specific context can help predict the quality of care that patients may receive.

Olthuis, Dekker and Leget (2006) compared the level of death anxiety between nurses working in an accident and emergency department and nurses working in a hospice. The study found that nurses working in an accident and emergency department were more comfortable in this environment than in an environment involving the care of terminally ill or dying cancer patients. Furthermore, these nurses view a patient's death as a failure. The authors concluded that nurses working in accident and emergency departments should have minimum contact with caring of terminally ill or dying cancer patients.

Nurses are normal human beings like any other person and, like other people, they differ in terms of their value and belief systems. According to Ghavamzadeh and Bahar (1997) the majority of nurses seem to view death as a natural part of life. Nurses who accept death as a natural part of life seem to have a more positive attitude towards caring for dying cancer patients and these patients receive the best care.

2.7 PROVISION OF SUPPORT TO THE NURSES IN AN ONCOLOGY SETTING.

According to a study done by Ablett and Jones (2007), caring for terminally ill cancer patients is considered to be very stressful because there are factors that affect nurses emotionally and spiritually. Some of the nurses carry a huge emotional burden at the end of the shift because of the suffering that their patients go through. It is very important that oncology nurses are looked after and that coping strategies are implemented to mitigate the emotional impact that caring for dying cancer patients has on them (Ablett & Jones, 2007).

A study conducted in Iran by Nikbakht Nasrababadi and Emami (2006), reported that patients received poor nursing care in an oncology environment due to a shortage of nursing staff. Oncology nurses were being overworked because most of the nurses prefer to be transferred to other areas of practice (Nikbakht Nasrababadi & Emami, 2006). Minnaar (2003) found that oncology nurses leave the field because they do not feel valued by the management and their concerns were not being taken into consideration by the nursing managers.

According to Nikbakht Nasrabadi, Emami and Parsa (2003), cancer is still one of the leading causes of death and coping with oncology care is developing with time for nurses. End-of-life care is a major problem in Iran where, according to Sedigheh, Helen, Abbas (2007), a lack of education in the clinical or academic areas is related to the level of care for terminally ill cancer patients. Lack of education and experience, cultural and professional limitations all contribute to attitudes among nurses towards caring for terminally ill cancer patients (Iranmanesh, Abaszadeh & Darrgahi, 2008). Nurses need management to provide them with short courses related to cancer to help them cope better in an oncology environment.

On the other hand, the attitudes of nurses towards caring for the dying seem to be influenced by a lack of education and clinical exposure. Dunn et al (2005) believe that more education and or more experience (Wessel & Rutledge, 2005) leads to less anxiety among oncology nurses. According to Minnaar (2001), oncology nurses want to be supported in as many ways as possible, according to their different needs – such as the environment, interpersonal relationships, development and growth, physiological and social needs, the need to self-actualisation and problem solving.

2.8 THEORETICAL FRAMEWORK

Watson's theory of caring was used as a framework for the study as the basis for the development of caring strategies for nurses when caring for terminally ill cancer patients.

2.8.1 INTRODUCTION

Nurses play an important role in developing a caring and supportive environment that acknowledges death, in order to help family members to accept and deal with loss and grief (Birkholz et al, 2004).According to Watson's (1996) theory, a caring attitude is a skill and a positive attitude that nurses should acquire in order to be able to provide humane care to their patients. Most people choose a nursing career because they want to care for the sick. A nurse who demonstrates compassionate care towards patients has respect for human dignity and has a positive attitude towards improving the quality of care patients, deserves to enhance their wellbeing. Caring takes place every time a nurse is in contact with the patient. Nurses believe that a good caring relationship with their patients contributes to the speedy recovery of their patients. (Watson, 1996)

Watson’s theory proposed 10 carative factors which contribute to the development of a caring attitude by nurses, indicating a humanistic value system which has been internalised by these nurses as a caring attitude, outlined as follows.

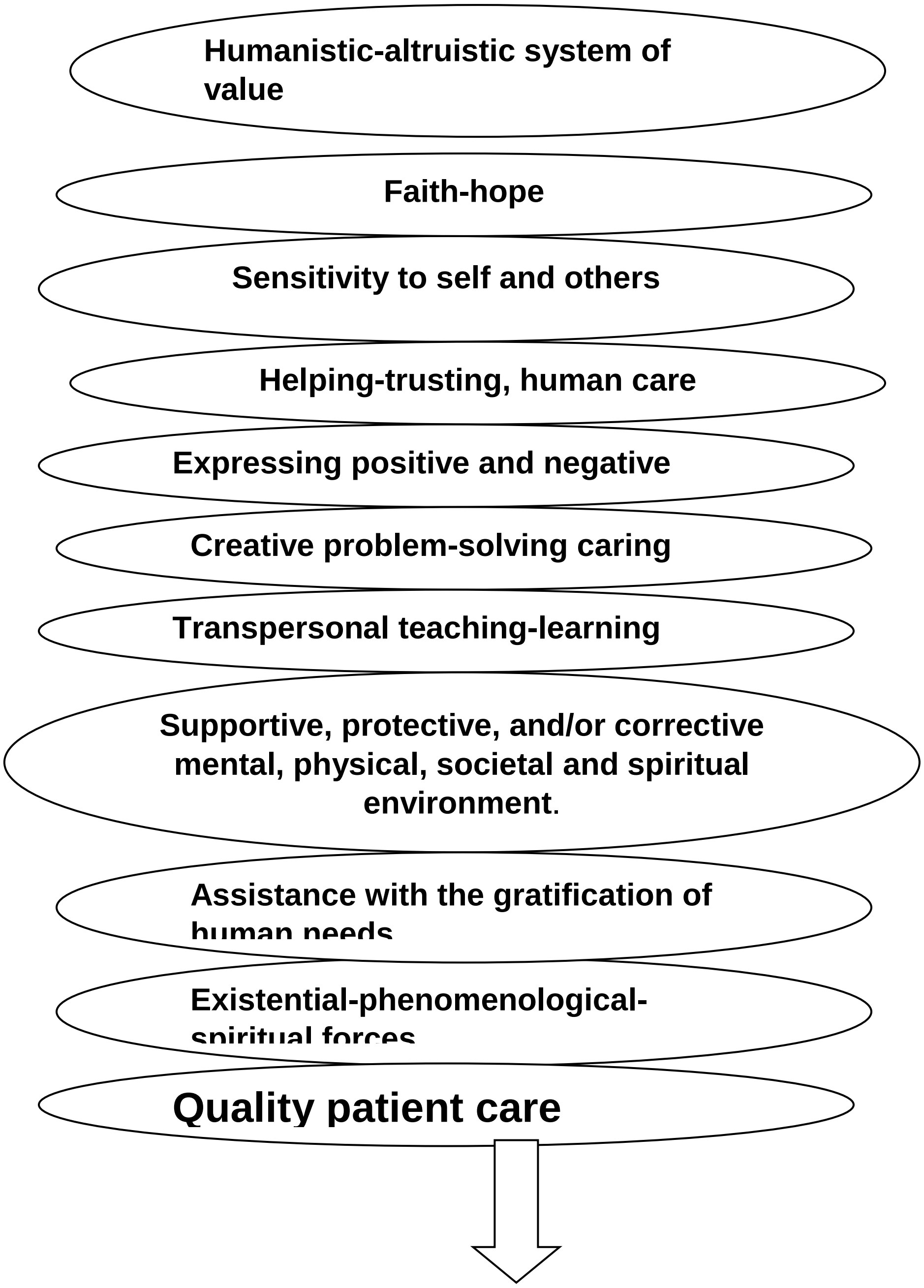


FIGURE 2.1 WATSON’S THEORY DEVELOPED 10 CURATIVE FACTORS

(Adapted from Watson & Woodward, 2010)

2.9.1. **Humanistic-altruistic system of values**. The value of humanity is learned at an early age. It is a value shared with parents when grooming their child or humanity can be mediated through one's own life experience. In this value the oncology nurse has the ability to enter into the world of the patient and let patients get to know the nurse as a caring individual. Humanity can be expressed by oncology nurses who are able to love, respect and to value the patients that they are taking care of (Meleis, 2012).

2.9.2. **Faith-hope**. Commitment is the best ingredient of caring. When nurses have hope they live in a world full of possibilities and they will commit themselves to their work. Hope is guided by their commitment to their patients. The more nurses are committed to their work, the more hope patients gain from care provided by these nurses. Patients are scared of their imminent death; they need nurses to make them feel physically better and to instil in them a hope that they will pull through the pain they experience. Therefore, this will help them to become physically and emotionally well. (Mok & Chiu, 2004).

2.9.3. **Sensitivity to self and others**. According to this carative factor of Watson's theory, a nurse is the individual who cares for the patients and the patients need the nurse to assist them to pursue their daily activities, e.g. taking medication, bed bathing, linen changing and so forth. The two are interrelated because action takes place based on their interrelationship. It is the category of behaviour where one needs to know who he/she is in order to have a sense of unity with others (Parker & Smith, 2010).

2.9.4. **Helping-trusting, human care relationship**. Nurses provide a helping hand because they bath and feed their patients. Cancer patients suffer from extensive pain so they need nurses who care for them, insuring a pain free death. The most important characteristic of this curative relationship developing a good nurse-patient relationship and empathy, giving patients the warmth they need for their wellbeing. (Olthuis & Dekkers, 2003)

2.9.5. **Expressing positive and negative feelings**. Watson (1979) outlines the fact that expressing positive and negative feelings assists in improving one’s level of awareness because every behaviour has a meaning. According Breggin (2008), ignoring odd behaviour is virtually the same as ignoring the person. Taking odd behaviour seriously shows an interest and concern for the person.

2.9.6. **Creative problem-solving caring process**. This is the type of carative aspect were a nurses looks for factors contributing to their patients’ ability to deal with stressful moments in their lives, how to set their goals, how to come up with problem solving techniques and now to be able to evaluate the effectiveness of the skills used (Sherman, 2013;Sitzman, & Eichelberger, 2011). It is important to observe the way in which a person deals with a stressful situation. If a patient is not coping, the nurses need to initiate goal-setting to improve the situation; evaluations should be made to see whether therapy is helpful for the condition or not. In the event that steps taken are not effective, referral to other relevant health professionals should be the next step (Weigel, Parker, Fanning, Rayna & Gasbarra, 2007).

2.9.7. **Transpersonal teaching-learning**. Nursing is a caring relationship-based practice. Nurses connect and embrace with the spirit or soul of terminally ill cancer patients through the process of caring (Watson, 1979).

2.9.8. **Supportive, protective, and/or corrective mental, physical, societal and spiritual environment**. Onset of illness and loss of a loved one can arouse a sense of threat in the patients and their families. A caring nurse must be able to care and support the patient as well as the family members during this difficult time. This can be achieved when the hospice nurse takes care of the dying patient to ease his/her journey and, because nurses are socialised to be caretakers, they are supposed to be able to handle human feelings and complex human situations (Kelley & Christensen, 2012).

2.9.9. **Assistance with the gratification of human needs**. This is grounded in a hierarchy of needs similar to that of Maslow. Oncology nurses need to ensure that the hierarchy of needs of patients has been attended to. Nurses ensure that physiological needs, safety needs, belonging needs, recognition needs and self-actualisation needs are taken care of, ensuring that patients die with dignity.(Berg & Danielson, 2007)

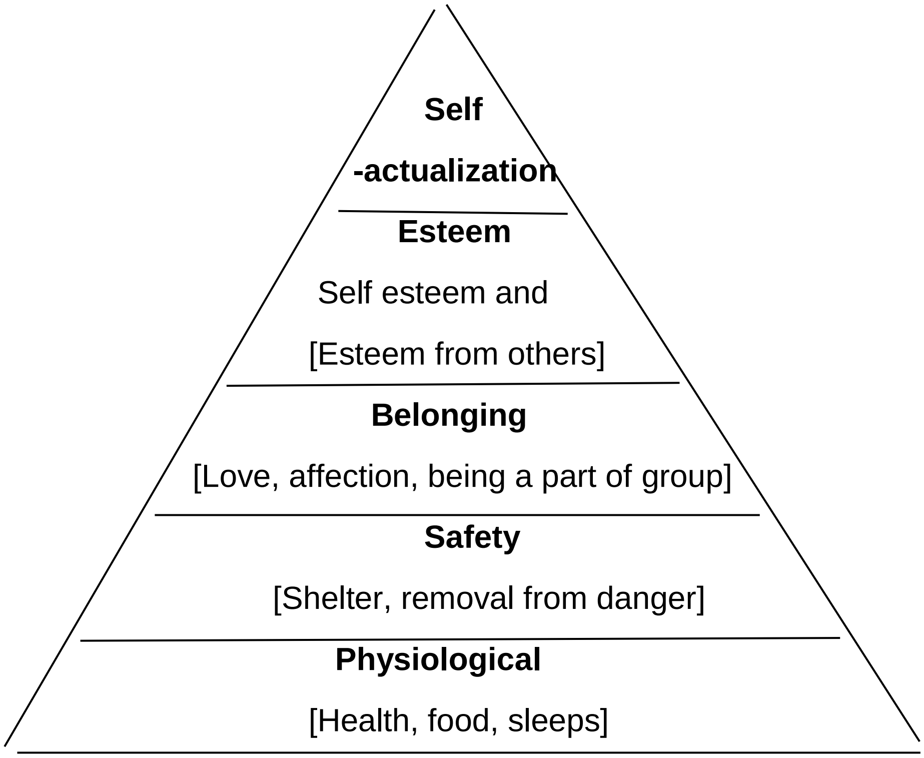


Figure 2.3 Hierarchy of needs according to Maslow (Adapted from Huitt Wiliam, 2004)

2.9.10. **Existential-phenomenological-spiritual forces**. The nurse using this carative factor may assist the patient to find the strength or courage to confront life or death. Watson's theory suggests that each nurse must turn inward to face his or her own existential questions before being able to assist others to cope with the human predicament. The art of caring is based on a professional friendship between the nurse and the patient and includes elements of hope and love (Wengström & Ekedahl, 2006). In her theory of transpersonal caring (Watson 1996, quoted in Kelley & Johnson, 2002), emphasises the transpersonal caring relationship, where a nurse and a patient are touched by the human centre of each other.

The researcher chooses the Maslow's model which stated the hierarchy of need focusing on the daily needs of the terminally ill cancer patients. Oncology nurses ensure that terminally patients are being feed, patients are being bathed, and they do nappy changing and also provide a safe environment to them all the time. Oncology nurses prove psychological support to terminally ill cancer patients when necessary (Vassallo, 2001)

The researcher has identified a need to conduct a study on the experiences and practices of nurses caring for terminally ill cancer patients. The researcher, in support of the above theory, has been inspired by Bahrami, Parker and Blackman (2008) who stated that palliative settings are a challenging issue and need to be researched further.

2.10 CONCLUSION

A review of the literature has shown that a positive attitude towards caring for terminally ill cancer patients is vital in ensuring that patients receive good quality care. The researcher used Watson's theory to describe a nurse. A good nurse-patient relationship is essential for a dying cancer patient as it promotes the emotional, physical and psychological well-being of the patient (Mok & Chiu, 2004). Oncology nurses play a vital role in ensuring a safe and supportive environment for the patient and their family (Dunn, Otten & Stephen, 2005). Oncology nurses have identified a need for professional assistance, support from the management as well as colleagues to help them deal with their fear and emotions (Berg & Danielson, 2007). According to Hopkinson et al. (2004) the greater the availability of coping strategies the more nurses will have a positive attitude towards caring for terminally ill cancer patients and this will make them remain in the oncology setting for a long time.

Chapter 3 will address research methodology and research design used to achieve the research objectives.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

This chapter describes the research methodology used in this study. Qualitative research methodology was used in this study, which aimed to describe the experiences and practices of nurses caring for terminally ill cancer patients in the Pietersburg Provincial Hospital in the Capricorn District of the Limpopo Province. The population, sampling method, data collection method, ethical standards and the measures to ensure trustworthiness which were followed in this study are discussed below.

3.1.1 Objectives of the study were:

- To describe the experiences and practices of nurses who care for terminally ill cancer patients in Pietersburg Provincial Hospital, Capricorn District in Limpopo.
- To develop recommendations and strategies that might assist management of the Pietersburg Provincial Hospital to provide professional, clinical, physical and emotional support that could enhance the practice and knowledge to nurses who care for terminally ill cancer patients in oncology wards.

- **Research question was:**

What are the experiences and practices of nurses caring for terminally patient ill cancer patients in Pietersburg Provincial Hospital, Capricorn District in the Limpopo Province?

3.2 **RESEARCH METHOD**

Qualitative phenomenological research methodology was used in this study. Qualitative research methodology focuses on studying human actions in a natural setting with an emphasis on detailed descriptions and understanding of the phenomenon (Babbie & Mouton, 2009). The researcher interviewed nurses in The Pietersburg Provincial Hospital where the experiences and practices of nurses who care for terminally ill cancer patients was described in order to understand the problem studied.

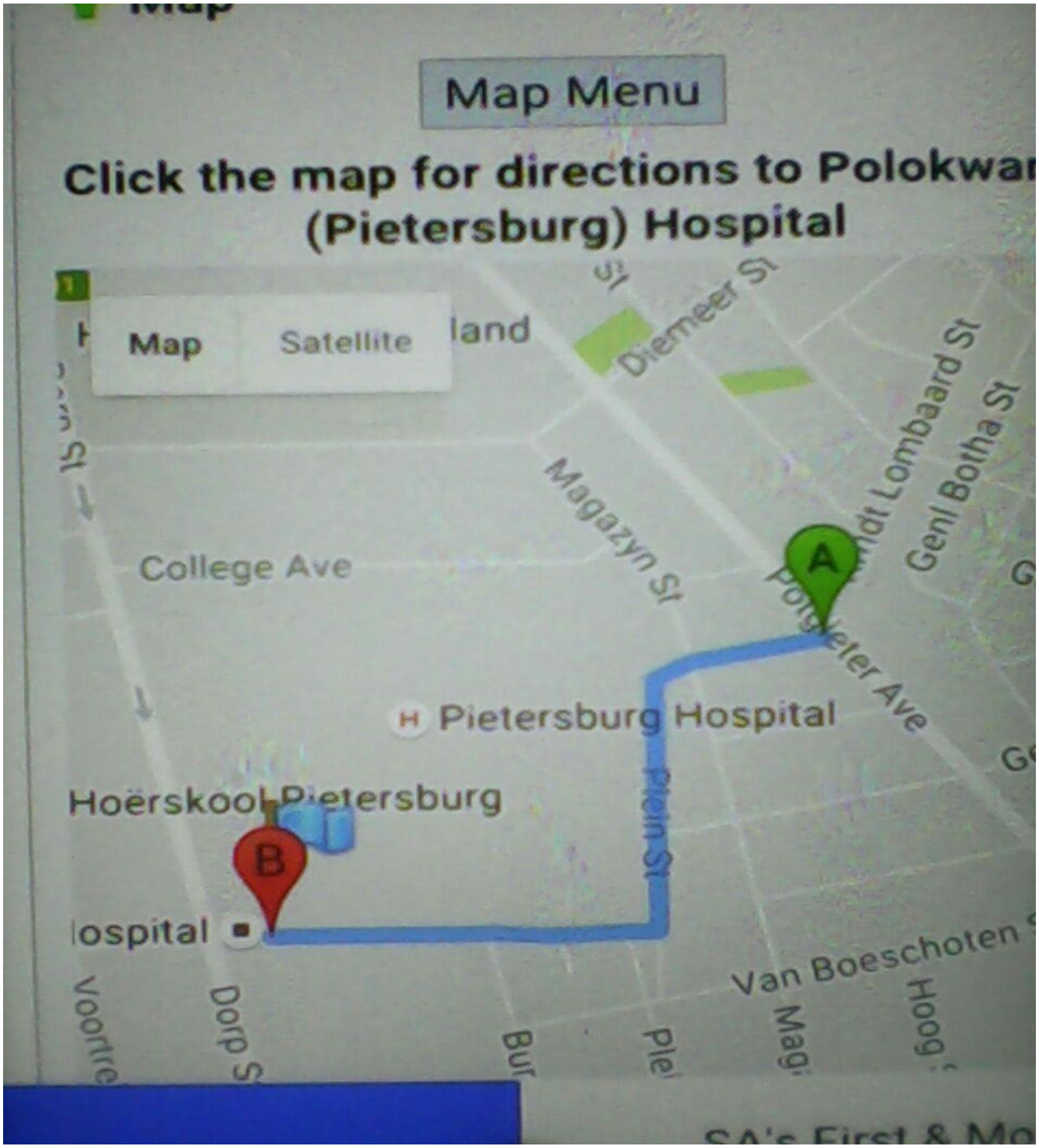
3.2.1 Study site

Limpopo Province is one of the nine provinces of the Republic of South Africa and is situated in the far northern part of the country. It is dominated by rural areas. There are two tertiary hospitals, 40 district hospitals and 440 clinics in Limpopo. The two tertiary hospitals are referral hospitals with different specialities. The Pietersburg Provincial Hospital, amongst other things, provides specialised care in oncology.

This tertiary hospital complex was chosen for this study, as it has designated wards that specifically provide care for cancer patients. The hospital has oncology wards staffed by nurses trained in oncology nursing. There are radiation services, and some of nurses are trained to provide care to all cancer patients referred to the hospital from all over the Limpopo Province.

The Pietersburg Provincial Hospital has three wards where terminally ill cancer patients are admitted, that is, a medical oncology ward, a paediatric oncology ward and a surgical ward. The medical oncology ward admits adult cancer patients, has 10 beds and is staffed by 11 professional nurses. The paediatric oncology admits children with cancer. There are 29 beds and 15 nurses (7 professional nurses, 3 enrolled nurses and 5 enrolled nursing assistants) attached to this ward. The surgical ward admits terminally ill cancer patients with skin, lung and mouth cancer. The ward has 29 beds and is staffed with 37 nurses (13 professional nurses, 12 enrolled nurses and 12 enrolled nursing assistants)

3.2.1.1 Figure 2.4. The map of Pietersburg Provincial Hospital



Click the map for directions to Polokwa
(Pietersburg) Hospital

(Adapted from Shai, 2012)

3.2.2. Research design

Research design is a plan that outlines how observations will be made and how the researcher will carry out the project (Stommel & Wills, 2004). The study followed a phenomenological, descriptive, exploratory and contextual research design because the researcher aimed to describe and explore the experiences and practices of nurses caring for terminally ill cancer patients in the Pietersburg Provincial Hospital.

3.2.2.1 Phenomenological research design

Phenomenological research design aims to describe what the real world consists of and what concepts and structures of experience give form and meaning to it (Scham, 2006). The researcher interviewed nurses working in an oncology setting where their own lived experiences occur when providing care to terminally ill cancer patients. The researcher, therefore, strived to describe the phenomenon as accurately as possible, refraining from any pre-concived framework, remaining true to the facts (Thomas, 2004). The researcher interviewed nurses working in an oncology setting to ensure data collected was accurate by not tampering with any information given to her.

The researcher got into the lived experiences of a phenomenon or concept of several individuals (Creswell, 2007). The researcher interviewed the nurses at the Pietersburg Provincial Hospital in the oncology unit where they have all their experiences related to the caring for terminally ill cancer patients. The researcher sought to describe everyday life by gathering explanations from the participants about what they were doing and feeling (Moule & Goodman, 2009).

The researcher gave participants time to clearly describe their daily lived experiences when caring for terminally ill cancer patients. Groenewald, (2003) stated that the researcher must set aside (bracket) her/his own preconceptions in order to enter the participant’s world, to ensure that she/he does not influence the subjects in any way. The researcher asked the central question “what are the experiences and practices of nurses caring for terminally ill cancer patients” followed by probing questions in order to collect a clear description, without leading the participants to say anything that might have an influence on their answers.

3.2.2.2 Descriptive research design

The focus of descriptive research is on describing the variables that exist in a given situation and, sometimes, in describing the relationships that exist among those variables (Johnson & Christensen, 2012). The researcher asked the nurses working in an oncology setting to describe their experiences when caring for terminally ill cancer patients.

According to Rubin and Babbie (2005), description is more likely to refer to a more intensive examination of phenomena and their deeper meanings, thus leading to richer descriptions. The researcher asked the “why” and “how” questions in order to get an in-depth understanding of the problem studied. The researcher used an interview guide throughout the research project. In this regard an intensive study of small number of instances was undertaken in order to produce detailed descriptions of these cases (Thomas, 2004). The researcher asked the participants to describe their experiences based on the experiences they had, merely to describe the problem studied.

3.2.2.3 The exploratory research design

This design focuses on exploring the unknown with the aim of understanding nature of the phenomenon studied (de Vos, Strydom, Fouche & Delport 2005; Pilot & Beck 2012). In this study the experiences and practices of nurses caring for terminally ill cancer patients were researched in order to get an in-depth understanding of the problem studied. Exploratory research design is conducted to gain insights into a phenomenon (Blaikie, 2000). The researcher wanted to understand more about the experiences that oncology nurses are exposed to on daily basis. The answer to a “what” question, according to Mouton (2001), constitutes an exploratory study. The researcher asked the central question “describe your experiences on caring for terminally ill cancer patients in Pietersburg hospital”. Clarity seeking questions were asked after the participant’s response in order to get the in-depth understanding of the problem studied.

3.2.2.4 Contextual research design

Contextual research design is used to gain an understanding of human experience from the viewpoint of the participants in the context in which the action takes place (Brink, 2006). Data collection took place in the oncology wards of the Pietersburg Provincial Hospital. The first interview took place between 07h00-0800 am as they were not yet started will the ward routine. The other interviews followed in between the routine only to those who were not busy with the ward routine to avoid interfering with patient’s care.

3.3 POPULATION AND SAMPLING

A population is a complete set of persons or objects that possess some common characteristics that are of interest to the researcher (Brink, 2006). The population of the research study included all nurses working in the Pietersburg Provincial Hospital.

- ***Target population***

The target population consisted of all nurses rendering care to terminally ill cancer patients in the Pietersburg Provincial Hospital. Sampling was undertaken on nurses working in the surgical and medical oncology wards who had 3 or more years’ experience.

3.3.1 Sampling procedure

Purposive sampling was used in the study. Purposive sampling is based on the researcher’s judgment and purpose of the study (Rubin & Babbie, 2005). In purposive sampling a particular case is chosen because it illustrates some features or process that is of interest in a particular study (Silverman, 2013). The population in this study was made up of professional nurses working in the Pietersburg Provincial Hospital. Purposive sampling is also seen as judgmental sampling (Rubin & Babbie, 2005). This type of sampling is based on the researcher’s judgment based on the problem studied. Pietersburg Provincial Hospital consist of three (3) main ward caring for terminally ill cancer patients which is Medical oncology ward, Surgical ward and Paediatric oncology (for children) which was chosen for the purpose of pilot study ,the remaining two wards were then selected for the purpose of the study.

In purposive sampling the researcher must first think critically about the parameters of the population and then choose the sample case accordingly. Clear identification and formulation of pre-selected criteria for the selection of respondents is, therefore, of cardinal importance (Maree 2007). The researcher purposely selected professional nurses with 3 years' or more experience working in an oncology setting than those with fewer years of service. Creswell (2007) adds that this form of sampling is used in qualitative research and that participants and sites are selected that can purposefully inform an understanding of the research problem of the study. In this research study the researcher herself undertook the interviews of nurses caring for terminally ill cancer patients.

Furthermore, it is outlined that purposive sampling is composed of elements that contain the most characteristics, representative or typical attributes of the population that serve the purpose of the study best (Grinnell and Unrau, 2008; Monette, Sullivan & De Jong, 2005). The researcher purposely chose the Medical oncology ward and Surgical ward because the professional nurses employed there render care to terminally ill cancer patients.

- **Inclusion criterion**

Inclusion criterion is a list of characteristics that are essential for participants to be included in the sample (Burns & Groove, 2009)

Professional nurses working in medical oncology ward and surgical ward working at the Pietersburg Provincial Hospital with 3 years' experience and more were chosen because they have more experience with regard to caring for terminally ill cancer patients. Male and female professional nurses were included in the study. The researcher interviewed 7 professional nurses working in the surgical oncology ward and 8 professional nurses working in the medical oncology ward.

- **Exclusion criterion**

Nurses with less than 3 years' experience working in oncology wards were excluded because they have less experience in relation to the problem studied.

- **Sampling size**

The 15 nurses with 3 years or more working experience in an oncology ward were interviewed till data saturation was reached.

3.4 DATA COLLECTION

Data collection took place at the Pietersburg Provincial Hospital. Data on the experiences and practices of nurses caring for terminally ill cancer patients was collected using semi-structured one to one interviews asking a central question with an interview guide because this approach is more free-flowing with its structure being limited only by focusing on the research. The researcher wrote field notes. Field notes assisted the researcher with sequencing the events in the order they occurred. A voice recorder was used to capture all the interview sessions and later transcribed verbatim in order for the researcher to listen to the statements made by the participants. Data collection took place in a room open ward. The researcher ensured that data collection took place in a quiet and open ward, conducive to the interviews, away from destructions

The interviews were done in English. The researcher asked a central question: “what are your experience and practices of caring for terminally ill cancer patients in the Pietersburg Provincial Hospital”? Probing questions were asked to gather more information and to encourage the nurses to elaborate on the topic studied (Brink, 2006). The researcher asked the nurses to elaborate on their experiences when caring for terminally ill cancer patients by asking clarity seeking questions. The interviews took place from the 14/08/2015 to the 08/11/2015 depending on the availability of the participants. Four to five interviews were conducted a day were each interview session took 10-20 minutes. Flick (2006) warns, that with easier recording options, researchers should take care to limit recordings to what is absolutely necessary in order to answer the research question. The researcher ensured that the participant was answering the questions asked to get the in-depth of the problem studied.

3.4.1 Preparatory phase

The researcher has gaven the Chief Executive Officer of the Pietersburg Provincial Hospital an approval letter from the Medunsa Research Ethical Committee (MREC) and a permission letter from Limpopo Province Department of Health and Social Development provincial office to conduct the research study and asked for permission. The researcher then explained the objectives of the study and discussed the involvement of the participants and planned dates for collection of data. Permission to conduct research study was granted by the Chief Executive Officer and Area and Unit managers of the wards to allow the researcher to continue with preparations for the interview sessions that were to be conducted after this phase. The researcher then identified the participants and made contact with them in the hospital. Participants were nurses caring for terminally ill cancer participants.

3.4.2 Information session

Semi structure one-to-one interviews asking a central question was used in the study where the researcher gave information to the participants on how the interview session would be conducted. Semi structured interviews are social interactions between the researcher and the participant at an area of interest, while still allowing considerable flexibility (Dicicco-Bloom & Crabtree, 2006). The researcher discussed what was expected of the participants and that participation in this study was voluntary and that they could withdraw at anytime without being threatened. The use of a voice recorder during interviews was discussed, indicating that it was going to capture all the information that they would be giving. The researcher also discussed the objectives and purpose of the study with the participants.

Semi structure one-to-one interviews asking a central question is aimed at understanding the experiences of other people and the meaning they make of those experiences (Berg & Danielson, 2007) this session, the researcher outlined the central question that was asked throughout the interview sessions to all participants, namely, “what are your experiences and practices when caring for terminally ill cancer patient in Pietersburg hospital”. The question or questions to be answered were be prepared and reviewed with experts in the field and even with selected participants. Monette (2006) mention that an interview is built up from three kinds of questions prior to talking to the participant, that is, the central question, probing questions and follow-up questions, in order to complete or clarify the answer. The researcher then confirmed the dates of the interviews with the Department of Health, Area managers and Unit managers of the wards and the professional nurses who were to be interviewed for the purpose of the study.

3.5 INTERVIEW PHASE

Conducting the semi-structured interview

A total of fifteen (n=15) participants consisting of seven (n=7) professional nurses working on a surgical ward and eight (n=8) professional nurses working on a medical oncology ward were voluntarily included in the semi-structured interview sessions. The researcher started the interview sessions by greeting the participants, introducing herself and then welcomed the participants. The researcher outlined the purpose and objectives of the research study, showing them the letter of permission to conduct the study from the institution involved.

After explaining the use of the recording device and that their participation was voluntary and confidential, participants were asked to sign a consent form. Obtaining informed consent implies that all possible or adequate information on the goal of the investigation; the expected duration of the participant’s involvement; the procedures which will be followed during the investigation; the possible advantage, disadvantages and the dangers to which participants may be exposed, as well as the credibility of the researcher is presented to the participant before participation (Royse, 2004; Monette, 2006).

3.5.1 Interviewing techniques that the researcher used

During interviewing the researcher applied the following techniques to ensure an effective interview (Jarbandhan & Schutte, 2006; adapted from Seidman, 1998).

- The participants were doing 90% of talking, while the researcher was listening.

- The researcher was asking one question at a time, questions were clear and brief.
- The researcher was asking open-ended questions as they do not predetermine the response of the participant.
- The researcher was asking questions when answer was not clear to her.
- The researcher was avoiding leading questions and was repeating the key question throughout.
- The researcher did not interrupt good stories because she thought of a good question, she was just jotting down questions she wanted to ask and asked them later.
- The researcher made a follow up on what the participant was saying.
- The researcher was quick to try and pull the participant to stay into the subject and keep the participant focused so she could ask for concrete answers.
- The researcher was not putting the tape recorded on and off trying to avoid unnecessary attention to it.
- The researcher was alert ensuring she capture all the necessary information even when the tape was off.
- The researcher ended the interviews at the reasonable time around 16h30 as is the knocking of time of the participants. The last interview was from 15h30 unless special arrangements were made.

3.5.2 Communication techniques

Active interviewing is not confined to asking questions and recording answers, like other instances of ordinary conversation. Trouble-free exchanges rely on mutual attentiveness, monitoring and responsiveness (Holstein & Gubrium, 1995). Several communication techniques are utilised during interviewing. The following communication techniques were used during the interview phase:

3.5.2.1 Probing

The purpose of probing to deepen the response to a question, to increase the richness of the data being obtained and to give clues to the participant about the level of response that is desired (Brink, 2006). It is a technique used to persuade the participant to give more information about the issue under discussion (de Vos et al, 2005). The researcher asked the central question followed by probing questions to get an in depth account about problem studied. Probing includes the following:

- **Contradicting**- deliberately giving an opinion opposite to the participant's, attempting to arouse his or her further comments.
- **Linking**- linking up the participant's comment with the information which the researcher wants to know.
- **Faking puzzlement**- pretending to be confused, indicating elaboration is needed.
- **Challenging**- demanding more information to prove the validity of the participant's claims.
- **Encouraging**- giving compliments to encourage the participant to carry on.
- **Showing understanding and allowing time for elaboration**. Letting the participant know that his/her comments are understood and valued, and allowing him/her time for further comments.
- **Acknowledging**- repeating the participant's answer to show attention
- **Direct questions**- asking questions to get more information.
- **Procuring details**- asking further questions to see if more information can be obtained (Monette, Sullivan & DeJong, 2005)

3.5.2.2 Reflection

These questions reflect back on something important that the person has just said in order to get him/her to expand on that idea. An example of reflection during data collection is "you said working in oncology setting is stressful, did I represent you well on this aspect?"

3.5.2.3 Clarification

Clarification embraces a technique that is used to get clarity on unclear statements (De Vos et al, 2005). In this study, clarity-seeking questions were asked to help to link participant's perception and factors identified in different interviews to get a better understanding of the experiences and practices of nurses caring for terminally ill cancer patients. An example of clarification is when the researcher asks the participant "So, you seem to be saying caring for terminally ill cancer patients is emotionally demanding?"

3.5.2.4 Listening

The researcher should have superb listening skills (De Vos et al, 2005). The researcher should have good listening skills in order to gather quality information from the nurses caring for terminally ill cancer patients.

3.5.2.5 Encouragement

The researcher encourages the participant to pursue a line of thought by encouraging the participant to say more into the given situation (Brink, 2006). An example to encouragement is "I find caring for terminally ill cancer patients fascinating! Can you tell me more?"

3.6 COMMON PITFALLS IN THE INTERVIEWS

Careful planning can reduce problematic interviews. Donalek (2005) advises that, if problems arise, rather reschedule the interview.

Interruption- telephones were kept away as they can distract the participant as thoughts can be lost if phone ring from time to time. Fifteen participants were interviewed, four to five participants were interviewed per day depending on their availability.

Competing distractions- the researcher did not plan to hold many interviews in one day as this might result in low quality interviews on the part of both the participant and the researcher.

Stage fright- the use of a tape recorder as well as the use of open ended questions can make the participant feel vulnerable but, in this case, the participants were not uncomfortable.

Awkward questions- during the interviews the researcher tried to remove unnecessary questions which were not part of the interviews.

Jumping- the researcher asked questions in a logical order.

Teaching and preaching- the researcher was not trapped into teaching mode by the questions asked by the participant on health information for example if the participant was misinformed, which may trap the researcher into preaching role. If there was misinformation, corrections were made after the interviews.

Superficial interviews- if the researcher moves the participant too quickly, frequently the interviews become too shallow because the researcher has insufficient time to observe non-verbal cues and has no time to get to know the participant.

Confidential information- the participant may give information which is unethical, for example, if the participant is talks about threats of suicide, even if the participant labels this as confidential. The researcher must act on information that is life-threatening.

The use of translators- can slow the process, as the translator first has to translate or may not accurately convey the effective meaning and expression of the participant. In this study the researcher did not use translators.

3.7 POST INTERVIEW TIME

Semi structure one-to-one interviews asking a central question, interview session lasted for approximately 10-20 minutes with each participant included in the interviews. The researcher thanked all the participants at the end of the session for sharing their experiences of caring for terminally ill cancer patients and for giving her their time.

3.8 DATA ANALYSIS

Babbie, (2013) defines qualitative data analysis as a method for examining social research data, without converting the data into a numerical format, for the purpose of discovering underlying meanings and patterns of relationship. The researcher transcribed the tapes verbatim. The researcher used Tesch's proposed eight steps to analyse qualitative data as outlined in (Creswell, 2013).

Step 1

The researcher started analysing data by reading all the transcripts carefully in order to obtain a sense of the whole and then wrote down some ideas.

Step 2

One interview was selected and read to get the in the information, and the thoughts came to mind were written down.

Step 3

The researcher made a list of all the topics. Similar topics were grouped together to form themes and sub-themes.

Step 4

The themes were abbreviated as codes, which were written next to the appropriate segments of the transcripts. The researcher tried out this preliminary organising scheme to see whether new themes and codes would emerge.

Step 5

The researcher found the most descriptive wording for the themes and sub-themes. Lines were drawn between themes to show their relationships.

Step 6

The researcher made a final decision on the abbreviation for each theme and alphabetised the codes.

Step 7

The data material that belonged to each theme was assembled and a preliminary analysis was made.

Step 8

Then the independent co-coder complete coding, the researcher and the co-coder reached an agreement on themes which were identified independently (Creswell, 2013).

The researcher used the following general guidelines in the analysis of qualitative data (adapted from Rapley, 2008):

- Considered the research question
- Continued to use the research diary where all decision and courses of action as well as analytical thoughts and critical reflections about the research were routinely written down right from the beginning of the research up until the end.
- Transcribed the text in sufficient detail
- Read and re-read the text, played and replayed audio recordings in order to become thoroughly familiar with it.
- Critically evaluated words used by participants and critically listened attentively to be able to capture all that was said and done.
- Identified the different topics or themes and coded those encountered by means of a line-by-line analysis of each interview transcription.
- Tested the preliminary findings during follow-up interviews.

The researcher also made a summary of the themes and the sub-themes identified before taking the collected data to the independent coder who helped with the coding of raw data. When the independent coder completed coding raw data and common themes and subthemes emerged a summary of the study was formulated.

3.9 MEASURES TO ENSURING TRUSTWORTHINESS

Trustworthiness is the extent to which research is worth taking note of, paying attention to and to convince others that findings of the research study can be trusted (Babbie & Mouton, 2009). Brink (2006) proposed the following four alternative constructs they believe reflect the assumptions of the qualitative paradigm more accurately. In this study the following measures were adhered to throughout the study to ensure trustworthiness:

- **Credibility**

Credibility alludes to confidence in the truth of the data and interpretation thereof (Brink, 2006). Credibility of a study is ensured by active engagement in activities that have a likelihood of producing credible data by prolonged engagement in research credibility and data triangulation (Polit & Beck, 2012). The researcher visited the participants before the interviews to make arrangements and also to hold briefing sessions. The interviews lasted for 10-20 minutes. There was prolonged engagement in the field with participants over a period of 2 months until data saturation was reached and follow up interview sessions were conducted to clarify important issues related to the study that the researcher needed to explore more deeply.

Triangulation of the data collection methods was employed. The researcher used a voice recorder to capture all interview sessions and field notes were written during data collection. Credibility was also ensured by involving a co-coder during data analysis.

- **Transferability,**

This refers to the degree to which the findings of the data can be applied to the other groups (Botma, Greef, Malaudzi & Wright, 2010). In this study, the researcher ensured transferability by drafting a clear description of the research method, data collection method and analysis. In this study, a qualitative research methodology was used where nurses with 3 or more years' experience in caring for terminally ill cancer patients were purposefully selected and interviewed using a semi- structured interview approach with guide. These participants were able to give information with regard to the problem studied.

- **Confirmability**

Confirmability guarantees that the findings, conclusions and recommendations are supported by data (Brink, 2006). The researcher ensured that the findings of the study were what the oncology nurses said, without bias on the part of the researcher (Babbie & Mouton, 2009). In this study the researcher ensured that the research study was a true reflection of the data collected through the use of field notes and a voice recorder. De Vos et al (2005) state that it is important to ask whether the findings of the study could be confirmed by another person in order to ensure confirmability. In this study all documents, such as transcripts, voice recordings and field notes, were compiled and handed over for audit by the co-coder to come to a conclusion about the data collected.

- **Dependability**

Dependability refers to whether the research findings will be consistent if the research is repeated with similar participants in a similar context (Babbie & Mouton, 2009). The dependability of data refers to the stability of data over time. In this study the researcher ensured dependability by using detailed methodology, interview notes and a voice recorder. Dependability is an alternative to reliability, in which the researcher attempts to account for changing conditions in the phenomenon chosen for study as well as changes in the design created by an increasingly refined understanding of the setting. This represents a set of assumptions very different from those shaping the concept of reliability.

Dependability was assured by the rich description of the research method and design in this study where supporting documents, such as the transcripts, a voice recorder and the field notes were given to the co-coder to make themes and sub-themes. Data sources were kept safe as part of the audit trail.

TABLE: 2.9.1 SUMMARY OF THE FOUR MEASURES OF TRUSTWORTHINESS

CREDIBILITY	Prolonged engagement and persistent observation in the field	The researcher stayed in the field for 2 months in order to have sufficient time

		to collect data To give a detailed explanation of the research question on different occasions The researcher stayed in the field till data saturation was reached
	Source of data triangulation	The researcher used the following for data triangulation: Interviews Voice recorder Independent coder Transcriptions of the record
	Research credibility	The researcher is being supervised by experienced qualitative researcher
TRANSFERABILITY	Purposive sampling	Participants with three years’ or more experience were purposefully selected as they have more experience regarding the phenomenon studied.

CONFIRMABILITY	Independent coder	Voice recorder, field notes and transcripts were be given to the independent coder as part of the audit trail
DEPENDABILITY	Independent coder	Voice recording, field notes and transcripts were given to the independent coder for auditing. Themes and sub-themes formulated.

3.10 BIAS

Bias refers to any influence that may produce distortion of particular findings of the study (Botma, Greef, Mulaudzi & Wright, 2010). The researcher collected data as it was given to her by the participants and did not manipulate this data, even when information was presented that she was aware of. Furthermore (Pilot & Beck, 2012) explain that the researcher strives to bracket out the world and to confront the data in its pure form. The researcher put aside what she knew about the phenomenon to ensure data was collected in a pure form. The researcher also used a pilot study to identify any ambiguity and pitfalls the questioner might experience.

3.11 PILOT STUDY

A pilot study is a smaller version of the major study and is used to develop and refine the data collecting instruments, methodology, or data collection processes (Burns & Grove, 2009). Pre-testing a measuring instrument consists of carrying out all the aspects of the data collection process on a small scale (Grinnell & Unrau 2008;

Monette, Sullivan & De Jong 2005). Furthermore, by performing a pilot study, the researcher was able to recognise any unforeseen problems and made adjustments, before the main study was conducted (Brink, 2006). Bless, Higson-Smith and Kagee (2007) provide what is perhaps the most encompassing definition of a pilot study when they describe such as study as a small study to refine a large piece of research to determine whether the instrument is appropriate.

The researcher conducted a pilot study at the Pietersburg Provincial Hospital paediatric oncology ward where healthcare professionals render care to terminally ill cancer patients to assess the interview guide for unforeseen problems and make adjustments. Four participants were interviewed and asked a central question “describe your experience of caring for terminally ill cancer patients in the oncology setting”. Those who participate in the pilot study did not participate in the main study, as it should be (Rubin & Babbie, 2005; Urau, Gabor & Grinnell, 2007). The main study took place in the medical oncology ward and in the surgical ward of the hospital where fifteen participants were interviewed.

3.12 ETHICAL CONSIDERATION

Ethics refers to codes of conduct that guide the researcher and standards that should be followed in a given profession when conducting research (Babbie, 2013). Ethics implies preferences that influence behaviour in human relations, conforming to a code of principles, the rules of conduct, the responsibilities of the researcher and the standards of conduct of a given profession (Babbie, 2007; Bless, Higson-Smit & Kagee 2006; Monette, Sullivan & De Jong 2005; Walliman 2006). The researcher can act unprofessionally, which does not mean the researcher is unethical. For example, a researcher being late for an interview session is considered unprofessional but not unethical.

- ***Ethical clearance,***

The research proposal was sent to Medunsa Research Ethics Committee (MREC), to ensure that the moral ethical standards were adhered to and for the ethical clearance.

- ***Permission to conduct the study***,

Permission was requested from the Limpopo Provincial Department of Health Ethics Research Committee. Permission was also requested from the Chief Executive Officer of the facility and the unit manager at the Pietersburg Provincial Hospital where data was collected.

- **Informed consent**

Obtaining informed consent implies that all adequate information on the goal of investigation, procedures to be followed, advantages and disadvantages, and dangers to which the participants may be exposed, be explained to the participants (de Vos, Strydom, Fouche & Delpot, 2005). In the research study, the researcher obtained consent, verbally and in writing, from participants before conducting the research interview sessions. The researcher ensured that the participants were aware that participation was voluntary and that they could withdraw from the research study if they felt uncomfortable with interview. Informed consent is a necessary condition, rather than the luxury or an impediment (Burns & Groove, 2009). The researcher explained to the participants that she would be using a voice recorder and taking field notes during data collection. Participants signed consent forms voluntarily. The collected data was analysed.

- **Violation of privacy**

Privacy can be violated in a variety of ways and it is imperative that researchers be reminded of the importance of safe guarding the privacy and identity of the participants and to act with the necessary sensitivity where the privacy of participants is relevant (Yegidis & Weinbach 2006). Privacy, in its most basic meaning, is to keep to oneself that which is normally not intended for others to observe or to analyse. Every individual has the right to privacy and it is his or her right to decide when, where, to whom and to what extent his or her attitudes, beliefs and behaviour can be revealed. In this study the researcher Ensured privacy by informing participants about all possible limits of this principle and steps that were to be taken to ensure that no breach of this principle would take place. The researcher did not in any instant use hidden video cameras, one-way mirrors or microphones because this could expose participants to risks.

- **Avoidance of harm**

The fundamental ethical rule of social research is that it must bring no harm to participate either in physical or emotional manner (Babbie, 2007). Everything we do in life can possibly harm someone and, therefore, researchers should weigh the risks against the importance and possible benefits of the specific research project (Babbie, 2007). The researcher has an ethical obligation to protect participates within all possible reasonable limits from any form of physical discomfort that may emerge from the research project (Creswell, 2003). The fact that negative behaviour of the past might be recalled to memory during the investigation could be the beginning of renewed personal harassment or embarrassment. In this study, researcher had the firmest of scientific grounds to extract personal information from participants.

- **Principle of beneficence**

This principle is often understood as an obligation to minimise possible benefits and to minimise possible harm (Grinnell & Unrau, 2008). The assessment of all possible risks should be negotiated during the planning phase of the study (Ritchie & Lewis, 2003).The researcher assessed all the risks that may emerge and negotiated them during the planning phase of the study. Monette et al (2005) point out that a research project may even have positive effects on the participants and similarly, it may take years before any beneficial effects on the participants can be seen. The researcher explained the advantage of the study and how the findings of the study could benefit the oncology nurses. The researcher ensured that the participants were not exposed to any form of physical or emotional harm as far as she was aware.

- **Confidentiality and anonymity,**

The process of ensuring confidentiality refers to the researcher's responsibility to prevent all data gathered during the research study from being divulged or made available to any other person (Brink, 2006). In the study, the researcher maintained confidentiality by ensuring that no one had access to data collected, with the exception of the researcher's supervisors who were involved in the study. Voice recordings recorded on the voice recorder were kept under lock and key. The process of ensuring anonymity refers to keeping the names of participants a secret (Brink, 2006). In this study, the researcher used codes instead of participant's names.

- **Deception of participants**

According to Neuman (2006) cited by de Vos et al (2005), deception occurs when the researcher intentionally misleads the subject by the way of written or verbal instruction. Neuman (2000) says that deception occurs when the researcher intentionally misleads participants by way of offering incorrect information in order to ensure that the participants take part in the interviews when they would possibly have refused. In this study, there researcher ensured that participants were not being deceived and misled regarding the research study and were given all the relevant and necessary information regarding the research study.

- **Debriefing of the participants**

Debriefing sessions are sessions during which subjects get the opportunity, after the study, to work through their experiences and the aftermath of the process, where they can have their questions answered and misconceptions removed (McBurney, 2001). In this study, the researcher gave the participants an opportunity to work through their experiences and the aftermath of the interviews in order to minimise possible harm that might have happened despite the precautions taken. Being taken through a directed and reflective process, especially in qualitative research, affects the persons involved and they discover things about themselves that they did not know before (Patton 2002).

Through debriefing, problems generated by the research experience can be corrected (Babbie, 2013). The easiest way to debrief participants is to discuss their feelings about the project immediately after the session or to send a newsletter telling them the basic intent or results after the session (Salkind, 2000). The researcher rectified any misconceptions that arose in the minds of the participants after the completion of the study.

3.13 SIGNIFICANCE OF THE STUDY

The researcher believes the findings of the study might be beneficial to the following:

- Nurses

The recommendations of the study might assist professional nurses with better coping strategies when caring for terminally ill cancer patients.

- The Department of Health

The Department might have a view of what the experiences of professional nurses caring for terminally ill cancer patients are, which might guide them when formulating policies.

- Patients

This might help patients receive the best care for their wellbeing because nurses will also have better coping skills.

3.14 LIMITATION OF THE STUDY

The study was limited to a tertiary hospital in the Limpopo Province. The results cannot not be generalised to all public hospitals in the Limpopo Province. The reason the researcher choose a tertiary hospital is that all other public hospitals refer cancer patients to the Pietersburg Provincial Hospital.

3.15 CONCLUSION

In this chapter, research method and design were discussed using the following:

A sample population of nurses working in an oncology setting with 3 or more years' experience in caring for terminally ill cancer patients was selected for the purpose of the study in order for the participants to describe their experiences using semi structure one-to-one interviews asking a central question. Data analysis methods and measures to ensure trustworthiness that was adhered to were also discussed.

CHAPTER 4

DISCUSSION OF RESEARCH RESULTS

4.1 INTRODUCTION

This chapter presents the results of data that was collected during semi structure one-to-one interviews asking a central question where nurses caring for terminally ill cancer patients working at the Pietersburg Provincial Hospital were interviewed. The themes and sub-themes emerged during data analysis using Tesch's open coding data analysis method are discussed and direct codes from participants were used to support the findings. Direct verbatim statements by the participants are presented in italics. Literature is presented to support the findings from current research articles, books, theses, dissertations and periodicals. The themes and sub-themes are supported by the literature that reinforced the study results.

4.2 BIOGRAPHICAL DATA OF PARTICIPANTS OF THE STUDY

Fifteen professional nurses working in an oncology setting, 8 working in a medical oncology ward and 7 working in a surgical ward of the Pietersburg Provincial Hospital, with 3 or more years' experience working in an oncology setting were chosen as the research population.

Table 4.2.1

Category of Prof Nurse	Qualification	Years of experience	Gender
Bridging, community health nursing	Degree	03-10 years	Female
Bridging	Diploma	03-10 years	Female
Bridging	Diploma	11-20 years	Female
Bridging	Diploma	0 3-10 years	Male

Bridging, community health nursing, midwifery and training in oncology	Honours, B Tech in oncology	03-10 years	Female
Bridging, midwifery, and community health nursing	Degree, B Tech in oncology	03-10	Female
Bridging, midwifery, and management	Degree	03-10 years	Female
Bridging	Diploma	03-10 years	Female
Bridging and midwifery	Degree and B Tech in oncology	11-20 years	Female
Bridging and midwifery	Degree and B Tech in oncology	11-20 years	Female
Bridging and midwifery	Degree and B Tech in oncology	03-10 years	Female
Bridging community health nursing and midwifery	Degree	03-10 years	Female
Bridging community health nursing and midwifery	Degree	03-10 years	Male
Bridging community health nursing and midwifery	Degree	03-10 years	Male
Bridging	Diploma	11-20 years	Male

4.3 DISCUSSION OF THE FINDINGS

The discussion of these findings is based on this table below, which presents the themes and sub-themes that emerged during data analysis using the Tesch's open coding data analysis method.

Table 4.3.1: Themes and sub-themes reflecting the experiences and practices of nurses who care for terminally ill cancer patients in the Pietersburg Provincial Hospital

Main themes	Sub-themes
1. Experiences of caring for cancer patients	1.1 Analogous experiences during provision of care experienced 1.2 Nurse-patient emotional attachment experienced 1.3 Self-blame related to failure to relieve patients' symptoms 1.4 Development of avoidance behaviour related patients' suffering 1.5 Appreciation of care versus lack of appreciation from family members 1.6 Caring for cancer patients a stressful experience 1.7 Views related to reallocation to other unit
2. Views related to patients' personality and experiences during admission	2.1 Withdrawal symptoms related to knowledge of the diseases. 2.2 Fear of death experienced 2.3 Painful thoughts related to disclosure to family members 2.4 Denial of the disease condition experienced
3.Provision of care and support to patients during admission	3.1 Provision of basic nursing care 3.2 Isolation of patients a bad thought 3.3 Minimal versus enough family support encouraged

	3.4 Continuous management of pain effected 3.5 Provision of psycho-social support
4. Suggestions related to care provision during admission	4.1 Enhancement of family involvement during admission 4.2 Significance of provision of psychological care
5. Provision of support to professional nurses providing care	5.1 Support versus lack of support from management and colleagues 5.2 Lack of report to management to attract support 5.3 Existence of psychological support 5.4 Lack of cancer care related-related training

4.4.1 THEME 1: EXPERIENCE OF CARING CANCER PATIENTS.

The findings indicated that nurses have different feelings with regard to caring for terminally ill cancer patients. Seven sub-themes emerged under this theme namely: Analogous experiences during provision of care experienced, nurse-patient emotional attachment experienced, self-blame related to failure to relieve patients’ symptoms, development of avoidance behaviour related to patients’ suffering, appreciation of care versus lack of appreciation from family members, caring for cancer patients a stressful experience, views related to reallocation to other unit.

Sub-theme 1.1: Analogous experiences during provision of care experienced.

According to the researcher caring for terminally ill cancer patients was emotionally demanding, strenuous and stressful because of the extensive pain that patients experience. In this study professional nurses indicated that caring for terminally ill cancer patients seemed stressful and heartbreaking. This was confirmed by a participant who said ”*Mmh, when those patients arrive we feel like ooh gosh another pain because once you nurse those patients is touching than the other patient even HIV, HIV is nothing. Those patients the way they feel pains we can even give morphine four hourly the way they get severe pain”…*

Another participant with the same opinion said: ... "*actually, caring for cancer patients is stressful, because this patients when coming to the hospital sick like that you sort of become so connected with this patients, take them as you sister, brothers and then in a long run you fine that you are there but the breaking or the sad thing is that at the end of the day you lose them.*"

According to Nedland et al. (2004), caring for terminally ill cancer patients is physically, emotionally and spiritually demanding. Similar findings were documented by Block (2001), i.e. that working in an oncology setting is highly stressful because of the regular exposure to the pain and suffering that patients go through on daily basis until they die. Furthermore, nurses caring for terminally ill cancer patients encounter death, sorrow and emotional challenges in their everyday lives. (Sandra, Marzena & Gabriella, 2015).

Sub-theme 1.2: Nurse-patient emotional attachment experience

Most of the patients diagnosed with cancer spent most of the time in the hospital with for treatment. Oncology nurses deal with a disease that threatens human life. This requires nurses to be committed to their work and to ensure that there is a good nurse-patient relationship. Most of the nurses end up being attached to certain patients to an extent that they are like family to them. The findings revealed that the nurses bond with the patients to such an extent that they feel like they are one of the family members of the patient. This was emphasised by participant who said: … "*Yes, we are bonding and we are like we treat each other like a sister and a brother, like a father and a mother in a family*.

Another participant with similar experiences said: … **"***Like we do bound and then like we do share our stories and we just become one big family*.

Another participant said *"you develop that relationship with the patient, a close relationship of friend or a mother and her child if she is younger than you so you can guide the patient that she shouldn't default treatment*." Developing a personal relationship with a cancer patient can carry the risk of becoming emotionally overwhelmed which may result in unresolved grief and may reduce the nurse’s subsequent ability to work (Sandra, Marzena, Gabriella, 2015).

According to study done by Morrow, (2009), there is a close relationship between oncology nurses and the dying cancer patients. Furthermore, De Kock, (2011) stated that for the nurses to work effectively, it is important for them to insure that they cope with the emotional impact patients have on them as they consider oncology patients as the own relatives.

Sub-theme 1.3: Self-blame related to failure to relieve patient symptoms

According to the researcher, oncology nurses work day and night caring for terminally ill cancer patients in order to relieve their symptoms. They give medications as ordered and keep on giving the patients hope in order to assist them to fight for life, though at the end they blame themselves, feeling that they did not do enough to ensure that the patient survives, causing a sense of failure on the part of some nurses. The findings indicate that most of the oncology nurses blame themselves, feeling as if they did not do enough to help patients survive when caring for the terminally ill cancer patients, causing the nurses to question themselves a great deal if they feel that they have done enough for the patients while providing care.

This was confirmed by participant who said: … “*And that make one to question why is such happening and you can see you are losing a person completely, and it end to the point [ya gore] (that) it is sad, it depresses one and then you come to the point seeing this person disappearing in your eyes and you just wonder and the is nothing I can do for this person*”.

A participant with similar feelings said “*It is traumatising because every time you look at the patient you feel sad that you can’t carry his pain to yourself, it is impossible you just look at him and only give medication to relieve pain*.” According to the study done by Morita, Fujimoto, Fukumoto and Itoh (2006) the sense of failure among oncology nurses led to a feelings of helpless, guilt, failure and anger, resulting in a feeling of personal failure when treatment fails and patients end up dying.

Nurses feel responsible for the lives of their patients; their ambition is to provide high quality care to the patients and their relatives and failure to that results in nurses blaming themselves for the failure when the patient dies.(Sandgren. Thelesius & Fridlund, 2006).

Sub-theme 1.4: Development of avoidance behaviour related to patients suffering

The researcher has observed that caring for terminally ill cancer patients affect the emotional state of the oncology nurses. Oncology nurses feel relieved when they do not have to care for very ill cancer patient because they hate to see patients suffer from the disease. Some end up feeling relieved when they are allocated to care for patients who are stable, developing avoidance behaviour towards dying cancer patients. The findings pointed out that some nurses feel relieved when they are off duty or allocated to the side of the hospital where they admit stable patients and avoid certain patients (those who are very ill cancer patients). This was confirmed by participant who said: … *"I went for day offs [resting days] but when I came back I was so relieved that the sister in charge allocated me to the side where there were stable patients, because I didn't wanted to see that part where she struggle a lot because I was even avoiding to go to her sideward [cubicle for very ill patients] not because I don't want to help*."

A participant with similar feelings said "*I want them to come to the hospital and go for chemo or be transferred to Johannesburg so that I can't see them on daily basis, when they are coming we say shoo that patient is back*". . According to Braun et al. (2010) oncology nurses usually demonstrate avoidance behaviour in order to be able to cope with their discomfort regarding death of the patients. Caring for dying cancer patients sometimes makes some nurses sad and uncomfortable, leaving some oncology nurses with an option of avoiding terminally ill patient (Mystakidou, Parpa, Thilika, Kalaidopoulou & Vlahos, 2002).

Subtheme 1.5: Appreciation of care versus lack of appreciation of care by family members

Family members have expectations from the nurses when their patients are in hospital and when their expectations fail, they become aggressive and see every little mistakes they come across. The findings of this study indicated that family members differ in character. There are those who do not appreciate the efforts of nurses when caring for their sick relatives. This was emphasised by a participant who said: …. **“***yes we do involve them, is just that they are complaining about small things like sometimes they will tell you that nurses are not feeding them the way they do, and then sometimes when they want to go to the toilet we don’t take them and is like somewhere somehow honestly speaking it is very difficult because you find that we are two and they are four on the some ward while*.....”

A participant who had the same experience said “*No is like family don’t accept especially this situation and some of them they are very aggression, aggressive indicating that we not assisting their sick relatives”*.

On the other hand, some families appreciate the work done by nurses. This was emphasised by a participant who said: … “*We try as much as possible because most the family members they are different they are those who appreciate, they are those who will come and complain about little things and I think that is a way of dealing with aggression”*. In support of these findings Pavlish and Cerosky (2007) state that some families believe that death is a preventable phenomenon which happens due to professional failure. Similar findings were presented by Cincotta (2004) who found out that family members have to deal with anticipatory grief, which includes a feeling of guilt, disappointment and denial, which may lead to conflicts and dysfunction within the family and antagonism towards the caregivers who, they perceive, did not do enough.

Sub-theme 1.6: Carrying for cancer patients is a stressful experience.

It is heartbreaking to care for dying cancer patients because as a nurse you get use to them like your own family member where you share your personal experiences and end up being emotionally attached to these patients. Working in an oncology setting is considered to be to be very stressful. The findings of the study indicated that most oncology nurses consider caring for terminally ill patient a stressful job. This was confirmed by a participant who said… *“it is so stressful because we understand this signs that patient are having, for example when i first worked in here, i was used to work* *with them but not closed, not intensely but in the general ward, so now i see them and when this oncology patient complain for example, when they have Ca of the colon, the patient will be having difficulty in passing stool and they complain of constipation, once I nurse these patients I also experience constipation."*

Another participant with similar feelings said: *….* **"***It is stressful and challenging we lose our patients*". Abeloff (2004) outlined that working in the oncology environment is considered stressful since nurses are exposed to incurable disease, pain and suffering of the patients. Additionally, Sinclair and Hamill (2007) stated that nurses who deal with pain, fear and suffering related to death tend to suffer similar pain and stress.

The nurses believed that the caring for end-of-life patients provokes emotional reactions, such as sadness, frustration, helplessness and inadequacy. Caring for patients who are about to die, and not being able to help them, causes frustration and emotional stress. Nurses are forced to confront their own existential anxiety and often think of the patients, leading to a particular mental stress (Sandgren,Thelesius & Fridlund, 2006).

Sub-theme 1.7: Views related to relocation to other unit

Caring for terminally ill cancer patients is emotionally demanding for some oncology nurses. Oncology nurses work day to day trying their best to assist terminally ill cancer patients live longer with failure. At the end of the day they start blaming themselves as if they did not do enough, some end up feeling that relocating to other area of speciality will be the best except for oncology nursing. The findings of this study indicated that some nurses consider caring for terminally ill cancer patients as emotionally demanding. Relocation is seen as an option to help them cope because they will be removed from these terminally ill cancer patients. This was emphasised by a participant who said: … "*Ooh no, I really want to relocate, i really want to get out of bed side nursing because of the emotional pain that i experience every now and then, for the fact that am quite an emotional somebody, it makes me too vulnerable*."

Oncology nurses experience a great deal of stressors that need to be identified and, if not identified, nurses may point out that they are under stress and feel burnt out, which may result in absenteeism and low retention rate. (Barnard, Street & Love, 2006).

On the other hand, some participants indicated that, while caring for oncology patients is emotionally demanding, they love working in an oncology setting, despite the challenges. A participant with a different view indicated that: …*"no, i love to work in this ward. I don't want anyone to relocate me; I'm enjoying working with these patients especially the cancer once."*

Another participant with a similar view said *"No i just wanted to care for terminally ill cancer patients and nurse them psychologically, spiritually and physically. They must know we still love them; we are still there through all those stages of cancer*. The personalities of oncology nurses differ, with some nurses believing that working in a stressful environment does not result in physical or psychological impacts on their lives or to illness (Marchand, Demers & Durand, 2005).

4.4.2 THEME 2: VIEWS RELATED TO PATIENTS PERSONALITY AND EXPERIENCES DURING ADMISSION.

The findings of this study show that there are various challenges related to the personality of an oncology patient. Four sub-themes emerged from this theme, namely: withdrawal symptoms related to knowledge of the disease, fear of death experienced, painful thoughts related to disclosure to family members, suspicious behaviour displayed, denial of the disease condition experienced.

Subtheme 2.1 Withdrawal symptoms related to knowledge of the disease

According to the researcher, most of the time when cancer patients are being admitted in the ward especially for the first time, they will be able to communicate and do some things on their own. But once they get to know that the disease has metastasised to the whole body and that there is nothing more that doctors can do, they start to isolate themselves and withdraw from the things that they used to enjoy and even complain about many things in the ward. In this study, oncology nurses indicated that cancer patients have a tendency to develop withdrawal symptoms after finding out that they are terminally ill. This was confirmed by a participant who said: ….*“Then when they get to know that their condition is terminal then they start to be difficult, they start to have withdrawal symptoms, they start losing hope and become a total different person from what you saw in the ward. Some of them they will complain a lot, they will find a little mistake*.”

A participant with similar experiences said; “*Patients become so difficult and this is affecting us because others they come late to the hospital when the cancer disease has spread.”* Patients’ grieve differently, some will start feeling pity for themselves, while others become unwilling to communicate and start complaining about a number of things. In support of this Hottensen (2010) found that most patients, after learning that their cancer disease has already advanced or is in terminal stage, start experiencing anticipatory grief. This anticipatory grief is in response to multiple loses being experienced, which results in isolation, conflicts, a dysfunctional relationship with the family and unwillingness to communicate.

Furthermore, according to Ramfelt et al. (2002), when patients confront this life-threatening illness it affects their attitude and perception. Most patients withdraw from the activities they used to enjoy the most and lose courage and hope and the will to live.

Sub-theme 2.2 Delayed process of revelation of hurting feeling

Education plays an important role in the relief of a patient’s fear and concerns’. Nurses prefer not to have to break the news about death and dying to the relatives. Oncology nurses have a responsibility of keeping the relatives informed about the prognosis of the patient of which some of the nurses prefer doctors to be the once to break the sad news.

The finding indicated that nurses do not like revealing bad news or giving relatives false hope about the diagnosis of the cancer patients. This problem was acknowledged by a participant who said: ….. *“No they don’t give us challenges; the challenge is just to tell the relatives that your sister is going to die.*” Participants reported that they do not like to talk about death to the families of dying cancer patients and, instead, felt that they needed training in regards to how to communicate the situation to patients and their relatives (Ho, Barbare, Hidalgo & Camp, 2010).

Furthermore, Morrow (2009) stated that nurses working in an oncology setting find it very difficult and uncomfortable to talk about death and dying to patients and their relatives.

Sub-theme 2.3: Painful thoughts related to disclosure to family members

It was evidenced from the findings of this study that some nurses find it difficult to inform relatives that their loved ones will die. According to the researcher's observation some of the patients die even before their family members can be counselled about their cancer disease. This was acknowledged as a problem by a participant who said: … "*Some of the relatives you know is not easy to say someone is going to die, there are stages of grieving*." This was supported by the participant who said *"family starts to be related to fetch their patients and some they start looking for mistakes because of anger after knowing that their relative is going to die*"

According to Dunn et al., (2005), talking about death, providing care to terminally ill cancer patient and giving emotional support to families is acknowledged as quite a difficult role to perform. Similar findings were documented by Olthuis and Dekkers, (2003) who stated that, in particular, oncology nurses feel inadequately prepared to talk about death as well as dealing with the emotional demands of the patient and relatives.

Sub-theme 2.4: Denial of the disease, condition experienced

Denial is one of the stages of death which most of the terminally ill cancer patients go through. They will blame God for what is happening to them. Some patients withdraw, while others will even start defaulting their treatment because they are in denial. Other patients start believing that they have been bewitched.

Denial is one of the personality problems identified in this study. One participant said: … "*so we have realized that others start treatment and some they don't adhere to treatment and then they go to traditional healers and then they come back late, by the time they come to the hospital for consultation the cancer will have spread*."

Another participant said “*the only challenge is that the patients come late when the disease has already metastasized*”. Similarly, Cincotta (2004) found that, when patients and their families become aware that the cancer is at an advanced stage advanced, they begin to experience anxiety, loneliness, denial, guilt, depression and sadness.

De Kock, (2011) reported that cancer disease can cause dysfunction of the family leaving the patient and the family with a feeling of aggression, denial and anxiety.

4.4.3 THEME 3: PROVISION OF CARE AND SUPPORT DURING ADMISSION

The study findings indicated that oncology patients need nurses to support and care for them at all times. Five sub-themes emerged under this theme, namely provision of basic nursing care, isolation of patients’ bad thought, minimum verses enough family support encouraged, and encouragement of psycho-social support.

Subtheme 3.1: Provision of basic nursing care

Oncology nurses ensure that basic needs of the patients are taken care off on daily basis. Nurses try their best on daily basis to care for patients who cannot do things for themselves. For example, they assist patients who cannot bath and feed themselves. This was outlined by a participant who said: … “*on daily basics, people from night staff they continue with giving of medication, they make sure that the basic needs like bed bathing, they bath those patients who need to be baths, they feed those who need to be feed, then we end up giving medication according to what the doctor has prescribed and they are those general small things that we help with*.”

Another participant, who supported this statement, said: ….. **“***Am doing bathing, linen changing, am friendly to the patient, build trust among each other.*” Provision of nursing care take place in hospice were oncology nurses involves patients and their families to facilitate caring for the patient holistically meaning physically, psychologically and emotionally thus including bathing, feeding, promoting rest and sleep (Vassallo, 2001).

Similar findings were documented by Huitt (2004) who stated that there are basic needs for each an everyone to survive, i.e. physiological needs, safety needs, belonging needs, recognition needs and self actualisation needs.

Sub-theme 3.2: Isolation of patients a bad thought

When oncology nurses see that a patient is terminally ill, they take that patient into the side ward or isolation ward so that other patients cannot be traumatised by the situation, hoping that the very ill patient will die peacefully. This is seen as a good practice in most of the oncology wards.

One participant said: …..“*It is so discouraging plus in our ward [ne] when the patient is very ill if we see this patient might die anytime, we have two side wards and we isolate very ill patients from other patients so that they cannot see that she/he is not doing well and here we come conforming the fact that you are not going to make it by putting the patient aside in the sideward [our cubicles], they are quite small, dark and the fresh air comes through the window*,”

Isolation of a patient seems to be a bad idea because the patient will start to feel isolated from the real world while still alive and nurses also limit a patient’s visitors. Patients end up feeling lonely and isolated. Lynette (2003) stated that isolation was seen as a bad idea because it resulted in to poor quality of care and adverse events.

Sub-theme 3.3: Minimum versus enough family support encourage

Family plays an important role in the wellness of the patient. Patients need their families to support them and help them cope with the challenges that they are going through on daily basis. When family members are there with the patient, they will be able to understand what their relative is going through. The findings indicated that family members are encouraged to accompany the patients to the hospital to assist with the care of the patient. This was emphasised by a participant, who said: ….. *“so we want the family to assist in care of the patients because at least if the patient comes with the family or somebody from home we give the talk to that somebody on how to take care of this patient, we do want the family to take care of the patients at home*”.

It is the responsibility of the nurse to assist patients and their family members to develop coping strategies, to ensure that the family is always there for the patient and to provide care when at home (Hottenson, 2010).

Similar findings where documented by Haas (2016) who stated that the most important role of the family is to be there source of support to the person diagnosed with cancer.

Sub-theme 3.4: Continuous management of pain effected

Cancer patients go through extensive pain and need regular attention. Oncology patients go through extensive pain that requires strong analgesics to easy their pains; even to the point of requiring four hourly analgesics. The pain may become so severe that not all kinds of analgesics can be effective.

This was outlined by a participant who said: ….. "*Just imagine the patients are in pain, they are crying of pain everyday. They are complaining with the treatment we give and then they will tell you --- doctor you are giving me this but am trying to take this tablets, but after taking it after few hours i have pain again, can you see that the patient is having continues pain which needs management."*

This was supported by a participant who said *"giving of those pain analgesics is just, is only reassuring".* According to Costello (2006) bad death is characterised by pain.

The quality of care of a dying cancer patient means adequate pain control and management of their symptoms (Allen, 2009).

Subtheme 3.5: Provision of psycho-social support

Cancer is a chronic illness that can incapacitate a person to the extent that he or she is unable to go to work and care for his or her family, resulting in psychological and social problems as the patient will worry about who is going to take care of the family. Most of the cancer patients especially on the last sage of cancer they become unable to mobilize and do things on their own.

The result of this study indicated that oncology patients need psychological and social assistance. One participant said: ….. "*after interviewing the patient or talking to the patient and then we will talk to the doctor maybe to provide the patient for grant, then we will send the patient to the psychologist for psychological problem and also send the patient the social worker for social problem, so that they can go there to evaluate the area where the patient comes from".*

According to the Palliative Care Overview (2009) it is the responsibility of an oncology nurse to care for the patient as a whole or in totality, meaning taking care of their physical, psychological, social and spiritual needs.

Furthermore, according to study done by Morrow (2009), the challenge of the professional nurse caring for dying cancer patients is meeting their psychological, emotional and their spiritual needs.

4.4.4 THEME 4: SUGGESTIONS RELATED TO CARE PROVISION DURING ADMISSION.

The findings of this study included suggestions related to the provision of care during admission. Two sub-themes emerged from this theme, namely enhancement of family involvement during admission and the significance of provision of psychological care.

Subtheme 4.1: Enhancement of family involved during admission

Nurses prefer patients to come along with their relatives to the hospital, especially during the admission, so that the family members can give the patient's history to the hospital staff and so that the nurse can explain the diagnosis of the patient to the family. In this manner, the family members can be supportive of the patient. In this research study, it was found that nurses prefer patients to come to the hospital with their relatives during the admission so that they can explain the diagnosis to the patient as well as to the family.

This was emphasised by a participant who said…'*especially when the patient comes for the very first time, we need the family so that they can come to give us the history of the patient, even during the course of the treatment we need them because the treatment that we are giving which is chemotherapy has got some side effect so this people they are supposed to know exactly what is happening so that at home they can be able to take care of this poor patient*."

"yes, very much important because when the family comes with the patient here if we give education because if the patient is feeling pain can't hear anything, patient will just

say yes without understanding, so we want the family because at least if the patient comes with the family or somebody from home we give the health education to somebody on how to take care of this patient, so we do want them to take care of them at home''

According to Belcher, Brittian and Fish (2002), it is the responsibility of the nurses to assist the patient and family by working collaboratively to be able to recognise, clarify and identify problems.

Similar findings were documented by (Sandra, Marzena & Gabriella, 2015) who stated that it is important to attend to the patient's and relatives' psychosocial concerns to improve relationships and level of care from the day of admission.

Subtheme 4.2: Significant of provision of psychological care

It is important that family as well as the patient be counselled about the disease so that they are better able to cope by being better informed about the illness. The more family members are counselled about the illness of the more they will be able to accept their patient.

The finding of this study indicated the importance of providing psychological care. This was emphasised by a participant who said…*"and we also do counselling before we give chemotherapy as you know it has a lot of side effect." This was supported by the participant who said ("ya ya [yes yes] i think since there is nothing that we can do physically more than psychologically.*

Another patient with similar opinion said "We can nurse them more psychologically to relieve psychological pain." psychological dimension of the terminally ill cancer patients target the mental state of the patient, and the emotional health". The nurse must be open and sensitive towards the patient's emotional state by attending to any psychological needs from the day of admission. (Minnaar, 2003)

Similar findings were documented by Alimi, Rubino, Pichard-Léandri, Fermand-Brulé, Dubreuil-Lemaire and Hill (2003) who stated that caregivers provide assistance with food and psychological support and ensure that the individual is comfortable.

4.4.5. THEME 5: PROVISION OF SUPPORT TO PROFESSIONAL NURSES

The findings of the current study has suggestions with regard to support that should to given to oncology nurses. Four sub-themes emerged from this theme; namely support verses lack of support from the management and colleagues lack of reporting to management to attract support, existence of psychological support and a lack of cancer-related training.

Subtheme 5.1: support verses lack of support from the management and colleagues

Management has a very important role to play when it comes to the job satisfaction. Nurses feel that it is important for management, as well as colleagues, to support them to ease the challenges that they go through on daily basis. The findings of the study revealed that some oncology nurses get support from the management and colleagues, which has a positive impact on the nurses.

This was emphasised by a participant who said…**“** *they really supporting us, because they organize with the person to come and check on our blood, the full blood count, they sometimes send us for chest x- rays they do that even mammogram.*”

On the other hand, some nurses believe that management does them sufficient support in order for them to cope with their daily stressors.

“*Something like that no, but I know it should happen but I have never see it happen here. We know like even our staff that if you have got a problem, you go to the operational manager for help, I have never seen it happening here as I say we are trying to cope like there is no support from management”*

“*No the support i think, i cannot say it is enough because what we are planning, we are planning to visit our patients at home with our own resources. The management is not doing enough*”

Larrabee, Jonney and Ostron, (2003) indicated that it is the duty of the nurse manager to monitor job satisfaction and implement support strategies for oncology nurses. Similar findings were documented by Barnerd, Street & Love (2006) who found that insufficient support of nurses make them feel undervalued.

Furthermore, according to study done by Grbich, Parish and Glaetzer (2006), a lack of sufficient support from the colleagues and management leads to stress among palliative care nurses.

Subtheme 5.2: Lack of report to management to attract support

Management should ensure that the working environment of nurses is considered by ensuring that there is two way communications between staff and the management. Lack of communication in the working environment result in misunderstanding or If the management avoid the concerns raised by stuff members, it will result in negative attitude that can be displayed by the stuff members.

In this study, nurses complained that, even if they send a report to the management that they have a problem in the ward, they do not get a positive response if the operational manager does not agree with their complaint. This was confirmed by a participant who said… *“to the management, so if you come up with something neh, then because she [operational manager] is not the one who came with that point, then it will not taken seriously*.”

Another participant said *“we do go to the management to request some of the things we need but they take time to respond to our request or sometimes they just don’t respond”.* According to Minaar (2003) it is the responsibility of the management to ensure that nurses adapt to their work environment and to provide the necessary equipment, sufficient staff, two way communication and more effective training.

Similar findings were documented by Grbich et al. (2006) who stated that insufficient support from the management led to stress among palliative care nurses.

Subtheme 5.3: Existence of psychological support

Caring for terminally ill cancer patients has been regarded as stressful and challenging, therefore, nurses need psychological support to help them cope with these challenges. Therefore it is important that oncology nurses should be provided with psychological support to help them cope with challenges.

This statement was emphasised by a participant who said… **“***No it affect us psychologically, because that is why in our unit we have realized that problem and we have our psychologist in our unit.”*

Another participant, who supported this statement, said “*yes, there is, there is a psychologists that when you need you can talk you can go to”.* Oncology nurses need access to professional assistance to support and help them deal with their emotions and anxiety (Monette,et al. 2005).

Subtheme 5.4: Lack of cancer care related – training

Education is very crucial because oncology nurses will be able to have knowledge about what is important when caring for terminally ill cancer patients. It is important that the nurses as well as the management ensure that the staff members are always informed about their working environment. If oncology nurses are oncology trained there are some of the management they can provide to the patient before the doctor can recommend.

Despite the fact that they are caring for dying cancer patients, they feel management is not supporting them enough by giving them oncology training **“***i like to work with this people but i think if our OPM can stress this to our management just to take us for short courses.*”

Another participant said “*no, management does not train us”*

It is important that nurses get educated on how to deal with death and dying as this is what they face on a daily basis. It was evident from the findings of this study that nurses need oncology training and the hospital should train those who are working in oncology unit. On the other hand, few nurses reported that the hospital had sent them for training. This was confirmed by a participant who said… *“eeh (yes) it is the hospital who took us to training.”*

Oncology nurses are valuable resources who need training. (Barnard, Street & Love, 2006).

Similar findings were documented by Minaar (2001) who stated that oncology nurses should usually be supported in terms of different needs, e.g. environment, problem solving, development and growth, physiological and social needs and the need for self-actualisation.

4.6 CONCLUSION

According to the results of this study, oncology nurses need psychological support to help them deal with the emotional challenges they come across on daily basis. Some oncology nurses reported that a failure to attend to their emotional challenges leads them to blame themselves, especially when looking at their patients deteriorating on daily basis. They reported that it leads them to have a sense of failure or they start blaming themselves for not being able to assist their patients. Other oncology nurses feel that they would relocate out of the oncology department if the challenges persist. Some family members appreciate the work of the nurses, while other family members start blaming the nurses if the patient’s condition deteriorates. Family members become aggressive and complain about the service that oncology nurses are providing to these patients. Some family members will complain that the patient was not feed or changed position, while others still believe that death is preventable which that can be avoided if nurses work harder.

Some nurses delay revealing a poor prognosis to the patients which leaves oncology nurses in a difficult position because they always try their level best to care for dying cancer patients. It is, therefore, important that patients, as well as the relatives, be counselled about cancer. Oncology nurses need their managers to assist them with debriefing session at least once a month to help them to cope well with the daily stressors. Oncology nurses indicated that they needed colleagues to assist them when they are short staffed.

On the other hand, some oncology nurses appreciated the management of The Pietersburg Provincial Hospital for giving them an opportunity undertake a B Tech Oncology, while other professional nurses requested that management makes short courses available to them so that they may better cope with terminally ill cancer patients and provide quality patient care, as caring for terminally ill cancer patients is stressful and heartbreaking.

CHAPTER 5

THEORETICAL FRAMEWORK

5.1 INTRODUCTION

The findings of this study and the literature concerning the experiences and practices of nurses caring for terminally ill cancer patients at the Pietersburg Provincial Hospital are discussed in this Chapter. The theory outlines the importance of caring in an oncology setting in order to ensure that quality nursing care is provided. The researcher collected data from one-to-one interviews with 15 professional nurses with 3 or more years' experience working in an oncology setting. Data collected from the oncology nurses were analysed using the Tesch's open coding data analysis method, where 5 themes and their sub-themes emerged.

5.2 CONTEXTS

The study was conducted at a selected tertiary hospital in the Capricorn District of the Limpopo Province. The researcher conducted the study in a surgical ward and in the medical oncology ward. Participants in the study were professional nurses who play an important role in the care of oncology patients at the Pietersburg Provincial Hospital.

5.3 THEORETICAL FRAMEWORK OF THE EXPERIENCES AND PRACTICES OF NURSES CARING FOR TERMINALLY ILL CANCER PATIENTS

The study was based on Watson's theory of caring, where patients need nurses to care for them. Caring takes place every time a nurse is in contact with a patient. According to Watson's theory, the structure of the science of caring is built upon 10 carative factors.

5.3.1 Humanistic-altruistic system of value

According to this theory a nurse should learn the principal of humanity at an early age to be able to develop a personal relationship with cancer patients as if they were their friend, family, or life partner. Their ability to develop humanity will have either a negative or positive influence on their patients (Scheman, 2013). Despite what the nurse is going though she/he must be able to show love and respect towards his or her patients

(Meleis, 2012). This study found that nurses are able to develop a relationship with the patients to the extent that they bond with their patients who feel like their family. Nurses end up being emotionally attached to the patients and when these patients die they do not cope well with the situation.

5.3.2 Faith-hope

This carative factor says that a nurse should be able to instil hope and faith in the patient. The nurse should be able to encourage the patient to believe that everything will be fine. According to the findings of the current study, nurses feel it is important that the patient's relatives should always be there so support their patients so that the terminally ill cancer patients can still have courage to live. It is the responsibility of the nurse to assist patients and their family members to develop coping strategies, to ensure that the family is always there for the patient and to provide care when at home (Hottenson, 2010).

5.3.3 Sensitive to self and others

This carative factor sees a nurse, as a caring person, who must establish a one-to-one relationship such that both the patient and the nurse have a sense of unity (Parker & Smith, 2010). In this study, patients differ in their personalities where some develop suspicious behaviour or withdrawal symptoms when they see that they are going to die. This makes caring for terminally ill cancer patients a difficult task to undertake.

5.3.4 Helping-trusting human care relationship

According to Watson's theory, a nurse must be open, honest and willing to accept patients in a positive way and have a positive attitude towards the patient. According to the findings of this study, oncology nurses experience painful thoughts related to disclosure of the patient's poor prognoses to the family members as they usually react aggressively. Morrow (2009) stated that nurses working in an oncology setting find it very difficult and uncomfortable to talk about death and dying to patients and their relatives.

5.3.5 Expressing positive and negative feeling

This carative factor says that a nurse should be able to know the patient in totality. The nurse should be able to know if the patient is happy or sad or if the patient needs some sort of intervention. According Breggin (2008), ignoring odd behaviour is virtually the same as ignoring the person. In this study it has been shown that nurses are also human beings who also experience emotional stressors and they feel that management is not doing enough to ensure that they are psychologically well. At the same time, on a daily basis, they ensure that patients are coping even when patients and their family members become aggressive due to the illness.

5.3.6 Creative problem solving process

According to Watson's theory, the nurse manager must be able to monitor the nurses' well-being. If a nurse is not coping, he/she must be referred to a psychologist for effective intervention (Sherman, 2013). In the current study, some nurses indicated that there was insufficient support for them from the management, which sometimes makes them to carry their emotional burdens home with them, resulting in poor patient care.

5.3.7 Transpersonal teaching-learning

In this carative factor says that the nurse must educate patients and their family members about the prognoses of the disease that the patient has. The problem identified in this study was the fact that nurses did not feel comfortable talking about the inevitability of death to the patient or the patient's relatives. In this study, nurses reported a sense of failure and that they hated seeing relatives cry as they experience anticipatory grief. (Cincotta, 2004).

5.3.8 Supportive, protective and or corrective mental, physical, social and spiritual environment.

According to Watson's theory of care, in this carative factor a nurse must care for the patient holistically, meaning that they must take care of the patient psychologically, physical, emotionally and spiritually (Vassallo, 2001). This study showed that nurses try their best to ensure that patients were comfortable and well taken care of. Nurses also ensured that family members were supported during this difficult time.

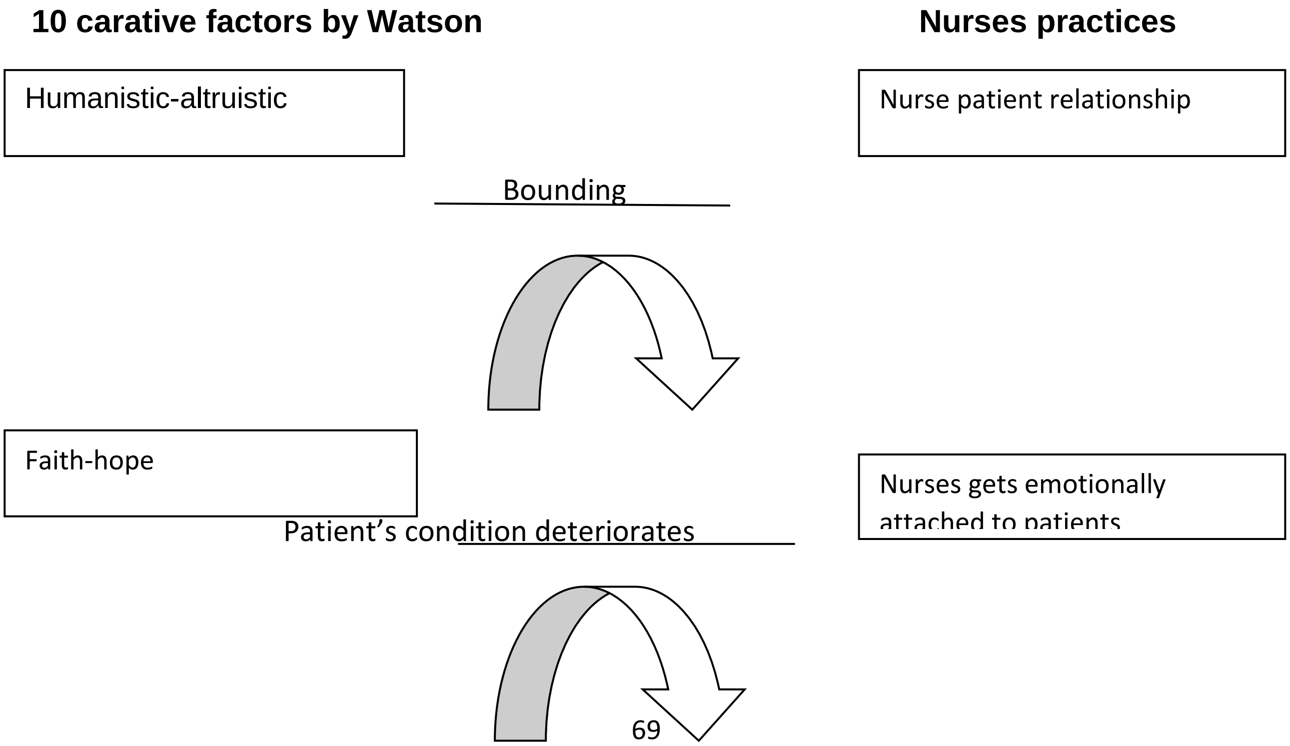
5.3.9 Assistance with gratification of human needs

According to this carative factor, the nurse must ensure that the patient’s needs to survive, function, integrate and to grow are attended to The results of this study show that nurses bath the patients, change nappies, give medication to the patients and refer the patients to the a psychologist, if the need arises. According to Huitt (2004) who stated that there are basic needs for each an everyone to survive, i.e. physiological needs, safety needs, belonging needs, recognition needs and self actualisation needs

5.3.10 Existential-phenomenological-spiritual forces

This carative factor encourages a nurse to assist the patient to find the strength and courage necessary to live without loved ones and with the knowledge of approaching death. In this study it was shown that nurses encouraged patients to live a positive life and even assisted them by calling pastors to come and pray for them.

5.3.10.1. Figure 5.1 TABLE ON THE DIFFERENCE BETWEEN 10 CARATIVES FACTORS AND NURSES’ PRACTICES



Sensitive to self and others

Nurses develop one to one patient care

Patients develop withdrawal behaviour

Help trusting, human care relationship

Nurses experienced difficulty in disclosure about death

Patient and family grief

Expressing positive and negative feeling

Nurses come across stressors

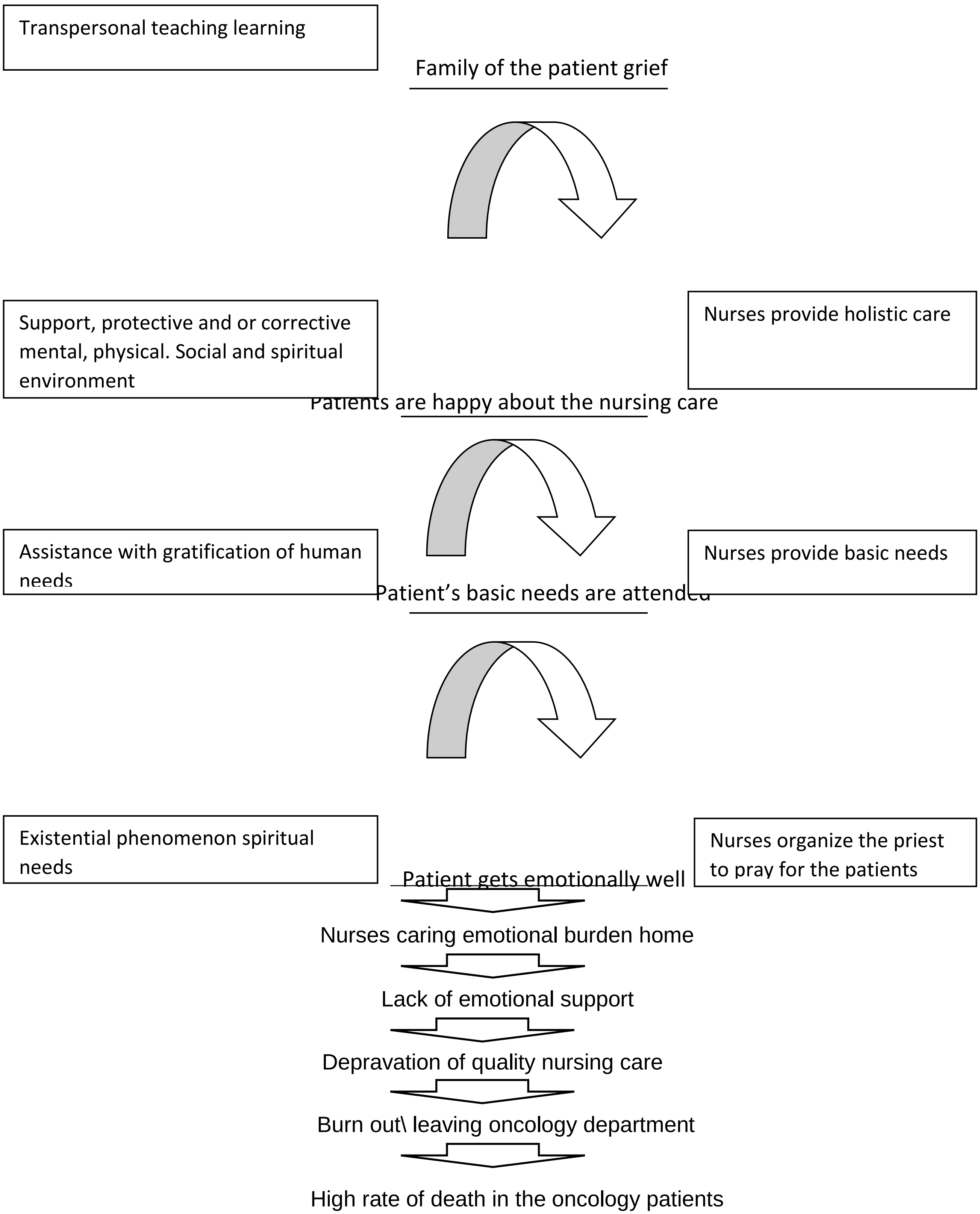
There is poor patient care

Creating problem solving process

Lack of support to nurses by management

Poor quality patient care

Nurses have a sense of failure disclose about death



ADAPTED FROM WATSON & WOODWARD (2010).

5.4. LIMITATIONS

There were some limitations identified in relation to the theory that guided the study. Watson’s theory of care emphasises the importance of caring in an oncology setting. According to Watson’s theory regarding the carative factor of faith-hope and in the helping-trusting human care, relationships seemed to be difficult for the oncology nurses as they end up developing avoidance behaviour towards the patients due to a feeling of guilt for failure to meet a patient’s expectations.

5.5 CONCLUSION

This chapter has outlined the application of the Watson’s theory of caring to a study undertaken to determine the experiences and practices of nurses caring for terminally ill cancer patients at the Pietersburg Provincial Hospital. The researcher came up with the following coping strategies for oncology nurses: provision of debriefing session after exposure to a traumatic situation, provision of short courses regarding cancer diseases or even take staff members for B Tech oncology.

CHAPTER 6

SUMMARY, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION.

6.1 INTRODUCTION

The results discussed in Chapter 4 revealed that professional nurses in a tertiary hospital in the Capricorn District of the Limpopo Province have a problem when caring for terminally ill cancer patients. In Chapter 5, a theoretical framework for carations of caring was formulated. Therefore, carations of caring can be used by the management of the Pietersburg Provincial Hospital when dealing with oncology nurses who render nursing care. Furthermore, these Watson's caring carations might assist in determining the course of action to be taken as far as the nurse's emotional state is concerned.

6.2 OBJECTIVES OF THE STUDY WERE

- To describe the experiences and practices of nurses who care for terminally ill cancer patients in Pietersburg Provincial Hospital, Capricorn District in Limpopo.
- To develop recommendations and strategies that might assist management of the Pietersburg Provincial Hospital to provide professional, clinical, physical and emotional support that could enhance the practice and knowledge to nurses who care for terminally ill cancer patients in oncology wards.

6.3 SUMMARY

The purpose of the study was undertaken to describe the experiences and practices of professional nurses who care for terminally ill cancer patients in the Pietersburg Provincial Hospital and to explore the relationship between demographic variables and nurses experiences towards death. In the end it was hoped to develop recommendations and strategies that might assist the management of the Pietersburg Provincial Hospital to develop appropriate skills and emotional support in order to assist nurses who care for dying cancer patient in the oncology wards. The problems identified by health care professionals in the Pietersburg Provincial Hospital were discussed in Chapters 4 and 5, which included some of the following themes.

1. Experiences of carrying cancer patients.
2. Views related to patients personality and experiences during admission.
3. Provision of care and support to patients during admission.
4. Suggestions related to care provision during admission.
5. Provision of support to professional nurses providing care

6.4 LIMITATIONS

In this study, data was collected from one tertiary hospital campus in the Capricorn District of the Limpopo Province, therefore, the results cannot be generalised to all public hospitals in the Limpopo Province.

6.5 RECOMMENDATIONS

The following recommendations are made regarding oncology nurses in an oncology setting where they render care to terminally ill cancer patients. Recommendations are made to the management of Pietersburg Provincial Hospital, Professional nurses and to the patient's families.

6.5.1 Recommendations to the management

1. To facilitate good working conditions for oncology nurses at the Pietersburg Provincial Hospital there should be a psychologist who can assist nurses to cope better with the daily stressors in their work, as oncology nurses said caring for terminally ill cancer patients live stressful and heartbreaking working lives.

2. The management should also insure that a psychologist is readily available to assist nurses to vent all their frustrations, as these nurses are not coping, despite all the interventions.

3. The nurses should be relocated out of the cancer unit to other surgical wards where they do not have to deal cancer patients, in order to avoid nurses leaving the department as a result of the challenges that they face in the oncology department.

6.5.2 Recommendations to the professional nurses

1. It is recommended that nurses should always inform the patient’s relatives about the patient’s prognosis on daily basis. Patients, as well as relatives, need psychological intervention to be able to accept the disease and its implications. If patients and their relatives are not counselled about the disease they may both develop aggression, withdrawal or even become suspicious, believing that everything that nurses do is aggravating the condition.

2. There should be awareness campaigns conducted by oncology nurses to educate the community about cancer. These campaigns should consist of signs and symptoms and also the treatment of the cancer disease so that the community does not delay seeking treatment for the disease and visit the clinics or the hospital when the disease has metastasized. If the community receives sufficient information about the disease, they will be able to get treatment early, before the cancer can spread to other areas. This will also reduce the workload of oncology nurses.

6.5.3 Recommendations to patient’s families.

1. It is recommended that families should always work together with nurses during this difficult time.

2. Family members should also know that oncology nurses are attached to their patients and that when they die they also grieve. Most of the time family members blame nurses, feeling that they could have done more than they did to save the patient from death.

3. Family members should be able to accept that death is a natural outcome. The coming together of patient, family and the nurse is regarded as a special moment. (Praeger, 2002).

6.5.4 Significance of providing psychological support to the patients and family members.

1. Patients and family members experience a great deal of stress, and also need a psychologist to assist them to deal with the emotional stress that they experience on daily basis.

2. Relatives need regular counselling, at least twice a month, to be able to deal with the pain of losing their loved ones even while there is really nothing they can do to assist.

6.5.5 Significance of provision of support to the professional nurses providing care

1. The results of the study show that there is insufficient support from the management and colleagues for oncology nurses. Nurses need to be empowered, as knowledge is the key to success.

2. The researcher recommends that the hospital management create a platform were all health care professionals are able to communicate their problems, or where health care workers can hold monthly meetings with the managers to help address their problems.

3. On the other hand, some of the nurses reported that they need training or to be offered short courses to help them care for their patients. Nurses who are oncology trained reported less anxiety, than those who are not trained.

4. Therefore, the quality of care received by a patient when nurses are trained in the field of oncology nursing is better than the care given by those nurses who are not trained in the field.

6.8 APPLICATION OF WATSON'S THEORY

The Watson's theory assisted the researcher to be able to compare the experience and practices of professional nurse at Pietersburg Provincial Hospital providing care to terminally ill cancer patients and the 10 carations of Watson’s theory. According to the researcher’s observation if professional nurses working in the oncology setting can get support from their working environment, this can improve the quality of care patients receive on daily basis. According to Watson a positive attitude is displayed when a nurse is physically, mentally and social wellbeing is attended to. The application of Watson’s theory was worthwhile because the researcher was able to identify the cap that can be cause by lack of support and corrective mental, physical, social and spiritual environment.

6.7 CONCLUSION

This chapter has assisted the researcher to see if the objectives and the purpose of the study had been achieved. The limitations of the study were outlined and recommendations were made which may assist in describing the experiences and practices of professional nurses who care for terminally ill cancer patients in The Pietersburg Provincial Hospital in order to develop strategies that might assist the management of the Pietersburg Provincial Hospital to provide appropriate skills and emotional support to nurses who care for dying cancer patients in oncology wards.

It is clear that nurse managers avoiding the odd behaviour displayed by the nurse it is the same as avoiding the person and may result in nurses developing a negative attitude. This negative attitude may have a negative impact on the patients. The adaptation of the Watson’s theory may have a broader implication for the tertiary hospital and beyond.

Finally, in the caring of terminally ill cancer patient it is very important to identify the daily stressors that may bring about bad attitude, bad behaviour and this may compromise the quality of care that patients receive in different hospital campuses, as was found in this study.

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8. APPENDIXES

8.1 APPENDIX: 1 INTERVIEW GUIDE

Part 1

Demographic information

Age	21- 30 years	
	31- 40 years	
	41-50 years	
	51-60 year	
	61 years and above	

Gender	Male	
	Female	

Highest Educational Qualification	Certificate	
	Degree/Diploma	
	Post basic/Honours	
	Masters/doctoral	
	B Tech in oncology	

Nursing qualifications	Bridging	
	Midwifery	
	Community health nursing	
	Training in oncology	
	Other oncology related courses	

Period of employment	3-10 years	
	11-20 year	
	21-30 years	
	31-40 years	
	41-50 year	
	60 years and above	

Part 2

INTERVIEW QUESTIONS

Central question

Please tell me about your experiences of caring for terminally ill cancer patients?

Probing questions

What are the professional services that you provide daily to these patients who are terminally ill with cancer?

Can you tell me about the relationship that you have with these patients?

Involving the family, is there a way that you involve the family in taking care of these patients?

What are the challenges that you encounter in involving the family?

Can you describe the support provided by the hospital management to make you cope with your challenges?

Is there any training offered to you by the management to do?

Does management offer you any debriefing session to ensure that you are coping well based on the challenges you have?

How would you evaluate your ability to care for the dying cancer patients?

Based on the challenges that you have would you still love to continue working in the oncology ward?

8.2 APPENDIX 2: WORK PLAN

DATE	ITEM	ACTIVITY	RESPONSIBILITY
January-March 2014	Research proposal	Submission of final research proposal to supervisor	Student
		Questionnaire and interview guide design	
		Editing of the research proposal	
		Presentation of research proposal in the nursing department	
April-July 2014		Submission of final research proposal to University of Limpopo Higher Degrees Committee	Supervisor
		Submission research proposal to Medunsa Research Ethics Committee	
August-October 2014	Data collection	Pilot study	**Student**
		Refinement of the data collection tool	
		Field data collection	
	Data analysis	Data coding and entry	
November-January 2015	Final copy of the research	Submission of the first draft	Student
		Submission of the second draft	

		Proof reading	
February-April 2015		Submission to external moderator	Supervisor
		Binding	Student
		Final submission of the dissertation	

8.3 APPENDIX 3: BUDGET

ACTIVITIES	DETAILS	MOTIVATION	TOTAL
Administration	Printing paper @ R40/rim (10) rims. Pens @R5.00 each (3) Files @ R18.00 each(4) Staples @ R40 each(1)	Preparation for data collection tools and data collection	R527
	Photocopying @ R.50 (200) Pages Binding @ 200 (10) books	Data collection tools, photocopying and binding of dissertation	R3000
	Printer @ R1500 Cartridges @ R800 (2)	To print project documents	3100
Airtime	R300 per month (2)	For communication with supervisors and participants	R600

Material for collecting data	Note book @ R10.00(1) Voice recorder @ R1100 (1) Memory stick 8GB @ R120.00(1)	For field notes For data collection For storage of data	R240
Transport	1. Seshego to Polokwane hospital 25km @ R3.50 for 4 trips	For contact, to conduct the interviews and for giving feed back	R350
	2. Seshego to Turfloop 60km @ R3.50 (3)	For consultation and presentation to Higher degree committee	R630
Editing	1. For editing of the proposal 28 pages @ R35.00 per page. 2. for editing of the final report 200 pages @ R35.00 per page.	To edit the language of the proposal	R960 R7000
Coding	Independent coder 28 pages at R100.00 Statistical analysis 200 pages at R35.00	Data analysis	R2800 R7000
Research assistant	Salary R250.00 per day for 1 person (4) days	For data collection	R1000
Total			R27207.00

8.4 APPENDIX 4 Consent form

UNIVERSITY OF LIMPOPO (Turf loop campus) ENGLISH CONSENT FORM

Statement concerning participation in a Research Project

Name of study: the experiences and practices of nurses caring for terminally ill cancer patients at Pietersburg hospital.

I have heard the aim and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I know that sound recordings, scientific publications which will be electronically available throughout the world. I consent to this provided that my name is not revealed. I understand that participation in this study is completely voluntary and that I may withdraw from it any time and without supplying reasons. This will have no influence on my work.

I know that this study has been approved by the Medunsa Research and Ethics Committee (MREC), University of Limpopo and Pietersburg Hospital. I am fully aware that the results of this study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this study.

………………………………………..

Name of the volunteer signature of the volunteer

……………………………. ………………………… …………………

Witness place date

Statement by the Researcher

I provided verbal and/or written information regarding this study.

I agree to answer any future questions concerning the study as best as I am able.

I will adhere to the approved proposal.

KGOSANA ANDROULLA ISABELLA……………………….. ………………………….

NAME OF THE RESEARCHER SIGNATURE DATE PLACE

APPENDIX 5 Letter requesting permission to conduct research

P.O. BOX 4053

POLOKWANE

0700
10.04.2014

Pietersburg hospital
Private bag x 9316
Polokwane
0700

Dear sir/madam

RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I Kgosana A.I, Student No: 200521243, a student in masters in Nursing Sciences at the University of Limpopo (Turfloop Campus) under the supervision of Ms. P.M Mamogobo, hereby request a permission to conduct a research study at Pietersburg hospital in ward S (surgical ward) and medical oncology ward.

Research topic:

The experiences and practices of nurses caring for terminally ill cancer patients in Pietersburg hospital, Capricorn district in Limpopo province.

All information received from participants will be treated confidentially and will be used solely for the purpose of the research study. For more information, contact my supervisors

KGOSANA ANDROULLA ISABELLA
Cell: 071 879 7570
Yours faithfully
………………………

Letter requesting permission to conduct research

P.O. BOX 4053

POLOKWANE

0700
10.04.2014

Department of health and social development
Private bag x9302
Polokwane
0700

Dear sir/madam

RE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I Kgosana A.I, Student No: 200521243, a student in masters in Nursing Sciences at the University of Limpopo (Turfloop Campus) under the supervision of Ms. P.M Mamogobo, hereby request a permission to conduct a research study at Pietersburg hospital in ward S (surgical ward) and medical oncology ward.

Research topic:

The experiences and practices of nurses caring for terminally ill cancer patients at Pietersburg hospital, Capricorn district in Limpopo province.

All information received from participants will be treated confidentially and will be used solely for the purpose of the research study. For more information, contact my supervisors

KGOSANA ANDROULLA ISABELLA
Cell: 071 879 7570
Yours faithfully
………………………

Participant no. 1

Participant no. 1 is a female of ages between 41 and 50 years old has done bridging course, in terms of her nursing qualifications she has midwifery and a post basic qualification of B Tech in Oncology. She has been working in the Oncology ward for a period between 3 to 10 years

Researcher: Morning

Participant: Morning

Researcher: How are you?

Participant: I am fine

Researcher: I am Isabella Kgosana; I am student in the University of Limpopo, doing masters. My study is about the experiences and practices of nurses caring for terminal ill cancer patients. I have a consent form that I will ask you to sign for me to show that participation is voluntary and any question you don't feel comfortable answering just tell me I will go to the next question. So this is the consent form (giving the participant) can you sign it for me.

Participant: yes

Researcher: I have few questions to ask you starting from demographic information, can i start?

Participant: yes

Researcher: and then ok, can you tell me about your experiences when carrying for terminal ill cancer patients, how is it? Mmh, in my aah in my study, I'm not going to use your name, then i will call you participant no 1

Participant: ok

Researcher: and then ok, can you tell me about your experiences when carrying for terminal ill cancer patients?

Participant: initially ok, when they came here, they come walking, able to do things themselves, some of them they come talking, some of them who don't know that they condition is terminal have hope that they will go home, so one gets to know a person while still functioning quite well. We get to know them because most of them we turn to know them because we spent most of the time with them, because most of them turn to tell you about their kids, their families, what they are dreaming about. Then when they get to know that their condition is terminal then they start to be difficult, but not that difficult psychologically, they start to withdraw, they start losing hope and become a total different person from what you saw in the ward. Some of them they will complain a lot, they will find a little mistake. Some of them they will become suspicious with everything e le (not being) well. You find some of them keep quiet, they withdraw. They don't say much, they keep quiet, that the same person you so in the ward initially, they withdraw and for me personally is very touching and that made me question many things, especially if the patient is a young person. And that make one to question why is such happening and you can see you are losing a person completely, and it end to the point ya gore (that) it is sad, it depresses one and then to you come to the point seeing this person disappearing in your eyes and you just wonder and there is nothing I can do for this person, is just the medication and you know it won't do any change except to relieve pain and then you come to a situation where someone doesn't want to drink medication. They don't want to drink because they don't want medication until you ask them they not going to take it. They is nothing positive except that they will be relieved from pain so ...... it kind of like drain someone spiritually, it kind of like drain emotional being, you cannot leave this pain because most of the patient I have nursed in an oncology, most of the patient even if I don't remember their names I will never forget their faces, i will never forget their faces. You go home and you wonder you think gore (that), we are really powerless, we are quite powerless, only God can intervene and then you come here then you work hard and you know patient want make it, it made me realised that am just a human being nje (just). Am just a person nje (just), the is no much I can do, not to say what I do don't add value like especially in this ward we had one patient in room 9, then I remember that lady to the point that we use to talk a lot, she used to tell me about her husband, the kids, how she used to live and everything and what she is hoping for when she gets out of here, thought she did go home after a long struggle, but seeing the patient going through that struggle, it is so painful. I went for offs but when I came back I was so relieved that they didn't but me on her side, because I didn't want to see that part where she struggle a lot because i was even avoiding to go to the cubicle not because I don't want to help or to run away from that pain of seeing her going down like that. Though she went home i didn't see the patient, not that I want to see the patient, but it helped me to ease the pain, it helped me to deal with the pain ya (yes) fortunately i was never allocated on that side. So in short i will say it drains you the every being that you are inside and then you find that, I have realise some of my colleques they don't prefer going to the patient, we only go when she needs up, but some they are fine. You find that you interact with them, we talk and talk, but that chance you come to the patient you don't know even know you want to cry. You can see this patient is not doing well, you the patient i understand your situation, she looks at you and say what the hell are you talking about? What do you understand about my situation? And most of them they don't say it, you can fill it. The facial expression, they look at you like what are you talking about so i have realised that i don't really understand what they are really going through, i wish i understand because i believe one can never understand something she has never gone through. The only thing that you can understand is what you have experienced. I can only tell them i can relate to what you are going through, I have never lived in that situation, that's when you will see some they come back a little for that moment they go back again. I feel like ending this hospital policy for patients like those nee we were suppose to nurse them with family if a person can just choice the person they wanna spend most of the time with, if they can let that person to be there and support the patient to feel supported and everything though that's me with oncology patients

Researcher: so you think maybe they need support?

Participant: ya ya (yes yes)i think since the is nothing that we can do physically that more that psychologically because we failed more in the physical part of it. Cant the patient be...... nursed more emotionally the psychological part of it maybe. We can nurse them more psychologically to relieve psychological pain. Yes we give them medication, it helps them with pain. You can see patient can live but that doesn't mean the person is ok in terms of psychological and then i think the psychological pain is way painful than the physical pain, i don't know i don't no

Researcher: ok, what are the professional services that you provide to this patients on a daily bases?

Participant: on daily basis, people from night staff they continue with giving of medication, they make sure that the basic needs like bed bathing, they bath those patients who need to be baths, they feed those who need to be feed, then we end giving medication according to what the doctor has prescript and they are those general small things that we help.

Researcher: ok, so you basically do that to those who are really sick, but those who can walk?

Participant: those ones who can walk, who can walk we basically give them medication.

Researcher: ...because they can help them self

Participant: we only assist only where they can feel like they need assistance

Researcher: ok, can you tell me about the relationship that you have with the patient?

Participant: i remember two of them, but this one, i remember number three of them, the one was a white lady but isn't it when they are coming the way you respond to the patient that maybe the patient will start to to be open depending on the personality of the patient. This once like when i came in for the registration of the patient like they started verbal conversation, then they started verbal or something that will make laugh, then we start the conversation, and then, know then you start to know the patient behold the disease because they came and tell you sister am here, am missing my baby and they will tell me about their son and daughter and what is it that they like and if she was home what is it that she could be doing, how she relate to her kids, what happened when they party and everything about that, and then she specifically told me that she had one daughter and two boys, the other one is 14 years of age and she, when she sow she was not making it, she said sister i don't worry that am dying, am worried about my kids, my baby, they are the once that make me worry, they don't even now know that i have cancer, they don't even know that i have this condition because am thinking that my husband should bring them they must see me for the last time because i can see that am not making it. So we turn to have this attachment because you get to know the reflection of who the person is, when she is at home so that kind of build this bond, this connection and though one tense to remain as professional as possible so example, for me am quite an emotional somebody, so for me as much as i try not to think about it, it pops up even a home i mean if am thinking of sometime their faces just come then i start remembering it. The pain and everything and is so painful infect is discouraging actually. It is so so discouraging plus in our ward ne when the patient is very ill if we see this patient might go anytime we have two side wards and put them in meaning we isolate them there patient can see that she is not doing well and here we come conforming the fact that you are not going to make it by putting the patient aside and our cubicles, the side ward cubicles i don't like them, i don't like them in such a way that the kid of cloud the live, the patient, they are quite small dark and no fresh, the fresh air comes through the window, but imagine staying in the dark room night and day, what does that do to a person? I don't want to be in such situation even if am sick or you can just imagine, i have never ask them but is just something am wondering that is somehow adding to the pain that patient is feeling already. If they are here they are getting attention, they get medical attention as soon as possible because we understand their illnesses, the only thing i was even asking my colleques is that whoever was designing this two rooms has he or she cared in the mind, the is gonna be a person staying in here because is isolate the patient because they are already isolated to their families and put them there and instead they are even isolated from the natural things like light, isn't it that one you going to see light and at least in the other cubicles if you open the curtain you can see that the weather is hot

Researcher: or it's raining today

Participant: but in there the is nothing thing, is kind of like you but them in the dark and this is the way you gonna end, i don't think they wanna die in such kind of situation, so what can you do

Researcher: involving the family is the any involvement like mmh, do you involve the family in the process of dying of this patient?

Participant: Involving the family in the process of this patient dying they come during visiting hours that is why earlier i said they can allow them to see them any time as much as possible. In fact they try their best on this one, but i feel that is not enough for the patient, we try as much as possible because most the family members they are different they are those who appreciate, they are those who will come complain about little things and i think that is a way of dealing with aggression

Researcher: aggression? They have, as am lessoning to you i can hear you are facing challenges when involving the family specially to care for this patients, the type of challenges that you normally experience is that family is normally aggressive is that what you said?

Participant: ya(yes) let me not say aggressive, some of them they turn to complain, you find that initially they will come and say think you, but when the patient start to deteriorate they start complaining about this and that. So since know that they are dealing g with pain process so we know

Researcher: so you know how to handle them?

Participant: yes

Researcher: ok, is any support that you get from management to cope with the challenges

Participant: they try their best especially with the fact that we have the operational manager and area manager they try but i don't know with other colloquies of mine, but for me am sometimes feel that am comfortable. They was this patient infect she was 35 or 36 terminally ill and then though they were going trough divorce so she was so suspicious of everything and i remember i was on night duty she didn't want to be given something she didn’t see. She wanted me to come with the needle and show it to her, is a needle then open it or i must give it to her, she open it, give it to me because she was saying you people are the once who cause my disease and just like are of the same age with this lady what if it was me in that situation, could i have handled it, how could i have handled it, how was I’m going to cope. I could just imagine that she has kids every mother want to see her kids grow up and go on with live, but with her she is trying to come up with, like she want to see her kids grow up and that pain, and that is when......2013 i still remember her face and she was, the physical expression that was on her face so far for me is kind of like, it disappoints actually

Researcher: but the support that they give you, what kind of support do they give you?

Participant: the kind of support?

Researcher: do they provide as you said you need?

Participant: i thing there must be a psychologists to come

Researcher: ooh, come and counsel you?

Participant: to council, but has never been arrange maybe because we not go back to them and say this is what is happening. But i think they try day by day. There are support the, our psychologists must start to see the staff for support.

Researcher: so sometimes you can forget some of the things that are so touching?

Participant: yes

Researcher: ok, it there any training offered to you by management in terms of oncology is consent?

Participant: no, not that i know of

Researcher: no? Ok

Participant: let me not say no, i don’t know maybe about the area were the is only oncology nurses

Researcher: am taking about this specifically this ward?

Participant: none

Researcher: ok, how would you evaluate your ability to care for dying oncology patient, is it stressful or what?

Participant: shoo, for me is quite stressful

Researcher: stressful? , ok

Participant: very stressful

Researcher: ok, based on the challenges that you mmh have experienced would you still love to work in oncology ward or would you love to be relocate?

Participant: ooh no, i really want to relocate, i really want to get out of bed side nursing because of the emotional pain that i experienced and then, for the fact that am quite and emotional somebody. I used to work from other wars but i have never used to feel this pain because i have noticed that its affect me not that in the work place even out, so that is why am saying its affect me emotionally

Researcher: so you trying to say sometimes you take the emotional state that you will be in home?

Participant: yes

Researcher: ok, alright, we have reached the end of our interview, thank you very much. It was good talking to you

Participant: thank you